Maternal and Child Health Consortium

Organizational Narrative
September 19, 2023

Organization History: MCHC was founded in 1991 in response to a community health needs assessment that identified gaps in prenatal care access in Chester County and disparities in maternal and infant health among low-income families. Since 1991, MCHC has ensured that families in Chester County have access to quality, culturally competent health care and resources to maintain their health. In 1995, with initial funding from the Robert Wood Johnson Foundation and multiple private foundations, MCHC began providing prenatal case management for pregnant and parenting women and their babies. In 1997, with funding from the federal Healthy Start program, MCHC became one of 106 Healthy Start programs throughout the country. MCHC's Family Benefits Program provides uninsured families with bilingual, bicultural assistance with accessing state subsidized health insurance programs and in 2010 was augmented to include food benefits enrollment. To address a gap in kindergarten readiness among low-income families with children in southern Chester County, MCHC launched the Family Center Program in 2006 to build school readiness and parents' ability to support their child's early learning.

Goals: Reduce health disparities and increase access to health care among families with young children. This includes providing more at-risk pregnant and parenting women with a continuum of care outside of the doctor's office, ensuring uninsured and food insecure families do not experience gaps in health insurance or food benefits coverage, and providing low-income families with pre-school aged children with kindergarten readiness support.

Key Achievements: MCHC's most significant achievement continues to be that 85%-95% of high-risk pregnant women receiving Healthy Start home-visiting services have a baby born at a healthy birth weight. Since the coronavirus pandemic, the MCHC team has stepped up to meet the increasing demand for food access, nearly doubling projected SNAP enrollments every year since, resulting in 1,500+ children every year who have access to healthy, regular meals. MCHC's Family Center Program hit a milestone in the last year, serving 150 low-income student families through kindergarten readiness programs, three-times the program capacity when it started. MCHC is an accredited organization by PANO Standards for Excellence, a long-time United Way partner, and has received numerous special recognitions from agencies such as the American Academy of Pediatrics, the American Psychiatric Association, and other multilateral organizations.

Distinctiveness: MCHC has cultivated a trustful relationship with local nonprofit partners and community members alike over the last several decades. The staff team brings passion and a wealth of experience working with individuals and families in education, public health, and social work, and have specialty training in medical interpretation, trauma-informed care, and evidence-based home-visiting teaching models. The staff is also multicultural, bilingual in English and Spanish, and has roots in the communities that they serve, making them uniquely positioned to meet the needs of our most underserved community members.

Key Initiatives: The **Healthy Start** Program reduces the prevalence of low-birth-weight births and improves birth and maternal health outcomes through home-visiting perinatal services for pregnant and parenting people with children ages 0-18 months. MCHC's Community Health Workers (CHW) provide socio-emotional strengthening and support, provide health and early childhood developmental education, and hands-on parental involvement and learning using the evidence-based Parents as Teachers (PAT) model. Home visits are for 1-2 hours weekly or monthly depending on the level of need, up until the target child is 18 months old. Comprehensive health risk assessments evaluate participants' needs and Adverse Childhood Experiences screenings (ACEs) ensure participants scoring 4+ receive chronic disease management and resiliency education; those scoring 9+ receive increased contact and 14+ scores are referred to behavioral health counseling. Edinburgh Perinatal Depression Scale (EPDS) screenings administered prenatally and at one and six months postpartum, assess maternal depression and ensure women at highest risk are being served. As a result, rape and domestic violence survivors, women seeking

medical and mental health diagnosis and premature babies with developmental delays are receiving care. MCHC's Diabetes and Heart Disease Prevention education modules are provided during home visits to ensure participants better understand their healthcare risks and how to improve their long-term health. The curriculum was adapted from the CDC's Diabetes Prevention Program.

MCHC's **Family Benefits** Program increases access to care and reduces health disparities through health insurance and food benefits enrollment assistance. Family Benefits serves families with children ages 0-19 years-old by enrolling eligible families into state-subsidized health insurance (MA/CHIP) and food stability programs (SNAP, WIC) so that families may access medical care and keep food on the table. Family Benefits Specialists wrap services around all children by assisting families in enrollment navigation to obtain or renew coverage. During 1-hour annual appointments, staff confirm applicant eligibility including household income verification, citizenship, and employment for benefits applications and provide healthcare and nutrition education and awareness. Staff maintain communication with the County Assistance Office on behalf of applicants to ensure applications do not "fall through the cracks," especially in cases where applicants are in serious poverty and food insecure. Staff not only assist uninsured individuals with completing applications, but also track each application approvals. This enables our staff to record approval of each application and to accurately track deadlines for income verification and reapplication procedures, ensuring that families meet these deadlines and that there are no gaps in coverage. Staff also conduct community outreach to local schools, health fairs, clinics, social service and health care agencies, networking events to enroll eligible community members and inform the community of our services and the importance of coverage.

MCHC's **Family Center** Program provides home-visiting services for low-income families with children ages 0-5 years-old in southern Chester County to help families prepare the target child for kindergarten. The program provides school readiness preparation during bi-weekly home visits by MCHC's bilingual, bicultural Parent Educators, in addition to health insurance enrollment, group connections including Parent's Cafe, and parent-children educational activities. Parent Educators provide early childhood developmental education, hands-on parental involvement and learning using the PAT model. They work closely with families to address the barriers that prevent each child from being optimally prepared to succeed in school such as self-care skills and age-appropriate academic skills. Kindergarten preparedness culminates with a summer Kindergarten Transition Program (KTP) for the Family Center's five-year-old children. The two-week program simulates aspects of a school environment to ensure the best possible transition into their kindergarten year and is complemented by parenting classes for parents to learn how to support their child's learning. The KTP includes an assessment of each child's mastery of important preschool skills to ensure that all skills are acquired by the end of the program.

Community Needs: In the wealthiest county in Pennsylvania, 1 in 4 Chester County residents cannot make ends meet, the hardest hit being families with children (ALICE Threshold, 2010–21; ACS 2010–21). Hispanic and Black individuals are likelier to be uninsured or under-insured and for women, perinatal health status shows significant ethnic and racial disparities. In Pennsylvania, 5% of white women have late/no prenatal care compared to 10% of Hispanic women and 11% of Black women. Similarly, the preterm birth rate for white infants is 9% compared to 10% of Hispanic infants and 14% of Black infants (March of Dimes Peristats, 2022). We see this trend locally, as preterm birth and low birth weight correspond to high-needs characteristics like lack of prenatal care access or insurance, chronic health conditions. Currently, 6% of Chester County residents under 65 years old do not have health insurance and 9% of households receive SNAP benefits (24,000 households), 53.8% of which have children under 18 years old (USDA SNAP Households, 2018). On average, food insecure families in the U.S. spend 45% more on health care than food secure families, with strong correlations between food insecurity and poor health outcomes (Center on Budget and Policy Priorities, 2021). In southern Chester County, children in low-income families are entering kindergarten without age-appropriate skills. In Kennett Square Consolidated School

District, 44% of residents speak primarily Spanish compared to 5% countywide, and 44% of families in KCSD are considered low income (PA DOE Public School Enrollment Report, 2021-22).

Why it's important to fund now: Maternal and child health disparities are some of the most significant and challenging issues of the day. In the United States, giving birth has more risk than in any other high-income country and women are experiencing severe maternal morbidity events and even dying from pregnancy-related issues – most of which are preventable. Low-income families with children are struggling to keep food on the table and afford other basic living expenses. Young children are not reaching age-appropriate developmental milestones before entering kindergarten and are at risk of falling behind. This is where the role of community-based programs have a tremendous impact.

How the impact and results will be demonstrated: Success is determined by the number of individuals served by a program and the outcomes of the support provided. Goals are set every year based on PAT case management recommendations for home visitors, staffing and resource capacity, and previous outcomes. All staff have access to laptops and mobile Wi-Fi for program and benefits enrollment efficiency and to capture participant information. This information is entered into MCHC's cloud-based case management database system, Apricot, and reviewed by program managers on a weekly and monthly basis. Pre- and post-tests and surveys are administered to measure change, gather feedback, and overall satisfaction. Updates on MCHC's impact by the numbers and success stories are on social media, in monthly newsletters, and in annual reports.

Program goals for 2023-24:

Healthy Start: 300 pregnant and parenting women and their babies will receive Healthy Start services; 95% of infants will be born at a healthy birth weight (typically > 5.8 lbs.); 95% of pregnant women will receive health coverage for prenatal care and/or delivery; 95% of infants will receive insurance within 45 days to ensure prompt entry into pediatric care; 90% of women will breastfeed for the first six months postpartum; 85% of pregnant women with an EPDS score of 14+ will demonstrate fewer symptoms of depression (decreased postpartum EPDS score); 100% of women with a 4+ ACEs score will receive increased support and referrals for additional mental health care resources; and 85% of parents will demonstrate an increased sense of confidence and knowledge in their parenting skills.

Family Benefits: 1,800 eligible individuals will be enrolled into health insurance (MA/CHIP) and 1,200 individuals will be enrolled into SNAP food benefits; 85% of families will be approved.

Family Center: 120 families will enroll into the Family Center Program; 95% of parents will report an increase in knowledge of their child's emerging development and improved parenting capacity. **Kindergarten Transition Program:** 85% of children participating in the Kindergarten Transition Program will achieve Kindergarten Readiness as indicated by a pre/post-test; 90% of parents will report increased confidence in navigating school systems and supporting their child's success in school.

Diabetes and Heart Disease Prevention Education: 250 individuals will participate in diabetes and heart disease prevention education activities (conducted through home-visits and small group sessions); 90% of participants will report increased knowledge of risk factors, nutrition, and exercise in preventing diabetes and heart disease.