Q1 Please provide your contact information below.

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Title and Organization	**Buffalo Prenatal Perinatal Network**
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State/Province	**NY**
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Q2 Please describe your company or organizations overall goals and mission.

The agency has an overall mission, to collaborate and coordinate with key stakeholders in Erie County to improve maternal and infant/child health outcomes for high-need women and families who reside in targeted high risk areas in Erie County.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

Our home based Community Health Worker (CHW) and Healthy Families program have been in existence for over 20 years serving the underserved populations on the East and West and South Side of Buffalo, along with Lackawanna and parts of Tonawanda and Cheektowaga. They are primarily but not limited to African-American and Hispanic women since they have the highest rates of infant mortality and low birth weight infants. We recently started a Responsible Fatherhood Initiative to support the fathers in our program. The CHW program is our “boots on the ground” staff who seeks out the disenfranchised woman who is either in a preconception, prenatal or postpartum life-course stage and provides intensive case management services to assist them. They perform street outreach in high risk neighborhoods to find clients. Upon assessment of needs, clients are linked to health insurance, health care providers and other basic needs including housing, food, clothing, etc. If a child is involved, the family is followed for 2 years. One of the reasons for the success of the program is the fact that the staff provides transportation for the clients to MD appointments which increases their compliance. This program was part of the DSRIP maternal infant community health collaborative pilot with the Millennium PPS since the project was modeled after ours. Our Healthy Families NY program is the largest in NY and provides an evidence based curriculum to pregnant and parenting women. The Healthy Families program collaborates with local clinics and birthing hospitals along with community based organizations to find families in need of services. Families are engaged in the program when they are pregnant and then are followed by our Family Support Workers until the child is 5 years old. The program focuses on four key goals : supporting positive parent-child bonding, promoting optimal child and family health, development and safety, enhancing family self-sufficiency, preventing child abuse and neglect.Due to our years of experience we have seen success with our clients including reduction in LBW infants by half (resulting in a savings of $700K due to decreased NICU stays); 96% client attendance at prenatal, postpartum and well-baby visits; accomplishment of a 77% breastfeeding rate; 97% children up to date on immunizations ; 1 of 2 mothers enter or reenter employment; 1 of 3 mothers resume school. Both of the programs reflect 86% of our staff being women of color with 30% who speak Spanish and serve our clients who are composed of 80% women of color. 10% of our employees are former clients and all our staff are culturally, ethnically, and linguistically indigenous to the targeted populations.
The program is very scalable and feasible because the need is so greatly identified in birth outcome data, and the program offers employment to community residents. The training is thorough and prepares the staff well. There are many strategies that utilize trained community health workers in different arenas, to exhibit great success with decreasing some of the social determinants that effect health poorly. The Healthy Families program is evidence based and has many years of research behind it to prove its successful outcomes. Various research studies have utilized data from our program, to illustrate success. The curriculum used is entitled “Growing Great Kids”. Both programs are ideal for the Medicaid population because it provides support and essentials to the program participants that they do not have in their lives. The unique aspect of us providing services in the clients’ home allows us to meet them where they are. We are able to determine their needs much more accurately once we evaluate them in their home setting. The fact that we help provide transportation also overcomes a huge barrier for them and ensures compliance with maintaining medical related appointments. These type of services helps us to avoid the risk factors that may befall this population and result in adverse outcomes. As mentioned the program could be initiated fairly quickly at approximately 6-9 month.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.

Yes (please specify when and the estimated number of people impacted):

1997 15,000

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)

Education,

Health and Health Care ,

Economic Stability

Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**