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Family Health Team

The Best Gift of All

Newborn Baby Program

Presented by:

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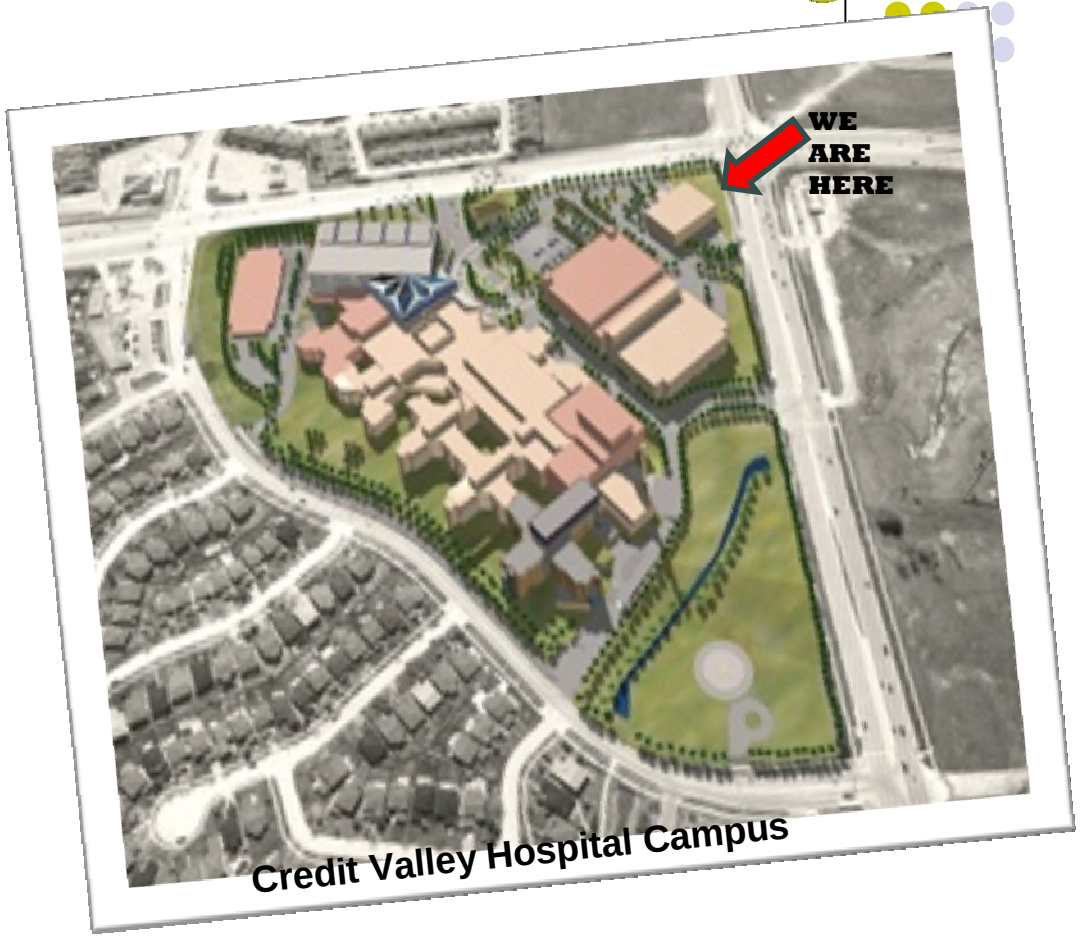
Presentation Overview

- Evolution of Post Partum Care
- Newborn Baby Program
- Film Clip
- Patient Case Examples
- Outcome Study

Organizational Profile

- Credit Valley FHT is nestled in Southwest Mississauga on the Credit Valley Hospital Campus
- Academic Family Health Team:
17Clinical Team Members, 15 Administrative Team Members and 16 Residents
- Chronic Disease Management: Diabetes Management Program, Healthy Lifestyles Program
Registered Nurse run INR Program and Postpartum Wellbaby Clinic, LMA Program
A COPD/Asthma Program, Smoking Cessation Program, Walk for Wellness Program
The Impact Project and B.E.T.T.E.R. Project
- Integrated hospital and community based diabetes education program within the Mississauga/Halton LHIN
- 8578 Rostered Patients
- 28524 Annual Visits



Credit Valley Hospital Campus

Quality Improvement & Innovation Partnership

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Identified Gaps

- Shortened length of stay for Mom and Baby to 24 hours vaginal birth and 72 hours caesarean section
- CVH Post Partum Clinic revised mandate to deal with High Risk mom and babies only
- Unaffiliated Babies

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Program Access Process

Baby Identified

- L&D/Postpartum Unit identify baby as unaffiliated
- No plan for primary care for baby and/or family members

CVFHT is Contacted

- L&D/Postpartum Unit contacts FPRN or leaves voicemail on dedicated line
- On weekends voicemail is left and business card given to mom with follow-up instructions

FPRN Visit

- FPRN visits mom/babe prior to discharge from hospital to arrange first clinic visit
- If discharged on weekend, FPRN contacts mom on Monday morning to arrange first clinic visit

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Program Elements

- Maternal Assessment
  - Postpartum Physical assessment
  - Postpartum Depression assessment
    Edinburough scale
  - Breastfeeding assessment
- Baby Assessment
  - Weight
  - Feeding Intervention
  - Jaundice Assessment
- Mother/Baby bonding
- Referral to Community Agency
  - Peel Public Health
  - PPD program

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Case Examples

- Example #1

Yellow Fellow

- Emergency visit avoided and direct admit to paediatric unit

Case Examples

- Example #2

  Dehydrated Dan

  - Dehydration dx early and optimal use of resources and handoff to providers

- Example #3

  Slow to Gain Sue

  - avoid hospitalization – engaged community resources
  - system navigation and frequent follow up

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Pilot Study Outcomes

- Sample size - 35 moms and babies
- 86% seen within 72 hours of discharge

MD/NP Consult 49%

2nd Visit Weight Check 60%

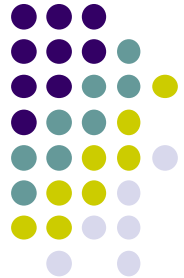
Public Health Referral 11%

Billirubin Check 23%

Billirubin Recheck 20%

ER Transfer 3%

Program Outcomes



- Avoidance of double doctoring by meeting the parent(s)/babe on the post partum unit prior to discharge

******Early assessment and early diagnosis leads to better patient outcome and use of resources******

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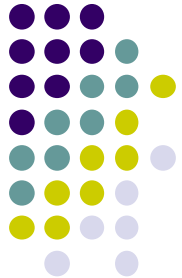

Analysis / Next Steps

- Data suggestive of increased risk for ER visits, fragmented care through walk in clinics

- Continue to collect data
- Expand program to include all babies in practice
- Continue to build relationships with community partners
- Provide Postpartum clinic teaching opportunities with residents

Questions?