BRIDGES TO MOMS PROGRAM EVALUATION 2023

January 2024

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Background

Bridges to Moms (BTM), a program of the Division of Women's Health, Department of Medicine at Brigham and Women's Hospital, began in January 2016. The program provides community-based, intensive case management, and social support for homeless and housing insecure pregnant women and new mothers. Patients of the obstetrical service at Brigham and Women's Hospital (BWH), a high-risk referral hospital in Boston, are referred to Bridges to Moms, a targeted outreach program. BTM addresses the whole health of the women, during and after the prenatal and post-partum periods, and throughout the first year of the baby's life. Its goal is to improve health care access and equity, and thereby change the health trajectory of the mothers and their children. Women who receive the personalized and focused services from Bridges to Moms are better positioned to gain greater self-sufficiency.

Bridges to Moms participants are demographically diverse, united by a common experience of homelessness or housing instability during pregnancy and the postpartum period. Bridges to Moms seeks to meet the unaddressed needs of homeless women and their families and promote improved birth outcomes, consistent access to routine medical care, and stable housing.

Dr. Roseanna Means, Attending Physician at BWH and an Associate Professor in Medicine at Harvard Medical School, is the Founder and Principal Investigator of Bridges to Moms. She oversees and assigns referrals from across the BWH to her outpatient community-based field team comprised of community health workers who provide support to women in the prenatal, perinatal, and postpartum periods. Bridges to Moms' services address complex needs related to social determinants of health: transportation assistance, food security, housing advocacy, and personal safety. Patients enrolled in Bridges to Moms are encouraged and assisted to connect to ongoing primary care for improved continuity. Community health workers communicate with enrolled women regularly by phone, text, and email, connect them to needed services and advocate on their behalf at government agencies.

Evaluation Methods

Bridges to Moms conducts an annual Program Evaluation to quantify the impact of Bridges to Moms participation on maternal and child health outcomes from the previous year. This analysis assessed outcomes for Bridges to Moms clients and a comparison group of women experiencing housing insecurity and significant social determinants of health needs who received care at BWH but were not enrolled in Bridges to Moms.

Bridges to Moms strives for continuous quality improvement. As such, the program implemented its first client satisfaction survey in the spring of 2023 to assess through a qualitative lens the impacts the program had on participants, including program strengths and opportunities for improvement. Results of the client satisfaction survey were overwhelmingly positive, with 62% of respondents reporting an improvement in housing, 88% reporting that BTM helped connect them to primary care, and 87% reporting that BTM helped provide them with mental health support.

Intervention and Comparison Group

The intervention group for this evaluation included all Bridges to Moms clients who were referred and accepted enrollment in the Bridges to Moms program in 2022 and delivered between October 1, 2022, and September 30, 2023. The intervention group included 93 women in total. For a subset of

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analyses, the intervention group was limited to women who were enrolled in Bridges to Moms in the advanced prenatal period (30 days or more before delivery, N=83).

The BWH comparison group was identified by searching the electronic medical record (EMR) at Brigham and Women's Hospital for references to homelessness. Hospital registration did not capture housing status so a word search software program, Mass General Brigham's Research Data Patient Registry (RPDR), was utilized to identify charts where relevant words were embedded in the clinical notes. Search terms utilized included "homeless", "homelessness", "inadequate housing", "housing instability", "housing insecure", and "shelter." A research assistant reviewed identified records for documentation of homelessness or housing instability and extracted data from the charts of women who met the established inclusion criteria: documented housing insecurity in the medical record, prenatal care received at either Brigham and Women's Hospital or by a community health center midwife with delivery privileges at Brigham and Women's Hospital, and a delivery occurring at Brigham and Women's Hospital prior to September 30, 2023. In total, 93 BWH comparison patients were identified.

It is possible that there are systematic differences between housing insecure women who do or do not get referred to Bridges to Moms from BWH (e.g., patients with complex medical, behavioral health, or social needs may be more likely to be referred to Bridges to Moms by BWH staff), which would limit comparability between the intervention group and the BWH comparison group.

Timeframes Analyzed

This Program Evaluation includes data on all women enrolled in Bridges to Moms who delivered between October 1, 2022, and September 30, 2023. This timeframe was chosen to include all women who were referred on a rolling basis from January 1 of the previous year who delivered by the end of September of the following year. The end of September is chosen as the endpoint to allow for the inclusion of inpatient data on any babies born in that calendar year who ended up in the NICU. In general, NICU admissions can last up to 3 months. The comparison group includes data on a matched cohort of women who received prenatal care from and delivered at Brigham and Women's Hospital between October 1, 2022, and September 30, 2023. Since Bridges to Moms participants are followed until the baby turns one year old, data on housing status at one-year post-partum will only include those moms who turned one year old during the study period. The number of women referred during a calendar year is different than the number of women included in the timeframe for the Program Evaluation.

Bridges to Moms is a steadfast program. In calendar year 2023, the program received 134 referrals, of which 116 referrals were accepted. Of the accepted referrals, 7 participants were removed from the caseload due to lack of engagement or moving out of area, and 5 individuals never enrolled, leaving 104 women as active in the program during the 2023 calendar year. Given that women from the previous year continued to be served until their babies turned one year old, at any one time, the Bridges to Moms team is caring for over 200 individuals.

Outcome Evaluation

In addition to a comprehensive assessment of participant characteristics, prenatal and postnatal outcomes were evaluated between the intervention group and the comparison group to assess the impacts of Bridges to Moms participation. In a previous evaluation, it was determined that the impact of the Bridges to Moms program on prenatal and birth outcomes varied based on when clients began receiving services, with more pronounced outcomes for clients who had been enrolled longer. Therefore, women were grouped based on their time of enrollment in Bridges to Moms into

two categories: 1) advanced prenatal (enrolled more than 30 days before delivery), and 2) prenatal (enrolled less than 30 days before delivery). There were 6 women in the BTM Intervention Group whose prenatal care was limited due to having arrived from outside the US late in pregnancy. Among those 6 women, the number of prenatal appointments kept as a percent of those that were scheduled in the last weeks of pregnancy ranged from 40% to 100%. During those last weeks of pregnancy, BTM provided crucial transportation. For prenatal and birth outcomes, the analysis was restricted to the subset of the intervention group that enrolled in Bridges to Moms in the advanced prenatal period (N=83). An in-depth overview of the outcomes assessed in this program evaluation are summarized below in Table 1.

Table 1. Summary of outcome evaluation analyses		
Category	**Outcomes**	**Groups analyzed**
Access to care	Number and percentage of prenatal appointments attended	Advanced prenatal intervention group vs. comparison group
	Percent of prenatal visits completed against standard of care (15 visits)	Advanced prenatal intervention group vs. comparison group
	Number and percentage of postpartum appointments attended	Full intervention group vs. comparison group
	Pediatrician identified, primary care doctor for mother identified	Full intervention group vs. Comparison group
Newborn health	▪ Gestational age ▪ Birth weight ▪ APGAR score at 1 minute ▪ APGAR score at 5 minutes ▪ If neonatal intensive care unit (NICU) attention was required, number of days in the NICU	Advanced prenatal intervention group vs. comparison group
*Maternal engagement in the NICU	*Percentage of days with a maternal visit or call to NICU	*Advanced prenatal intervention group vs. Comparison group
Housing status	Percentage of participants who improved the stability or quality of their housing	BTM participants only

*Only for mothers with newborns that required a NICU stay

Statistical Methods

Independent t-tests were used for continuous variables and chi-squared tests of association were used for categorical variables (or Fisher's exact test in cases with small cell counts) to determine if outcomes were significantly different for Bridges to Moms participants vs. comparison women or infants. Additionally, simple and multiple linear regression models were used to assess the impact of Bridges to Moms participation on gestational age and birthweight. Participants with missing data were not included in analyses (therefore, the total sample size varies across different analyses). A

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threshold of p<0.05 was used to determine statistical significance. All statistical analyses were performed using SAS version 9.4, © SAS Institute Inc., Cary, NC, USA.

Results

Participant Characteristics

Bridges to Moms supported 93 women who met the criteria for the intervention group, of which 74 (79.6%) were homeless or housing insecure at the time of program referral and 19 (20.4%) had stable housing. Of the 93 women in the intervention group, 10 were enrolled in Bridges to Moms for less than 30 days before delivery (prenatal), and 83 were enrolled for 30 or more days before delivery (advanced prenatal).

Bridges to Moms participants were on average 29 years old. The majority of participants were Hispanic (66.3%) and an additional 30.1% were Black, non-Hispanic. Over one-third (36.6%) of participants spoke English as their primary language, while 55.9% spoke Spanish as their primary language. The women enrolled in Bridges to Moms have a complex medical history, many with trauma and/or mental illness. Of participants enrolled, 32% have been diagnosed with anxiety, 30% with depression, and 42% with a history of trauma. See Table 2 for a comprehensive summary of participant demographics and comorbidities for intervention and comparison groups.

Table 2. Demographic and clinical characteristics for Bridges to Moms participants and BWH comparison group					
	Bridges to Moms N=93		**BWH Comparison N=93**		
	N	%	N	%	p-value
Race/Ethnicity					0.3388
Black, non-Hispanic	28	30.11	26	27.96	
Hispanic	61	66.30	54	58.06	
Other, non-Hispanic	4	4.30	13	13.98	
Primary Language					<.0001
English	34	36.56	65	69.89	
Spanish	52	55.91	26	27.96	
Other	7	7.53	2	2.15	
Housing status during pregnancy					0.0009
Unstable	74	79.57	53	56.99	
Stable	19	20.43	40	43.01	
Age					
Age (mean, std. dev.)	28.90	(5.97)	28.49	(5.02)	0.6088
Parity and gravidity (Mean, std. dev.)					
Previous Pregnancies (gravida)	2.74	(2.40)	3.01	(1.77)	0.2872
Term pregnancies (para)	1.14	(1.22)	1.17	(1.10)	0.8501
Abortions or miscarriages	0.60	(0.82)	0.84	(1.10)	0.0064
Substance Use					
Alcohol use during current pregnancy	2	2.15	3	3.23	0.3246
Substance use during current pregnancy	4	4.30	10	10.75	0.1987
Smoking during current pregnancy	0	0.00	5	5.38	0.0722
Mental health conditions					
Anxiety	30	32.26	49	52.69	0.0048

Depression	28	30.11	65	69.89	<.0001
PTSD	2	2.15	11	11.83	0.0096
Trauma	39	41.94	47	50.54	0.2394

* Many Bridges to Moms patients are not asked about trauma during outpatient visits for a variety of reasons: the acuity of social complexities they face, the greater number of participants requiring translators compared to the Comparison Group, and sensitivity toward cultural differences in non-English speaking patients. Unless self-reported, the totals for trauma and other mental health conditions may be underrepresented in the data.

Resources Provided to Participants

As part of their services, the Bridges to Moms program provides resources to participants including meal vouchers for use at the cafeteria at Brigham and Women's Hospital, transportation to medical appointments for prenatal, postpartum, and primary care, and gift cards and tangibles to subsidize groceries and baby expenses. Bridges to Moms tracks the distribution and usage of transportation services, and the distribution of meal vouchers, gift cards, and tangibles for participants.

During calendar year 2023, across all BTM participants, 2118 taxi vouchers and Lyft rides were given to 146 participants. On average, participants used 81% of the vouchers that they received. The 17 BTM participants with infants in the NICU received on average 5 taxi vouchers or Lyft rides (range 0 to 22).

Additionally, 2605 meal vouchers were provided to 84 BTM participants during calendar year 2023. The average number of meal vouchers given per participant was 27 (range 0 to 80). Moreover, 104 BTM participants received 253 gift cards or tangibles, with an average of two gift cards and tangibles given per participant (range of 0 to 8).

Outcomes

This analysis explored the impact of the Bridges to Moms program on access to care, child health, and maternal engagement in the NICU by examining data for the Bridges to Moms intervention group compared to the BWH comparison group.

There were some interesting differences in the demographic and clinical characteristics of Bridges to Moms participants vs. the comparison group. Compared to the BWH comparison group, Bridges to Moms participants were more likely to identify as Hispanic and were more likely to speak a language other than English as their primary language (p<.0001). Bridges to Moms participants had lower reported rates of all mental health conditions and lower rates of substance use during pregnancy than mothers in the comparison group. The differences in mental health and substance use rates among BTM mothers compared to the control group is multi-factorial; many BTM patients are from outside the US, do not speak English as their primary language, and may have a fear of disclosing this information to strangers. BTM participants were, on average, slightly older than the BWH comparison group, and had slightly lower rates of previous pregnancy than their BWH counterparts, although these were not statistically significant. Finally, although both Intervention Group and Comparison Group participants experienced housing insecurity, BTM participants were more likely to have unstable housing (i.e., fewer housing options) than the BWH comparison mothers, with 80% of BTM mothers experiencing unstable housing during pregnancy (p=0.0009).

It is important to note that variables such as trauma, mental health disorders, and substance use during current pregnancy are self-reported by participants and as such may be under-reported. It is also possible that some demographic and clinical characteristic variables could be impacted by differences in data collection and documentation protocols between different BWH clinics, or across different providers.

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Access to Care

Table 3. Access to care outcomes					
	Bridges to Moms		**BWH Comparison**		
Advanced prenatal intervention group	**N=83**		**N=93**		
	N	**%**	**N**	**%**	**p-value**
Prenatal visits (Mean, std. dev.)	10.19	(2.57)	10.33	(3.19)	0.0479
Percent of standard of prenatal care (15 out of 15 prenatal visits)	3	3.13	6	6.32	0.2981
Prenatal visits at BWH (Mean, std. dev.)	9.89	(2.68)	10.62	(3.03)	0.3296
Percent of prenatal visits attended at BWH (out of scheduled visits) [%, range]	80.06 N=61	(40-100)	77.63 N=81	(27-100)	0.6188
Full intervention group	**N=93**		**N=93**		
	N	**%**	**N**	**%**	**p-value**
Postpartum visits (Mean, std. dev.)	1.31	(0.75)	1.45	(0.73)	0.1998
Percent of standard of postpartum care (at least one postpartum visit)	77	82.80	83	89.25	0.2162
Safe birth control method utilized postpartum	63	67.74	66	70.97	0.6333
Pediatrician identified	84	90.32	45	47.37	<.0001
PCP identified	82	88.17	72	77.42	0.0520

Results of the analysis of prenatal and postpartum visit attendance suggest that participants enrolled in Bridges to Moms may have improved access to maternal care (Table 3). Bridges to Moms participants in the advanced prenatal group had a similar number of prenatal visits attended (mean=10.19) as those in the control group (mean=10.33), despite having a smaller number of women who began receiving prenatal care early in their pregnancies (p=0.0479). Unlike the Comparison Group, the BTM Intervention Group included patients who received their prenatal care from a midwife at a Community Health Center who has delivery privileges at the BWH. Although fewer BTM participants received prenatal care at Brigham and Women's Hospital than those in the control group, BTM participants had a higher percent of appointments attended out of those scheduled than those in the control group, although this difference was not statistically significant. In terms of postpartum visits, Bridges to Moms participants had similar postpartum visit attendance as those in the BWH comparison group.

Bridges to Moms offers transportation for the women to access their appointments, and for those BTM mothers with infants in the NICU. This service may be a crucial factor contributing to the higher rates of attendance at prenatal appointments among BTM participants compared to the BWH comparison group.

For the purposes of this Evaluation, the Bridges to Moms team checked every participant's chart for a PCP listing. To improve accuracy, knowing that electronic charts may not have the most recent provider listings, all of the PCPs for Bridges to Moms patients were confirmed either by the patient or the provider. Of the women in the full Bridges to Moms intervention group, 82 (88%) had a PCP identified and confirmed. This was a significantly higher percentage connected to primary care (p=0.052) than in the BWH comparison group, which had 72 (77%) with a PCP identified, using only chart data. Additionally, 84 (90%) of the BTM participants had a pediatrician identified for their newborn compared with 45 (47%) of mothers in the BWH comparison group (p<.0001).

The differences in pediatrician and PCP status for the Bridges to Moms group vs. the BWH comparison group were statistically significant; however, these results should be interpreted with caution. Many comparison group women are not followed in the postpartum period as closely as Bridges to Moms participants, and when conducting EMR chart review it can be difficult to determine the difference between missing data (which is excluded from analysis) and a known lack of PCP or pediatrician (which is counted as "No" in the analysis). As a result, in some cases missing data may have incorrectly been entered as a "No" in the data set rather than being entered as missing, and the comparison data summarized in the tables may not accurately represent the true outcomes.

Newborn Health

Compared to the BWH comparison group, the mean gestational age among infants in the advanced prenatal intervention group was approximately 3 days longer among Bridges to Moms babies ($p<.0001$). Despite the complexities of mothers and infants in the Bridges to Moms group, infants of mothers in BTM had similar birthweights as their counterparts in the BWH comparison group. There were no statistically significant differences in premature birth (defined as infants born at less than 37 weeks gestational age) between BTM participants and the BWH comparison group. BTM babies had slightly lower APGAR scores at one-minute of birth than BWH babies ($p=0.0184$), although at five minutes APGAR scores were similar between the two groups.

Table 4. Newborn health outcomes (advanced prenatal intervention group)					
	Bridges to Moms N=83		BWH Comparison N=93		
	Mean	Std. Dev.	Mean	Std. Dev.	p-value
Gestational age (days)	270.74	14.02	267.89	20.21	<.0001
Gestational age (weeks)	38.68	2.00	38.27	2.89	<.0001
Gestational age less than 37 weeks (n, %)	13	13.54%	14	14.74%	0.9657
Birthweight (grams)	3213.50	649.40	3151.60	633.40	0.8140
Low birthweight (less than 2500 grams) (n, %)	10	12.20%	9	9.7%	0.1041
Apgar Score 1 minute	7.49	1.47	7.86	1.14	0.0184
Apgar Score 5 minutes	8.70	0.84	8.71	0.96	0.2194

*Unadjusted model

To account for demographic and clinical differences between groups that could impact outcomes, this analysis also modeled the relationship between birthweight and enrollment in Bridges to Moms as well as the relationship between gestational age and enrollment in Bridges to Moms, adjusting for trauma, primary language, and stable housing.

In the adjusted model with the BWH comparison group, the mean gestational age of infants was two days longer among mothers enrolled in the Bridges to Moms program, compared to the BWH comparison group, although this was not statistically significant. Additionally, the mean birthweight was extremely similar between babies born to mothers enrolled in Bridges to Moms program and babies with mothers in the BWH control group in the adjusted model. There were no statistically significant differences in mean APGAR scores between BTM babies vs. babies in the BWH comparison group.

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Table 5. Multiple linear regression model* for newborn health outcomes (advanced prenatal intervention group)					
	Bridges to Moms N=83		BWH Comparison N=93		
	Mean	95% CI	Mean	95% CI	p-value
Gestational age (days)	269.81	(265.56, 274.05)	267.37	(263.65, 271.10)	0.4354
Gestational age (weeks)	38.54	(37.94, 39.15)	38.20	(37.66, 38.73)	0.4354
Birthweight (grams)	3184.62	(3029, 3340)	3168.37	(3032, 3305)	0.7132
Apgar Score 1 minute	7.47	(7.15, 7.78)	7.83	(7.55, 8.10)	0.2664
Apgar Score 5 minutes	8.68	(8.45, 8.90)	8.70	(8.50, 8.89)	0.9834

*Adjusted model. BWH comparison: stable housing, trauma, primary language

NICU Outcomes

Next, we looked at the average number of comorbidities of infants upon NICU discharge and the average length of stay in the NICU for infants that required a NICU stay (Table 7). For the Bridges to Moms advanced prenatal group, there were 17 (17.7%) infants that required a NICU stay; for the BWH comparison group there were 15 (15.8%). Babies of Bridges to Moms participants stayed an average of 20 days in the NICU compared to 24 days for babies in the BWH comparison group (p=0.0012), despite that BTM babies in the NICU had slightly higher numbers of infant comorbidities than BWH comparison group babies.

Table 6. NICU newborn health outcomes (advanced prenatal intervention group)			
	Bridges to Moms	BWH Comparison	
	N=17	N=15	p-value
Length of stay in NICU - days (mean, std. Dev.) [range of length of stay]	20.06 (14.80) [7-68 days]	24.20 (35.91) [1-140 days]	0.0012
Comorbidities on NICU discharge (mean, std. dev.)	3.29 (1.79)	3.20 (2.14)	0.4902
Maternal Comorbidities	2.29 (1.40)	2.67 (1.23)	0.6348

Of note, the control group experienced one outlier for NICU length of stay (N=140 days), which influenced the average length of NICU stay for control group participants' babies compared to BTM participants. Removing this outlier (Table 7), the mean NICU length of stay for babies of Bridges to Moms participants was 20 days, which is approximately four full days longer than the NICU length of stay of the BWH comparison group, which had a mean NICU length of stay of approximately 16 days. These results are not statistically significant, however, with the national average daily cost of a NICU bed being $5000, any reduction in NICU length of stay could translate to significant cost-savings.

New for 2023, an additional measure for maternal comorbidities at delivery was added to assess maternal factors in mothers with babies in the NICU. Comorbidities assessed included premature membrane rupture, gestational diabetes, hypertension, and delayed access to prenatal care. This analysis found that BTM mothers had fewer maternal comorbidities than mothers in the BWH comparison group, although this was not statistically significant.

Table 7. NICU newborn health outcomes* (advanced prenatal intervention group)	Bridges to Moms	BWH Comparison	
	N=17	N=14	p-value
Length of stay in NICU - days (mean, std. dev.) [range of length of stay]	20.06 (14.80) [7-68 days]	15.93 (16.83) [1-67 days]	0.6196
Comorbidities on NICU discharge (mean, std. dev.)	3.29 (1.79)	2.64 (1.19)	0.3350

*With 140-day control group NICU outlier removed

Maternal Engagement in the NICU

Maternal engagement in the NICU was measured by visits and phone calls made by mothers while their infants were in the NICU for the advanced prenatal Bridges to Moms intervention group compared to the BWH comparison group (Table 8).

On average, Bridges to Moms participants had similar levels of contact with their infants in the NICU compared to mothers in the comparison groups. BTM participants called or visited the NICU on average 96% of hospitalization days, while mothers in the BWH comparison group visited or called 94% of hospitalization days. Of note, Bridges to Moms provides transportation to moms who have infants in the NICU to support these new mothers and assist with infant bonding, which may be a contributing factor to the high levels of contact between BTM mothers and infants in the NICU.

Table 8. Maternal engagement in the NICU (advanced prenatal intervention group)	Bridges to Moms	BWH Comparison	
	N=17	N=15	p-value
Number of days mother visited or called NICU (mean, std. dev.)	18.76 (13.47)	22.20 (34.67)	0.0006
Percent of days mother visited or called NICU (%, std. dev.)	95.76% (12.00)	94.37% (9.65)	0.4191

Housing Status

Since 2021, Bridges to Moms has evaluated the housing status of participants at four separate timepoints during their enrollment in the program: 1) at enrollment to the program, 2) at delivery, 3) at discharge, and 4) at one year after enrollment. The BTM team decides if the stability or condition of a participant's housing has improved between referral and discharge or between referral and one year after enrollment, and if so, the BTM participant is determined as having an upward housing trajectory. Out of 73 mothers in the 2023 cohort, 52 (71%) had an upward trajectory in their housing status between any of these two points of measurement. This included participants who were doubled up, couch surfing, being evicted or living in shelters at enrollment, who were living in subsidized or unsubsidized apartments at discharge. Others were in the same type of housing but had moved into a more stable or higher quality form of that type of housing (e.g., moving from an apartment with pest control issues and other safety violations to a well-managed apartment building). The Bridges to Moms program places a strong emphasis on the importance of stable housing, which is reflected in the high percentage of participants who experienced an improvement in their housing status during their enrollment in the program.

Conclusions

Bridges to Moms provides needed social and medical support services to a racially and linguistically diverse population of vulnerable pregnant women and new mothers, many of whom have co-occurring behavioral health conditions. This investment of a community-based team is an important adjunct to the traditional obstetrics care model. In the traditional model, mothers with social determinants of health (SDOH) needs are referred to the social workers at the hospital, who may not have enough time to manage the many gaps in services when typically, their cases are closed 6 weeks post-partum.

Results of the analysis suggest that enrollment in Bridges to Moms may positively impact access to care. In comparison to the BWH comparison group, there were a higher number of prenatal visits among women who enrolled in Bridges to Moms at least 30 days before delivery and a higher percentage in comparison with the standard of care (15 prenatal visits). BTM participants also had a higher percentage of postpartum visits completed than BWH comparison group mothers. Moreover, BTM participants were more likely to be on stable birth control following delivery, and both BTM mothers and their babies were more likely to be connected to a primary care provider compared to the BWH comparison group.

Enrollment also had an impact on housing status. Over 70% of BTM participants had improved their housing status from enrollment to discharge or at one year after enrollment. BTM likely also has an impact on other SDOH needs, and future evaluations will assess this.

For babies requiring a NICU stay, there was a similar mean length of hospital stay between the intervention group and comparison groups, even though infants in the intervention group had a higher mean number of comorbidities. In addition, the majority of participants in the Intervention Group in this study were women whose primary language was not English and who had moved to Boston from outside the US within the year prior to delivery. They faced additional social, cultural and linguistic stressors in addition to the pregnancy, housing insecurity and other variables that the Comparison Group shared. That their outcomes were similar or better than the women in the Comparison Group is notable and speaks to the commitment of the Bridges to Moms team to health equity for all.

It is important to note that the analysis conducted for this evaluation is limited by small sample sizes. Furthermore, the groups being compared may differ in additional demographics or clinical characteristics not measured here. Nevertheless, the results of this evaluation highlight some interesting findings along with several areas for further exploration to deepen understanding of the impact of the Bridges to Moms program on maternal and child health.

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