INTRODUCTION AND DEFINITION

Supporting communities to give every child a Healthy Start.
Healthy Start EPIC Center

Prepared by the HS CoIIN with support from JSI for the Healthy Start EPIC Center

The Purpose of Defining Standards and Policies for Healthy Start Case Management and Care Coordination

Healthy Start (HS), with over 100 grantees across diverse populations, service delivery settings and geographic locations has the goal to deliver and demonstrate the value, impact and economy of a mixed provider model with its benefits of implementing community-based, family-centered care in delivering perinatal services. To do this, the Healthy Start CoIIN in partnership with Healthy Start EPIC has worked to identify core components and program standards that define and distinguish the Healthy Start approach to positively impacting the health of women, infants, children and their families.

The purpose of defining standards for Healthy Start core services is to demonstrate the commonality, effectiveness and value of Healthy Start as a comprehensive, flexible and holistic mixed-provider model that enhances the portfolio of programs and services designed to improve maternal and child health. One goal of this effort is to establish Healthy Start program effectiveness and efficiencies in achieving beneficial birth, child health, and maternal life-course outcomes. Therefore, our collective understanding of case management and care coordination (CM/CC) must have a common base of core standards that are shared across HS sites. Each site may employ their own agency systems and protocols to meet these standards and to ensure a best match for the local environment, agency structure and populations being served.

Defining Healthy Start Case Management and Care Coordination

Healthy Start conceptualizes CM/CC according to the activities and services included in the collaborative relationships between enrolled participants and their Healthy Start staff team which partners with them in their care.

Healthy Start teams are comprised of personnel ranging from medical, nursing, social work, nutrition, and mental health clinical staff to health educators, health aides, community health workers, promotoras, neighborhood health advocates, system navigators, doulas, and many other workers outside of clinical settings.

The CM/CC roles in Healthy Start are not as much defined by positions, titles or degrees; rather they are defined by what the role requires in the way of core competencies as established in the Healthy Start perinatal modules of care covering required knowledge and skills to most effectively serve Healthy Start participants.

The HS CoIIN therefore agreed: that it was acceptable for Healthy Start programs to use the terms case management and care coordination interchangeably; that the Healthy Start CM/CC model builds on both HRSA's Case Management (that has been a core service since HS's inception) as well as Agency for Healthcare Research and Quality's (AHRQ) definitions of Care Coordination, which is "The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."; and that to hybridize "CM/CC" as a defining term would be a good fit that best incorporates the range, scope and diversity of settings and staffing in which the Healthy Start Programs are implemented.

Specifically, the definition for CM/CC within the Healthy Start program is stated as follows:

> Healthy Start's Case Management/Care Coordination is a partnering process between a Healthy Start affiliated provider and a Healthy Start enrolled participant and their family during which a strength-based, collaborative relationship is developed to support management of health and social needs, including participant risk screens, family needs assessments, establishment of care plans, providing needed services and health education, and ensuring maintenance of referrals and follow-up. Contacts between the Healthy Start provider and the Healthy Start participant may occur through home visiting, face-to-face encounters, and emerging care modalities that best meet the needs of the Healthy Start community.

The core components of Healthy Start CM/CC service delivery plan will document the following services:

- Screening and intake;
- A comprehensive assessment protocol for each enrolled participant;
- Creation of a service care plan;
- Identification and documentation of appropriate services;
- Facilitation and documentation of linkages to additional services;
- Monitoring of progress documented in the service plan;
- Reassessment and responsiveness to changes as needed; and,
- Case closure and the discharge plan.

Sources

- Bureau of Primary Health Care's (BPHC) Service Descriptors for Form: https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf
- Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: https://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html
- NHSA Healthy Start Core Standards

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Subsequent Healthy Start CoIIN will need to provide more detail and information of guidelines outlined below

I. Recruitment for Outreach, Intake and Enrollment that is community-based and family-centered with established:

1. Eligibility criteria for enrollment, participation and completion in Healthy Start
2. Goals for minimum expected annual number of participants to be served
3. Strategies for outreach and marketing that ensure deep reach into marginalized populations
4. Intake protocols
5. Informed agency consent protocols that are HIPAA compliant

II. Family-Centered Case Management and Care Coordination that (is)/(has):

1. Timely, comprehensive and appropriately targeted screening across each perinatal period
2. Care plans that are based on, and linked to, results of the initial screens and related participant goals
3. Established protocol for making referrals to support services, and have responsibility for tracking and recording the status of referrals over time

III. Protocols for ensuring timely and complete data collection and entry into program's database that includes:

1. A case record for Healthy Start participants which includes intake and enrollment forms
2. Ongoing assessments of need and how frequently adjustments to care plans are reviewed, and on record
3. Each enrolled participant has contact with their Healthy Start provider regularly to update progress, needs, and service delivery status including case closure with associated documentation.

IV. CM/CC staff have clear understandings of Healthy Start program goals and expected evidence of outcomes:

1. Demonstrated by core competencies for each area of work tasks being performed
2. Attained through Staff Core Competencies and accurate, complete and timely tracking of HS enrolled participants

V. Efforts of Healthy Start CM/CC Staff are focused around Healthy Start Performance Measures:

1. Improving women's health where every enrolled woman will:
    - Be screened for depression during the prenatal, postpartum and interconceptual periods as well as be referred and connected for treatment services as identified
    - Have health insurance
    - Have a medical home (source of regular health care)
    - Have a documented reproductive health plan
    - Complete a post-partum visit
    - Complete a well-woman visit
2. Improve Family Health and Wellness:
    - Implementing a trauma informed approach to service delivery
    - Knowing and teaching benefits of initiating and sustaining breastfeeding
    - Assuring healthy pregnancy spacing
    - Teaching and observing safe sleep behaviors
    - Supporting attendance at prenatal visits and promoting 37+ week deliveries
    - Assuring recommended schedule of well-child visits
    - Screening for and addressing any intimate partner violence
    - Including and promoting father involvement during pregnancy
    - Coaching fathers' understanding of their child's development and needs
    - Modeling activities such as reading with children or age-appropriate play
3. Promote Systems Change
    - Potentially utilize the expereinces from the case management/care coordination system to inform the implementation and direction of the local Community Action Network (CAN)
4. Assure Impact and Effectiveness
    - Guidelines for conducting ongoing assessments of need and care plan adjustments
    - Each enrolled participant has regular contact with their CM/CC provider to update progress, needs, and status (eligible, enrolled, voluntary withdrawal, lost-to-follow up, and completed) with defined close-out process and documentation.
    - Healthy Start Screening Tools (or their equivalent) must be completed. These tools provide the foundation for CM/CC interventions in the development of care planning, referrals, and subsequent follow-up
    - Attained through Staff Core Competencies and accurate, complete and timely tracking of Healthy Start enrolled participants
    - Completion of Healthy Start Community Health Worker 101 Modules and other Healthy Start EPIC core competency modules

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In partnership with the HS CoIIN, the HS EPIC Center developed, implemented, analyzed and produced a summary of Lessons Learned from the Field based on feedback from 84 of the 100 HS grantees. As stated in the July 31, 2017 document provided to the Division (ref), "the current funding period has afforded the opportunity and means to build a foundation that advances the key Healthy Start principle of promoting equity through a standardized system of care. Structural flexibility is the defining flexibility factor that enables HS to address the unique needs of participants within the contexts of their families and community, and must be preserved". (pg 62). The following are best practices reported by at least one of the 84 of the current 100 Healthy Start sites when surveyed regarding lessons learned in CM/CC. These are useful guidelines, practical examples and worthwhile insights from local sites of what has worked in implementing aspects of CM/CC Healthy Start services.

Training and Professional Development

- Consistent training of CHW with EPIC center tools as well as other CHW training. Training must be done in a way that provides staff adequate time to learn materials and needs to be ongoing with booster trainings and other supportive resources
- Additional staff considerations emphasized the value of team communication and consistent staff supervision. Best practices related to communication included holding regular meetings, applying a team approach in case conferencing, and remaining "strength-based with your team - model for them what you expect them to provide to the families"
- Incorporating motivational interviewing and utilizing a goal –oriented approach with incentives was also mentioned

Staffing Considerations

- Use of CHWs/promotoras to connect with immigrant populations
- Multidisciplinary staffing approaches which include nurses, social workers, doulas, community health workers, development specialists, IBCLCs or Lactation Counselors and mental health professionals
- Increased efficiency of assigning clients to case managers by territory to decrease travel time, and a team approach that enables support of a lead case manager for high risk cases and other issues

Outreach Practices

- Increased outreach allowed community members to become more familiar with HS services. This gave the opportunity to educate women on major health issues that impact pregnancy and women's health
- Stationing community health workers at various locations in the community to provide education and resources enhances women's knowledge and access to services
- Connecting women and families together within the community creates ongoing support and encouragement throughout the pregnancy and after

Home Visiting and Community Based Settings

- Home visiting should allow for services within the family home or environment that the participant and their family feel most comfortable in.
- Community-based interventions work best to eliminate barriers to accessing Healthy Start services
- When at all possible delivering services in the family's home is best practice.

Administration of Healthy Start Screening Tools

- When administering the screening tools and other screens/assessments, engage in consultation with medical providers and mental health professionals, if available. This will support the development of a comprehensive care plan.

Connection to Medical Home

- Formal connection to clinical service providers and use of a Referral Pathway Tool /system.
- The value of the medical home was mentioned as a means to providing comprehensive, high quality care. Specifically mentioned were the use of clinical decision support tools and shared decision-making between HS provider and medical provider, evaluating participant experience and making adjustments, accordingly, providing case management plans, and using population medical management
- Increasing healthcare accessibility by monitoring clients' appointments to ensure postpartum visits occur and provide transportation support for participants' appointments as appropriate/needed
- MOUs in place and subcontracted with the local hospital and Health Department, which allowed sites to build relationships for acquiring referrals and providing quality care and follow up to the participants.

Referrals

- Develop an accessible and convenient referral system to facilitate community referrals between WIC, Healthy Start, Cribs and other resources

Relationship based approaches

- Be sensitive, flexible, and creative when implementing every aspect of the program model (site-based groups, including early childhood education and parenting education; home visits; screenings; and resource referral) because everyone is experiencing different challenges and has different levels of sensitivity, emotional responses, and learning styles. Solicit feedback from families. With sensitivity, flexibility, and creativity, use the feedback to inform programming
- Importance of the relationship between the HS provider and HS participant.

Incentives

- Provide transportation support in the form of bus ticket or taxi vouchers and client incentives to address basic need such as safe sleep devices

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Case Management/Care Coordination Definition

Healthy Start's Case Management/Care Coordination is a collaborative process and relationship between (a) Healthy Start-affiliated provider(s) and a Healthy Start enrolled participant [and their family] during which services are provided that assist in the management of health and social needs, including participant risk screens, family needs assessments, establishment of care plans, and ensuring maintenance of referrals, tracking and follow-up systems. There must be face-to-face contacts between the provider and the participant.

Sources

- Bureau of Primary Care' Form 5A service descriptors outline the general elements for services. https://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf
- NHSA Healthy Start Core Standards

Case Management/Care Coordination Competency Checklist

Case Managers/Care Coordinators (CM/CC) will ensure the health education and intervention they provide to participants match Healthy Start's performance measures. This checklist links the Performance Measure to the CM/CC's Core Competency and the Screening Tool Question. All perinatal stages are included in this table. This will be broken down by perinatal stage after approval.

ALL STAGES at least one face to face visit during this time period

PERFORMANCE MEASURE	ACTION/CAPACITY	SCREENING TOOL AND QUESTION*
The percent of Healthy Start women and child participants with health insurance.	☐ Ensure connection to health insurance or have access to health insurance for those who are eligible.	**Preconception Q16** 16. Please tell me what kind of health insurance you have: **Prenatal Q11** 11. Please tell me what kind of health insurance you have: Multiple Choice. **Postpartum (Child) Q13** 13. Please tell me what kind of health insurance your baby has/babies have: **Postpartum Q32** 32. Please tell me what kind of health insurance you have: **Interconception (Child) Q14** 14. Please tell me what kind of health insurance your child has: **Interconception (Woman) Q35** 35. Please tell me what kind of health insurance you have:

The percent of women with a well woman visit.	☐ Ensure well woman visit.	**Preconception Q17** 17. During the past 12 months, did you see a doctor, nurse, or other health care worker for preventive medical care, such as a physical or well visit checkup? **Prenatal Q7** 7. How many weeks or months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children). **Postpartum Q33, Q33.1, Q33.2** 33. Since your child was /children were born, have you had a postpartum visit for yourself? A postpartum visit is the regular checkup a woman has 4-6 weeks after she gives birth. 33.1 When did you have your postpartum visit? 33.2 Do you have one scheduled? **Interconception Q36** 36. During the past 12 months, did you see a doctor, nurse, or other health care worker for preventive medical care, such as a physical or well visit checkup?
The percent of women with a postpartum visit.	☐ Ensure postpartum visit.	**Postpartum Q33, Q33.1, Q33.2** 33. Since your child was /children were born, have you had a postpartum visit for yourself? A postpartum visit is the regular checkup a woman has 4-6 weeks after she gives birth. 33.1 When did you have your postpartum visit? 33.2 Do you have one scheduled?
The percent of women with a reproductive life plan.	☐ Ensure completion of reproductive life plan.	**Preconception Q42, Q43.1** 42. Do you plan to have any children? 43.1. Are you satisfied with your birth control method? **Prenatal Q50, Q51.1** 50. Do you plan to have any more children after this baby is born? 51. Do you and your partner have a method of birth control that you plan to use until you are ready to become pregnant again? **Postpartum Q14, Q15.1** 14. Do you plan to have any more children? 14.1 How many children would you like to have? 14.2 Would you like to become pregnant in the next year? 14.3 How long would you like to wait until you become pregnant? 15. Are you using any form of contraception or birth control to either prevent pregnancy or prevent sexually transmitted infections? 15.1. Are you satisfied with your birth control method? **Interconception Q16 - Q18.1** 16. Are you pregnant now? 17. Do you plan to have any more children? 17.1 How many children would you like to have? 17.2 Would you like to become pregnant in the next year? 17.3 How long would you like to wait until you become pregnant? 18. Are you currently using any form of contraception or birth control to either prevent pregnancy or prevent sexually transmitted infections

The percent of pregnant women that abstain from cigarette smoking.	☐ Provide information and resources about smoking cessation.	**Prenatal Q39, Q40** 39. In the past 12 months, how often have you used the following? 40. Do you currently smoke any cigarettes or use any tobacco products? **Postpartum Q42** 42. Did you smoke any cigarettes or use any tobacco products during the last 3 months of your pregnancy?
The percent of women who receive IPV screening.	☐ Administer IPV screening (and link to referral, if needed).	**Preconception Q35** 35. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had in the last 12 months so that we can help you if needed. **Prenatal Q43** 43. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had during the last 12 months so that we can help you if needed. **Postpartum Q44** 44. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had during the past 12 months so that we can help you if needed. **Interconception Q54** 54. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had during the past 12 months so that we can help you if needed.
The percent of women who receive depression screening and referral.	☐ Administer maternal depression screener and link to referral, if need.	**Preconception Q32** 32. Over the past two weeks, how often have you experienced any of the following, would you say never, several days, more than half the days, or nearly every day? **Prenatal Q38, Q38.1, Q38.2** 38. Over the past two weeks, how often have you experienced any of the following, would you say, never, several days, more than half the days, or nearly every day? **Postpartum Q40** 40. Over the past two weeks, how often have you experienced any of the following? Would you say never, several days, more than half the days, or nearly every day? **Interconception Q51** 51. Over the past two weeks, how often have you experienced any of the following? Would you say never, several days, more than half the days, or nearly every day?
The percent of women who conceive within 18 months of previous birth.	☐ Provide health education about the benefits of adequate birth spacing.	**Prenatal Q1, Q2 (Calculate)** 1. How many weeks or months pregnant are you? 2. What is your baby's due date? **Postpartum Q 1.1 (Calculate)** 1.1 When was your baby / were your babies born? (Interconception Q1 (DOB of most recent live birth) 1. Please tell me the dates of birth for any children older than 6 months and younger than 24 months old.)

The percent of women and children with a usual source of medical care.	☐ Ensure connection to primary care provider for all Healthy Start participants.	**Preconception Q14, Q15** 14. A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your personal doctor or nurse? 15. Is there a place that you USUALLY go for care when you are sick or need advice about your health? **Prenatal Q9, Q10** 9. A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your personal doctor or nurse? 10. Is there a place that you USUALLY go for care when you are sick or need advice about your health? **Postpartum (Child) Q10, Q11** 10. Do you have one or more persons you think of as your baby's/babies' personal doctor or nurse? 11. Is there a place that your baby/babies USUALLY goes/go for care when he or she is sick or when you or another caregiver need advice about your baby's health? **Postpartum Q30, Q31** 30. Do you have one or more persons you think of as your personal doctor or nurse? 31. Is there a place that you USUALLY go for care when you are sick or need advice about your health? Interconception (Child) Q12, Q13 12. Do you have one or more persons you think of as your child's personal doctor or nurse? 13. Is there a place that your child USUALLY goes for care when he or she is sick or when you or another caregiver needs advice about your child's health? **Interconception (Woman) Q33, Q34** 33. Do you have one or more persons you think of as your personal doctor or nurse? 34. Is there a place that you USUALLY go for care when you are sick or need advice about your health?
The percent of children with well child visit.	☐ Ensure connection to primary pediatric care provider for all Healthy Start participants who are children.	**Postpartum Q1.1, Q12** 1.1 When was your baby / were your babies born? 12. When was your baby's/babies' last visit to a doctor, nurse, or other health provider for a well-child check-up? **Interconception Q1, Q15** 1. Please tell me the dates of birth for any children older than 6 months and younger than 24 months old. 15. When was your child's last visit to a doctor, nurse, or other health provider for a well-child check-up?

The percent of child participants who are placed to sleep following safe sleep behaviors.	☐ Provide health education materials regarding safe sleep behaviors.	**Postpartum Q5, Q6, Q7** 5. In which one position do you most often lie your baby/babies down to sleep now? 6. In the past 2 weeks, how often has your new baby/have your new babies slept alone in his or her/their own crib or bed? Would you say always, often, sometimes, rarely, or never? 7. Please tell us how your new baby/ babies most often slept in the past 2 weeks. **Interconception Q5, Q6, Q7** 5. In which one position do you most often lie your baby/babies down to sleep now? 6. In the past 2 weeks, how often has your new child/have your new children slept alone in his or her/their own crib or bed? Would you say always, often, sometimes, rarely, or never? 7. Please tell us how your child/children most often slept in the past 2 weeks.
The percent of children who were ever breast-fed or fed breast milk.	☐ Share health education regarding the benefits of breastfeeding and support new mothers to breast-feed.	**Postpartum Q2** 2. Did you ever breast feed or pump breast milk to feed your baby/babies after delivery, even for a short period of time? **Interconception Q2,** 2. Did you ever breast feed or pump breast milk to feed your child/children after delivery, even for a short period of time?
The percent of children who were breastfed or fed breast milk at 6 months.	☐ Share health education regarding the benefits of breastfeeding duration in in the first year of life.	**Postpartum Q2.1** 2.1 How many days, weeks or months did you breastfeed or pump breast milk for your baby/babies? **Interconception Q2.1** 2.1 How many days, weeks or months did you breastfeed or pump breast milk for your child/children?
The percent of women that demonstrate father/partner involvement during pregnancy.	☐ Support father/ partner involvement during pregnancy.	**Prenatal Q49, Q49.1** 49. Would you describe your partner or the father of this baby as: 49.1. What is your partner's or the father of your baby's role in your life? **Postpartum Q50, Q50.1** 50. Would you describe your partner or the father of your baby/babies as: 50.1. What is your partner's or the father of your baby's /babies' role in your life?
The percent of children whose mother/caregiver reports supportive father and/or partner involvement.	☐ Support father/partner involvement in the child's life.	**Postpartum Q50, Q50.1** 50. Would you describe your partner or the father of your baby/babies as: 50.1. What is your partner's or the father of your baby's /babies' role in your life? **Interconception Q59, Q59.1** 59. Would you describe your partner or the father of your child/children as: 59.1. What is your partner's or the father of your child's role in your life?
The percent of children read to 3+ times per week.	☐ Reading daily to child (ren) living in the home.	**Interconception Q3** 3. Please tell me the number of days you or a family member read to your child during the past week. Reading includes books with words or pictures but not books read by an audio tape, record, CD, or computer.

*__Screening Tool and Questions__ refer to original Healthy Start Screening tools.