



Case Management/Home Visitation

The Problem

The health care system today is fragmented, complex, and increasingly difficult to navigate without expert guidance. Additionally, during pregnancy there may be complications related to pregnancy or pre-existing conditions compounding the problems due to lack of access, knowledge and/or support. Integration of services to provide comprehensive perinatal care at the appropriate level and support of the woman and her family are key to improving outcomes. According to the guidelines for Perinatal Care, fifth edition, "When populations needing reproductive health care are widely dispersed, both geographically and economically, a carefully structured, well organized system of supportive services becomes necessary to ensure access." A multidisciplinary case management approach has shown success with different levels of personnel including community workers, social workers, doulas, perinatal nurses and others participating in the care coordination and support of the woman and her family.

Rationale

Case management provides a comprehensive foundation for support and coordination of services for pregnant women and their families. Poor birth outcomes can be significantly reduced with case management coordination of services and supportive measures.

Interventions

A trained professional should provide case management with a degree in relevant fields of nursing, public health, social works, or other equivalent degrees. Trained lay personnel (e.g. promotoras, doulas, resource mothers) bring unique strengths to case management services and should be supervised by a trained

professional. The case managers should facilitate care coordination with the prenatal care and other service providers and include a schedule of home visitations. While the activities of the case managers should be tailored to the individual needs of the clients and their families, their core activities are described below:

1. Psychosocial assessment for strengths and social stressors (e.g. support network, recreation, domestic violence, financial hardship, working conditions, housing problems, child care needs),
2. Needs assessment for counseling and referral to social, financial, educational, and vocational assistance programs,
3. Health assessment for health practices and behaviors, and medical conditions,
4. Care coordination and case management to facilitate client follow-up with care and referral services (e.g. facilitate transportation to attend prenatal care appointments, counseling client and family about the availability of the warmline and other services).

Steps to Implementing Case Management/Home Visitation

The following steps serve as a guide to providing case management services:

Philosophy

1. Services should use client-centered, strengths-based, empowerment approaches to partner with clients to make health improvements.

Assessment

1. Strengths assessment including perceived sources of support, health practices, recreation, goals and needs.



2. Risk assessment including medical and obstetrical (historical) assessment for past conditions, chronic and acute illnesses, medications, obstetrical history, and psychiatric history should be conducted in first trimester and again in the second trimester. Women at risk or with specific diseases or conditions should be followed more often depending on acuity.
3. Psychological assessment for adverse health behaviors (tobacco, alcohol, illicit drug use), psychological conditions (including screening and referral for depression), and domestic violence
4. Nutritional assessment for body mass index, dietary intake, and food purchasing resources

Health Promotion

1. Promotion of health behaviors (proper nutrition; avoidance of smoking, alcohol, street drugs; avoidance of sexually transmitted infections, and dental hygiene)
2. Health education for pregnancy related topics (i.e., growth and development during pregnancy, danger signs and symptoms, healthy nutrition, strategies to reduce unhealthy practices, child birth preparation, breastfeeding, parenting, post partum care, infant care, contraception);

Intervention Strategies

1. Coordination and support of prenatal care services throughout pregnancy and beyond for at least one year. Services that continue through the child's second birthday demonstrate significant, improvements over programs and are recommended

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2. Linkage to referrals/treatment for medical and dental conditions through established referral network
3. Referral for treatment of adverse health behaviors (tobacco, alcohol, illicit drug use)
4. Nutrition classes, micronutrient supplementation, and referral to WIC program (as appropriate)
5. Support for compliance with care pathways and healthy behaviors
6. Advocacy for clients needs and goals
7. Home visitation

Collaboration Opportunities

Collaboration with the following types of organizations is recommended to provide a comprehensive approach for case management:

- Clinics
- Doctor's Offices
- Faith Based Organizations
- Community Based Organizations
- Hospital Based Organizations
- WIC
- Community Assessment Centers

Tools for Implementation

Several evidence based models for Case Management/Home Visitation exist, and provide training curricula.

Potential Outcome Measures

Measurement of the success of this intervention may include some of the following criteria:

- Proportion of women obtaining referral services for high risk conditions during pregnancy

- Proportion of women with preterm births or LBW Births
- Proportion of women with fetal or infant death
- Proportion of adolescent women with repeat pregnancies

Source Materials & Useful Resources

Curricula for the following programs:

- Nurse Family Partnership,
- Black Infant Health Programs
- Healthy Families

References/Resources:

The Case Management Society of America
www.cmsa.org

The American College of Obstetricians and Gynecologists <http://www.acog.org/> P: 800-762-ACOG

The March of Dimes Birth Defects Foundation at <http://www.modimes.org/>

National Center for Children Families and Communities/ Nurse Family Partnership at www.nccfc.org

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