

ISSUE BRIEF

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TRENDS IN PUBLIC HEALTH

Case Management: At the Heart of Healthy Start

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Healthy Start began as a demonstration in 1991, before becoming a fully operational program in 1998. This brief is based on Mathematica's evaluation of the demonstration, conducted for the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The analysis is based on data collected from 1994 to 1997, including two rounds of site visits to 15 Healthy Start projects across the U.S. and two rounds of telephone follow-up interviews. It also draws on service utilization data from each project's Minimum Data Set, as well as data collected in a cross-sectional survey of about 3,000 postpartum women living in the Healthy Start project areas. In the survey, equal numbers of participants and eligible nonparticipants were interviewed.

Linking Women to Services

The Healthy Start demonstration was intended to reduce infant mortality by 50 percent and to improve maternal and infant health in communities with high infant death rates. From its inception, Healthy Start emphasized changing entire systems of care for low-income women so they would have access to needed services. To link women with a continuum of health and social services, all 15 original Healthy Start projects implemented some form of case management.

Case management is a process that identifies clients and ensures that they receive services in a supportive, efficient, and cost-effective way. During the past decade, interest in case management has increased,

LAYING THE GROUNDWORK

HRSA's original framework for the Healthy Start demonstration in 1991 included the following guidance: "The sites will utilize a community-based, family-centered, and culturally competent approach that will strengthen the maternal and infant care system and bring childbearing-aged women, pregnant women, and infants into care early, maintain them in care, and assist families in changing their community and home environments to be more conducive to a healthy start for infants."

reflecting a dual concern for service coordination and accountability. Service coordination helps clients access services they need, while accountability emphasizes efficient service delivery. In Healthy Start, case management programs aimed to coordinate the efforts of multiple providers and link low-income women and their families to services.

The Healthy Start case management programs were based on a continuum that included four steps: (1) initial contact and outreach; (2) intake; (3) assessment, care planning, and referrals; and (4) ongoing contact and tracking. The first step, initial contact, involved an outreach worker or case manager proactively identifying and contacting pregnant women and women with young children. This was done through intensive neighborhood canvassing to find and enroll pregnant women, or canvassing in supermarkets, laundromats, or other areas where women were likely to congregate. Sometimes, staff made periodic visits to housing projects or used telephone contacts, hotlines, links to other programs, and mass media campaigns to engage potential clients.

The next step—intake—involved explaining Healthy Start and the case management process to a client and completing forms needed for the initial assessment and tracking. Intake could be done at the same time and place as the initial contact—for example, in the client’s home—or later, perhaps at a clinic or community provider’s office. At the same time, a needs assessment (the third step in the case management process) would be done. The assessment addressed a spectrum of physical, nutritional, emotional, social, housing, and financial needs to access a continuum of services. For example, a woman with five young children might be in need of WIC, food stamps, child care, and baby clothing. Similarly, one with a substance abuse problem and tenuous living arrangements might need treatment and counseling as well as housing assistance.

The last piece of the case management process was ongoing contact and tracking. Notably, it was also the most challenging part of the demonstration case management programs. This period, which began in pregnancy and continued for at least one year postpartum, involved monitoring services received and ongoing needs. Many case managers conducted this monitoring during home visits, although telephone contact as well as contact in doctors’ offices, clinics, and other sites were also used.

All of the sites used a mix of lay and professional case managers, but some relied heavily on lay workers as their primary case managers. These staff were community residents without previous professional training who were trained on the job or

CASE MANAGEMENT: GOALS AND CORE ACTIVITIES

Goals

- Improve access to services
- Increase consumer empowerment and satisfaction with services
- Ensure followup with service plans
- Increase community and institutional coordination and collaboration

Core activities

- Initial contact or outreach
- Intake
- Assessment, care planning, and referrals
- Ongoing contact and tracking

through special programs. They were familiar with their neighborhoods and with the residents, resources, and concerns therein. Overall, program staff felt that lay workers were helpful in enrolling women in Healthy Start and, with appropriate supervision, delivering case management services.

Accomplishments

Healthy Start projects succeeded in setting up case management programs in areas with little or no experience with these services, although implementation was easier for staff or programs with some experience. They also succeeded in using community lay workers as part of case management teams to identify and enroll high-risk women. Programs that relied heavily on lay workers also increased the employment of community residents, invested in the community, and facilitated community buy-in and support for Healthy Start.

Several areas of strength in the case management process emerged during the study. They included outreach and advocacy for clients. While outreach began with bringing women into the program, advocacy involved using knowledge of the client and the services available in the community to link women to health care and other support systems. Many of the women had few social supports, so they benefited greatly from case managers’ attention.

Referrals were also an area of strength. Case managers referred clients for an array of social and medical services, such as WIC, prenatal care, and substance abuse counseling and treatment.

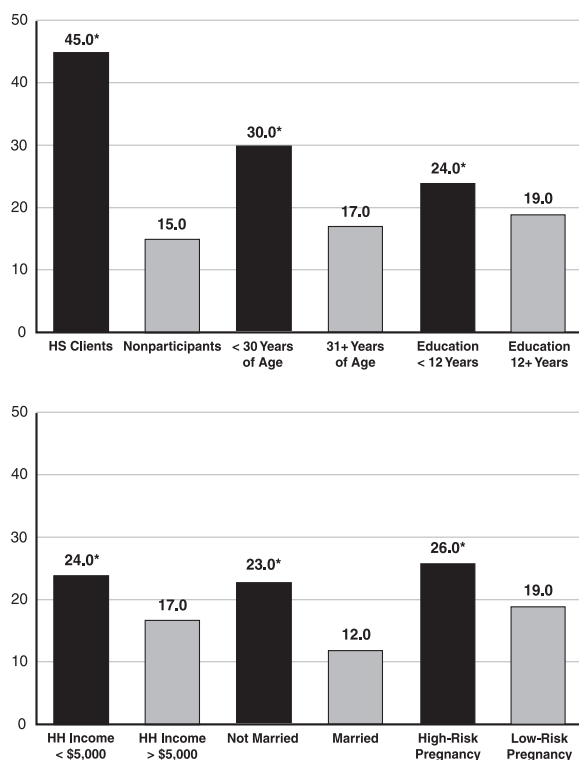
Healthy Start was less successful in implementing the case management activity of ongoing contact and tracking. Although the programs identified resources in the community, they were not able to monitor receipt of services and ongoing needs. This lack of followup prevented programs from fully assessing the impact of case management. Inability to track referrals thoroughly is a common problem in many case management and home visiting programs.

The programs also had difficulty in maintaining and engaging clients. Although case managers made repeated attempts to contact clients, either through telephone or home visits, they had difficulty completing these contacts. Scheduling home visits and making sure clients were at home for the visits were among case managers’ biggest challenges.

Nuts and Bolts: Who Got What

Healthy Start participants were more than three times as likely as nonparticipants to receive prenatal case management (45 percent versus 15 percent—see Figure 1).

Figure 1: Receipt of Prenatal Case Management Services (Percentages)



Source: Healthy Start Postpartum Survey 1996.

* $p < .01$

In general, women at higher risk of poor birth outcomes were more likely than other women to receive case management. Those receiving case management were likely to be under 20 years old, be African American, be unmarried, have less than a high school education, have annual income under \$5,000, have only one child, or have a high-risk pregnancy.

Table 1 describes use of prenatal services. The most common case management services were checking the mother's and baby's health. Other common case management services included help with public assistance programs, transportation assistance, clothing, and food. These services reflect the more social orientation of Healthy Start.

TABLE 1

PRENATAL CASE MANAGEMENT RECEIVED BY HEALTHY START PARTICIPANTS

Checked mother's health	67%
Checked baby's health	68%
Medicaid enrollment	14%
WIC enrollment	19%
Food stamp enrollment	13%
AFDC enrollment	10%
Alcohol/drug counseling	3%
Domestic violence	2%
Food	14%
Housing	9%
Transportation	26%
Clothing	23%
Baby furniture	12%
Child care	6%
Job training	3%
Job search	4%
Returning to school	9%

Lessons for the Future

Healthy Start grantees recognized the need to work closely with women and their families to ensure they received needed services during pregnancy and infancy. This close relationship was achieved primarily through case management programs.

While projects were generally successful in developing case management programs, these programs were limited in several ways. For example, caseloads were generally high—half the projects reported caseloads of 30 or more for lay workers and 50 or more for professional staff. High caseloads may limit the ability to implement the core functions of case management effectively.

Several important lessons emerged from the case management experience:

- Including community lay workers as members of case management teams was feasible, cost-effective, and helpful in identifying and enrolling high-risk women.
- Training and supervising case managers is important, given the high-risk nature of the population served, range and intensity of services needed, and use of community lay workers.

- Efforts to follow up and maintain contact, particularly with high-risk women, need more attention.
- Linking clients to available services is the ultimate goal of case management. Programs should improve their ability to track whether clients receive services. This could be done through case records or information data systems to assess whether a program is achieving its goals.

To Find Out More

To order the full report, *Case Management in Healthy Start*, visit Mathematica’s web site at www.mathematica-mpr.com. A variety of other publications, including additional copies of this issue brief, can be ordered or downloaded from the site.

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