



Where Babies and Families come first.

Project of Antelope Valley Partners for Health. Funded by First 5 L A

Case Management Model

Created in collaboration with:

- AVPH/AVBBC
- Black Infant Health
- El Nido
- Healthy Homes
- Antelope Valley Hospital
- L.A. County Department of Public Health

Case Management Model

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Case Management Program Description

- **Definition:** The AVBBC Staff accepts Case Management to mean:

A collaborative process of assessing, planning, facilitating, and advocating for options and services to meet an individual's family's needs through communication, assessment, and linkage to available resources.
- **Case Management Steps:** AVBBC Case Management program will consist of 6 steps.
 1. Initial contact with and to outreach of clients
 2. Intake of clients
 3. Assessment
 4. Care Planning
 5. Referrals/linkage
 6. Follow-up contact based on level of need and tracking of clients
- **Case Management Components:** The model will be based on traditional case management components;
 - **Client Assessment:** The designated team will conduct an assessment that will be comprehensive in nature and cover the client's health as well as psychosocial factors. The assessment will be done in-home if possible or in the office setting if necessary.
 - **Care Planning:** Based on information gathered through the assessment, the Case Management Team (Triage) will work together to identify problems, barriers, risk factors in order to devise the best plan possible to address these issues.
 - **Service Plan:** This will be the plan devised by the team to address the problems identified in the previous step. The service plan identifies the staff and/or agency (ies) assigned to the client, goals and objectives set.
 - **Service Monitoring/Follow-up:** The case management team will maintain regular contact with clients to ensure that they are securely linked to services and that they are progressing towards the achievement of their specified goals. Client's cases will be reviewed during Case Management Multi-Disciplinary Meetings.
 - **Case Recording:** All paperwork designated as necessary for a complete case file are to be completed and maintained in an organized, professional, accurate and timely manner. This also includes progress notes which are to be completed with each significant contact made between staff and clients.
 - **Client Termination:** Client's cases can be terminated due to noncompliance on the part of the client, client's moving out of the service area, their no longer desiring services, or that goals have been achieved.

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AVBBC Client Criteria

Please Note- Based on the HBI/AVBBC Scope of Work (SOW) and the need for improved coordination of services between agencies within the Antelope Valley; clients seen under the AVBBC umbrella will receive services based on the preexisting standards of the partnering agency delivering direct care and/or with standards devised by the case management committee for clients receiving direct care under AVBBC staff. Exceptions may be made with prior agreement/arrangement.

First 5 LA Client Eligibility Criteria Guideline

According to First Five LA, “The at risk group of women and new mothers” who will be the focus of this initiative include:

- Pregnant women or new mothers living on incomes below 300% of the federal poverty level who are at increased risk for having a low birth weight or preterm infants, fetal or infant death, or birth of an infant with a potentially preventable congenital anomaly.
- Pregnant women or new mothers with a chronic medical condition related to pregnancy complications and/or birth of low birth weight or preterm infants, fetal or infant death, or birth infants with potentially preventable congenital anomalies.
- Pregnant teens or teen mothers.

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Eligibility Criteria for AVBBC Clients

In addition to the First 5 eligibility criteria guideline, any combination of the following may be used to determine AVBBC client eligibility:

-Potential clients fall within the Target Population set forth by the AVBBC which is as follows:

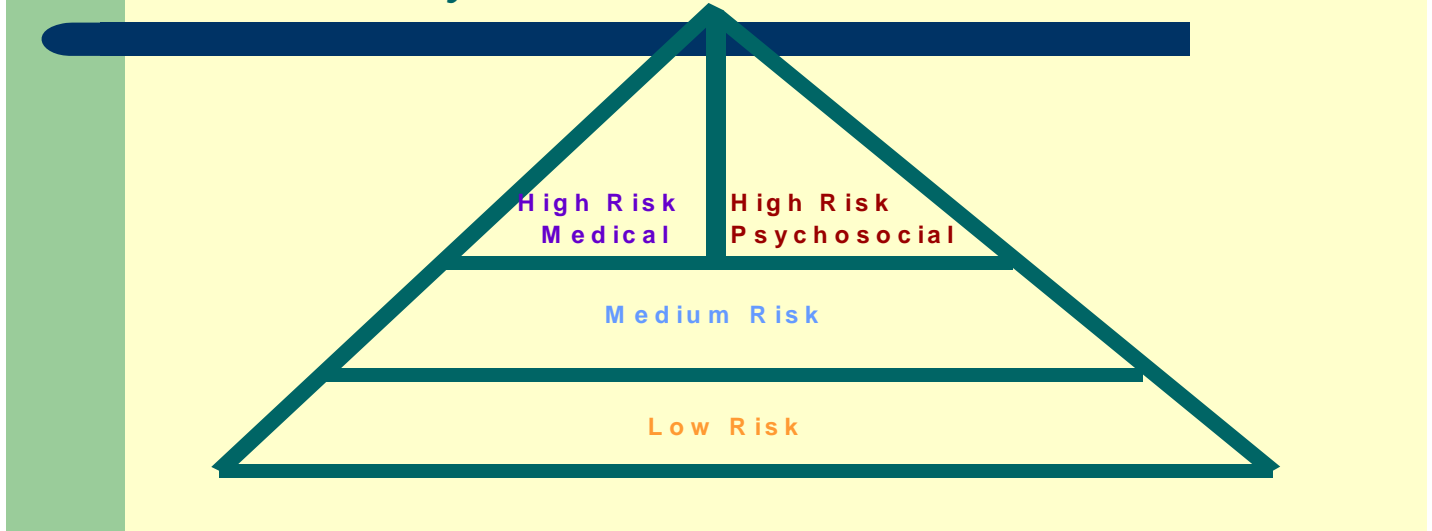
- African American women
- Teenagers
- High risk and/or at risk women

-A person qualifies for services if they are considered high risk based on the criteria set forth by the Initiative:

- Fall within the Target Population
- Had previous poor birth outcomes
- Have current medical or psychosocial complications in conjunction with pregnancy

Note- Women will be eligible for the program up to two years following delivery.

Case Management Model: System Levels of Care



System Levels of Care

Clients will be placed in three different categories: low risk, medium risk and high risk (medical and/or psychosocial).

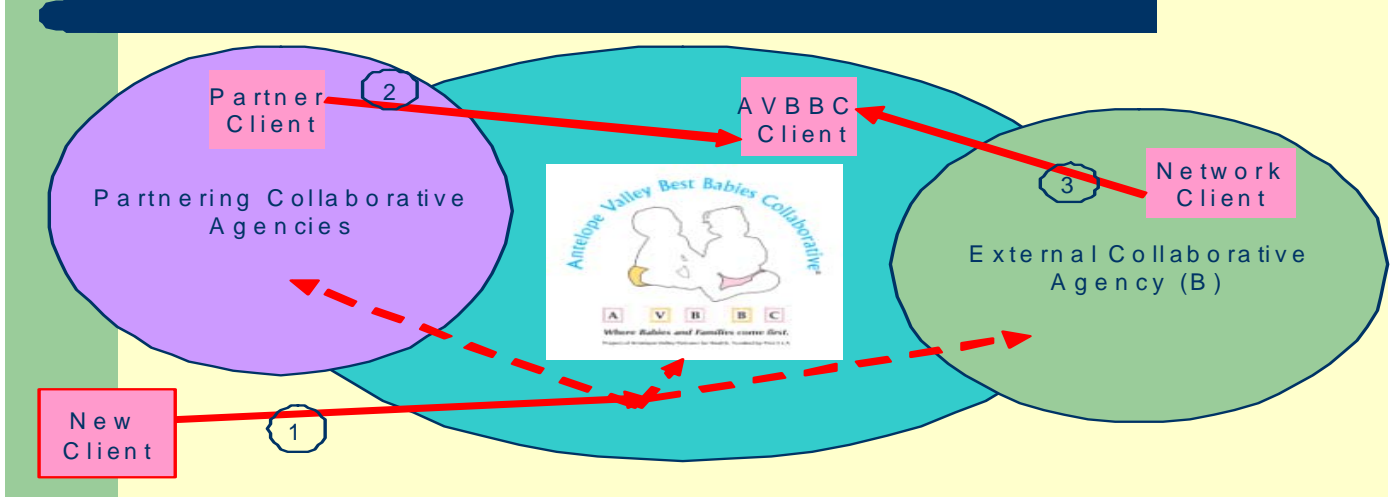
Low risk clients will be those who do not meet the criteria for medium or high risk.

Medium risk clients will possess more need than low risk clients, but may possess less pervasive or more easily resolved stressors than a high-risk client. Clients in this category will be those who are teenaged parents (age 16-18), have unstable living arrangements, but not homeless, those who have a mental health diagnosis, but are already receiving treatment for this issue. African-American women will automatically be included in this category due to high infant mortality rate (with the exception of those who otherwise meet high risk categorization criteria).

High Risk Clients (Medical) will possess medical conditions that are or may affect a healthy birth. For example, clients with gestational diabetes who are out of compliance, high risk pregnancies, clients with children with previous low birth weights or premature births or other health issues that could negatively affect the birth of a healthy child.

High Risk Clients (Psychosocial) are those who require immediate and more intensive services including counseling services and intensive case management provisions. They will possess issues that may undoubtedly impact the client's ability to have a healthy birth or raise a healthy baby. High risk clients will be those who are teenaged parents (ages 11-15), involved in gangs, possessing substance abuse issues, a current mental illness diagnosis (without treatment), history of abuse (inflicting or being victimized), homeless or be a danger to themselves or others.

Case Management Model: AVBBC Referral Process



Referral/Enrollment Route

Route 1: All partners and clients are encouraged to enter the collaborative through AVBBC triage (route 1). A new client may be recruited to AVBBC directly, where they will be assessed and placed into the appropriate partnering agency program according to AVBBC Agency Placement Guidelines (APG). Referred partners and clients will receive support and/or follow up of AVBBC staff, or the client may be referred out to an external collaborative agency. (Some overlap may occur as clients may also receive specific supporting services from multiple agencies not offered by the enrolled agency.)

Route 2: An existing client of a partnering agency may become a client of AVBBC if the agency's services are no longer adequate for the clients needs or they have a risk factor out of the partnering agency's scope. A new client entering a partnering agency that does not meet agency criteria is to be referred into AVBBC where they will be further assessed and placed.

Route 3: An existing client of an external collaborative agency may be referred into AVBBC for triage and placement.

Referral/Enrollment Process

A referral form is to be completed and submitted at the time of referral. The referral form with the potential client's information will then be reviewed. Following the review, the client/family will then undergo the Triage Process. During the Triage Process, the client will be assessed, the client's needs will be identified and discussed and the best plan of action will be determined.

*Please refer to the AVBBC Client Criteria and Agency Placement Guidelines.

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AVBBC Agency Placement Guidelines

Please Note- Based on observed best practices and specializations within each agency and their focused area of service, we are recommending that any persons receiving a referral for a client that could possibly receive the best care (based on his/her needs) from another agency within the collaborative, that you submit these referents directly to the AVBBC Clinical Social Worker for dissemination to the appropriate agency/services. Clients will be placed into agencies according to the guidelines set forth in the *Partnering Agency Specific Client Criteria* (table 1) and the *AVBBC Streamlined Client Criteria/Agency Placement Guidelines* (table 2a, 2b, 2c). Clients may also be referred completely out of the AVBBC to an external networking agency, or receive supplemental services from an external agency in addition to services provided under the AVBBC umbrella (see table 3: referral network)

TABLE 1: Partnering Agency Specific Client Criteria

Program Specifics	El Nido	B.I.H.	Healthy Homes	Nurse Family Partnership (NFP)	Partnership For Families (PFF)
Population served	Adolescent females under 19 yrs; males who are partners in pregnancy/parenting under 21 yrs;	Pregnant and/or parenting; African-American; 18 yrs & older	Women (child bearing age) w/newborn 3mos or below; medical cond. that may impact pregnancy; poor past preg.; @ risk due to d.v., mental illness, sub. abuse;	Low income, first time moms, and less than 28 weeks (7 months) pregnant.	Pregnant women with one of the following: ✓ Depression ✓ Domestic Violence ✓ Substance Abuse ✓ In the teens And live in Zip Code: ✓ 93243 ✓ 93523 ✓ 93534 ✓ 93535 ✓ 93536

TABLE 2a: AVBBC Streamlined Client Criteria (Pregnant)/ Agency Placement Guideline

Target Population	Age Limitations	Client Ethnicity	Agency Specialty Risk Factor	Best Agency
Pregnant	<19	Any Ethnicity	Domestic Violence (specific zip codes)	PFF
			Domestic Violence	Healthy Homes
			Substance Abuse (specific zip codes)	PFF
			Substance Abuse	Healthy Homes
			Mental Illness	Healthy Homes
			Low Income, first time moms, <7 mo	NFP
			All other non-specific risk factors	El Nido
Overflow	AVBBC			
	<18	African American	Use specific risks listed above, except:	Varies
			All other non-specific risk factors	BIH
			Overflow	AVBBC

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AVBBC Agency Placement Guidelines Continued

TABLE 2b: AVBBC Streamlined Client Criteria (Parenting)/ Agency Placement Guideline

Target Population	Age Limitations	Client Ethnicity	Agency Specialty Risk Factor	Best Agency
Parenting <i>* unless specified</i> <i>Moms eligible until</i> <i>Childs 2nd Birthday</i>	<19	Any Ethnicity	Substance Abuse (child <3 mo)	Healthy Homes
			Domestic Violence (child <3 mo)	Healthy Homes
			Mental Illness (child <3 mo)	Healthy Homes
			All other non-specific risk factors	El Nido
			Overflow	AVBBC
	<18	African American	Use specific risks listed above, except:	Varies
			All other non-specific risk factors	BIH
			Overflow	AVBBC
			Overflow	AVBBC

TABLE 3: AVBBC Referral Network

Common Referral Sources for the AVBBC	AVBBC Partnering Agencies	External Agencies referred to by AVBBC	Service Need; no referrals possible

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AVBBC Case Management Procedures

Triage Process

The triage team will consist of the MSW and RN. Both parties will review the client referral and take part in the client assessment. The assessment/intake will take place either in the home or office and will document and compile information that will depict the client as a whole person and identify problems, needs, risk factors and strengths.

*Based on the information gathered during the intake/assessment, a care plan will be devised for the client. At this time, it will be determined whether or not the client will be recommended for services from one or more agency within the collaborative, brokered services from another provider based on specific needs/issues, or if considered high risk, be provided with direct services by the Clinical Social Worker (for high risk psychosocial issues) and/or RN (for high risk medical issues).

Client- Case Manager Visitations

Clients will either primarily be seen in the home or office setting with visits also being made during scheduled doctor's visits or other important appointments in order to model, provide support and assistance to the clients.

Service Frequency

Low and medium risk clients will receive ongoing services and care with a required home visit being conducted one time per month. Phone and/or other significant contacts are to be made at least once bi-weekly.

High risk clients are to be physically seen at least once bi-weekly with a required home visit being conducted one time per month. Phone and/or other significant contacts are to be made at least one time per week.

Client Termination (Compliance)

AVBBC Client's cases can be terminated due to noncompliance on the part of the client, client moving out of the service area, no longer desiring services, or goals having been achieved. A client's case will typically be closed upon the youngest child's second birthday or the client's second year in the program with the exception of those who still demonstrate a great need for services beyond that point.

Please Note- All AVBBC Client's receiving direct care from a partnering agency may be terminated from participating in that agency as described in that agencies policies; however, no AVBBC client may be terminated from the AVBBC project before a thorough review has been conducted by the AVBBC Staff. Therefore, it is crucial that all agencies inform AVBBC Staff of client terminations ahead of time.

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AVBBC/Partner Case Management Commitment

Multi-Disciplinary Team Meetings (Case Consultations)

These meetings will take place once a month with each case within the AVBBC being scheduled for presentation and review. High-risk cases and those of great concern will receive priority. Emergency meetings can be called if and when staff determines that there is a case that needs immediate consult and that it cannot wait until the regularly scheduled meeting to take place. In this event, the Clinical Social Worker is to be notified and arrangements will be made to accommodate this request.

In addition, the Clinical Social Worker may also be contacted by AVBBC members in order to consult regarding potential clients or those who are already being seen by an agency within the collaborative.

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AVBBC Case Management Documentation

Documentation will be completed in a professional, thorough and timely manner. In addition to case notes being completed with each significant contact between staff and client, staff is to also document any services brokered for clients, collateral contacts made with other agencies or parties sought out to further assist the client and any other important information. Staff will also be responsible for the following client file components:

1. referral form
2. client information form (includes significant persons info)
3. signed application
4. privacy notice; rights information
5. authorization for release of information (to send and receive)
6. assessment of high risk
7. photo/media release
8. psychosocial assessment
9. nurse's assessment
10. action plan of care, which will include services client will be linked to, referrals made, agency (ies) involved, goals and objectives. This will be reviewed six months from admit date as well as annually)
11. client feedback form

* see appendix for tools

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AVBBC Case Management Best Practices

As members of collaborative dedicated to increasing healthy birth outcomes, decreasing the Infant Mortality Rate and providing the best services and support to pregnant and parenting women, our Case Management Program will do the following when working with our clients:

- ❑ Provide comprehensive services that address the whole person
- ❑ Strive to always be culturally sensitive and educate ourselves as much as possible regarding cultural differences, etc.
- ❑ Include family and/or other members of the client's support system in their care plan to ensure that clients are successful in achieving their specified goals and reducing the likelihood of poor birth outcomes
- ❑ Work with our client's from a strengths based perspective
- ❑ Educate and empower our clients
- ❑ Foster independence in our clients
- ❑ Be sure to keep abreast of services and resources in the community in order to ensure that our clients are linked and receiving what they need
- ❑ Be sure to note barriers to the services our clients need and work to remove those barriers
- ❑ Provide ongoing support to our clients while they are in our care

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AVBBC Case Management Client Education

A client of the AVBBC will be provided a comprehensive prenatal and infant care educational curriculum which will consist of (14 instructional/interactive classes and 6-7 social support and empowerment groups). The following schedule illustrates the proposed curriculum for the average AVBBC client:

Pregnant Women

2-3 Months of pregnancy	
3-4 Months of pregnancy	Legal Advocacy/ SSE
4-5 Months of pregnancy	
5-6 Months of pregnancy	
6-7 Months of pregnancy	Breastfeeding/SSE
7-8 Months of pregnancy	Birth & Post Partum Doula-Childbirth class
8-9 Months of pregnancy	

Post Partum/Interconception Women

1 Month Post Partum	
4 Months Post Partum	

Male Support & Education

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AVBBC Case Management Provider Education

Two separate curriculums have been developed for AVBBC provider education and is specific to Community Health Outreach Workers (CHOW's) and collaborative partners. The curriculum has been designed to furnish providers of the project with the minimum training requirements necessary to provide adequate culturally competent care and services to clients of the AVBBC.

Community Health Outreach Worker

Lactation Educator Training Program	

Collaborative Partners

Cultural Competency	