KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DIVISION OF PUBLIC HEALTH

BUREAU OF FAMILY HEALTH

Teen Pregnancy Targeted Case Management Manual

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TEEN PREGNANCY TARGETED CASE MANAGEMENT MANUAL

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SECTION ONE

GENERAL INFORMATION

INTRODUCTION

The purpose of the Teen Pregnancy Targeted Case Management (TPTCM) Manual is to assure consistency and uniformity in the implementation of the program and provide information and guidance for local provider agencies. The KDHE TPTCM manual must be used in the development of local provider agencies' TPTCM policy manual.

PHILOSOPHY

Pregnant or parenting teens who receive individualized, intensive case management services to assist them in the identification and utilization of personal, social and community resources, will be better able to meet the challenges in their lives and achieve their goals.

BACKGROUND INFORMATION

The purpose of the TPTCM is to provide comprehensive case management services to KanCare eligible pregnant and/or parenting adolescents in Kansas communities, with priority given to communities with greater numbers of adolescent Medicaid recipients. The project's goals are: to reduce negative consequences of teenage pregnancy for KanCare-enrolled teens and their children; to increase levels of self-sufficiency and goal-directedness relating to their own futures and that of their children; and to delay subsequent childbearing until completion of goals related to basic education/training; or they reach 21 years of age.

Under this initiative, grants are awarded annually on a competitive basis for the purpose of providing services for teens enrolled in Medicaid. Pregnant or parenting females less than 21 years of age receive individualized, intensive case management services to assist them in the identification and utilization of personal, social and community resources so they will be better able to meet the challenges in their lives and achieve their goals. The length of program participation is based on individual client needs and identified case goals with priority given to participants who are pregnant or within the period of 12 months post-delivery. The program provides an array of social services, including adoption education and information with no individual denied services based on inability to pay.

GRANT OBJECTIVES

The grant objectives are:

- 100% of pregnant teens participating in the program will receive adequate prenatal care, as measured by the Kansas Adequacy of Prenatal Care Utilization Index (http://www.kdheks.gov/hci/kacui.html) at entry into the program.
- Program participants will delay the birth of their second child until after completion of their basic education or vocational goals as measured by case management reports.
- 100% of program participants and their children will participate in well child (preventive) health programs as measured by immunization records and Kan-Be-Healthy/EPSDT schedules.
- 100% of teen parents will have demonstrated adequate parenting capacity at exit from the program as measured by case management reports of absence of substantiated incidents of child abuse and/or neglect as a result of the parent's action or inaction.
- Additional objectives may be added.

To achieve the grant objectives, case managers will be Social Workers or Public Health Nurses who are:

- Licensed to practice in the State of Kansas
- Trained in targeted case management
- Culturally competent
- Knowledgeable about adolescent development
- Diligent in conducting targeted outreach and recruiting eligible clients.
- Skilled in developing clearly delineated, client-specific case plans and providing supportive services to assist teens in attaining identified goals.

To achieve the grant objectives, provider agencies will:

- Provide comprehensive pregnancy support services and linkages to community resources for pregnant and parenting teens up to 12 months after delivery
- Conduct community outreach and recruitment activities to increase awareness and participation in program services
- Integrate adoption services, education and/or information into program services
- Actively recruit, select and train case managers
- Develop linkages with community programs and develop a referral network for related services
- Develop a team approach with social worker/nurse/advocate/case manager
- Develop strong education programs with emphasis on the eight life domains (Daily Living, Education/Training, Employment, Financial, Health, Key Relationships, Parenting and Empowerment).
- Use evidenced-based practices in their work with pregnant and parenting teens.
- Create and convene an advisory group that is reflective of the community to provide guidance and feedback regarding program services and direction. The advisory group shall include at least one adolescent, preferably an adolescent who has participated in the program.
- Develop and implement a process for assessing client satisfaction with services. At a minimum, client satisfaction should be assessed as the client exits the program

- Develop a program evaluation process that utilizes information from client satisfaction assessments and community needs assessment to evaluate the program and inform decisions about program improvement.

CLIENT GOAL PLANNING

Individualized plans in eight (8) life domains (Living Situation, Family, Social Relationships, Leisure, Work/School, Safety, Finances and Health) will be initiated for each participant within one month of entry into program. A sample *TPTCM CLIENT GOAL PLANNING* form is available in Appendix A. Progress towards completion of identified goals will be tracked for program participants utilizing individual goal tracking forms. A sample *TPTCM CLIENT GOAL TRACKING* form is included in Appendix B. Provider agencies may use the sample forms provided or develop comparable forms for program use.

The *TPTCM CLIENT GOAL PLANNING* (Appendix A) and *TPTCM CLIENT GOAL TRACKING* (Appendix B) forms, or comparable forms developed by the provider agency, will be part of each participant's file at the program site. Case managers will continuously monitor and document client goal plans, progress and referral outcomes.

ELIGIBLE APPLICANTS

1. This is a competitive grant application process. It is the intent of KDHE to award contracts so that services are available in all areas of the State, especially in areas with greater numbers of adolescent Medicaid recipients.
2. Organizations with documented experience and capacity to provide TPTCM services are invited to submit applications. An organizational chart is required from potential grantees as part of the application process.
3. Organizations with nonprofit status are eligible to apply. Proof of nonprofit status is required as part of the application for grant funding.
4. Grants are subject to availability of funds. Priority is given to continue funding of local organizations that consistently meet program objectives, reporting requirements, and participate in yearly education updates.
5. Grant funds may not be used for political purposes.
6. Grant funds may not be sub-granted to other agencies or individuals.
7. Contractual provisions of the State and KDHE will apply to all Grantees.

SECTION TWO

PROGRAM GUIDELINES

QUALIFICATIONS FOR ADMINISTRATORS, LOCAL COORDINATORS AND PREGNANCY CASE MANAGERS

The administrator will be an employee of the local agency receiving the grant. The administrator will demonstrate the ability to provide oversight of all TPTCM program services. The local coordinator will be a nurse or social worker licensed by the State of Kansas. A written request to waive the educational requirements must be made to KDHE prior to hiring a program coordinator. The local coordinator will demonstrate the ability to integrate services with other community efforts directed towards this population such as schools, DCF, YWCA, etc. in order to develop a community-wide system of care. The local coordinator may also be the program case manager in organizations with limited funding.

The case manager will be a registered nurse or social worker licensed by the State of Kansas. The case manager shall have a minimum of two years' experience working with pregnant teens, beyond basic professional education. Preferred, but not required, the case manager shall have experience working with pregnant teens in an outpatient clinic, office or public health prenatal program. The case manager should be knowledgeable about resources in the service area; experienced in establishing and maintaining communication linkages and agreements with community partners; able to assure the availability of and access to services and utilization of resources required by program.

RESPONSIBILITIES OF THE ADMINISTRATOR, LOCAL COORDINATOR AND CASE MANAGERS

The administrator is accountable for quality assurance, reporting of program activities, and compliance with program requirements. The program administrator will consult with the KDHE TPTCM Program Manager if questions arise filling the local coordinator position. When a coordinator is hired or replaced, the program administrator is responsible for providing the KDHE TPTCM Program Manager with the name and contact information for the local coordinator. The administrator will ensure that all reports are accurately completed and submitted on time. The administrator will ensure that at least one person from the local agency attends annual meetings and technical assistance sessions provided by KDHE. The administrator and coordinator of the local TPTCM program will participate in any scheduled site visits conducted by KDHE.

The local coordinator will be responsible for recruitment, screening, interviewing, selection, orientation and supervision of the case manager. The local coordinator and/or case manager will be responsible for the development and maintenance of relationships with key community partners.

The local coordinator and/or case manager will be responsible for recruitment and enrollment of clients/participants and providing case management services at both the client and community level. The case manager will be responsible for maintaining individual client records consisting of

(at a minimum):

- Current demographic information
- Tracking of client's goals and outcomes
- Program data
- Log of contacts that includes purpose, narrative assessment and process entries that report client strengths, challenges and life environment in a manner that assures continuity of services.

All records will be kept current and comply with Health Insurance Portability and Accountability Act (HIPAA) guidelines. TPTCM coordinator will complete and submit required reports in an accurate and timely manner.

PROGRAM EVALUATION AND MONITORING

On an annual basis each grant project will compile a master list of all client/participants in the TPTCM program. The list will include current clients and a list of clients that were in the program during the fiscal year. This list will be available on-site and will be reviewed as a quality assurance indicator of the information submitted by the grantee.

Program data collection and reporting are addressed in Section Three and Section Four of this manual.

GRANT FUNDING USAGE

Funds received by the Grantee are to be utilized for targeted case management and other specific services provided for the client by the Grantee or by others. Payments from sources other than grant funds are documented in the individual client's file. Grant funds for the following services are to be utilized after all other payment sources, including, but not limited to insurance coverage, special sliding fee and discount options and/or government assistance programs, have been exhausted:

a. ***Prenatal medical care*****:** Access to routine prenatal medical care can be provided by physicians or advanced registered nurse practitioners (includes certified nurse midwives). **Does not include payment for medical services.** Case managers will link clients to health care systems of care and healthcare coverage through Medicaid, KanCare and/or affordable insurance coverage for these services. Routine prenatal medical care includes laboratory tests and diagnostic ultrasound when the primary diagnosis supports the medical necessity for an OB sonogram.
b. ***Linkage to Medical care (non-pregnancy related) for the woman and offspring:*** Services by a licensed medical provider (includes physicians and advanced registered nurse practitioners) for the routine health maintenance, prevention/treatment of non-pregnancy related illness or injury.
c. ***Housing:*** Support for housing, excluding the client's usual residence.
d. ***Education:*** Activities that will facilitate the client's ability to advance toward a high school diploma, GED, vocational training or college education during the time the client is participating in the TPTCM services.
e. ***Promotion of Paternal Involvement and Responsibility:*** Opportunities that will support interaction between the mother and the infant's father as appropriate; interaction by the infant's father; assistance with the legal process for the establishment of paternity and parenting education.
f. ***Adoption Counseling and Referrals:*** Provision by the Grantee or facilitation of access to services that will provide accurate information regarding the adoption process.
g. ***Drug and Alcohol Assessment and Treatment*** Assistance by the case manager to obtain substance use screening, assessment and treatment by licensed or certified substance abuse programs/providers
h. ***Domestic Abuse Protection:*** Assistance by the case manager to any service or facility that will assure physical and emotional security and safety for the client, fetus, infant and other children.
i. ***Child Care****:* Assistance to obtain child care while the client is participating in the pregnancy support program and during post-delivery when the parent or guardian is absent, excluding in-home services.
j. ***Parenting Education/Support****:* Provision of parenting education to promote infant/child development and emotional support.
k. ***Transportation****:* Provision of transportation, when not otherwise available in the service area, for the client and child(ren) to access program services.

<u>Grant funds may not be used to purchase food and beverages</u>.

RELEASE OF CLIENT INFORMATION

Information about clients receiving services may not be disclosed without the individual's written consent, except as provided by law. Information may be disclosed in summary, statistical or other form that does not identify the individual.

NON-DISCRIMINATION

Services are provided without regard to religion, race, color, national origin, physical limitations, sexual orientation or marital status.

VOLUNTARY PARTICIPATION

Services are provided solely on a voluntary basis. Individuals are not subjected to coercion or mandated to receive services.

SECTION THREE

DATA COLLECTION REQUIREMENTS

DATA COLLECTION

In order for KDHE to fulfill obligations under Kansas Public Health Law (K.S.A. 65-101) and meet state and federal reporting requirements, minimum data elements must be collected and reported by each TPTCM provider agency.

Authority to collect the data is pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and Kansas Law as follows: HIPAA provides that a covered entity may disclose protected health information to a public health authority that is authorized by law to collect such information for the purpose of preventing or controlling disease, injury, or disability. *45 C.F.R. § 164.512(b)(1)(i).* KDHE is a public health agency that is authorized by state law to investigate the causes of disease, and is charged with the general supervision of the health of the state. *K.S.A. 65-101.*

DAISEY – SHARED MEASUREMENT SYSTEM

DAISEY, which stands for Data Application and Integration Solutions for the Early Years, is a shared measurement system designed to help communities see the difference they are making in the lives of at-risk children, youth and families.

DAISEY is the data collection and reporting system KDHE Bureau of Family Health developed to collect data on clients served by Teen Pregnancy Targeted Case Management. Implementation of this shared measurement system allows the KDHE Bureau of Family Health and their grantees to improve data quality, track progress toward shared goals, and enhance communication and collaboration.

Local grantees are required to make available in DAISEY client demographics and visit/encounter data on a real-time basis. All required client and visit data must be collected and entered into DAISEY by the 10th of each month. Access to necessary equipment and secure internet service is required. Upon approval by KDHE, provider agencies capturing real-time data in a system of record other than DAISEY (EHR for example) may elect to enter program data in DAISEY using aggregate entry forms. Aggregate entry forms must be completed by the 10th of each month.

Getting Started with DAISEY:

The DAISEY for KDHE website (http://daiseysolution.com./kdhe/) provides information for provider agencies to get started.

- Visit the "New to DAISEY" page: http://daiseysolutions.org/new-to-daisey/
- Watch the Ge*tting Started in DAISEY* webinar for an overview of DAISEY Implementation tools and resources.
- Check out DAISEY Implementation at a Glance.
- Request User Access

SECTION FOUR

REPORTING REQUIREMENTS

FISCAL AND PROGRAM REPORTS

Grantee will submit reports to KDHE through CATALYST as follows:

Report Type	Due
Financial Status Report	Quarterly (October 15, January 15, April 15, July 15)
Quarterly Progress Report	Quarterly (October 15, January 15, April 15, July 15)

QUARTERLY PROGRESS REPORTS

1. Grantee will submit to KDHE through Catalyst four progress reports during the contract year. The reports will include but will not be limited to the following information for the period covered by the report:
    a. Services provided and progress towards reaching identified goals and objectives.
    b. The number of teens who utilized the services and the services they received.
    c. Community outreach and program promotion activities.
    d. Description of how information from Client Satisfaction Survey responses was used to assess the program.
    e. Summary of TPTCM Advisory Group activities.
    f. Collaborative work with community partners.

SECTION FIVE

APPLICATION AND REVIEW PROCESS

APPLICATION SUBMISSION

Application guidance documents are posted online: ATL Library – http://www.kdheks.gov/doc_lib/index.html

1. KDHE will conduct an annual competitive application and review process open to all potential applicants through The Aid-to-Local grant application process.
2. Applicants must respond by submitting all information requested in the format prescribed by KDHE. Failure to submit all information requested shall be deemed sufficient cause for disqualification of the application from further consideration.
3. Designated staff from KDHE will provide technical assistance regarding the application process to potential applicants upon request.

APPLICATION REVIEW

1. Applications will be reviewed by individuals from KDHE.
2. The application will be reviewed for compliance to the Application and Program Procedures.
3. Reviewers will conduct a comparative assessment of the strengths and deficiencies of the applications, applicant experience with service provision, adequacy of service plans, budget and budget justification.
4. KDHE reserves the right to consider historic information and fact, whether gained from the local agency's application, question and answer conferences, references or any other source, in the application review process.

GRANT AWARD NOTIFICATION

1. Any grant award announcement or contract offer will be in writing from KDHE.
2. KDHE reserves the right to allocate funds based on need in accordance with data and information available to the KDHE.
3. Applications are reviewed on a competitive basis and as a result, not all applicants may receive an award. KDHE reserves the right to accept any application, to reject any or all applications, in full or in part and to waive irregularities and/or formalities as deemed appropriate.

SECTION SIX

OPERATIONAL DEFINITIONS

Adequate Prenatal Care

The Adequacy of Prenatal Care Utilization (APNCU) Index attempts to characterize prenatal care (PNC) utilization on two independent and distinctive dimensions – namely adequacy of initiation of PNC and adequacy of received services (once PNC has begun). The index uses information readily available on U.S. birth certificates (month of initial PNC visit, number of visits, and gestational age). This index does not assess quality of the prenatal care that is delivered, only its utilization. The assumption underlying this scale is that the earlier PNC begins the better. The American College of Obstetricians and Gynecologist (ACOG) recommends PNC begin in the first month of pregnancy; the Institute of Medicine now encourages pre-conceptual care.
Following the initial visit, the mother's visits should follow a schedule:

- Every 4 weeks for the first 28 weeks of pregnancy
- Every 2 to 3 weeks for the next 7 weeks (36 weeks)
- Weekly thereafter until delivery

Adolescent/Teen

At least 10 years of age and less than 21 years of age.

Caseload

An average assignment of 40 pregnant and parenting participants is assumed to be the full-time equivalent per case manager. Caseloads will vary over time. Client targeted case management load varies due to clients achieving their personal goals in life domains or moving out of the geographical service area.

Case management Entry

The process to enter the TPTCM programs: A pregnant female, less than 21 years of age, through a request for service by the client, referral by social service, health care, education or other may enter the program as funding allows.
Verification of need will be determined by each grantee in compliance with the grant application guidelines.

Case Management Exit

The process where a pregnant or parenting teen leaves the program. A client is exited from the program when one of the following occurs: completes identified case goals, reaches age limit (21 years old), is more than 12 months post-delivery, terminates participation, leaves service area, loses Medicaid eligibility or cannot be located. Clients who are not actively engaged in regularly scheduled (at least monthly) case management services should be exited from the program for one of the specified reasons.
Program Guidance: After 3 attempts to contact a client by phone and 1 additional attempt by letter within a one month period, the client should be exited from the program no later than the end of the following month if there is no response. If the client later requests

services, is within the 12 month post-delivery period, and still meets other program criteria, the case should be re-opened. In this situation the client would not be considered a new enrollee.

Client

A KanCare-eligible pregnant or parenting adolescent less than 21 years of age who is receiving regularly scheduled (at least monthly) face to face case management services. Clients may also be receiving additional services such group parenting education, peer to peer support groups, and social media interactions, however, adolescents who are solely receiving services other than face to face case management are not considered TPTCM program clients.

Note: Clients who are pregnant or within the period of 12 months post-delivery are the priority population to be served. Services may only continue past that time based on clearly documented individual client special circumstances and as long as it does not impact the program's ability to provide services to the priority population.

Full Term Birth

The American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine has issued a new opinion that defines the length of a full-term pregnancy. This includes the following definitions:
http://newsmomsneed.marchofdimes.com/?tag=full-term

- Early Term: Between 37 weeks 0 days and 38 weeks 6 days
- Full Term: Between 39 weeks 0 days and 40 weeks 6 days
- Late Term: Between 41 weeks 0 days and 41 weeks 6 days
- Post-term: Between 42 weeks 0 days and beyond

Pregnant

Containing a developing embryo, fetus or unborn offspring within the body.

Targeted

Provided to a specified population and/or provided in a priority geographic area. For purposes of TPTCM, the targeted population must be enrolled in Medicaid, less than 21 years of age and be pregnant and/or parenting. The priority geographic areas are counties with significant numbers of clients/participants in need of services.

TPTCM State Consultant

KDHE staff person responsible for administration and oversight the TPTCM grants. This person provides orientation and annual training for the grant recipient TPTCM. This person provides technical assistance, monitors project performance, approves all reports and recommends funding decisions in conjunction with KDHE Aid-to-Local funding process.

APPENDICES

TPTCM CLIENT GOAL PLANNING

CLIENT NAME: _____ CASE MANAGER: _____ DATE INITIATED: _____

GOAL CATEGORY Eight Life Domains	**WHAT IS CURRENTLY HAPPENING?**	**WHAT DO I WANT?**	**WHAT HAVE I DONE IN THE PAST?**
1. Living Situation (housing)			
2. Family (who in family unit, supportive)			
3. Social Relationships (father involved, friends supportive)			
4. Leisure (time for self, mental health)			
5. Work/School (job, child care)			
6. Safety (feel safe, domestic abuse)			
7. Finances (housing, transportation)			
8. Health (insurance, medical care)			

TPTCM CLIENT GOAL TRACKING

APPENDIX B

CLIENT NAME: _____ CASE MANAGER: _____

Date Initiated _____
Date(s) Reviewed _____
_____
_____
_____

Targeted goals may include the following:
Prenatal Medical Care; Medical Care (non-pregnancy); Housing; Education; Paternal Involvement; Adoption Guidance; Drug & Alcohol Assessment/Treatment; Domestic Abuse Protection; Child Care; Parenting Education/Support; Transportation; Other, specify

_____

I will complete this goal by doing the following goals in the listed categories.	Date Written	Responsible Party	Date to be Completed	Status Towards Achieving	Date Achieved	Comments
1. Living Situation (housing) Client's Initials ___						
2. Family (who in family unit, supportive) Client's Initials ___						
3. Social Relationships (father involved, friends supportive, need new relationships) Client's Initials ___						

APPENDIX B

TPTCM CLIENT GOAL TRACKING

4. Leisure (time for self, mental health) Client's Initials ___						
5. Work/School (job, child care) Client's Initials ___						
6. Safety (feel safe, physical or verbal abuse) Client's Initials ___						
7. Finances (housing, transportation, income, balance checkbook, budget) Client's Initials ___						
8. Health (insurance, medical care) Client's Initials ___						

Bureau of Family Health, Kansas Department of Health & Environment