

The logo of the Ohio Department of Health is a large, light blue circular emblem. It features a central silhouette of the state of Ohio. Above the state is a large, stylized caduceus (a staff with two snakes entwined around it). The words "OHIO DEPARTMENT OF HEALTH" are written in a circular path around the top and sides of the emblem. At the bottom, the motto "To protect and improve the health of all Ohioans" is written in a curved path.

**Ohio Department of Health (ODH)
Division of Family and Community Health Services (DFCHS)
Bureau of Child and Family Health Services (BCFHS)
Child and Family Health Services Program (CFHS)
Program Standards
2014**

Ohio Infant Mortality Reduction Initiative (OIMRI) Standards

February 2014

According to the Secretary's Advisory Council on Infant Mortality, *"Infant mortality, deaths to infants during the first year of life (measured as the rate of infant deaths per 1000 live births), has long been understood to be a reflection of how well a society takes care of its most vulnerable citizens. Infant mortality is a multi-factorial phenomenon, with rates reflecting a society's commitment to the provision of: high quality health care, adequate food and good nutrition, safe and stable housing, a healthy psychosocial and physical environment, and sufficient income to prevent impoverishment. As such, our ability to prevent infant deaths and to address long-standing disparities in infant mortality rates between population groups is a barometer of our society's commitment to the health and well-being of all women, children and families.*

Because of its multifactorial nature, risk factors for infant mortality include those related to women's health prior to and during pregnancy, those related to the pregnancy experience, those associated with the birth and newborn experience, and those associated with the child's health and well-being in the first year of life. Thus, many points of intervention for reducing infant mortality exist, and approaches are as disparate as expanding access to: primary care or family planning prior to pregnancy, high-quality prenatal care, specialty treatments for preterm or sick infants, breastfeeding support and immunizations, and safe housing and healthy neighborhoods." (SACIM, January, 2013)

As a State, Ohio ranks #7 for the number of babies born each year. So, optimizing care during pregnancy and the opportunity to survive the first year of life are areas in which Ohio has a huge responsibility. Yet, compared to all other States, during 2010 Ohio's infant mortality rates ranked #38, #47, and #49 for white, overall and black infant mortality, respectively. Black infants in Ohio die at almost 2.5 times the rate that white infants die and our overall infant mortality rate in 2010 compares with the United States overall infant mortality rates from 1995! Despite having some of the nation's best children's hospitals, Ohio babies are dying at unacceptably high rates and our black infant mortality rate is next to the worst in the United States.

In addition to clinical risk factors emphasized above, a growing body of literature clearly indicates that circumstances traditionally considered "non-clinical" have clinical sequelae, including compromised birth outcomes. According to the National Association of County and City Health Officials Health and Social Justice Committee Creating Health Equity Through social Justice, "Inequalities in health status in the U.S. are large, persistent, and increasing. Research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities... conditions such as polluted environments, inadequate housing, absence of mass transportation, lack of educational and employment opportunities, and unsafe working conditions are implicated in producing inequitable health outcomes. These systematic,

avoidable disadvantages are interconnected, cumulative, intergenerational, and associated with lower capacity for full participation in society...Great social costs arise from these inequities, including threats to economic development, democracy, and the social health of the nation.”

One of the ways Ohio has chosen to respond to this infant mortality crisis is the formation of the Ohio Infant Mortality Reduction Initiative (OIMRI). Now in its 22nd year, and located in 14 of Ohio’s most high risk communities, OIMRI programs have regularly provided improved infant mortality rates compared to the rates of non-enrolled citizenry from these same high risk neighborhoods. By doing so, OIMRI has become what I refer to as an “oasis” program. Webster’s defines “oasis” as fertile land in a desert or a place or time of relief: a place or period that gives relief from a troubling or chaotic situation. Regarding infant mortality, OIMRI sites have been placed in our most troubling and problematic communities and yet these programs continually provide substantially improved birth outcomes, as if an oasis in the middle of a desert. They have done so by augmenting clinical care with a social determinants of health approach that has proven itself to be an invaluable asset to the Ohio Department of Health and to mothers, babies and families throughout the entire State.

Sincerely,

Arthur R. James, MD, FACOG

Senior Policy Advisor, Ohio Department of Health

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Overview

“For as long as the United States has kept data on birth outcomes, the numbers have indicated that black babies are at greater risk of dying during the first year of life than babies from other racial/ethnic groups.” Arthur R. James, M.D., ODH Senior Policy Advisor

The infant mortality rate for African-American babies is almost two-and-a-half times the rate for whites. The infant mortality rate in Ohio is among the worst in the country for a U.S. born African American woman. Important determinants of racial/ethnic differences in infant mortality are low birth weight (LBW) and very low birth weight (VLBW). African-American women in Ohio are more likely than white women to deliver a LBW infant.

Infant mortality is a community problem. Eliminating the health and racial disparities of infant mortality will require a focus on reducing LBW and VLBW through the implementation of strategies aimed at improving the quality of prenatal care, pre-conception and inter-conception health; identifying underlying medical conditions; and understanding the role social supports and how environmental/societal factors such as stress, race housing, transportation, education, lack of economic opportunity, etc. contribute to poor birth outcomes. While Ohio has a safety net system of healthcare for uninsured/underinsured and Medicaid consumers, significant barriers to access remain.

The Ohio Infant Mortality Reduction Initiative (OIMRI) component of the Child and Family Health Services Program at the Ohio Department of Health (ODH) is a culturally specific home visitation program for expectant families that utilize peer and/or community connected Community Health Workers (CHW) to coordinate perinatal services for high-risk African American women. The Ohio Infant Mortality Reduction Initiative is designed to address the disparity in infant mortality in Ohio’s African American community. Using infant mortality data, programs have been established in neighborhoods with historically high rates of poor birth outcomes such as infant deaths, low birth weight, and very low birth weights.

The intent of the OIMRI Program is to reduce African-American infant mortality by achieving the following:

- Improve Maternal Health
- Improve Birth Outcomes
- Improve Infant and Child Health

Achievement of these goals can be accomplished by mutual understanding, compliance in meeting the OIMRI Standards, and collaboration with the greater community, clinics, hospitals, businesses, faith-based institutions, schools, non-traditional partners, etc. These efforts will serve to address the social determinants of health. The program addresses some of the barriers (e.g., financial, geographic, educational, cultural) that women and children experience and improves their access to and utilization of health care.

OIMRI provides trusted partners for community connectedness to implement a comprehensive approach to address the social determinants of health; targeted outreach to recruit high-risk mothers early in pregnancy; and on-going support to mothers throughout pregnancy and up to the child's second birthday.

Program Description

OIMRI is a client-centered, goal-oriented process designed to assess the risks, barriers, and needs of a pregnant woman and her family for particular health and social services such as social/emotional health, chemical dependency treatment, housing, and other advocacy; assist women in obtaining those services; and coordinate those programs and services to avoid gaps and duplication. OIMRI services may be provided to women from conception through the child's first 24 months of life.

These program standards will provide guidance for the development of program policies and definitions of outreach, case management, and home visiting and care coordination components of OIMRI. The OIMRI programs are funded to provide community-based outreach, case management and care coordination services in targeted communities with high-risk, low-income African-American pregnant women and families. When a disparate health condition affects the general population, it affects low-income and African-American Ohioans at a higher rate and more severely.

The OIMRI perinatal service coordination program, is a home visiting program that was developed by the Ohio Department of Health to address the racial/ethnic disparities found in perinatal and infant mortality and low birth weights. The program aims to reduce racial/ethnic health disparities among African-American minorities including perinatal and infant mortality, low and very low birth weights. One way of working to achieve these improved outcomes is by providing funding for community-based outreach and perinatal care coordination services in targeted census tracts/neighborhood area/communities with high-risk, low-income pregnant women and families.

A home visit:

- is a face-to-face interaction between the home visitor and a family or parent
- is scheduled in advance-not a chance meeting.
- is planned for a certain period of time-usually 60 to 90 minutes.
- usually takes place in the family home but may take place at a mutually convenient place such as a work place, library, or neighborhood site.
- offers social support and discussion of topics that are important to families.
- involves planned activities and topics based on the family's needs and the goal of the program.
- requires planning before the visit and follow-up after the visit.

Source: *Partners for a Healthy Baby Home Visiting Curriculum*

The OIMRI component utilizes the community care coordination model to empower communities to eliminate disparities. The community care coordination model supports employing individuals from the community as trained advocates who empower pregnant women and expectant fathers to access resources. These professional Community Health Workers (CHWs) provide a cultural and linguistic link to the community and to community resources through family-centered services. The following CHW definition was adopted by the American Public Health Association, Community Health Worker Section, "A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

In OIMRI, services performed by vital CHWs to improve birth outcomes, focus on improving maternal health, preconception and inter-conception health, education and maternal self-sufficiency. Information and services are provided in a manner that is culturally and linguistically appropriate to the needs of the target population that may be considered a difficult to reach population. The CHW conducts case finding/outreach; makes home visits on a regular basis during pregnancy and through the baby's second year of life; identifies and reinforces risk reduction behaviors; provides appropriate education; increases health knowledge; provides resource materials; identifies and works with the client's strengths; methodically engages the client in incorporating life-changing behaviors; collaborates with other agencies in making appropriate referrals to assure positive pregnancy and infant health outcomes; and may conduct or participate in the community public education activities to raise awareness. Through a range of activities such as outreach, community education, informal counseling, social support and advocacy, the CHW facilitates in building individual and community capacity.

Program Components

The OIMRI community care coordination model includes five core components: 1) planning; 2) training; 3) supervision; 4) standardized care processes; and 5) data collection and evaluation.

- 1. Planning-** The utilization of current data to target OIMRI services in specific neighborhoods and census tracts with the highest rates of poor birth outcomes and associated risk factors. It also may include conducting client surveys of prenatal care appointment waiting times; consumer surveys to determine specific barriers to care; Geographic Information System (GIS) mapping of infant mortality, low birth weight and other risk factors; and assessment of the availability of prenatal care providers in the targeted community.
- 2. Training-** Standardizing the education and training of CHWs and supervisors is an important component of the model. OIMRI projects develop a local plan to address and/or eliminate barriers to early and continuous prenatal care. OIMRI projects hire and train appropriate community health workers and supervisors who are culturally and linguistically appropriate, and connected to the population of interest and can implement this model. Trainings include, but are not limited to, a Community Health Worker Certificate Program at a college that provides core competency areas and a clinical practicum as required by the Ohio Board of Nursing for CHW certification. Also required is training in a comprehensive curricula providing appropriate guidance for home visitors and others working with pregnant women and their families as approved by ODH (i.e. *Partners for a Healthy Baby Home Visiting Curriculum*).
- 3. Supervision-** Supervision is to be conducted by an individual who has culturally and linguistically appropriate skills, and/or culturally connected to the community, and is trained in or has experience in the implementation of the community care coordination services model. This individual should have experience with or sound knowledge about working with a high risk, low income women of child bearing age.
- 4. Standardized Care Process-** The care coordination model uses a standardized care process that facilitates consistency of home visiting procedures and clearly delineates the expected actions of the community health worker.
Source: *Partners for a Healthy Baby Home Visiting Curriculum*
- 5. Data Collection and Evaluation** - Establishing and implementing a common data collection system that documents the impact of services is vital to measuring outcome. The OIMRI data system currently includes the trimester prenatal care was initiated assessment of risk factors, outcome of the pregnancy including gestation, weight of the infant, the number of well child visits made in the first and second year, and the immunization status at one and two years of age. Four (4) specific OIMRI reports are

submitted to ODH: (1) Client Intake, (2) Birth Outcome, (3) Exit Report, and (4) Case Load Analysis Report.

Evaluation is the process of determining if the OIMRI Program was successful in achieving its intended outcome. Local programs should use evaluation data such as satisfaction surveys and chart reviews to inform staff development and continuous quality improvement.

These Standards will help the manager/supervisor and community health worker in assuring compliance and accountability with the statewide OIMRI program. In addition, it is intended to assist all OIMRI projects in developing job duties, responsibilities of the manager/supervisor and community health worker, and data collection and reporting.

We are committed to continuous improvement in the implementation, evaluation and quality assurance of the overall program as well as to the success of each local project. The purpose of the OIMRI Program is to fund perinatal service coordination projects within specific targeted census tracts and/or neighborhoods for high risk, low income, and uninsured/underinsured pregnant women.

OIMRI programs exist in 14 counties in Ohio with high, unacceptable infant mortality rates. They are Allen, Butler, Clark, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Richland, Stark, Summit and Trumbull counties.

All applicants for the OIMRI component are required to demonstrate the need for CFHS OIMRI funding by reporting the results of their community health assessment. These results must include data about the OIMRI target population, evidence of need of OIMRI services and how programs will address the need. In addition, eligibility and justification for the submission of an application is outlined in the Child and Family Health Services Request for Proposal.

The applicant must develop its OIMRI program plan and budget based on the needs and gaps in perinatal services as identified in their community health assessment. Any applicant requesting funding for OIMRI must provide a letter of support from the local Help Me Grow Program outlining how Help Me Grow and OIMRI will collaborate in serving the target population.

In the grant application, local projects must provide a detailed overview of the OIMRI component including outreach activities and incentive programs for clients including the specific census tracts in which these services will be targeted/provided; the number of clients the OIMRI project plans to serve in a fiscal year; and the number of community health workers, supervisor, etc. funded with CFHS dollars and whether they are employed full-time or part-time.

Projects are responsible for systematic quality assessment and improvement, and are accountable for all OIMRI program and fiscal requirements to assure the monitoring, administrative oversight, appropriateness and effectiveness of the perinatal service coordination program.

Administration

The OIMRI Program utilizes the community care coordination model to empower communities to eliminate disparities. The community care coordination model supports employing individuals from the community as trained advocates who empower individuals to access resources. Professional community health workers (CHW) provide a cultural link to community resources through family-centered services. These services focus on achieving success in health, education, and self-sufficiency. The CHW makes home visits on a regular basis during pregnancy and through the baby's second year of life; identifies and reinforces risk reduction behaviors; and collaborates with other agencies in making appropriate referrals when necessary to assure positive pregnancy and infant health outcomes. The structural arrangement should facilitate their integration to and acceptance by the applicant and/or contract agency.

OIMRI Staff

The staff funded by ODH must comply with the OIMRI Standards and CFHS Administrative Standards.

The basic staff for an OIMRI Program includes one supervisor, indigenous, full time community health workers. The supervisor may be a social worker, nurse or licensed community health worker. Grant funds may pay an appropriate percentage of the time of a fiscal employee, if necessary. The funds should not be used to supplant the salaries of agency staff who are not directly related to the execution of program.

Administrative Staff

OIMRI projects managers ensure adequate supervision of Standardized Care Processes so that home visits and client case reviews meet the content and quality of CFHS standards and that caseloads are maintained as indicated in the Standards. OIMRI projects ensure ongoing data collection and evaluation in order to assess program success and client outcomes.

Each local project is responsible for assigning only one manager/supervisor for OIMRI. The administrative oversight and division of responsibilities of OIMRI is clearly delineated within the project. The OIMRI supervisor must:

- Recruit, hire and supervise culturally and linguistically appropriate community health workers. Ideally, CHW positions are full-time positions. Part-time positions must be pre-approved by ODH.
- Ensure that CHWs have experience with at risk, low-income women of child bearing age.
- Schedule and hold staff meetings at least bi-weekly.
- Determine the type/nature of the client assessment.
- Ensure that all client evaluation materials are completed and documented in the client file in a timely manner.
- Ensure the assessment of child development at appropriate intervals and the documentation of results.
- Provide case review and case conferencing for all community health workers.
- Assure compliance of community health workers in carrying out all perinatal service coordination components and activities; in meeting clients' needs; in choosing appropriate content of home visits; documenting of home visits; and in accurately defining the frequency and intensity of home visits.
- Review all referrals to ensure potential referrals fit the OIMRI client definition and risk criteria prior to assigning any referral to the appropriate community health worker.
- Assure that community health workers carry out all components (case finding clients, client assessment, care coordination, client input, home visiting, community education) as defined by the OIMRI Program.
- Ensure that community health workers are adequately trained and receive periodic in-services and training on related perinatal service coordination (outreach, case management, home visiting and care coordination) skills. OIMRI staff should receive periodic in-services and training on areas that benefit the provision of services to families (e.g., pre and inter conception care, breastfeeding, screening, social determinants of health, mental health, and smoking).
- Monitor and review client satisfaction surveys.
- Ensure that OIMRI client satisfaction surveys are audited annually.
- Conduct and maintain a record of annual client chart audit.

The OIMRI Program expects local OIMRI projects to use brochures, pamphlets, videos or handouts to reinforce education with the family and should include culturally and linguistically appropriate educational, promotional and health education/advertisements. When possible, OIMRI projects are encouraged to obtain low cost or free of charge printed materials and videos and to evaluate educational materials for low literacy. Potential purchase of educational material(s) must have prior approval by the OIMRI Program before purchase. The description of the material(s); purpose, type, number and total expense must be submitted for approval.

Workshops, classes, seminars, out of state travel and/or other types of educational program expenses for clients, must be submitted for approval prior to the event(s).

Staff Accountability

Project personnel must be qualified to perform the OIMRI responsibilities and tasks as further described in the Appendix. Project personnel must have the appropriate training and skills to perform their job duties and responsibilities. Project staff is responsible for complying with the OIMRI Standards.

- The OIMRI Project supervisor must develop a mechanism for defining, reviewing and updating the local project policy (including goals, objectives and evaluation components). Any changes must be forwarded to ODH OIMRI Program Coordinator for approval.
- OIMRI staff must adhere to a client confidentiality policy to protect client's information and right to privacy.
- The OIMRI supervisor must review all OIMRI clients' charts/files kept by community health workers for quality assurance and compliance with the OIMRI program requirements. During the administrative chart review, the following should be reviewed:
 - Services offered including appropriateness and effectiveness (i.e., intake, screening, assessment, curriculum, progress, referrals).
 - Supervisor case review and consultation. Supervisor review should include the date of the review and signature of the supervisor.
 - Client concerns are documented and addressed.
- The OIMRI supervisor may designate staff person(s) who will be responsible for entering of client information and the completion of all required OIMRI reports that are submitted to the ODH OIMRI Program quarterly. In that capacity, the designated individual(s) will be responsible for ensuring that all reports are fully and accurately completed as described in the protocols, and that they are submitted on time. This individual will also serve as the ODH primary contact when there are reporting concerns and issues.
- Community health workers should meet with the project supervisor when problems or conflicts arise; these should be addressed per local agency policy.
- The OIMRI supervisor and community health workers should work to maintain robust resource lists and networks so that clients may be referred to appropriate health and human services.

Documentation and Reporting

Project management and community health workers must complete and submit all OIMRI data to the ODH OIMRI Program in a timely and accurate manner (all reports are due to ODH quarterly by the 15th of the month following the end of a quarter). Lack of compliance and failure to respond to OIMRI reporting disqualifies the project for continuation funding. Data reporting ensures accountability, quality of the reporting and evaluation.

Each OIMRI project must have the capacity to complete all OIMRI program reports and related client information locally for all OIMRI clients as described in the OIMRI Standards, and as stipulated in the OIMRI program reporting requirements in the Request for Proposal.

Project manager/supervisor must designate one data entry staff person who will be responsible for the entering of data and for the quality assurance of all reporting forms that are printed and submitted to ODH/OIMRI Program quarterly. In that capacity, the designated individual will be responsible for ensuring that all reports are fully and accurately completed as described in the protocols and are mailed on time. This individual will also serve as our primary contact within your project when addressing reporting concerns and issues. However, the supervisor is ultimately responsible for the submission of accurate OIMRI data reports.

OIMRI must document all outreach, case management, and home visiting and care coordination activities uniformly. All outreach, case management, and home visiting and care coordination forms developed by the project must be used consistently by each community health worker for each OIMRI client.

Each OIMRI client's file must have a copy of each one of the reporting forms as submitted to ODH (Client Intake Report, Birth Outcome Report, Exit Report and Caseload Analysis Report, if appropriate.). A new OIMRI Client Intake Report should be completed when updates are necessary. In addition, the files should include the following:

- Documentation of intake and eligibility determination
- Signed consent forms
- Documentation of assessment(mother and child)
- Documentation of appropriate screenings (mother and child)
- Referral forms and documentation of other correspondence
- Tracking of referral follow-up
- Documentation of materials provided
- Documentation of pathways/care process
- Case notes including the name of the staff member and the date

- Documentation of attempted, but unsuccessful contacts

Files must be kept for each OIMRI client in a secured file area. Client confidentiality is required. Project management must review files/charts of community health worker caseload for quality assurance.

Failure to assure quality of reporting such as submitting incomplete and/or late program reports per OIMRI Reporting Protocols will jeopardize the receipt of further payments and/or continuation funding.

Case Finding

Case finding component includes outreach. Case finding is the identification, recruitment and enrollment of OIMRI clients. The OIMRI client is an African American, uninsured/underinsured, high risk pregnant woman from the project's specific geographic target area(s), census tracts and/or neighborhoods. Local projects should consider various strategies to locate and reach women of child bearing age.

The purpose of case finding is to locate (per census tracts/neighborhoods) and enroll low income, uninsured/underinsured, high risk pregnant women in need of access to prenatal care, and to provide continuous support through their pregnancy, postpartum care and until the infant is two years of age. The child should receive appropriate and timely screenings utilizing, at a minimum OIMRI identified tools.

Outreach should include the development and uniform maintenance of tools to be used for the outreach component including the assessment and documentation of risk factors and the enrollment of the OIMRI client. Provide door to door canvassing and/or distribution of program literature in targeted census tracts/neighborhood areas. Community health workers must canvass on, at a minimum, monthly basis.

The following outreach strategies are offered to assist in case finding:

- Place program information in places that potential clients are likely to visit such as apartment complexes, child care providers, places of worship, grocery stores or markets, health and human services agencies, libraries, businesses, health care providers, laundromats, libraries, food pantries, shelters, community centers, etc.
- Be visible at community events.
- Network with professionals and organizations that may interact with potential clients.

Case finding includes screening of in-coming referrals as not all referrals are appropriate and/or meet the client definition and risk factor criteria OIMRI Program. Referrals must be reviewed and assigned to appropriate community health workers by the OIMRI Program supervisor. If during canvassing the community health worker finds a woman who is pregnant, but she does not meet the criteria for enrollment in the OIMRI Program, the CHW will refer the individual to the appropriate agency for services. She is not counted as an OIMRI client. The project may only document the referral.

All community health workers must adhere to the following guidelines:

- Provide case finding and recruitment of OIMRI Program clients in specific targeted census tract areas and/or neighborhoods as described in the grant application. Case finding includes grassroots outreach in targeted census tracts/neighborhood area(s).
- Community health workers must maintain an OIMRI standard determined caseload. A new full-time employee should maintain a caseload of 15-20 clients while attending a semester-long community health worker training and curriculum training. All full-time community health workers hours should maintain and manage 40-45 clients for a 40 hours per week schedule on a continuous month to month/quarterly basis. Ideally, CHW positions are full-time positions. Part-time positions must be pre-approved by ODH. The caseload of all OIMRI community health should be comprised of 40% pregnant women and 60% of the caseload comprised of post-partum women, on average. Failure of the OIMRI program to maintain the required caseload may jeopardize the receipt of further payments and/or cause a reduction in funding.
- Once a pregnant client is identified, enroll her using the OIMRI Client Intake Report. The OIMRI Client Intake Report must be completed by the community health worker who enrolled the client in the OIMRI Program and complete a consent form.
- Ensure client with consent form as established by local project.
- Assist client, if necessary, with the completion of the Combined Programs Application form and provide any follow-up assistance.
- Reinforce recruitment with prompt home visiting and care coordination.
- Postpartum women are not enrolled as clients. Postpartum women not enrolled in OIMRI may be referred to the appropriate service agency for care.
- The OIMRI supervisor and community health workers should work to maintain robust resource lists and networks so that clients may be referred to appropriate health and human services, housing, food banks, etc.
- Once a client is either terminated (e.g., miscarriage, abortion, stillborn, infant dies) or exits (child is two years of age) from the project, the community health worker is responsible for recruiting a replacement as quickly as possible in order to maintain the required caseload.

Case Management

Case management assures continuous prenatal care and access to needed medical services for OIMRI clients, and provides clients with the tools and experiences to successfully make and keep their own appointments in the future. Case management services are provided to clients throughout the pregnancy until the child's second birthday. Preconception and interconception care that addresses birth spacing is one approach to improving birth outcomes. A potential client is determined eligible for the program, case management commences. The OIMRI Program uses a case management system where community health workers augment clinical care by employing efforts to address non-clinical concerns that could influence maternal and infant health.

Case management includes:

- Assessing needs
- Ensuring necessary screening (at a minimum):
 - Edinburgh mental health screening for depression
 - Ages and Stages Questionnaire for developmental and socio-emotional screening
- Establish client's preference of health care provider and linking client with health care provider
- Developing and implementing the care plan within 30 days
- Reassessing the care plan
- Evaluating progress
- Documenting change in risk behaviors
- Documenting referrals and follow up interventions
- Coordinating services with WIC and other service agencies in the community
- Assuring the newborn(s) has a medical home and is receiving routine care including immunizations
- Reinforcing reproductive life planning and contraception
- Program data collection and evaluation

Document family, mother and child goals as well as if the goals were achieved and/or the barriers to addressing the goals. Document home visits including the client progress and curriculum used (e.g., mental health, parenting, systems issues, environmental factors, social supports). Include the date, duration and time of the home visit as well as the type of service provided along with the signature of the home visitor.

Community health workers must document in clients' files specific support, referral and follow-up. Document all outreach/contacts, case management and home visit activities per client, including well child visits and immunizations. Community health workers should:

- Document all contacts (e.g., phone, e-mail, text, home visit, letter).
- Complete all outreach and home visiting forms established in each project for client contact (e.g., daily log, home visit log, phone/text log, referrals, follow-ups).
- Conduct follow up of all referrals and appointments.
- Document observations of clients' mental and physical health and social determinants of health (e.g., housing, work/education, social support).
- Document work with the clients to establish care coordination plans and self-improvement goals.
- Act as liaison between the client and other agencies for referral services and document follow-up.
- Document/report enrollments in WIC.
- Document that client's child receives well child care services and immunizations.
- If the clients is pregnant within two years of delivery, report client's second pregnancy. Client must be terminated in the Caseload Analysis Report. Then, a new OIMRI Client Intake Report must be submitted for the second pregnancy (note it on the form as "second pregnancy within a year"). Both the first and second pregnancies must be followed separately using two sets of reporting forms (OIMRI Client Intake, Birth Outcome and Exit Reports).
- Review all charts of all clients for quality assurance (at least quarterly).

Community health workers must maintain an OIMRI standard determined caseload. A new full-time employee should maintain a caseload of 15-20 clients while attending a semester-long community health worker training and curriculum training. All full-time community health workers hours should maintain and manage 40-45 clients for a 40 hours per week schedule on a continuous month to month/quarterly basis. Ideally, CHW positions are full-time positions. Part-time positions must be pre-approved by ODH. The caseload of all OIMRI community health should be comprised of 40% pregnant women and 60% of the caseload comprised of post-partum women, on average. Failure of the OIMRI program to maintain the required caseload may jeopardize the receipt of further payments and/or cause a reduction in funding.

Refer to Appendix: Referral Sources and Community Resources for a list of community resources for OIMRI clients.

Loss to follow-up

If successful contact cannot be made with the client, the community health worker should document all the attempts. A minimum of three attempts to contact should be made within a 30 day time period. The date and time of the attempted contacts should be recorded in the client's file. The final contact should be written and sent via postal mail; the letter should explain that contact has been unsuccessful and the client may contact the OIMRI Program to reengage. A copy of the letter should be maintained in the client's file.

Community health workers are not to provide enrollment and case management for CFHS direct care patients only. This is an outreach services program; it is a community/neighborhood based program that collaborates with the CFHS, other clinics, and service organizations. CFHS Projects may not use the OIMRI community health worker at CFHS clinics or for other purposes or activities not supported by these Standards.

Document whenever OIMRI participation is discontinued. The exit and/or termination should include the reason for the discontinuation of services and a summary of the services provided to date including accomplishments.

Care Coordination and Home Visiting

The OIMRI Program utilizes the community care coordination model to empower communities to eliminate disparities of premature births, that may result in low birth weights, very low birth weights, infant death or maternal death. The community care coordination model supports employing individuals from the community served, as trained advocates who empower their clients to access resources. Professional community health workers provide a cultural link to the community and community resources, through family-centered services. These services focus on achieving good results in physical, mental, emotional health; education, independence and self-sufficiency. This trusted home visitor, makes home visits on a regular basis during pregnancy and through the baby's second year of life; identifies and reinforces risk reduction behaviors; and collaborates with other agencies in making appropriate referrals when necessary to assure positive pregnancy and infant health outcomes.

The community health worker is a trained, skilled advocate from the targeted community who empowers the pregnant woman to access community resources through education, outreach, home visits, and referrals. The community health worker helps recognize potential problems to prevent poor health outcomes for the family.

An OIMRI client is a low-income, high-risk pregnant woman of African American descent from a specific geographic target area(s) (e.g., census tracts and neighborhoods). The family remains on the program until the infant's second birthday.

Care coordination is a dynamic process that includes continual assessment, referrals and providing and facilitating support. Care coordination is dependent on the individual client's needs and readiness for intervention. Networking in the community serves as a valuable tool in assisting clients to help assure systems of care, referral and support. The community health worker's role as someone culturally connected to the community is vital to developing a trusting relationship with the client. These critical components help ensure that the necessary connection is made resulting in appropriate intervention, assessment and referral occur.

Home visits are the primary mode of communication in the OIMRI Program. Telephone or email communication may serve as secondary support. During the home visit and care coordination process, the client receives assessments, education, referrals and support. The *Partners for a Healthy Baby* is the primary curriculum. The nationally recognized curriculum is research-based and practice-informed. By following the curriculum the community health worker utilizes a planned sequence of topics essential to achieving outcomes.

The home visit should be conducted in the place and at the time that is convenient for the client. The care plan for the client should be based on the client's needs as well as the family resources and individual goals. The OIMRI project develops home visiting protocols based on the following guidelines.

- Assessment components: how to identify critical health education needs in safety, environment, family support, etc. Develop and implement consistent, uniform assessment tool (s).
- Visit frequency and intensity: based on risk factors and assessment of needs. If the pregnant female is a high risk client, visits and/or contacts should be adjusted accordingly. As a guide, visits should occur at a minimum: one home visit every two weeks for the first month of program participation; one home visit per month for the remainder of the pregnancy; one home visit every two weeks for the first two months post-partum; and one home visit per month for the remainder of the program participation (child turns two years old). In addition, telephone, email and text messages may occur.
 - 1st trimester program entry: 10-15 home visits
 - 2nd trimester program entry: 8-12 home visits
 - 3rd trimester program entry: 5-10 home visits
 - One-year post-partum: 10-15 home visits
 - Two-years post-partum: 10-15 home visits

- Communication/Bonding: empowerment and mentoring of clients. Community health worker creates a relationship free of dependency. Encourage independent decision making.
- Social Support: provide client support as needed and as appropriate. Client case review should be completed in a team approach with the manager/supervisor and community health worker.
- Coordination of services with other service organizations: WIC and other service agencies, faith-based organizations, in the county/multi-county. Community health worker must document in clients' files specific referral and follow up services.
- Appointment verification: documentation of compliance with appointments (e.g., prenatal, WIC and Medicaid).
- Abuse/Neglect: Report suspected abuse or neglect and document appropriately.
- Education reinforcement: reinforcement of health education provided in prenatal care, WIC and well child appointments and encouraging independent problem-solving. The community health worker reinforces client OIMRI Program education during home visiting. This component should include but is not limited to:
 - nutrition for mom and baby
 - reproductive life planning
 - birth spacing
 - vitamins
 - utilization of WIC services
 - safe sleep
 - breastfeeding
 - screening
 - smoking cessation/substance abuse
 - child development
 - stress
 - immunizations
 - assessing level of understanding of knowledge/information provided by health care providers and other agency support systems.
- Quality assurance: monitoring and evaluating the quality of the home visits. Develop monitoring tool and document plans for improvement and tracking.

Personal Safety

While conducting outreach and home visiting, the personal safety of OIMRI staff is important. The following recommendations are made to help ensure the personal safety of staff. Refer to Appendix: Home Visiting Personal Safety.

Help Me Grow

The local OIMRI project develops the process that infants and toddlers identified with developmental delays or disabilities or who have a medical diagnosis and are receiving services from the proposed OIMRI component will receive Help Me Grow Early Intervention Services. Plans to collaborate with Help Me Grow occur to prevent duplication of efforts for services to pregnant women, children and families are developed and documented.

Healthy Start

If there are other local perinatal community care coordination programs such as federal Healthy Start, the OIMRI project must provide an explanation of how they collaborate. A detailed plan describing how collaboration will occur to prevent duplication of efforts for services to children and families served by will be provided to ODH.

WIC

WIC and OIMRI coordination efforts are required for the enrolling of low income, uninsured high risk pregnant women with the completed Combined Programs Application (CPA) forms to identify low income, uninsured high risk pregnant women not enrolled in WIC and assist them in enrolling by completing and submitting the CPA form to WIC. This also augments collaboration between OIMRI and WIC projects in order to more quickly and thoroughly meet the nutritional needs of pregnant women and infants. Community health workers should assure that all clients get an appointment with WIC and should follow up with their clients for compliance.

Appendix A: Project Manager/Supervisor Responsibilities

- Directing, documenting and coordinating the activities of the grant
- Quality assurance components of this grant including the administrative oversight and accountability issues
- Managing/supervising all community health workers
- Being culturally and linguistically appropriate
- Meeting project goals and objectives, and for completing the activities and evaluation components as described in the grant application
- Providing direct supervision to all community health worker staff
- Accompanying an employee on the initial home visit
- Conducting a home visit with each community health worker at least once a year
- Representing the project and attending all related local inter-agency meetings, collaborative meetings and/or consortiums/boards
- Designating staff, as necessary, for data entry and quality assurance of all OIMRI reporting
- Completing the OIMRI Caseload Analysis report
- Reviewing and submitting all OIMRI Reports quarterly to ODH/OIMRI Program Consultant
- Conducting an annual OIMRI chart audit
- Establishing and maintaining staff meetings with project staff
- Ensuring attendance at trainings and quality assurance activities as needed and necessary to acquire , update, and maintain skills and information
- Assuring periodic in-services and trainings for OIMRI staff are program related
- Screening all referrals and for making the assignment to appropriate staff
- Providing and assuring proper chart/file auditing of all OIMRI clients per community health worker
- Timely and accurate financial reporting to ODH Grants Management
- Notifying and submitting personnel changes (hiring, firing and/or resigning) in a timely manner to ODH Program Consultant
- Ensuring the availability of a community resource guide

Appendix B: Community Health Worker Responsibilities

This includes community health workers, nurses and social workers that are culturally connected to the clients and communities served.

- Documenting all outreach and home visiting activities in each client's file
- Recruiting and maintaining a caseload
- Conducting door to door and/or other grass roots canvassing activities
- Case Management of clients
- Being culturally and linguistically appropriate
- Providing face to face home visits and education with each client in their caseload
- Completing OIMRI Client Intake Report, Birth Outcome Report and Exit Report
- Completing the OIMRI Client Intake Report for each client in their caseload
- Updating client risk factors. An updated OIMRI Client Intake Report must be completed
- Outreach, case management and home visiting and care coordination activities as described by ODH Standards
- Providing appropriate referrals and follow up services for each client
- Assuring enrollment in WIC with completed CPA forms
- Case finding and client identification; liaison between client and service agencies; facilitate entry into prenatal care; provide reinforcement of education and linkages to health care and social services
- Ensuring attendance at trainings and quality assurance activities as needed and necessary to acquire , update, and maintain skills and information
- Encouraging and empowering clients in independent problem-solving
- Maintaining client confidentiality
- Reporting and maintaining regular contact with the Project Manager/Supervisor
- Meeting and complying with the Quality Assurance (accountability) issues related to this position

Appendix C: OIMRI Community Health Worker Six Basic Competency Areas

1. Health Care

- 1.1 Recognize the physical, emotional and spiritual components that can impact a person's state of health.
- 1.2 Demonstrate documentation skills using the approved note format.
- 1.3 Locate and explain basic medical terms using the medical dictionary.
- 1.4 Identify and recall the major body systems.
- 1.5 Discuss in basic terms the major functions of each body system.
- 1.6 Describe how different legal and illegal substances affect the body.
- 1.7 Describe local health systems and their referral processes.

2. Social Services

- 2.1 Identify and refer people who have basic social, educational, and employment needs.
- 2.2 Describe social and community resources and their referral processes.
- 2.3 Identify entitlement programs and utilize their resources with clients.
- 2.4 Recognize and report signs of family violence.
- 2.5 Recognize and make appropriate referrals for signs of mental health problems.

3. Communication Skills

- 3.1 Demonstrate effective interpersonal communication skills.
- 3.2 Utilize the ability to listen and build and maintain trust, respect and empathy.
- 3.3 Compose written communications using correct grammar, spelling, and format; report information in a brief and complete style to health care/service providers.
- 3.4 Demonstrate effective interview techniques for information.
- 3.5 Use appropriate telephone techniques.

4. Individual and Community Advocacy

- 4.1 Respect diversity by being an advocate for people's rights, self-esteem, equal treatment of all, and strength through interdisciplinary teamwork and partnerships.
- 4.2 Empower people and communities through their own strengths and resources to solve their problems and address their needs.
- 4.3 Use case finding techniques to identify needs, motivate people to obtain care, make referrals, connect people with systems and providers, and complete follow-up strategies to assure that people receive the services they need.
- 4.4 Serve as a community liaison between people and providers by maintaining knowledge of local agencies and providers; by educating those agencies/providers about the beliefs and practices of the people served; and by promoting favorable health and social outcomes.

5. Health Education

- 5.1 Promote healthy lifestyle choices through proper nutrition, exercise, and stress management; encourage people to manage and reduce health risk.
- 5.2 Explain to people the steps for taking a temperature in an adult and a young child and for follow-up with the thermometer reading.
- 5.3 Explain basic prevention and wellness topics.
- 5.4 Explain age-appropriate injury prevention techniques.
- 5.5 Educate about preventive health screenings and health promotion practices.

6. Service Skills and Responsibilities

- 6.1 Demonstrate and practice confidentiality and its importance in relation to the individual and the community.
- 6.2 Use appropriate pathways and agency protocols for care coordination, including documenting and releasing client information.
- 6.3 Ensure that all client documentations are submitted for review by a supervisor within specified time guidelines.
- 6.4 Demonstrate basic CPR skills.
- 6.5 Demonstrate the basic components of an effective home visit, including personal safety.
- 6.6 Identify the emotional dynamics involved in care coordination and utilize a personal and professional support system to cope with these dynamics.
- 6.7 Demonstrate the ability to take a temperature in an adult and a young child and to follow-up with the appropriate steps for the thermometer reading.
- 6.8 Practice efficient time management and document time allocation accurately.
- 6.9 Demonstrate conflict management skills, utilizing cooperation, leadership and respect for differences
- 6.10 Perform basic clerical, computing, and office skills
- 6.11 Demonstrate the ability to set healthy boundaries with clients
- 6.12 Exhibit friendliness, sociability, confidence, professional conduct and appearance; demonstrate organizational abilities including coping with stress, goal-setting, planning, and priority-setting
- 6.13 Exhibit qualities of patience, open-mindedness, motivation, self-direction, care/empathy, commitment to community work, honesty, reliability, flexibility, adaptability, persistence, creativity and resourcefulness.

Appendix D: Referral Sources and Community Resources

The following information is not intended to be an exhaustive list. Rather, it is a sampling of programs, agencies and facilities that may be available in your community. Some may serve as a referral source to OIMRI and others may be a resource for families or serve as both a referral source and a resource for family needs.

Source: Ohio Help Me Grow Home Visiting Program Manual 2010

Child care/preschool: County Department of Job and Family Services; faith-based programs; child care centers; home child care providers; college or high school child care centers; Head Start and Early Head Start; Mother's Day Out programs; Ohio Child Care Resource & Referral Association (www.occrra.org).

Dental: Safety Net Clinics; Healthy Start/Healthy Families

Department of Job and Family Services (DJFS): OWF, unemployment, employment assistance, cash assistance, SNAP (food stamps), subsidized child care, foster care, adoption, child support, child abuse/neglect, kinship

Electric/utilities: Home Energy Assistance Program (HEAP), PUCO, weatherization programs, community action agencies

Financial and/or material assistance: County Department of Job and Family Services (see DJFS); Catholic or Lutheran social services; veteran's services; Salvation Army; Goodwill; churches, temples, mosques and other faith-based entities; foundations; pregnancy centers; service groups such as Kiwanis or Lions Club (e.g., for glasses); financial counseling and foreclosure prevention programs; Benefit Bank (<http://www.thebenefitbank.com/TBBOH>).

Food: Food pantries; DJFS

Health/Medical: Hospital prenatal and pediatric clinics; health department prenatal and pediatric clinics; neighborhood health centers (known as Federally Qualified Health Centers); Regional Perinatal Centers; family planning clinics; STD clinics; hospital labor and delivery departments; obstetrical physicians; developmental pediatricians; children's hospitals; free clinics; Healthy Start/Healthy

Housing: Housing organizations which provide counseling and/or low income housing; homeless shelters and advocacy groups; foreclosure prevention programs; community action agencies.

Job training: DJFS, vocational schools

Mental Health: Mental health counseling services; substance abuse counseling services; domestic violence counseling services; advocacy groups for mental health, substance abuse, and domestic violence

School/education: GRADS (Graduation Reality and Dual Role Skills) program; adult basic education programs; local school districts; libraries; vocational schools; guidance counselors

Suspected child abuse/neglect: DJFS

WIC/Nutrition: Women Infants and Children (WIC) clinics; County Department of Job and Family Services (SNAP); pediatric clinics and neighborhood health centers (Federally Qualified Health Centers); pediatric hospital-based nutrition services accessed through ambulatory services departments; food pantries.

Other Potential Sources: 211/County-based Information & Referral Agency (<http://www.211ohio.net/local.htm>); "Preventing Infant Mortality in Ohio" publication (available at www.odh.ohio.gov); Child Protective Services Agencies; military base referrals.

Source: CFHS Program Standards Child and Adolescent Health Direct Care

Child Development: Ages and Stages Questionnaire: A developmental screening tool to screen infant and young children one month to 5 ½ years old. It is available in English, Spanish and French. <http://agesandstages.com/>

Bright Futures: Developed by the American Academy of Pediatrics (AAP) and offers guidelines for Health Supervision from infants to adolescents.

- 3rd Edition Guidelines
- 3rd Edition Pocket Guide

Ohio Medicaid Healthchek: Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. It provides a group of services to children and teens younger than age 21 which include: prevention, diagnosis and treatment. The purpose of Healthchek is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatment are covered.

<http://medicaid.ohio.gov/FOROHIOANS/Programs/Healthchek.aspx>

Source: CFHS Program Standards Perinatal Health Direct Care

Information and resources include breastfeeding; domestic violence; smoking cessation; substance abuse (tobacco, alcohol and other drugs); oral health; nutrition; and mental health/ depression.

Domestic Violence:

- The American College of Obstetricians and Gynecologist' Committee Opinion. Intimate Partner Violence. February, 2012.
- Academy of Violence and Abuse <http://www.avahealth.org>
- Futures Without Violence www.futureswithoutviolence.org
- Forensic Healthcare <http://www.forensichealth.com>
- Ohio Domestic Violence Network www.odvn.org
- Choices www.choicesdvcos.org
- National Center on Domestic and Sexual Violence <http://www.ncdsv.org>
- National Sexual Violence Resource Center <http://www.nsvrc.org>
- Sexual Assault Forensic Examination Technical Assistance Project (SAFE TA) <http://www.safeta.org>
- Strangulation article <http://www.forensicnurse.org/associations/8556/files/OTESummer06.pdf>
- End Violence Against Women International www.evawintl.org
- Faith Trust Institute www.faitrustinstitute.org
- Rape, Abuse & Incest National Network www.rainn.org
- Drugs of Abuse/Drug Facilitated Sexual Assault www.projectghb.org
- National Sexual Violence Resource Center www.nsvrc.org
- Sexual Assault Nurse Examiner/Sexual Assault Response Team <http://www.sane-sart.com/>

Depression/Mental Health: Edinburgh Postnatal Depression Scale 1 (EPDS) - The Edinburgh Postnatal Depression Scale has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression.

www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Appendix E: Home Visiting Personal Safety

When visiting homes, you should be aware of your own personal safety. There are steps you can take in the office, before the visit and during the visit which increase the likelihood of feeling and remaining safe.

In the office before the visit

- Tell other staff your schedule and where you will be
- Check with fellow staff regarding possible known risks
- If your first time traveling to the location, have clear directions and/or map
- Let the parent(s) know you are coming

Before the Visit

- Keep your car doors and windows locked
- Store valuables out of sight BEFORE you arrive
- Park where you can see your car during the visit; Do not park in a driveway
- Choose well-lit parking with a safe walking route & park in the direction you intend to leave
- Be cautious of dead-end streets
- Walk confidently and purposefully toward your destination
- Be alert and observant
- Wear shoes that allow for easy movement
- Carry minimal cash, your ID and keys on your person
- Identify yourself to management and security personnel in the housing complex
- Become known to businesses in the neighborhood
- Have a way to contact 911 (Even a cell phone with no service contract will still connect you to 911 for free)
- Above all, trust your instincts: leave if you feel uncomfortable!
- Drive around the area first looking for unsafe conditions: poor lighting, unsecured animals, potential sources of help
- Incorrect address? Do not search by knocking on strange doors!
- Think you are being followed? Enter the nearest public place
- People loitering? Walk around or cross the street; remain respectful
- Pause at door and listen before knocking. Knock before entering
- Find out if the parent is home before entering
- Do not enter if you believe an unsafe condition exists

In the Home

- Reschedule if you feel uncomfortable
- Be aware of —traffic in and out of home
- Be aware of pets
- Do not enter dark rooms or basement
- Leave immediately if you become aware that a firearm is present
- When sitting, choose a hard chair, with your back to solid wall, if possible
- Note the exits and sit as closely to them as possible

How to get out

- If you are uncomfortable, you don't have to stay!
- Have a cell phone, keep the power on, and keep it with you when you're in the home. Then you can always say, "Oh, my phone is vibrating, I've just missed this call from my supervisor. I need to call her, please excuse me."
- Or, you can also have a preprogrammed speed dial button to the office. Again, say, "My phone is vibrating and press the speed dial."
- In either case, you can say on the phone, "Oh, no, when did that happen?" and then tell the family, "There's an emergency. I have to leave right away!"
- Several phrases could be linked to a plan with your office. Depending on what you say, the office could either call the police, or call you back in a few minutes to make sure you are okay.
- Have a selection of excuses for leaving – but they need to be convincing and not something a family could help you with. For example, if you say, "I have a headache," a family could just offer you some OTC medication.

Source: Ohio Help Me Grow Home Visiting Program Manual 2010