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# MCH Innovations Database

## Practice Summary & Implementation Guidance

# Young Parent-Centered Case Management

The Massachusetts Pregnant and Parenting Teen Initiative's young parent-centered case management model is a two-generation model providing case management to expectant and parenting adolescents using a positive youth development approach that builds on participants' strengths. The program goal is to increase life opportunities and enhance family stability among young families through supporting educational attainment and employment; improving access to health services; supporting child development; and promoting healthy relationships.

Cutting-Edge | Emerging | **Promising** | Best

| Location | Topic Area | Setting |
|---|---|---|
| Massachusetts | Service Coordination/Integration | Community |

| Population Focus | NPM | Date Added |
|---|---|---|
| Cross-Cutting/Systems Building | NPM 3: Risk-Appropriate Perinatal Care, NPM 4: Breastfeeding, NPM 6: Developmental Screening, NPM 7.1: Injury Hospitalization – Ages 0 to 9, NPM 10: Adolescent Well-Visit, NPM 15: Adequate Insurance | October 2020 |

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# Section 1: Practice Summary

## PRACTICE DESCRIPTION

The Massachusetts Pregnant and Parenting Teen Initiative (MPPTI) uses a two-generation model to provide case management to expectant and parenting adolescents using a positive youth development approach that builds on participants' strengths. The program goal is to increase life opportunities and enhance family stability among young families through supporting educational attainment and employment; improving access to health services; supporting child development; and promoting healthy relationships. The key population for MPPTI is young parents aged 14-24 who may not be eligible for other young parent programs due to program eligibility restrictions or program requirements. To reach the program goal and meet the needs of young families, MPPTI employs a **young parent-centered case management practice**.

## CORE COMPONENTS & PRACTICE ACTIVITES

The MPPTI young parent-centered case management practice is a flexible model emphasizing relationship-building and social/emotional supports to serve young parents whose needs cannot be met with less comprehensive program models. The practice also uses a data-driven approach to identify the needs of young parents and best practices for meeting those needs. Youth input – through digital storytelling, youth focus groups, and participation of youth in funding-related site visits – is incorporated into programming. Real-time data and tracking of performance measures allows for accountability and process improvement. MPPTI continually adapts its program model to fill gaps in programming for young parents.

Core components of the practice that have been intentionally designed and adapted to benefit the key population are comprehensive case management, relationship building, team-based approach, social/emotional support, flexible, data-driven approach, and youth input.

**Core Components & Practice Activities**

| Core Component | Activities | Operational Details |
|---|---|---|
| Team-based approach to strength-based case management | • Weekly or monthly check-ins<br>• Comprehensive health assessments, including | The staffing model at MPPTI-funded agencies includes a program coordinator, community health worker (CHW) or youth worker, and licensed clinical social worker (LICSW) or registered nurse (RN) with |

| | | |
|---|---|---|
| | behavioral health assessments (e.g. PHQ-9)<br>• Educational and employment counseling<br>• Support accessing housing<br>• Contraceptive counseling<br>• Child development assessments (e.g. ASQ-3)<br>• Referrals to additional supports as appropriate | a background in mental health. Teams meet regularly to discuss participant care. Providers are also required to have referral partnerships with domestic violence agencies, clinical health providers, schools and alternative education programs, and other community organizations that may fill gaps in the services provided directly by the MPPTI agency, such as housing agencies. |
| Relationship building | • One case worker is the point person for each participant to facilitate relationship building<br>• Life plan booklets for young parents and a life plans guide for case workers<br>• Focus on trusting relationships as opposed to compliance-based requirements | MPPTI program staff report that building relationships with participants is key to engaging them in the program and getting them enrolled in direct services such as educational programs and reproductive health care. Building a relationship with participants through offering assistance with basic needs, childcare, and offering social/emotional support options should be prioritized for the initial months of programming over immediately working with participants on education or employment goals. |
| Flexible, data driven approach incorporating youth voice | • Youth digital storytelling<br>• Youth input into programming<br>• Quantitative data collection<br>• Continuous quality improvement processes | Real-time data and tracking of performance measures allows for accountability and process improvement. MPPTI has continually adapted its program model to fill gaps in young parent programming. |
| Social/emotional supports | • Support groups for young parents<br>• Art-based therapy<br>• Social groups and outings for families | Many young parents are isolated and can benefit from programs that enable them to build their social/emotional support networks. Multiple avenues for connecting both with other young parents and with program staff increase the strength of social/emotional support networks and can improve the resiliency of young parents. |

## HEALTH EQUITY

MPPTI incorporates a racial justice frame into the program approach through providing training on racial equity and the historical context behind health inequities. This approach seeks to explicitly name the role of racism in health inequities and examine the systemic and institutional factors impacting health. We examine surveillance data to explicitly describe and identify health inequities so that root causes can be better understood and addressed and examine program data to ensure that participants experiencing health inequities are being reached and provided with comprehensive services. Our practice also encourages the hiring and retention of staff that represent the populations in the communities we work in order to better serve youth experiencing health inequities and creates mechanisms for youth program participants to have a voice in the services they receive, including using motivational interviewing to identify their needs and goals and digital storytelling to share their experiences as young parents.

Our practice works toward addressing social determinants of health on multiple levels. On an individual level, youth program participants receive supported referrals or directly access healthcare, education, training, and job readiness programs. Participants also build trusting relationships with case workers and have the opportunity to build community or social connections with other young families. On a community and institutional level, funded community agencies partner with healthcare providers, schools or other educational programs, housing agencies, and job placement agencies, among others. While case management and community partnerships will not solve deep-rooted systemic issues of educational quality or housing availability in a particular community, the partnerships and case management allow young parents to access programs that they may not otherwise be aware of and navigate complicated systems, such as accessing health care or public housing.

## EVIDENCE OF EFFECTIVENESS

Among MPPTI participants engaged in the program for 6 months or more, there were significant increases in employment, contraceptive use, and health insurance. At program entry, 7% of participants reported having full-time employment compared to 17% after 6 months in the program (McNemar's test, $p<.001$). Any employment (inclusive of full and part-time) increased from 26% at program entry to 37% after 6 months (McNemar's test, $p<.001$). Among participants engaged in the program for 9 months or more, there was a 4% increase in the percent of participants with stable housing, but the increase was not statistically significant.

Other program outcomes among participants engaged in the program for 6 months or more included:

- 58% of participants made progress[1] toward individualized academic and/or career goals.
- 18% of participants with a high school diploma or equivalent were enrolled in a postsecondary program over the course of the program.

[1] Academic and career goals are identified by participants and broken down into smaller action steps. "Progress" here is defined as successfully completing at least one of the smaller action steps identified.

- 98% of participants were enrolled in health insurance.
- 71% of participants who were pregnant at intake reported attending a postpartum visit 21-56 days following the birth.

A notable finding was that, while participants experienced positive outcomes such as obtaining jobs, enrolling in school, and finding housing, it generally took 6 months or more of program engagement to achieve these outcomes. An exception to this was enrolling in health insurance and increasing use of a contraceptive method: these changes could be seen within 3 months of enrollment. As a result of this finding, we incorporated a 6-month minimum of program engagement as an element of the practice.

# Section 2: Implementation Guidance

## STAKEHOLDER EMPOWERMENT & COLLABORATION

Our stakeholders include internal stakeholders from other programs within MDPH, community agencies that we partnered with for program implementation, young parents, program participants, and other state agencies. Stakeholder involvement increased over the course of the program as relationships were built both internally across MDPH, with the community partners funded to implement the program and the youth they served, and with other youth-serving state agencies. The community-based agencies we partnered with all have significant experience serving young people, including young parents, and bring unique strengths and perspectives to program delivery. Youth program participants had a significant role in providing feedback on the program model and practices used over the course of the program. The program practice activities were continually adapted to better meet the needs of young parents based on their feedback. Program participants created digital stories to share how being a young parent has impacted their lives and their experience with the program. These stories have been shared with other stakeholders to raise awareness about the program model and the lives of young parents in the state.

Practice activities were initially developed with significant input and collaboration with existing young parent and youth serving programs at MDPH. After partnering with community agencies to implement the program, MDPH received significant feedback on the program staffing model, program requirements, data collection tools, and program activities from community agencies and their youth participants during phone calls and site visits. This feedback was used to modify the practice activities during a subsequent round of funding. Initially the program model included a prescribed staffing model, universal requirements for all program participants (i.e. each participant must receive educational counseling even if the participant indicates an interest to work on employment skill-building), and detailed data collection. Through annual site visits with both staff and program participants, provider meetings, interviews with program staff, focus groups with youth, and

analysis of program data, MDPH worked with community agencies and their youth program participants to make decisions on which practices in the initial program model to retain and which practices to modify. As a result of this collaboration, the program model was adapted to allow for more staffing flexibility to more efficiently use grant funds at the community agency level, a young parent-centered case management practice where youth take the lead in selecting which activities they want to work on, and a focus on relationship building with program staff and among program participants. In addition, the data collection system was simplified to focus on the key program outcomes that MDPH and community agencies were most interested in. The data collection system was also updated to include reports that community-based agencies could run independently so that they could conduct quality improvement (QI) at the agency level without needing to contact an MDPH staff member to access QI reports.

We partnered with other state agencies to get a better understanding of duplication of services, best practices, and how the state can best meet the needs of all young families across the state. While MPPTI can fill gaps in programming for some young parents, streamlining services across state agencies would be beneficial. A shared assessment or intake form and a coordinated process for triaging referrals would be promising first steps toward more coordinated services that were discussed during these convenings. Additional steps could include the development of shared performance measures or joint funding of community-based agencies to provide more comprehensive services on a continuum.

Annual site visits and provider meetings allowed for intentional space for both youth participants and community agencies to participate in program decision-making. Youth participants were invited to all site visits and participated in the meetings to share what they liked about the program, what was useful and what was not useful, and which practices were most beneficial to them. As an example, after the practice of young parents selecting their own goals was added as a component of the program, young parents were asked during a site visit if they found it helpful to select their own goals and if they understood and felt comfortable with the forms and prompts used to create these goals with their case workers. At annual provider meetings, community agencies shared effective practices with each other and with MDPH. In some cases, these practices were integrated into the program model across all the funded agencies.

Stakeholders – especially community agencies and program participants - made significant contributions and decisions in shaping our young parent-centered case management practice. Our practice was continually adapted because of stakeholder decision-making. Additionally, the impact of stakeholder contributions resulted in a practice that was widely shared within MDPH, with other state agencies, and at conferences. While we collected information on stakeholder involvement and community partnerships throughout the program period, we did not employ a standardized rubric or other formal measure to assess the extent to which stakeholders were actively involved in decision-making practices. However, the practice was adapted iteratively over the course of the program period with significant input from multiple stakeholders. Some examples of decisions made in conjunction with stakeholders include moving away from prescribed activities or goals for young parents to young parent-driven decision making, changing program staffing to allow for a single point of contact/case worker for each participant rather than required meetings with multiple staff

members, significant changes to the data collection system and automated reports, and integration of social/emotional activities and supports such as wellness groups, family nights, and field trips.

## REPLICATION

This practice has not yet been replicated.

## INTERNAL CAPACITY

MPPTI's young parent-centered case management practice is overseen by the Massachusetts Department of Public Health (MDPH) and implemented by community-based agencies. The practice could be replicated at the state or community level. At the state level, a program coordinator oversees funding, technical assistance, and training for five community-based agencies and an evaluator oversees data collection and quality improvement/program evaluation. The staffing model at community-based agencies includes a program coordinator, a community health worker (CHW) or youth worker, and a licensed clinical social worker (LICSW) or a registered nurse (RN) with a background in mental health. In general, each community health worker/youth worker acted as the case manager for up to 25 young parents. Depending on the size of the program, multiple community health workers could be hired. If a community-based agency is implementing the practice without the support of a state or local health department, a mechanism for collecting quantitative and qualitative data on the program would be important to examine services provided and participant outcomes.

Training community health worker/youth worker staff on contraceptive counseling, child developmental screenings, and what to do if a participant discloses domestic violence or an immediate behavioral health need are important for working with young parents. Because working with young parents, particularly those with histories of trauma, can be difficult for staff (and especially if staff have similar backgrounds as the young parents they serve), we recommend building supports into staff management for self-care and time during team meetings or supervisory meetings to discuss ways staff can avoid burn out, take care of themselves, and continue to provide high-quality services.

## PRACTICE TIMELINE

| Phase: Planning/Pre-Implementation | | |
|---|---|---|
| **Activity Description** | **Time Needed** | **Responsible Party** |
| Hire and train program staff | Months 1-3 | Program coordinator |
| Set up data collection systems | Months 1-3 | Program coordinator / Evaluator |
| Build relationships among organizations serving young parents to ensure adequate referral relationships | Months 1-6 | Program coordinator / Other program staff |

| Phase: Implementation | | |
|---|---|---|
| **Activity Description** | **Time Needed** | **Responsible Party** |
| Recruit participants and identify participant needs | Months 3-18 | Community health workers |
| Provide case management programming and referrals | Months 3-24 | Community health workers / Clinician |
| Social / emotional supports for young parents | Months 3-24 | Community health workers / Clinician |
| Collect and integrate young parent input into programming | Months 6-24 | Community health workers / Program coordinator / Evaluator |

| | | |
|---|---|---|
| Implement continuous quality improvement that includes young parent voice | Months 6-24 | Community health workers / Program coordinator / Evaluator |

| Phase: Sustainability | | |
|---|---|---|
| **Activity Description** | **Time Needed** | **Responsible Party** |
| Align practices with existing programs to reach young parents not served by existing programs | Months 3-24 | Program coordinator |
| Collaborate with community-based agencies and state and local stakeholders | Months 3-24 | Program coordinator |
| Diversify funding sources | Months 1-24 | Program coordinator |
| Disseminate program findings and success stories | Months 12-24 | Program coordinator / Evaluator |

## PRACTICE COST

Most costs associated with implementing the practice are staff costs. Because staff costs can differ depending on the location of the program, we have included a sample budget for funding the practice at one community-based agency. This is based on staffing costs in Massachusetts. To successfully implement the practice, you should budget for at least the staffing listed below. This budget assumes that staff are attached to an agency that covers administrative and office space with other funds. Funds may need to be added to this budget for those costs.

| Budget |
|---|

| Activity/Item | Brief Description | Quantity | Total |
|---|---|---|---|
| Program Coordinator | Oversees program management & supervises staff | $73,500 | $73,500 |
| Community health workers (CHWs) | CHWs act as case managers for program participants. | $117,000 | $117,000 |
| Clinician (behavioral health or RN) | The clinician provides services including health counseling, facilitating groups, and/or individual and group counseling. | $48,000 | $48,000 |
| Program supplies | Materials including life plans, printing, misc. supplies | $4,000 | $4,000 |
| Transportation | Vouchers or other transportation for participants | $2,500 | $2,500 |
| Stipends | Stipends for childcare costs for participants to attend program-related events | $1,000 | $1,000 |
| Meals | For participant events | $3,000 | $3,000 |
| Staff mileage / travel | Staff conducting home visits / delivering supplies | $1,000 | $1,000 |
| | | **Total Amount:** | **$250,000** |

## LESSONS LEARNED

Based on MPPTI referral and enrollment patterns, and focus groups conducted among young parents in Massachusetts, we learned that there are gaps in services for some young parents. These gaps may also exist in other states or jurisdictions.

*Program eligibility restrictions* – There are few programs serving young parents between the ages of 20-24 and parents under the age of 19 having a second or higher order child. The programs that do exist may not be widely available. In addition, many programs serve young parents with infants, but there are fewer programs serving young parents with children who are preschool or school aged. While teen parents aged 15-19 often are eligible for programs that help them work toward completing their education and parenting their children, many young parents aged 20-24 giving birth were teen parents and continue to require support in accessing education, employment, health care, and early education and care for their children.

*Multiple case workers* - Many young parents have 4-6 case workers across multiple agencies with differing program eligibility and required documentation[2]. Negative experiences with health care providers and/or fear of being judged or stereotyped by providers may impact youth seeking or remaining engaged in services[3]. MPPTI community-based staff reported that they have to reach out to the same young parents multiple times before a relationship that is strong enough to talk about topics like education/ employment goals, parenting, behavioral health, and housing can be built. Having multiple case workers hinders the development of trusting relationships and may interfere with young parents remaining engaged in programming and/or being upfront with their case workers about what their needs are.

*Compliance-based requirements* - Some programs restrict eligibility to participants who can commit to prescribed attendance requirements up front or must obtain jobs or reach other goals according to predetermined timelines. Young parents with the greatest needs – especially in terms of housing and social/emotional needs – may not be able to meet compliance-based requirements within the allotted amount of time if they are struggling with concurrent challenges such as housing and childcare, a history of trauma, the stresses of being a parent, and a lack of a strong social/emotional support network.

MPPTI uses a flexible, data-driven approach and continually adapts its program model to fill gaps in programming for young families in the state. Drop-in or short-term programs where young parents must meet prescribed requirements meet the needs of many young families and remain crucial to providing a comprehensive support network for families. However, the needs of many young parents cannot be met with short-term programming: the social/emotional needs of many young parents mean that longer-term program models focused on relationship-building and overcoming trauma may be needed to assist these young parents with meeting their family's needs in the short-term and achieving self-sufficiency in the long-term.

*Relationship building* and *social/emotional support* are two key strengths of the MPPTI young parent centered case management practice. Many young parents are isolated and can benefit from programs that enable them to build their social/emotional support networks. MPPTI program staff

[2] MA State Convening on Young Families. (2019). Summary of Focus Group Results, unpublished.
[3] Harrison, M. E., Clarkin, C., Rohde, K., Worth, K., & Fleming, N. (2017). Treat me but don't judge me: A qualitative examination of health care experiences of pregnant and parenting youth. *Journal of Pediatric Adolescent Gynecology,30*(2), 209–214. https://doi.org/10.1016/j.jpag.2016.10.001.

report that building relationships with participants is key to engaging them in the program and getting them enrolled in direct services such as educational programs and reproductive health care. MPPTI offers not only referrals to clinical behavioral health counseling, but also offers support groups for young parents, art-based therapy, and social groups and outings for families. Multiple avenues for connecting both with other young parents and with program staff increase the strength of social/emotional support networks and can increase the resiliency of young parents.

The major challenges we faced in implementing our practice included recruiting and retaining participants and ensuring continuity of care for young families. As described above, we learned that relationship-building with staff members and building social/emotional supports into the program were assets in terms of recruiting and retaining program participants. We found that agencies that focused more on these elements reported fewer challenges with both recruiting participants and keeping them engaged in programming. Funding for our practice changed over the course of the program because of changes in federal and state funding. When funding levels change and program staff may be moved into different positions or leave due to uncertain funding, this harms relationships with program participants. Building sustainability into programming or adapting existing young parent programs with consistent funding streams can mitigate some of the challenges related to funding. In addition, because young parent programs have historically targeted services toward young mothers, there is limited data on the needs of young fathers and a limited evidence base on effectively engaging young fathers in programming. Recruiting and retaining young fathers in programming continues to be both an ongoing need and a challenge.

## NEXT STEPS

MDPH is continuing to work with internal and external stakeholders to identify strategies for sustaining our practice and integrating it into other existing programs for young parents. Current activities and next steps include:

- Collaborating with MDPH programs and other state agencies to incorporate elements of MPPTI into existing programs
- Continuing to work closely with internal and external stakeholders toward the goal of streamlining services for young families across the state and providing services on a continuum
- Continuing to work with funded community-based agencies to increase their capacity to sustain the program through collaboration within their organizations and through building partnerships with other organizations
- Raising awareness about the program and the needs of young families by sharing program outcomes and giving young parents opportunities to share their stories to raise awareness about their needs, challenges, strengths, and opportunities for their families

## RESOURCES PROVIDED

- *N/A.*

## APPENDIX

- Program Logic Model *(See page 15.)*

# Young-Parent Centered Case Management Practice Logic Model

**Goal:** Increase life opportunities and enhance family stability among young families in target populations in priority communities

## INPUTS

**Expertise:**
- Program staff
- Evaluator
- Community based staff
- TA & training

**Successful strategies:**
- Positive youth development
- Trauma-informed approach
- Validated health assessments
- Medically accurate materials
- Men's programming
- Life plans

**Partnerships:**
- Health: reproductive, primary, pediatric, EI
- Concrete supports: housing, transport, food
- Domestic violence
- Social/emotional support: counseling, community groups
- Education/employment: high schools, IHEs, vocational training
- Community advisory groups

**Communications:**
- Website
- Materials & strategies

**Evaluation:**
- Evaluation tools
- Performance measures

## ACTIVITIES

### COMMUNITY LINKAGES
- Outreach
- Program promotion
- Community networking
- Creation & maintenance of strong referral network, including community advisory groups

### DIRECT SERVICES
Assessments, counseling, referrals, goal setting, case management:
- Health care
- Child health & development
- Education & employment
- Concrete supports
- Parenting support

### COMMUNICATIONS
- Promote program website
- Share program success stories at community events & with community partners

### SUSTAINABILITY
- Develop & implement sustainability plans

### EVALUATION

## OUTPUTS

- Staff recruited & retained
- Community partnerships in place
- Community advisory groups formed and active
- Referral network created, maintained & monitored
- Participants receive direct services for health, education, employment, and social supports
- 75% of participants remain in program 6+ months
- Program website developed & kept up to date
- Program information shared with community & public at state & local level
- Sustainability plans developed & implemented
- Quality improvement cycles conducted

## OUTCOMES

### Short-Term <1 year
- Increase school, college & vocational training enrollment
- Increase social connectedness
- Participants make progress toward individual goal achievement
- Increase in child health practices
- Increase continuous contraceptive use
- Decrease depression
- Participants

### Intermediate
- Increase HS and HiSet completion
- Increase employment
- Decrease rapid repeat pregnancy
- Decrease unintended pregnancy
- Increase stable housing
- Children achieve develop-mental benchmarks
- Increase awareness about

### Long-Term
- Increase economic security
- Reduction in reliance on public assistance
- Increase educational attainment
- Increased self-sufficiency
- Increase in children's school readiness
- Increase healthy relationships