Women's Health Education Navigation (WHEN) Program

An Innovation Station Promising Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	New York	**Title V/MCH Block Grant Measures Addressed**
Category:	Promising	**NPM #1:** Percent of women with a past year preventive visit. **NPM #2**: Percent of cesarean deliveries among low-risk first births **NPM #3**: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) **NPM #4**: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months **NPM #5**: Percent of infants placed to sleep on their backs **NPM #11**: Percent of children with and without special health care needs having a medical home **NPM #14**: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes **NPM #15**: Percent of children 0 through 17 years who are adequately insured
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Practice Description

The goal of this program is to increase the incidence of healthy pregnancies, positive birth outcomes, and healthy infants in a vulnerable population of women and infants who are justice-involved. We improved access and integration of services related to preconception care, primary care, prevention, and social support through a well-integrated referral network; we improved integration and access of services for pregnant women through case management;

and improved the level of knowledge about behaviors that promote healthy pregnancies, healthy birth outcomes, and positive parenting behaviors through planned educational sessions.

Purpose

Justice-involved women are at particular risk for poor birth outcomes due to numerous co-occurring high-risk behaviors including substance abuse, poor nutrition, lack of family planning, and more. 70% of the women in New York Prisons have a substance abuse problem prior to being incarcerated, and 39% have a serious mental health diagnosis, both of which can cause complications in maternal and child health. Women who are justice-involved generally have lower income, with the majority being recipients of Medicaid/public health insurance. The requirements and restrictions placed on women throughout the judicial process may result in neglect of medical care and social service needs, particularly if more basic needs such as safety, food, or housing must be prioritized. The judicial system is not positioned to link to women's health care services, which are often outside the scope of judicial case management, and this allows women's healthcare to slip through the cracks.

The goals of the Women's Health Education Navigation (WHEN) program are to increase the incidence of healthy pregnancies, positive birth outcomes, and healthy infants in a vulnerable population of women and infants who are justice-involved.

Program Objectives

To improve access and integration of services related to preconception care, primary care, prevention, and social support through a well-integrated referral network; improve integration and access of services for pregnant women through case management; and improve the level of knowledge about behaviors that promote healthy pregnancies, healthy birth outcomes, and positive parenting behaviors through planned educational sessions.

Target Population Served

Pregnant or parenting women who are involved with the justice system.

Practice Foundation

The WHEN Network has used the model from its original two sites in Syracuse and Niagara Falls to develop a third site in Buffalo and a fourth site in Manhattan. This model of patient navigation and case management is based around the constrained choice framework, with the Patient Navigator helping the client to establish a medical home and addressing all of the social determinants of health that can impact pregnancy outcomes, filling a gap between health, justice, and human services.

The patient navigator collects intake and needs assessment information for each client. Referrals made and kept are tracked in order to demonstrate linkage across health, social service, and justice systems. Long-term success of the WHEN Program will result in increased court compliance, reduced recidivism rates and improved birth outcomes for the women served.

The development of the original Patient Navigation Program was informed by the constrained choice framework, which recognizes that women's choices are informed or determined by

factors and constraints both within and beyond their control[2,3]. Women involved in the court system often have circumstances, such as mental health or substance use issues, homelessness, domestic violence, financial constraints, and other social disadvantages, which preclude their justice involvement. Based on the constrained choice framework, they must often prioritize these needs over their justice system requirements, which puts them at risk for recidivism, noncompliance, and other outcomes. Further, court-involved women may be subject to institutional constraints preventing them from making the choices women outside the justice system could make[3]. Case management has been shown to have a positive effect for pregnant women in circumstances that often co-occur with court involvement. Women who abuse substances, a common concern in the court system, and were also pregnant stayed in treatment longer and had more favorable treatment outcomes if they were receiving case management services[4]. The WHEN program aims to generate more positive justice and maternal & child health outcomes by addressing the constraints faced by this population and subsequently empowering the women involved.

References:

2. Bird, C. & Rieker, P. 2008. The Effects of Constrained Choices and Social Policies. Gender and Health. Boston: Cambridge University Press.
3. Holsapple, S. & Jensen, M. 2013. A Model Program for Patient Navigation: Using the Justice System to Offer a Health Care Intervention to Improve Birth Outcomes—Understanding Constrained Choice and Drug Treatment Court. Journal of Applied Social Science 20(10). 1-20.
4. National Drug Court Institute. 2006. Drug Court Case Management: Role, Function, and Utility. Drug Court Case Management: Monograph Series 7.

Core Components

Core components are those essential practice elements which are observable and measurable.

- *Example: The goal of our program was to improve the number of perinatal depression screens among OB/GYN providers. We did this by conducting a yearlong practice improvement program for OBGYN practices across the state. The core components of this program included virtual training by a nurse educator, provision of a referral sheet tailored to the local area for positive screened women, and follow-up with practices by our program manager.*

The WHEN Program includes preconception/interconception health education, case management, patient navigation, and linkage to community-based services. After referral from the courts, jails or other community agencies, the Patient Navigator addresses women's immediate needs including housing and food, in addition to coordinating transportation, accompanying clients to medical appointments, guiding them through social services application processes, and arranging appropriate services for clients with mental health, substance abuse, or chronic health care issues.

Practice Activities

Core Component	Activities	Operational Details
Assessment & linkage	Assessment of medical and social service needs with referrals and linkages to external services	The Patient Navigator assesses addresses women's immediate needs including housing and food, in addition to coordinating transportation, accompanying clients to medical appointments, guiding them through social services application processes, and arranging appropriate services for clients with mental health, substance abuse, or chronic health care issues.
Education	Positive pregnancy and parenting behaviors	Provide referrals and linkages to external community resources that are identified with families and/or individual family members. Social supports must be integrated into a broad network of family services in order to meet the varying needs of families (Thompson, 2015). There is increased evidence that adequate social and material supports are necessary for children's safety (Pelton, 2015; Thompson, 2015).

Evidence of Effectiveness (e.g. Evaluation Data)

The Patient Navigator at each site uses the WHEN Database to enter client intake, needs assessment, pregnancy status, visits/contact, and referral information. This information is then evaluated by an external program evaluator.

During the 2016 program year, A total of 152 women (118 new) received either supportive or comprehensive case management and over 500 referrals were made to a wide range of service providers. These are both increases over the previous program year. Of the 152 case managed women, 40% were pregnant and 18 of these clients were known to have delivered infants. Of the 18 infants born, only two were born premature for a preterm rate of 12.5%. Some of the most common referrals made include housing, clothing and other basic needs, as well as WIC. An additional 800 women received health education from the patient navigators through various workshops in the jails, courts, and community events.

March of Dimes hired an external evaluator to begin building the evidence base for the WHEN program's effectiveness, with a focus on designing a model for eventual replication across the state. Client data from each site is entered in the WHEN Database for evaluation purposes. The evaluation measures for the WHEN Program are: number of women served; number of women educated; number of women case-managed; number of women referred to services - time to referral, type of referral, and referrals kept; and birth outcomes for pregnant women. Anticipated long-term success of the WHEN Program will result in reduced recidivism rates and improved birth outcomes for the justice-involved women in the communities served.

Replication

The current iteration of the WHEN program was operational through the Center for Court Innovation in Syracuse, NY and Niagara Falls Memorial Medical Center in Niagara Falls, NY

since 2012-2017. The third site, in Buffalo, NY opened in October 2015 based on the model from the two original sites. A fourth site in Manhattan was also launched in November 2015. We found that without external funding, sustainability is a challenge. None of the current programs exist purely as WHEN due to other funding streams that require service to men and women however, pregnant and parenting women are still served in Syracuse and Manhattan.

Peer-reviewed journal articles, conference presentations, etc.:

- Holsapple, S. 2011. Patient Navigation through the Justice System: A Response to the High Infant Mortality Rate in One Community. Societies Without Borders 6(3). 157-189.*
- Holsapple, S. & Jensen, M. 2013. A Model Program for Patient Navigation: Using the Justice System to Offer a Health Care Intervention to Improve Birth Outcomes—Understanding Constrained Choice and Drug Treatment Court. Journal of Applied Social Science 20(10). 1-20.*
- March of Dimes New York Chapter Board Presentation, "The Patient Navigator Program: A Women's Health Education and Navigation Program", June 2015, Albany NY
- March of Dimes Northern Tier Chapter Staff Retreat, "The Patient Navigator Program: A Women's Health Education and Navigation Program", August 2015, Syracuse NY
- Crouse Hospital OB/GYN Grand Rounds, "Ten Things That Matter When Working With Court-Involved Pregnant Women", September 2015, Syracuse NY
- The WHEN program was scheduled to present at the 2016 AMCHP Annual Conference

*peer-reviewed journal articles from an early iteration of the Syracuse program

Section II: Practice Implementation

Internal Capacity

March of Dimes staff provided project management and convened the partners that comprise the WHEN Network on a quarterly basis to provide site updates, discuss best practices and challenges while working to continuously improve upon processes and data tracking.

Collaboration/Partners

The WHEN project is jointly funded by March of Dimes and The Health Foundation for Western & Central New York and conducted in collaboration with Center for Court Innovation and Niagara Falls Memorial Medical Center. In addition to these partners, March of Dimes volunteer leadership lent their varied expertise and were vital in implementing this program.

Practice Cost

Original annual costs were $45,000 for staff, evaluation, meetings and travel. Grant costs for each site are approximately $55,000 the majority of which is allocated to the Patient Navigator salary line. Cost per client ranges from $324 to $600.

Anticipated cost savings include increased compliance with court-mandated activities, reduced recidivism rates and improved health outcomes resulting in reduced burden of need for justice and public health costs in the community.

Budget			
Activity/Item	Brief Description	Quantity	Total
Salary	Patient Navigator	1	$45,000-$55,000
Office Supplies	Paper, toner, pens, etc.	1	$500-$1,000
Travel	Stakeholder meetings, client meetings	1	$3,000-$5,000
		Total Amount:	$48,500-$61,000

Practice Timeline

The earliest iteration of the WHEN program was in Syracuse in 2007 with a focus on folic acid education for court-involved women. In 2011, March of Dimes funded a new iteration of the program with a focus on patient navigation and case management of pregnant and parenting women who were justice-involved. In 2013, March of Dimes secured a co-funder in The Health Foundation for Western & Central New York and over the next 4 years replicated the project in 3 additional sites.

Practice Timeline				
Phase	**Description of Activity**	**Date/Timeframe**	**# of hours needed to complete/ oversee activity**	**Person(s) Responsible**
Planning/ Pre-implementation	Secure external funding	1 year	60 hours	March of Dimes staff
	Issue targeted RFP	3 months	10 hours	March of Dimes staff
	Selected sites through volunteer review	1 month	5 hours	March of Dimes staff and volunteers
	Executed grant agreements	1 month	3 hours	March of Dimes staff

Implementation	In person meetings with sites	3 months	30 hours	March of Dimes staff and site staff
	Program delivery	1 year	480 hours	Site staff
	Convening meetings	Quarterly	12 hours	March of Dimes staff, volunteers and site staff
Sustainability	External evaluation	3 years	100 hours	UBMD Obstetrics & Gynecology
	Secure external funding	3 years	30 hours	March of Dimes staff
	State and National recognition	2 years	50 hours	March of Dimes staff

Resources Provided

The Center for Court Innovation, a WHEN Network Partner, has created a PowerPoint presentation entitled “Ten Things that matter When Working with Court-Involved Pregnant Women” for professional education.

The WHEN Network has created a WHEN Program Guide and WHEN Database Guide, to be used by program staff, as well as a preconception/interconception health script and PowerPoint presentation to be used for educating clients. The WHEN Patient Navigator also uses March of Dimes consumer education resources, such as the “9 Things to Do Before You Get Pregnant” wallet card.

Below is the link to the Center for Court Innovation’s Patient Navigator Program, a WHEN Network partner:
http://www.courtinnovation.org/patient-navigator-program

For materials developed, contact:
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Lessons Learned

Strengths

Improving birth outcomes among a high-risk population was the primary impetus of this program. For the March of Dimes, the polio vaccine was only the beginning. Over the last few decades, we helped eliminate rubella, advocated for regionalized newborn intensive care, funded the development of surfactant and other lifesaving treatments, worked to fortify the grain population with folic acid to prevent neural tube defects and brought newborn screening to every

baby. Our strong partnership with the Health Foundation for Western & Central New York provided an opportunity to leverage additional resources and improve birth outcomes in a vulnerable, often overlooked population. Our strong partnership with the Center for Court Innovation provided a vehicle to drive relationships with courts across diverse geographies. The Center for Court Innovation has well-established relationships within the justice system and knowledge of how the system works. Clients often find the justice system confusing leading to compliance issues that our Patient Navigator can help them to avoid.

Challenges

We learned early in the implementation that although our program sites were serving clients with similar demographics and accomplishing similar outcomes, the implementation looked different with one site hospital-based utilizing a Patient Navigator and the other court-based utilizing a Licensed Clinical Social Worker. With consistent outcomes realized we worked to accommodate flexibility in activities. Sustainability without private funders has emerged as a primary challenge. Also, the client population is not only high-risk but also transient in nature making long-term evaluation challenging.

Overcoming Challenges: We held regular WHEN Network meetings to keep partners engaged and to continuously work towards model fidelity. Once evaluation measures were agreed upon, flexibility in implementing the model proved to be an asset versus a challenge. Having an evaluator on our team working towards consistency in data collection and reporting and ongoing modification of the database used for tracking has proved invaluable.

Lessons Learned

During the first phase of implementation we focused on identifying and agreeing upon consistent and meaningful evaluation measures that accurately reflected the work being done. Moving into the next phase, we plan to keep those essential elements and expand the program to additional sites. We learned the importance of balancing consistency with adaptability in order to establish a replicable model. The model can be implemented with fidelity across sites yet is flexible enough to accommodate variations in the lead agency as well as the Patient Navigator's education and training. Partnering with the Center for Court Innovation and utilizing their strong relationships within the justice system was advantageous during implementation. Program activities are enhanced and more positive outcomes for clients are realized due to the Center for Court Innovation's knowledge of and relationships with the justice system. A well-developed referral network is key to being able to achieve the best outcomes for clients. Education and awareness about the program is essential in each community.

Next Steps

Programs no longer operate in Niagara Falls or Buffalo due to a lack of external funding however, a new iteration of the work continues in Syracuse and Manhattan, NY with a focus on human trafficking and inclusion of men. March of Dimes continues to work to identify sources within the health and justice systems to make the program sustainable; for example, Medicaid reimbursement, DSRIP funding, or being housed within a larger program, such as Healthy Families, Nurse Family Partnership or Community Health Worker programs.

Practice Contact Information

For more information about this practice, please contact:

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