



Healthy Start Interconception Care Learning Community



Content Area and Team Formation

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Focus of ICC Learning Community Project

1. Advance the quality and efficacy of interconception care (ICC) activities among Healthy Start grantees and communities
2. Improve each Healthy Start grantees' ICC component to better serve participants

Timeline for Learning Community Activities

	March	April	May	June	July	August
Meeting with HISA / communication	○					
Discuss with HISA board		○				
Blueprint		○				
Webinar 1: Introduction to ICC			○			
Webinar 2: Intro to QA & FQCA				○		
Webinar 3: Readiness assessment				○	○	
Webinar 4: Content topic & team formation				○	○	
Readiness assessment process				■	■	
Topic selection				■	■	
Team formation				■	■	
Workshop					■	■
ICC Learning Mtg						○
Workshop on topics					○	
Learn 3: Data and efficacy	○	○	○	○	○	○
Learning 4: HISA Learning Community Mtg						○

Agenda for Webinar

- Core content areas
- Categories of change and subtopics/change projects
 - Possible measures
- Framework for change initiatives
- Team formation
- Next steps



4

Core Content Areas

- *ICC Case Management*
- *ICC Risk Screening*
- *Family Planning/Reproductive Health*
- *Primary Care Linkages*
- *Maternal Depression*
- *Healthy Weight*



5

Rationale for Determining Core Topics

- Evidence base in literature and promising practices of grantees
- Work of the CDC's Select Panel on Preconception Care
- Our collective work doing evaluation and special studies with Healthy Start community



6

Categories of Subtopics/Change Projects

- Strengthen linkages and partnerships
- Advance the use of objective tools and methods
- Improve Healthy Start staff skills and protocols



7

Framework for Change Initiative

Core Content Area	Strengthen Linkages and Partnerships	Advance the use of objective tools and methods	Improve Healthy Start staff skills and protocols
ICC CM			
ICC Risk Screening			
Family Planning			
Primary Care Linkages			
Maternal Depression			
Healthy Weight			



8

Criteria for Subtopics/Change Projects

- Fit with Healthy Start guidance and structure
- Fit with grantee capacity
- Doable in a 9-month time period
- Measurable
- Specific (close to aim)



9

ICC Case Management/Care Coordination

Includes:

- Focus on implementing an effective staff team approach
- Build on existing strategies in use by Healthy Start grantees, home visiting, and other programs and projects
- Use evidence-based case management practices from an array of past projects and studies



10

ICC Case Management/Care Coordination: Subtopics/Change Projects

- Develop relationships with one or more programs such as home visiting
- Use case management tools consistently
- Devise tools to guide development of care plans
- Improve the referral process through protocols and communication among involved providers



11

ICC Case Management/ Care Coordination: Change Project Example

- Subtopic/Change Project: Consistent and effective use of case management “visit” tools (e.g. for all ICC participants and data collection)
- Possible measures:
 - Number of staff trained to use a specific case management visit tool
 - Number of ICC participants whose chart reflects use of tool



12

ICC Risk Screening

Includes:

- Focus on the content, process, and protocols for ICC risk screening
- Use evidence regarding validated screening instruments



13

ICC Risk Screening: Subtopics/Change Projects

- Systematically use an ICC screening tool based on national recommendations
- Enhance staff knowledge of and skills in consistent use of ICC screening tool
- Improve consistency of data reporting for ICC screening information



14

ICC Risk Screening: Change Project Example

- Subtopic/Change Project: Systematically use an ICC risk screening tool based on national recommendations
 - Review and revise tool currently in use
- Possible measures:
 - Healthy Start home team develops inventory of nationally recognized risk screening tools
 - Compare best practices for risk screening against existing tool
 - Adapt current tool to reflect best practices
 - Increase the number of participants who receive ICC risk screening



15

Family Planning Services and Linkages

Includes:

- Focus on appropriate counseling about family planning options, effective monitoring contraceptive use, and linking women to family planning services
- Develop protocols and tools



16

Family Planning Services and Linkages: Subtopics/Change Projects

- Develop relationships with family planning providers and organizations
- Use consistent and evidence-based approaches for educating on family planning methods at the end of prenatal care and in interconception care
- Effectively collect information on actual use of family planning methods
- Develop and implement a protocol for intensive ICC follow-up on family planning use
- Assure women attend appointments and fill prescriptions early in the postpartum period



17

Family Planning Services and Linkages: Change Project Example

- Subtopic/Change Project: Develop relationships with family planning providers and organizations (e.g., Title X, health department, Planned Parenthood, and hospital outpatient clinics)
 - Referral relationships
 - Shared knowledge and evidence-based approaches
 - Convene regular meetings to foster communication
- Possible measures:
 - Develop MOUs with f.p. organizations and agencies
 - Increase # referrals to f.p. organizations and agencies
 - Participate in regular meetings with family planning providers and organizations



18

Primary Care Services and Linkages

Includes:

- Focus on developing effective linkages to sources of primary care for low-income and uninsured women to FQHC, other clinics, etc.
- Build on existing strategies used by Healthy Start grantees to get participants to their PC or medical home
- Develop protocols and tools for monitoring primary care well-woman visits, including postpartum visits



19

Primary Care Services and Linkages: Subtopics/Change Projects

- Develop relationships with primary care clinics and providers who serve women without insurance coverage or ability to pay
- Effectively collect information about women's use of primary care and medical home
- Systematically encourage and support postpartum visits with a primary care provider/ medical home in the first 60 days after pregnancy
- Use a protocol at each Healthy Start ICC visit/contact to encourage use of and connection to primary care and a medical home



20

Primary Care Services and Linkages: Change Project Example

- Subtopic/Change Project: Use a protocol at each Healthy Start ICC visit/contact to encourage use of and connection to primary care and a medical home
- Possible measures:
 - Develop protocol or checklist to review with participant during visits
 - Increase number of women with whom HS grantee uses tool



21

Maternal Depression Screening and Brief Interventions

Includes:

- Focus on the content, process, tools, and protocols for evidence-based depression screening and brief interventions
- Build on existing strategies in use by Healthy Start grantees, research-based models, and other projects and studies



22

Maternal Depression Screening and Brief Interventions: Subtopics/Change Project

- Develop relationships with mental health providers who can serve women with depression
- Consistent use of a validated, objective depression screening tool, as secondary screening to ICC risk screening
- Strengthen staff skills in maternal/perinatal depression screening
- Develop and implement protocols for helping women gain access to appropriate medications and/or treatment as needed within 60-days postpartum before Medicaid coverage ends
- Learn how to use evidence-based home visit brief interventions for maternal depression



23

Maternal Depression Screening and Brief Interventions: Change Project Example

- Subtopic/Change Project: Consistent use of a validated, objective depression screening tool (e.g., Edinburgh), as secondary screening to ICC screening
- Possible measures:
 - Develop a protocol for schedule of depression screening (consistent with selected tool)
 - Increase the number of women who are screened using the recommended schedule



24

Healthy Weight

Includes:

- Focus on reducing postpartum weight and maintaining healthy weight using evidence-based practices
- Build on existing strategies in use by Healthy Start grantees, Healthy Weight in Women of Reproductive Age Action Learning Collaborative participants, and other projects and studies



25

Healthy Weight: Subtopics/Change Projects

- Develop relationships with local campaigns and organizations focused on reducing obesity and promoting healthy weight
- Consistent use of tools and methods to measure BMI and related assessments
- Use consistent and evidence-based approaches for informing and educating (counseling) on healthy weight
- Strengthen staff skills in effective health education and promotion related to healthy weight



26

Healthy Weight: Change Project Example



- Subtopic/Change project: Strengthening staff skills in effective health education and promotion related to healthy weight (must be culturally competent and evidence based)
- Possible measures:
 - Number of staff trained to deliver health education related to healthy weight
 - Develop and meet fidelity measures established for delivering health education



27



Selection of Core Topic and Subtopic/Change Project

- Before August meeting HS grantees will select their Core Topic by **JULY 6th**
- At the **August 3-4** meeting HS grantees will select their specific Subtopic/Change Project



28

Team Formation





29

Assemble Home and Traveling Teams

Who is on the Home and Traveling Teams?

- **Home teams** include individuals who will develop and implement the selected change in the HS project area (likely those whose work will be affected by the change)
- **Travel teams** include 5 of the home team members who will travel to the face-to-face Learning Community meeting(s)



30

Home Team Composition

- Includes: individuals necessary to accomplish the planned change; depends on the change project, the HS Grantee
- Examples: consortium member; community member; consumer; administrative and clinical HS staff; Local Health System Action Plan participant
- Considerations:
 - Diverse talents and skills
 - Outside perspectives
 - Size of team
 - People who work well together
- ***Each Grantee team will be unique to their work and setting***



Home Team Change Leader

- One member will serve as team leader; a person committed to the change and motivated/enthusiastic to lead the group
- Role of team leader:
 - Manage the home team's work
 - Call meetings
 - Encourage participation
 - Track tasks and progress
 - Supervise measurement and compilation of data
 - Communicate process to HS senior leadership



Home Team Requirements

- Will require regular, protected meeting time
- Will need support from HS leadership
 - Articulating why the Learning Community is important
 - Demonstrating commitment to the change project
 - Empowering the team and Change Leader to identify problems and experiment with new processes
 - Incorporating successful changes into routine practice



Travel Team Composition

- Includes:
 - Lead HS person who oversees day-to-day operations (e.g. Project Director, Project Manager, or Coordinator)
 - Lead case manager/supervisor
 - Active consortium member
- The remaining 2 members are at the discretion of the local HS project and should be relevant to the selected core topic
- You may choose to send a home team member who is instrumental to the change, can serve as a team leader either now or in future cycles



34

Travel Team Composition

How do we decide who to send if we haven't chosen our change project yet?

- Consider the topics described today and rank order those that are of most interest to you
- Think about the individuals who would be involved in making changes in your top ranked topics



35

Will the Home and Travel Teams Remain the Same for all 3 cycles?

- It depends on change projects selected by the HS Project each cycle
- Some teams may work together for 1, 2 or 3 cycles
- Travel team members may change because the HS project chooses a different change project
- Even if your home team remains the same, travel teams may change in later cycles





36

Questions?

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37

Questions and Answers

Thank you for attending this event.
Please complete the evaluation directly following the
webcast.

Archives of the event are located at
<http://www.mchcom.com>



38
