INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH DIVISION

Appendix E
Indiana's Early Start Program
Service Standard

Program Description

Through Indiana's Early Start program, Indiana State Department of Health Maternal Child Health Division (ISDH MCH) seeks to fund local agencies to provide supportive services to women in order to reduce barriers to accessing early care in the first trimester.

Applicants are required to provide access or referrals to medical, social, educational, and other services to pregnant women, with a focus on those who are considered high risk for adverse pregnancy outcomes. Indiana's Early Start program components include, but are not limited to, outreach, assessment, time-limited care plan development and monitoring, prenatal health education and nutrition counseling.

In order to ensure coordination with local support services to women early in pregnancy, a Memorandums of Understanding with the local WIC office and local Division of Family Resources (DFR) Office are essential to the success of this program.

Provider/Staff Qualifications

Indiana's Early Start programs are required to have a service coordinator capable of completing a basic health assessment (i.e. - a community health worker or nurse).

The project must have access to the physician or nurse practitioner providing prenatal care to the identified population.

Outreach

Outreach to all women of childbearing age is a priority. Outreach includes offering pregnancy tests at no cost to the patient, community engagement such as participating in community health fairs, and linking all women of childbearing age to a medical home and community resources for optimal reproductive care.

Required Components of Service or Program

Throughout the service, program staff directly connect with pregnant women and provide positive supportive services. Staff also work with other local partners to assist eligible patients through the enrollment process for Medicaid, WIC, and other relevant community resources.

This prenatal program aims to provide support services for pregnant women through:

- Direct Services
- Referrals/linkages to care
- Navigation and enrollment in health insurance
- Outreach

- Follow-up

Eligible Population
All women of childbearing age who believe they are pregnant or are pregnant but not yet being seen regularly by a primary care provider for prenatal care are eligible to participate in this program.

Required Service Components
At the first visit, every pregnant woman enrolled in the Early Start program will receive:

- Health and Pregnancy History
- Prenatal Risk Assessment
- Nutrition Assessment
- Height/Weight/ BMI
- Prenatal Labs
- Dispense Prenatal Vitamins
- First Trimester Education
- Medicaid Enrollment if Eligible
- WIC Referral
- Social Services Referrals
- Prenatal Care Coordination Referral

Women identified as high risk medically are referred to sponsoring physician within 1-2 weeks. Women not at high risk are seen by Early Start Coordinator until Medicaid is obtained or choose to to be seen by a prenatal care physician.

Women of childbearing age that may qualify for Medicaid but are not already enrolled, must be assisted through the process of presumptive eligibility, completing the Medicaid application, finding a provider that meets their needs, and any support needed for completing this process and making it to the first appointment. Indiana's Early Start providers are encouraged to link pregnant women in need of assistance in obtaining Medicaid or healthcare insurance to the MOMs Helpline (go to http://www.in.gov/isdh/21047.htm for additional information).

Providers shall maintain communication with all participants throughout the duration of their pregnancy and up to three months following delivery to offer supportive referrals and document pregnancy outcomes.

Regular face-to-face visits are a requirement of the program, whether in the participant's home, at a provider's office, or another community setting. Visits and communications for high-risk pregnant women are scheduled monthly with the participant throughout their pregnancy and until two months post-delivery.

Early Start programs are required to provide additional follow-up telephonically or with web-based technology to remind members of appointments, and to convey additional information.

Data Collection Methods/Reporting
Providers are required to implement a standardized process for data collection that meets the requirements for data reporting.

The expected number of participants enrolled will be a stated objective and monthly and quarterly reporting will be used to measure ongoing performance.

Providers will be required to report to ISDH the following:

- Participant engagement and retention
- Prenatal assessment indicators
- Demographics of participants
- Hand-written comments and success stories
- Birth outcomes

Expected Outcomes (detail of goal, outcomes, and measurements)
Primary goal of Early Start is the identification of pregnancy women and their early entrance into prenatal care (within the first 12 weeks of gestation).

Program success will be assessed through the following performance measures and their corresponding data points:

- Increase the percent of pregnant women receiving prenatal care in the first trimester.
- 100% of women receiving Early Start services will have a BMI assessment and education on appropriate weight gain and nutrition
- Prenatal education will be provided to 100% of all women at the initial appointment
- 100% of participants that use tobacco products will be provided with information and referral to a cessation program
- 100% of women receiving Early Start services will receive education about folic acid
- 100% of all pregnant women found to be at high-risk at the time of the Early Start assessment will be seen by a physician within two weeks of referral