Better Birth Outcomes

(formerly called Targeted Intensive Prenatal Case Management)

Illinois Department of Human Services (IDHS)

OVERVIEW

Goals of the program are to: *1)* decrease the incidence of infant mortality and morbidity resulting from lack of adequate prenatal care; 2) improve pregnancy outcomes; and 3) reduce the incidence of prematurity and low birth weight.

This program's services include: standardized prenatal health education (based on the March of Dimes *Becoming a Mom* curriculum; linkage and referral; coordination of care with primary and specialty medical care and other social services; referrals to childbirth education and parenting classes; inter-conception health education including Reproductive Life Planning and assistance in accessing contraceptive services; and overall care coordination to pregnant women with risk factors that lead to poor birth outcomes.

Intensive case management and care coordination, which includes a minimum of two contacts per month and one home visit each trimester of pregnancy, are provided by an RN or MSW case manager.

WHO IS SERVED?

Population(s)/Age Group:

- *High-Risk Pregnant Women*

Eligibility Criteria and Screening Tools:

Women who have high risk pregnancy indicators, including:

- Alcohol/substance abuse continuing during pregnancy
- Previous pre-term birth
- Tobacco use continuing during pregnancy
- Pre-pregnancy weight less than 100 lbs. or BMI greater than 30.
- Age 40 or greater at time of conception
- HIV or repeated STD infections (*single indicator risk factor)*
- Under 15 years of age
- Victim of domestic violence
- DSM_V diagnosis
- Short pregnancy intervals
- Homeless or in temporary housing
- Diseases that affect pregnancy
- Multi-fetus pregnancy (*single indicator risk factor*)
- Under 15 years of age
- Victim of domestic violence
- DSM_V diagnosis
- Low educational attainment (over age 18 and less than 10th grade education)
- Homeless or in temporary housing
- Diseases that affect pregnancy
- Low educational attainment (over age 18 and less than 10th grade education)

Eligibility is determined through administration of a standardized risk assessment tool. Except for the two single indicator risks noted above, women are eligible when two or more risk factors are present. The risk assessment is also used by care coordinators to develop and implement individualized plans of care to enrolled women.

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HOW ARE SERVICES DELIVERED?
Local Service System
BBO services are offered by community-based organizations, Federally Qualified Health Centers and Local Public Health Departments. BBO agencies are expected to build and maintain strong working relationships with community-based social services agencies also serving pregnant women. They are required to enter into Linkage Agreements with medical providers including hospitals, WIC agencies, local health departments within their service area, and other human and social service agencies.
Referrals into Program
The goal of BBO is to enroll women in the first trimester of pregnancy, and to assist women in accessing prenatal medical care in the first trimester of pregnancy. BBO agencies are expected to conduct aggressive outreach to reach women who normally do not seek care or services on their own. Referrals come from physicians and clinics, Medicaid, WIC programs, and other social service agencies in the BBO community.
Data Systems Used
Data is entered into the Cornerstone management information system and into state vital records for information pertaining to perinatal health status indicators.
STATE PROGRAM ADMINISTRATOR OR CONTACT
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