

## Chapter 14: Healthy Start Coding

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### Introduction

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Healthy Start coding provides information on types and quantities of services at the county and state levels. In the aggregate, Healthy Start codes can show the numbers of people who are at risk, who are in need of particular intensities of service, and who are receiving services that are Healthy Start funded. The coding of services also provides the opportunity to link intensity and duration of service delivery to outcomes in order to evaluate the effective implementation and impact of Healthy Start services.

Coding is critical for monitoring the Healthy Start program. Coding identifies services provided which are reimbursable by Medicaid for eligible women and infants enrolled in the Healthy Start system.

The Health Management System (HMS) is used to collect public health service and time data at the program component level for reporting data. At the state-level, data from all the Healthy Start providers is collected and analyzed to support departmental planning, budgeting, management, and administration, as well as reporting to the governor and state legislature.

HMS reports, based on coding, help business managers and program managers report to others who provide funding for Healthy Start. HMS coding, as reflected in the reports, also helps in planning future services for participants, full time equivalents (FTEs), and salary dollars that will be needed for the program. Finally, coding, as reflected in the reports, can provide a “picture” of the most effective packages of services that affect participants’ outcomes.

**Note: Wrap-around service providers** do not have access to the HMS system for data entry of Healthy Start services. Wrap-around service providers must complete an Encounter Form for services provided to program participants funded through Healthy Start. The encounter form should be submitted to the local CHD or other care coordination entity that has access to the HMS system and can input the services data into the HMS data system.

\* For detailed instruction on how to complete the encounter form, please refer to Appendix I.

### Standards and Criteria

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**Standard 14.1 Every Healthy Start participant will be registered into the Health Management System (HMS).**

*Criterion:*

Registration complies with the requirements of the Department of Health publication DHP 50-20.

**Standard 14.2 Providers of Healthy Start funded services will accurately code service information in a timely manner.**

*Criterion:*

Service information coding complies with the requirements of the Department of Health publication DHP 50-20.

**Standard 14.3 Providers of services funded by Healthy Start will enter, or forward for entry, accurate service information in the HMS in a timely manner.**

*Criterion:*

Coalition assures adequate staffing and resources necessary to support and maintain documentation and input of client data in the HMS system as applicable to the client served.

\*Note: References to encounter forms pertain only to those wrap-around service providers that do not use HMS.

**Standard 14.4 Healthy Start service providers will develop and implement an internal quality management and program improvement process for HMS coding.**

*Criterion:*

The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths, areas needing improvement, and a plan for quality management and program improvement.

## **Guidelines**

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### **Healthy Start Program Components**

Program components 22, 26, and 30 are used when the funding flows directly from the Healthy Start coalition to a non-county health department provider.

- Program component code 22 is the Healthy Start interconception program component code used for all Healthy Start care coordination and Healthy Start services provided to a woman between pregnancies (interconception) who is beyond the 8 week post-delivery period included in the prenatal program component or has an initial entry to Healthy Start after a pregnancy loss.
- The Healthy Start interconception woman is a non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death, or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post delivery.
- ♦ Program component code 26 is the Healthy Start prenatal program component code used for all Healthy Start care coordination and Healthy Start services provided to or on the behalf of prenatal participants and their families.
- ♦ Program component code 30 is the Healthy Start infant/child program component code used for all Healthy Start care coordination and Healthy Start services provided to or on the behalf of infant/child participants and their families. Children are eligible

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for services up to three years of age.

Program components 27, 31, and 32 are used when the funding flows directly from the Healthy Start coalition to a county health department provider. Included in these program components are any Healthy Start providers then subcontracted out by the county health department.

- ◆ Program component code 27 is the Healthy Start prenatal program component code used for all Healthy Start care coordination and Healthy Start services provided to or on the behalf of prenatal participants and their families.
- ◆ Program component code 31 is the Healthy Start infant/child program component code used for all Healthy Start care coordination and Healthy Start services provided to or on the behalf of infant/child participants and their families. Children are eligible for services up to three years of age.
- Program component code 32 is the Healthy Start interconception program component code used for all Healthy Start care coordination and Healthy Start services provided to a woman between pregnancies (interconception) who is beyond the 8 week post-delivery period included in the prenatal program component or has an initial entry to Healthy Start after a pregnancy loss. The Healthy Start interconception woman is a non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post delivery.

### **Substance Use Codes**

The Healthy Start program requires that care coordination staff code any substance use identified to three HMC Codes. These codes were created to capture substance use by category, such as alcohol, tobacco and other substance use. Additional details will be required to indicate the type of substance within each category.

#### **Tobacco Use**

**6620**

Use Code 6620 when tobacco use is daily (or in the past month) and is verified by any of the following:

1. The person's own admission to tobacco use;
2. There is positive cotinine or laboratory test verification that the person used tobacco;
3. A staff member witnesses the use;
4. A report from a reliable source such as a reliable family member or professional;
5. An infant's mother smoked during pregnancy as documented **by at least one** of the above criteria.

#### **Alcohol Use**

**6621**

Use Code 6621 when alcohol use is verified by any of the following:

1. A person under 21 has had at least one drink in the past 30 days.
2. A pregnant woman says she is drinking during pregnancy;\*

3. A woman says she drank 4 or more alcoholic drinks on an occasion in the last month;\*
4. A man says he drank 5 or more alcoholic drinks on an occasion in the last month;\*
5. A woman says she drinks more than 7 alcoholic drinks per week;\*
6. A man says he drinks more than 14 alcoholic drinks per week;\*
7. An infant's parent meets the criteria for 2, 3, 4, 5, or 6.\*

\*One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.

### Substance Use

**6622**

Use Code 6622 when person has abused schedule I or II drugs\* and is verified by any of the following:

1. Own admission;
2. A positive drug screen;
3. A staff member witnessing the use;
4. A report from a reliable source such as a reliable family member or professional;
5. An infant prenatally exposed to schedule I or II drugs, as documented by mother meeting the criteria for 1, 2, 3, or 4.

\* For a list of schedule I or II drugs, go to 893.03, F.S. which may be found online at <http://www.leg.state.fl.us/Statutes/>

## INITIAL CONTACT

**3101 - 3119**

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Initial contact after screening is the point-of-entry into Healthy Start care coordination. Healthy Start screening identifies those potential participants who are pregnant women who have received a score of 6 or more or children who have received a score of 4 or more on the Healthy Start screen or have been referred for Healthy Start care coordination services based on factors other than score. The initial contact is an evaluation of service needs. The initial contact or the attempt to contact occurs within five working days of the receipt of the Healthy Start screen or subsequent referral. If the initial attempt to contact is not successful, the second attempt to contact must be made within 10 working days from the first attempt to contact. If the second attempt to contact is unsuccessful, a third attempt to contact must be made within 10 working days from the second attempt to contact.

**See Chapter 4 on Care Coordination and Risk Appropriate Care, for detailed programmatic information.**

### Attempt to Contact

**3103**

This initial contact Attempt to Contact code is used when an attempt to provide an initial contact has been unsuccessful. At a minimum, three attempts to contact are made before discontinuing follow-up and coding 3114, Unable to Locate. The 3103 code may be used more than once. Code one service for every 15 minutes spent in this activity, including travel and documentation. Method of contact attempts are summarized in the

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Decision Matrix in Chapter 4.

Attempt to contact may be made by:

1. Telephone;
2. Face to face (home visit, WIC appointment, clinic appointment, or any other location);
3. Letter.

### **Exception to closure after three attempts:**

Invitational letters may be used as an initial contact Attempt to Contact (3103). The participant who has a score of less than 6 for prenatal or a score less than 4 for infant, has been referred for factors other than score, and has no Tier 1 or 2 concerns and needs, may be closed after 30 days if the participant has not made contact with the coordinator. Only one attempt to contact is required in this situation. Use code, 3119, Unable to Provide a Completed Initial Contact for these situations. See Chapter 4, Tier 1, Table 4.2a and Tier 2, Table 4.2b.

The Initial Contact includes:

1. Explaining the meaning of a positive Healthy Start risk screen including why the referral was made and addressing each risk factor with the participant;
2. Determining the participant's ability to access comprehensive prenatal services/child health care services;
3. Evaluating the participant's service needs by determining the availability of the participant's or family's assets, strengths, and resources to reduce their risk status using risk appropriate care principles;
4. Providing information about how risk factors can be addressed and what types of services are available in the community and through Healthy Start to improve chances of a healthy outcome;
5. Providing referrals to community resources;
6. Providing a name and phone number of a person at the agency providing Healthy Start care coordination who can be contacted for assistance if the participant or family is unable to access needed services;
7. Initiating the participant's Healthy Start care coordination record;
8. Initiating an Individualized Plan of Care;
9. Assigning a level of care based on the Healthy Start State Leveling System Criteria;
10. Providing follow-up with the participant's health care provider within 30 calendar days of the first attempt to contact to inform them of the results of the initial contact and the name and phone number of a contact at the agency providing

the initial contact.

If only an Attempt to Contact has been completed, code the time directly to the code 3103. This code may be used multiple times. Code service units in 15 minutes increments and service time spent attempting to contact should include time for travel and documentation.

When coding for services provided during the initial contact phase (3100) choose the appropriate outcome code (3101, 3102, 3110, 3111, 3112, 3113, 3114, 3119). Time spent providing the initial contact outcome is pre-coded as one service unit (15 minutes) to the initial contact outcome code. (The outcome codes are also used as a participant count).

Time in excess of 15 minutes is coded to 3115, including travel, documentation, and referral activities. If the selected outcome code is 3114 or 3119, time in excess of 15 minutes spent attempting to provide these services is coded to 3115 and should include time for travel and documentation.

 **Needs Tracking Only** **3101**

This initial contact outcome code is used when the initial contact indicates that a time-sensitive (within 10 days) initial assessment is unnecessary and the participant can be funneled directly into care coordination. Tracking may be face to face or non face to face. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

 **Participant Needs Assessment** **3102**

This initial contact outcome code is used when the initial contact results in a determination that the participant needs or desires a time-sensitive (within 10 days) face to face assessment. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

**Note:** Not everyone needs to receive an in depth, face to face initial assessment within 10 working days. If it is determined when providing the initial contact that a participant does not need an initial assessment in this time frame, the 3200 series of codes may be bypassed. On the next encounter, coding should begin in the 3300 series.

**Note:** If a participant is in need of services before the completion of the initial assessment the service should be provided and coded as ongoing care coordination either tracking or face to face.

**Initial Contact Care Coordination Closure Codes**

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 **Declines Services** **3110**

This initial contact outcome code is used when the participant verbally declines additional services after the initial contact service has been provided, even though the care coordinator believes further services are warranted. Code 3110 indicates that an

initial contact has been completed and all criteria outlined for providing the initial contact have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

 **No Further Services Needed** **3111**

This initial contact outcome code is used when the participant and the care coordination provider collaboratively agree that no further services are needed. Code 3111 indicates that an initial contact has been completed and all criteria outlined for providing the initial contact have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

 **Receiving or Will Receive Care Coordination from CMS/Early Steps** **3112**

This initial contact outcome code is used when the care coordination is (or will be) adequately provided by CMS/Early Steps. Code 3112 indicates that an initial contact has been completed and all criteria outlined for providing the initial contact have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

 **Receiving or will Receive Care Coordination from Another Provider, Not CMS/Early Steps** **3113**

This initial contact outcome code is used when the care coordination is (or will be) adequately provided by another provider, but not CMS/Early Steps. Code 3113 indicates that an initial contact has been completed and all criteria outlined for providing the initial contact have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the Initial Contact to service code 3115.

**Note: With the exception of 3114 and 3119, (Unable to Locate and Unable to Provide a Completed Initial Contact), Initial Contact outcome codes indicate that the participant did receive an initial contact and that all the criteria were met.**

 **Unable to Locate** **3114**

This initial contact closure code is used when the initial contact has not been provided. Use this code when:

1. Three attempts have been made and documented. These attempts may be made by telephone, face to face, or by letter. One attempt must be face to face;
2. The participant covertly declines services by not responding to attempts to contact.

**Follow-up will be discontinued for participants who are unable to be located.**

 **Unable to Provide a Completed Initial Contact** **3119**

This initial contact closure code is used when the initial contact has not been provided. Use this code when:

1. The participant refuses the initial contact before all components of the initial contact have been completed;
2. The participant has a score of less than 6 for prenatal and a score less than 4 for infant; is referred for factors other than score; does not have concerns, needs, or is a referral from other agencies; or does not have any Tier 1 or 2 concerns and has not responded to an invitational letter request to contact the coordinator. Close after 30 days if participant has not made contact with the coordinator. See Chapter 4, Tier 1, Table 4.2a and Tier 2, Table 4.2b.

 **Initial Contact Service Units** **3115**

This code is used to account for time spent providing an initial contact outcome service beyond the one service unit recorded for the initial contact outcome code. Include the time spent providing the evaluation of service needs, documentation, and travel. Also include telephone calls that are made to provide care coordination services. Code one service for every 15 minutes spent providing an initial contact outcome. It is used only with codes 3101, 3102, 3110, 3111, 3112, 3113, 3114, and 3119.

**Example:** Time spent providing the Initial Contact is 45 minutes and the outcome was that the care coordinator was unable to provide a completed initial contact (3119).

**Code:** Code 2 units to service to code 3115. One unit of service is captured with the coding of the outcome code 3119. Forty-five minutes is captured by adding the 2 codes' service units together.

**Initial Contact Rules**

Only one initial contact outcome (3101, 3102, 3110, 3111, 3112, 3113, 3114, or 3119) should be coded for each participant. The exception is 3103, Attempt to Contact, which may be coded as many times as necessary when attempting to provide the initial contact.

Note: If a closure code has been used and the participant returns for services during the same pregnancy or for the same infant, the case should be reopened using the appropriate code based on the point of care coordination at time of closure. If the initial contact was provided then the case would be reopened in the initial assessment phase if needed or in the on-going care coordination phase if an initial assessment is not needed. If the initial contact was not completed then the case should be reopened to complete the initial contact and proceed with care coordination as you would at the point of entry. In a case like this use of another closure code is warranted when it is time to close the case.

Time spent providing an initial contact and/or an Attempt to Contact is coded in



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15-minute blocks of time. Use the following examples and table to code number of services.

- a. If an attempt to contact is made, code at least one service, even if it took less than 15 minutes to provide the service (e.g., an attempt to contact took 5 minutes, code one service).
- b. If the service takes more than 15 minutes to provide, round the time to the nearest 15 minutes (7 minutes or less, round down; more than 7 minutes, round up). Use the following table as a guide.

Minutes	Services	Minutes	Services
1-22	1	83-97	6
23-37	2	98-112	7
38-52	3	113-127	8
53-67	4	128-142	9
68-82	5	143-157	10

With the exception of 3114 and 3119, (Unable to Locate and Unable to Provide a Completed Initial Contact), the initial contact outcome codes indicate the participant did receive an initial contact.

**Initial Contact Example**

M.J. is a potential Healthy Start participant. She is unmarried, living with a friend, and has a 4-year-old son. She has just discovered she is pregnant. Although her pregnancy is unplanned, she wants to keep her baby and will need help to do so. She was screened and is interested in becoming a Healthy Start participant.

The Healthy Start care coordinator, Ms. Smith, calls M.J. by telephone to make an initial contact. M.J. answers the telephone, and Ms. Smith discusses the following items with M.J.

- The meaning of M.J.'s risk screening and risk factors.

*Ms. Smith reminds M.J. about the risk screening form completed at her prenatal visit. She explains each of M.J.'s risk factors and how it could put her at risk for a poor pregnancy outcome (e.g. she explains that women who are pregnant and not married are more likely to experience stress during pregnancy and to have low birthweight babies, but that helping to find alternative support systems may help to mitigate this risk factor). Ms. Smith discusses how the Healthy Start program might help M.J. to address some of her risk factors and improve her chances for a healthy pregnancy and a healthy baby.*

- M.J.'s ability to access services.

*Ms. Smith asks M.J. if she has a regular doctor or a doctor she is seeing for her pregnancy. She learns that M.J. does not have transportation or a medical provider. She also needs food and a place to live.*

- Services that are available to M.J.

*Ms. Smith informs M.J. about the Healthy Start program and some of the services that are available in her community, including prenatal care, food banks, and transportation to the clinic.*

- A contact person that M.J. can call at Healthy Start.

*Ms. Smith gives M.J. her name and telephone number.*

- Determination of the need for further assessment.

*Based on their telephone conversation during the initial contact, Ms. Smith determines that M.J. has multiple and complex needs and, in her professional judgment, determines that M.J. would benefit from an initial assessment. She arranges a time to visit M.J. where she is living for an in-depth, face to face assessment.*

*(Note: It is not always clear whether an individual needs a face to face assessment. The Healthy Start program staff recommend that, if in doubt, provide a face to face assessment in the home, clinic, or other setting of the participant's choice.)*

During and after this initial contact, Ms. Smith also completes the following activities:

- Initiation of a Healthy Start care coordination record.

*Ms. Smith initiates a HMS record and documents the telephone conversation with M.J. and describes her needs. She also documents the planned visit to M.J.'s home and prepares feedback for the prenatal care provider.*

- Coding the Healthy Start service she provided.

*At the conclusion of the telephone conversation, Ms. Smith completes the requirements of the initial contact. She opens the care coordination record. She levels the participant at level 3\*, prepares an Individualized Plan of Care for M.J., prepares feedback to the prenatal care provider, and she codes the services she provided on the encounter form. The total time spent for the initial contact, including the conversation, charting, and the additional follow-up with the referring agencies, was 75 minutes. Ms. Smith codes one service unit (15 minutes) to outcome code 3102 (Participant Needs Assessment) because, based on her professional judgment, she has determined that M.J. needs a more in-depth assessment. Using code 3115, Initial Contact Service Units, she codes the remaining four service units (60 minutes) to capture the remaining time spent on the initial contact.*

### **Frequently Asked Questions Related to Initial Contact**

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**Q.** *If I make a home visit to attempt to provide the initial contact and the participant is inside the house but will not answer the door, how do I code this attempt and close this case?*

**A.** Use code 3103, Attempt to Contact. If this is the third attempt, you may also code 3114, Unable to Locate, which is the initial contact outcome code.

**Q.** *How do I code my activities when I have a participant referred to Healthy Start for*

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*factors other than a positive score on the Healthy Start screen and there is no indication of why?*

- A.** If you receive a referral to Healthy Start for factors other than score and there is no indication that the person has concerns or needs, you may complete and code an initial contact outcome in the following manner: Send a letter describing the Healthy Start program and instructing the participant to notify the Healthy Start contact person in the event that services are needed; code this activity as 3103, Attempt to Contact. If there is no response from the participant within 30 calendar days from the first attempt to contact, the case may be closed to care coordination using the initial contact outcome code 3119, Unable to Provide a Completed Initial Contact.

**Q.** *When do I code needs tracking only?*

- A.** When professional judgment has been made that ongoing care coordination services are needed, but the participant does not need a face to face assessment, the participant needs intensive tracking.

Use the initial contact service code 3101, Needs Tracking Only, for this participant.

**Q.** *What if I'm not ready to close a case when I find that another provider will be following the participant? Can I continue to provide services?*

- A.** You may continue providing services to the participant until you are comfortable that the participant is able to obtain needed services. Remember to be aware of limited resources as well as the needs of the participant when determining whether to continue following the case.

**Q.** *How do you know that someone needs tracking only if the person did not need or receive an assessment?*

- A.** At the initial contact, an evaluation of service needs is made to determine whether or not the individual needs an in-depth, face to face assessment. This determination is made by conducting the initial contact. Not everyone will need an in-depth, face to face assessment.

**Q.** *What if I've already used an initial contact outcome code for a participant, and the participant returns for services?*

- A.** Even if a closure code for the initial contact has already been used, services may be provided. Code the additional services provided using the appropriate 3100, 3200, or 3300-series codes to reopen the record to Healthy Start.

**Q.** *Can I code more than three attempts to contact potential participants?*

- A.** Yes. You may use code 3103, Attempt to Contact, as many times as are necessary. However, be sure to concentrate efforts on those with the greatest need. (Refer to the care coordination guidelines for more information on "attempts to contact" and closure of Healthy Start participants.) Remember, the number of services coded should include any travel time, documentation, and coordination with referral agencies. One service should be coded for each 15 minutes spent attempting to contact the participant.

**Q.** What code should I use when a family member answers the door or the telephone and states the prenatal participant is not at home?

- A. This should be coded as an attempt to contact, because contact with the participant was not successful.

## **INITIAL ASSESSMENT**

**3201-3215**

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Initial assessment of service needs is a face to face evaluation done in collaboration with the participant and family within 10 working days of the initial contact.

The initial assessment, or an attempt to contact the participant for this assessment, occurs within 10 working days of the initial contact. The initial assessment activities will be documented and the Individualized Plan of Care is evaluated to include the following provisions:

1. A face to face interview with the participant or child's parents/caregivers. The assessment may be completed in the clinic, in a community setting, or in the home at the time of initial contact if the initial contact is made during a face to face encounter.
2. Completion of an authorization for release of medical information, as appropriate.
3. Joint determination of the participant's and family's service needs, made in conjunction with the participant or family, to include evaluation of:
  - a. Participant's, parent/caregiver's, and family's concerns, priorities, and resources;
  - b. Participant's physical and emotional well-being, safety, and general appearance;
  - c. The home environment;
  - d. The participant's, parent/caregiver's, and family's knowledge and attitudes about pregnancy, childbirth, and parenting;
  - e. Parent/caregiver's child interaction;
  - f. Availability of a social support system;
  - g. Current situation with regard to services, health care, and risk factors, for example: housing, food, transportation, family planning, health services, school enrollment and participation, eligibility for Medicaid and WIC, ability to continue regular participation in ongoing care (including past appointment regularity), ability to comply with recommended treatments, (such as obtain and take medicines or stay on bed rest);
  - h. Any new risk factors, corresponding needs, and potential for change;
  - i. Characteristics of the parent at risk for child maltreatment;
  - j. If unmarried, plans for establishing paternity, child support, and involvement of father in child's life;

- k. Alcohol, tobacco, or other drug use.
- 4. An Individualized Plan of Care for continuing or discontinuing care coordination services based on the assessment.
- 5. Evaluation of the participant's level of care and documentation of leveling changes as needed.
- 6. A phone call or written note provided to the participant's health care provider within 30 calendar days of the assessment regarding progression of Healthy Start care coordination service delivery. If the initial contact and the initial assessment are completed separately or together within 30 calendar days of one another, one phone call or note will suffice.

On completion of the initial assessment choose one of the following codes to describe the outcome of the initial assessment. Code time spent providing the initial assessment as one service to the appropriate initial assessment outcome code, and the remaining time to 3215, including travel, documentation, and referral activities. If only an attempt to contact has been completed, code the time directly to the code 3203, Attempt to Contact.

 **Attempt to Contact** **3203**

This initial assessment code is used when an attempt to provide an initial face to face assessment has been unsuccessful. Minimally, three attempts to provide the assessment are made before discontinuing follow-up and coding 3214, Unable to Locate. The 3203 code is used more than once when attempting to provide the initial assessment. Code one service for every 15 minutes spent in this activity, including travel, documentation, and communication with referral agencies.

Attempts to contact for an initial assessment are face to face:

- 1. Home Visits
- 2. WIC or Clinic Appointment
- 3. Any other location where the participant and the Care Coordinator are face-to-face

\*Note: As you attempt to provide a completed face to face assessment, successful calls to the participant's healthcare provider, WIC, etc., to determine when the participant's next appointment is can be coded to 3321 as tracking, as you are tracking receipt of services and rescheduling the Initial Assessment.

In addition, successful calls to the participant between the provision of the Initial Contact and Initial Assessment, with the intent to follow-up on referrals and needed supplies or educational materials are coded as 3321. (If calls made for these reasons are unsuccessful, code the attempts to contact to 3303).

 **Needs Tracking Only** **3201**

This initial assessment outcome code is used when the participant needs less intensive

care coordination services. Code one service for each additional 15 minutes spent providing the initial assessment to service code 3215.

 **Plan Ongoing Care Coordination** **3202**

This initial assessment outcome code is used when the initial assessment results in a determination that the participant needs more follow-up than would be provided by tracking alone. Code one service for each additional 15 minutes spent providing the initial assessment to service code 3215.

**Initial Assessment Care Coordination Closure Codes**

 **Declines Services** **3210**

This initial assessment outcome code is used when the participant verbally declines additional services after the initial assessment service has been provided, even though the care coordination provider believes further services are warranted. Code 3210 indicates that an initial assessment has been completed and all criteria outlined for providing the initial assessment have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the initial assessment to service code 3215.

 **No Further Services Needed**

This initial assessment outcome code is used when the participant and the care coordination provider collaboratively agree that no further services are needed. Code 3211 indicates that an initial assessment has been completed and all criteria outlined for providing the initial assessment have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the initial assessment to service code 3215.

 **Receiving or Will Receive Care Coordination from CMS/Early Steps** **3212**

This initial assessment outcome code is used when the care coordination is (or will be) adequately provided by CMS/Early Steps. Code 3212 indicates that an initial assessment has been completed and all criteria outlined for providing the initial assessment have been met. Follow-up is discontinued. Code one service for each additional 15 minutes spent providing the initial assessment to service code 3215.

 **Receiving or Will Receive Care Coordination from Another Provider, not CMS/Early Steps** **3213**

This initial assessment outcome code is used when the care coordination is (or will be) adequately provided by another source, not CMS/Early Steps. Code 3213 indicates that an initial assessment has been completed and all criteria outlined for providing the initial assessment have been met. Follow-up is discontinued. Code one service for each

additional 15 minutes spent providing the initial assessment to service code 3215.

**Note: With the exception of outcome codes 3214, Unable to Locate, and 3219, Unable to Complete an Initial Assessment, the previous initial assessment outcome codes indicate the participant did receive an initial assessment and all the criteria were met.**

 **Unable to Locate** **3214**

This initial assessment outcome code is used when the initial assessment has not been provided. Use this code when:

1. Three face to face attempts have been made and documented, or
2. The participant covertly declines services by not responding to attempts to contact, or
3. Repeated unsuccessful attempts have been made to reschedule the initial assessment.

 **Unable to Provide a Completed Initial Assessment** **3219**

This initial assessment outcome code is used when the initial assessment has not been provided. Use this code when:

The participant refuses the initial assessment before all components of the initial assessment have been completed;

Follow-up will be discontinued for participants who are unable to be located.

 **Initial Assessment Service Units** **3215**

This code is used to account for time spent providing an initial assessment beyond the one service unit recorded for the initial assessment outcome code. Include the time spent providing the assessment, documentation, and travel. Also include telephone calls that are made to provide care coordination services. Code one service for every 15 minutes spent providing an initial assessment. It is used only with codes 3201, 3202, 3210, 3211, 3212, 3213, 3214, and 3219.

**Example:** Time spent providing the Initial Assessment is 75 minutes and the outcome was that the participant decline services (3210).

**Code:** Code 4 units to service to code 3215. One unit of service is captured with the coding of the outcome code 3210. Seventy-five minutes is captured by adding the units of service for both codes together.

**Initial Assessment Rules**

It is not always clear whether an individual will need an initial assessment. The Healthy Start program staff recommends that, if in doubt, **provide** a face to face assessment.

Only one initial assessment outcome should be coded for each participant. The code 3203, Attempt to Contact, may be used as many times as needed when attempting to

provide the initial assessment. Time spent providing an initial assessment and/or the attempt to contact is coded in 15-minute blocks of time. Use the following examples and table to code number of services.

- a. If an attempt to contact (3203) is made, code at least one service, regardless of the amount of time it took to provide.
- b. If the initial assessment takes more than 15 minutes to provide, round the time to the nearest 15 minutes (7 minutes or less, round down; more than 7 minutes, round up). Use the following table as a guide.

<b>Conversion Table for Time Spent to Number of Services</b>			
Minutes	Services	Minutes	Services
1-22	1	83-97	6
23-37	2	98-112	7
38-52	3	113-127	8
53-67	4	128-142	9
68-82	5	143-157	10

With the exception of 3214 and 3219, (Unable to Locate and Unable to Provide a Completed Initial Assessment), initial assessment outcome codes indicate the participant did receive an initial assessment.

**Note:** The use of formal screening or assessment tools, such as the NCAST assessment tool, the “Tell Us About Yourself” Questionnaire (DH 3131), and others, may be recorded if provided as a component of the initial assessment or as a component of ongoing care coordination. Administration of these assessment tools should be documented in the appropriate area of the participant’s record, under either initial assessment or ongoing care coordination, and the time spent administering the tool(s) should be captured either under time spent for initial assessment or ongoing care coordination. There is no specific HMS service code to indicate that these assessment tools were used.

**Initial Assessment Example**

The Healthy Start care coordinator, Ms. Smith, visits M.J.'s home to conduct the initial assessment.

- They discuss factors that may adversely affect M.J.'s pregnancy.

*She learns more about M.J.'s housing, transportation, and health care needs and that she also needs childcare and food.*

- Ms. Smith also asks M.J. about her priorities and concerns.  
*She learns that M.J.'s priority is finding a place to live and food for herself and her son.*

- Ms. Smith determines that M.J. has several barriers to health care and other services.

*Because M.J.'s case is complex, Ms. Smith will need to plan ongoing care coordination with M.J. so that all of her needs can be effectively addressed.*



- Ms. Smith codes 3202, Plan Ongoing Care Coordination, for M.J.'s initial assessment, and 4 service units to 3215 to cover the 75 total minutes she spent providing the initial assessment, including travel, documentation, and care coordination activities.

### **Frequently Asked Questions Related to Initial Assessment**

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- Q.** *What if the initial assessment reveals the Healthy Start participant needs services, but the participant states she no longer wants to participate?*
- A.** The Healthy Start care coordinator would try to explore why the participant changed her mind and would re-explain the Healthy Start program. If the participant still does not want to participate, and the care coordinator has met the criteria for providing initial assessment, the care coordinator would use code 3210, Declines Services. This code means the participant has declined services in spite of the fact that the provider feels services are warranted.
- Q.** *Can an initial contact and an initial assessment be provided in the same visit?*
- A.** Yes, as long as the encounter is face to face. Many care coordination providers have a person assigned to do both the initial contact and assessment at the same time. You would code both the outcome of the initial contact 3102, Participant Needs Assessment, and an initial assessment 3200 series code, depending on the outcome. Then split the remaining time between 3115, Initial Contact Service Units, and 3215, Initial Assessment Service Units.
- Q.** *Can the initial assessment be completed over the telephone?*
- A.** No, the initial assessment is an in-depth assessment and must be done in a face to face setting. The initial contact, which is an evaluation of service needs, can be done by telephone to determine if the participant needs the initial assessment.
- Q.** *When is it appropriate to use the initial assessment attempt to contact code 3203?*
- A.** This code is to be utilized to document unsuccessful attempts to provide the initial assessment face to face. This face to face attempt may be at the participant's home, community location, healthcare provider office, or other social service appointment.
- Q.** *How do I code an unsuccessful non face to face attempt to contact before the completion of the Initial Assessment?*
- A.** This unsuccessful attempt to contact the participant should be coded to Care Coordination attempt to contact 3303, because the initial assessment attempt must be done face to face.
- Q.** *Can I close a participant as Unable to Complete Initial Assessment (3214) without providing three face to face attempts to contact?*
- A.** Yes, if the care coordinator has provided numerous attempts to contact the participant by letter or phone call, they may close the participant to 3214 without providing three face to face attempts.
- Q.** *Is use of a formal screening or assessment tool such as the NCAST, "Tell Us About Yourself" Questionnaire, or other assessment tools considered to be an*

*initial assessment?*

- A. No, these formal assessment tools or screens do not meet all the criteria of a completed initial assessment per the HSSG. The care coordinator may chose to use these tools during an initial assessment visit and the time spent would be included in the service units coded.

## **ONGOING CARE COORDINATION**

**3303-3323**

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Ongoing care coordination is the ongoing work (usually after the initial contact and assessment) of the care coordinator assisting families with locating, coordinating, and using services in order to optimize pregnancy, birth, growth, and developmental outcomes.

Ongoing care coordination may include any of the following activities:

1. Tracking the participant's receipt of services (see Chapter 4, Care Coordination and Risk Appropriate Care, for tracking activities);
2. Continuing assessment of the participant's, parent/caregiver's, or family's concerns, priorities, strengths, and resources;
3. Planning with the family regarding how to address their concerns and priorities and how to maximize resources;
4. Developing a family support plan in accordance with approved protocols;
5. Providing referrals;
6. Follow-up on use of referrals and services;
7. Coordinating services with other providers/agencies/programs;
8. Reinforcing the health care regimen;
9. Providing anticipatory guidance;
10. Advocating on behalf of the participant and family;
11. Monitoring effectiveness of services provided and adjusting the plan for services as appropriate;
12. Care coordination transition to other providers when appropriate;
13. Maintaining ongoing communication with other providers, especially the prenatal or child health care provider;
14. Evaluation and update of the Individualized Plan of Care;
15. Evaluation and update of the participant's level of care.

Each time ongoing care coordination is provided, choose as many ongoing care coordination service codes as applicable. At the time ongoing care coordination is terminated, choose only one ongoing care coordination outcome code.

 **Attempt to Contact** **3303**

This ongoing care coordination code is used when an attempt to provide a care coordination service has been unsuccessful. Minimally, three attempts to provide ongoing care coordination are made before discontinuing follow-up. Code one service for every 15 minutes spent in this activity.

Attempt to contact may be made by:

1. Telephone;
2. Face to face (home visit, WIC appointment, clinic appointment, or any other location);
3. Letter;
4. Unsuccessful attempt to reschedule the Initial Assessment

 **Care Coordination Face to Face** **3320**

This ongoing care coordination code is used when care coordination activity is provided face to face with the participant. Code one service for every 15 minutes spent in this activity, including travel and documentation.

Use this code for time spent to develop a family support plan with participants who have been assessed as level 2 participants.

 **Care Coordination Tracking or Not Face to Face** **3321**

Use this ongoing care coordination code when providing tracking activities either face to face or non face to face, or when providing ongoing care coordination that is non face to face.

- Telephone calls to or on behalf of the Healthy Start participant;
- Referral activities, by telephone or face to face;
- Tracking activities, by telephone or face to face.

Code one service for every 15 minutes spent in this activity, including travel and documentation.

 **Initial Family Support Plan Meeting** **3322**

This ongoing care coordination code is used at the time that the family support plan is written (face to face). A family support plan is required for all level 3 participants. If the participant refuses to sign the written plan, still code 3322 for level 3 participants and

document in the progress notes the refusal to sign the plan. Use this code only when a level 3 participant receives a family support plan. If a family support plan is developed for level 1 or 2 participants, code as face to face ongoing care coordination (3321). Code one service for every 15 minutes spent in this activity, including time for travel and documentation.

 **Update Family Support Plan** **3323**

This ongoing care coordination code is used when the family support plan is updated (face to face). Minimally, this should be done every three months. Use only for updating a family support plan of a level 3 participant. Code one service for every 15 minutes spent in this activity. Updates to the family support plan developed for level 1 and 2 participants should be coded as ongoing care coordination (3321). This code (3323) should not be used with levels 1 and 2 participants.

**Ongoing Care Coordination Closure Codes**

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At the time ongoing care coordination is discontinued, choose only one ongoing care coordination closure code.

 **Declines Services** **3310**

This ongoing care coordination outcome code is used when the participant verbally declines or refuses services, in spite of the fact that the care coordination provider believes services are warranted. Code 3310 indicates that you have provided an ongoing care coordination service and that the participant has refused to continue ongoing care coordination. Follow-up is discontinued.

 **No Further Services Needed** **3311**

This ongoing care coordination outcome code is used when the participant and the care coordination provider collaboratively agree that no further services are needed. Follow-up is discontinued.

 **Receiving Care Coordination from CMS/Early Steps** **3312**

This ongoing care coordination outcome code is used when the ongoing care coordination is (or will be) adequately provided by CMS/Early Steps. Follow-up is discontinued.

 **Receiving Care Coordination from Another Provider, not CMS/Early Steps** **3313**

This ongoing care coordination outcome code is used when the ongoing care coordination is (or will be) adequately provided by another provider, not CMS/Early

Steps. Follow-up is discontinued.

**NOTE:** If the participant is moving to another county and will need Healthy Start Services, make the referral to the care coordinator in the county that the participant is moving to and code 3313.

 **Unable to Locate** **3314**

This ongoing care coordination code is used when a participant cannot be located after three attempts have been made and documented. These attempts will be according to the following guidelines:

1. Three attempts have been made and documented. These attempts may be made by telephone, face to face, or by letter. One attempt must be face to face.
2. The participant covertly declines services by not responding to attempts to contact.

Follow-up will be discontinued for participants who are unable to be located.

 **Ineligible for Care Coordination Services** **3315**

This ongoing care coordination outcome code is used when a participant has:

- ◆ completed postpartum and family planning appointment or eight weeks after delivery in program component 26 or 27;
- ◆ a child reaches three years of age in program component 30 or 31;
- ◆ Completed 3 years post delivery in program component 22 or 32
- ◆ moved out of the state

**Note:** If the participant moves to another county, make the referral to the new county of residence and close using code 3313, Receiving Care Coordination from Another Provider, not CMS/Early Steps. If the participant moves out of state, close using the code 3315.

 **Transition from Prenatal to Interconception** **3324**

This interconception code is used when at the end of the prenatal period it is determined by the Care Coordinator that the participant still needs Healthy Start services beyond the 8 week postpartum period, but there is no infant to whom to code services. Code only one service unit to this code and any additional time spent providing the transition to 3320 Care Coordination Face to Face or 3321 Care Coordination Tracking.

**Ongoing Care Coordination Rules**

Not all participants will receive an ongoing care coordination code. Some of them will not choose to receive these services or need to continue participating in Healthy Start.

Ongoing care coordination codes may be used as many times as needed. Care coordination closure codes may only be used once. An exception to this would be if you have closed a participant, then reopened, and then need to close at a further date after care coordination has been completed.

Ongoing care coordination closure codes may be coded along with other ongoing care coordination codes, if appropriate.

The number of ongoing care coordination service code units recorded is based on the length of time spent providing a service. Code one service for every 15-minute block of time spent, including travel, documentation, and communications with referral or primary care providers.

- a. If a service is provided, code one service at a minimum, regardless of the time it took to provide.
- c. If the service lasts longer than 15 minutes, beginning with the second 15 minute period, round the time to the nearest 15 minutes (7 minutes or less, round down; more than 7 minutes, round up). Use the following table as a guide.

<b>Conversion Table for Time Spent to Number of Services</b>			
Minutes	Services	Minutes	Services
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38-52	3	113-127	8
53-67	4	128-142	9
68-82	5	143-157	10

### **Ongoing Care Coordination Example**

The Healthy Start care coordinator, Ms. Smith, meets with the participant, M.J., to discuss the Healthy Start services that are available (this takes 15 minutes), and they make plans for M.J. to get parenting support and education classes. Ms. Smith had determined that M.J. needs level 3 services, so she initiates the required family support plan with M.J.'s cooperation (this takes 30 minutes). They discuss when they will talk again. **Ms. Smith is providing ongoing care coordination to M.J. through their face to face discussion of her needs and the initial development of a family support plan.** Ms. Smith spent an additional 45 minutes on travel, documentation, and communication with referral agencies and Mary's primary care providers.

To code this example:

- Ongoing care coordination code 3320, Care Coordination Face to Face, would be used to document the discussion of available services. The activity took 15 minutes, or one service.
- Code 3322, Initial Family Support Plan Meeting, would be used to document initiating the family support plan. The activity took 30 minutes, or two services.
- The additional time for travel, documentation, and communication with referral agencies or primary care providers (three services, or 45 minutes) would be split between 3320 and 3322. (Ms. Smith decided to add one additional service to

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- 3320 and two additional services to 3322.)
- So, the final total of one and a half hours (90 minutes) spent was coded by Ms. Smith as two services to 3320 and four services to 3322.

Note that the referral to parenting support and education classes is NOT coded separately. There is not a separate code for referrals because this is a part of ongoing care coordination services. When M.J. attends the class, the service will be coded at that time. If the class is not offered by the county health department or a coalition-contracted provider, M.J.'s attendance is not documented in HMS; however, her record should reflect the services to which she has been referred and the services she has received.

### REPORTING SERVICES IN 15 MINUTE BLOCKS OF TIME

#### Examples

1. The nurse talks to M.J., in a face to face setting, about her priorities and resources for 25 minutes.  
*Explanation: Two services are coded to 3320, Ongoing Care Coordination Face to Face, because 25 minutes is rounded up to two 15 minute blocks.*
2. An initial family support plan development for a pregnant woman takes 35 minutes.  
*Explanation: Two services are coded to 3322, Initial Family Support Plan Meeting, because 35 minutes rounds down to two 15 minute blocks of time.*
3. A 5-minute telephone call is made to a local provider to follow up on whether Susie is regularly attending her prenatal visits.  
*Explanation: One service is coded to 3321, Care Coordination Tracking or Not Face to Face, because at least one service is coded any time a service is provided to a participant.*

### Frequently Asked Questions Related to Ongoing Care Coordination

- Q.** *How would you code a face to face visit during which the Healthy Start care coordinator provided breastfeeding education?*
- A.** If the Healthy Start care coordinator meets the provider qualifications for breastfeeding education and support, both 3320, Care Coordination Face to Face, and 8008, Breastfeeding Education and Support, would be coded. If the visit was 45 minutes long, and breastfeeding education took 30 of the 45 minutes, you would code two services to 8008 and one service to 3320. You would also split the time it took to provide this service, including travel and documentation, between the two codes. If just one service unit covers needed travel and documentation, you may allocate the service unit to whichever code you choose.
- Q.** *After providing a Healthy Start initial contact, the care coordinator determines Healthy Families is the more appropriate agency. How would this be coded after the referral has been made and the participant accepted?*
- A.** Code 3313, Receiving Care Coordination from Another Provider, not CMS/Early Steps.

- Q.** *Can the initiation or updating of any plan of care, not just the single or multiple agency DOH Family Support Plan, be coded as 3322 for FSP Meeting or 3323 for Update FSP?*
- A.** Only code an activity as 3322, Initial Family Support Plan, or 3323, Update Family Support Plan, if it is developed or updated for a level 3 participant and meets all the criteria of the family support planning process outlined in Chapter 4, Care Coordination and Risk Appropriate Care. The document on which the plan is recorded is NOT the defining characteristic of the service. If the process is followed and documentation is provided on a comparable form, these codes may be used for equivalent activities. The copy of the family support plan is given to the participant or family.
- Q.** *Suppose I make a telephone call on behalf of a Healthy Start participant that lasts just five minutes?*
- A.** Code the telephone call as 3321, Care Coordination Tracking or Not Face to Face. You would code one service, even if the call or other activity takes less than 15 minutes.
- Q.** *Sometimes I contact another provider that is serving a Healthy Start participant to follow up on whether the participant is getting to her appointments, etc.. How do I code this type of contact?*
- A.** Code contacts to other providers as 3321, Care Coordination Tracking or Not Face to Face.
- Q.** *If we have been providing ongoing care coordination to a participant for a period of time and the participant moves, how do we close the participant out if the person hasn't contacted us?*
- A.** After you have documented at least three unsuccessful attempts to contact the participant (code each as 3303, Attempt to Contact), you may consider the participant lost to follow-up. Use the ongoing care coordination outcome code 3314, Unable to Locate.

## **HEALTHY START REFERRAL SERVICES**

**R001 – R023  
6620 - 6622**

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These are codes to be utilized by Healthy Start care coordination staff to document participant referrals for services based on an assessment of their risk and needs. Care Coordination staff are required to document the initiation, continuation and discontinuation of all referral services in the referral tracking module of HMS.

### **R001 Nutrition Assessment and Counseling:**

Use this code to document referral services for nutrition services conducted by a qualified counselor who provides intensive therapeutic nutritional assessments and counseling for participants found to be at high risk for adverse health outcomes related to nutrition.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 7 for additional information on provider qualifications.



**R002 Psychosocial Counseling:**

Use this code to document referral services for psychosocial counseling conducted by a licensed professional who provides counseling to improve emotional well being, alleviate stress and or enhance coping skills for participants with emotional issues.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 9 for additional information on provider qualifications.

**R003 Parenting Education and Support:**

Use this code to document referral services for parenting education and support conducted by qualified professional who provides comprehensive information and education to participants related to the care of newborns, infants, and children.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 8 for additional information on provider qualifications.

**R004 Childbirth Education:**

Use this code to document referral services for childbirth education conducted by qualified professional who provides information and education to pregnant participants and her family about pregnancy, labor and delivery.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 6 for additional information on provider qualifications.

**R005 Breastfeeding Education and Support:**

Use this code to document referral services for breastfeeding education and support conducted by a qualified professional who provides information and education to pregnant, prenatal, and post-natal participants about initiation, continuation and exclusivity of breastfeeding.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 5 for additional information on provider qualifications.

**R006 Interconceptional Counseling and Education:**

Use this code to document referral services for interconception counseling and education conducted by a qualified professional who provides information about support related to the optimal health status needed for women of reproductive age to improve future pregnancy outcomes.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 21 for additional information on provider qualifications.

**R007 Women, Infant, and Children Nutrition (WIC):**

Use this code to document referral services to the Women, Infant and Children (WIC) program to provide participants with nutrition counseling, food and formula vouchers, and breastfeeding services.

**R008 Food Resources:**

Use this code to document referral services to local food banks or programs that provide eligible women and families with groceries, toiletries, and household supplies.

**R09 Housing Assistance:**

Use this code to document referral services to local housing assistance programs that provide women and families with temporary housing, housing vouchers, or monetary assistance.

**R010 Child Protection System:**

Use this code to document referral services to local child protection agencies that assist families with home environments that jeopardized the safety and well-being of women and children.

**R011 Healthy Families Florida:**

Use this code to document referral services to the local Healthy Families Florida program. If the participant will be provided care coordination by Healthy Families, please also code the appropriate outcome closure code, **Receiving Care Coordination from Another Provider, not CMS/Early Steps**

**R012 Adult Education:**

Use this code to document referral services to local adult education programs that provide adults with education and training to obtain job skills or General Education Degree (GED).

**R013 General Education Degree (GED):**

Use this code to document referral service to local GED programs that provide community members with General Education classes and/or degree.

**R014 Other Educational Resources:**

Use this code to document referral services to local education programs that provides community members with education classes, programs, resources and or educational materials.

**R015 Sexually Transmitted Disease (STD) Clinics:**

Use this code to document referral services to local STD clinics that provide medical treatment and educational materials to treat and prevent STD infections.

**R016 Mental Health Services:**

Use this code to document referral services to local mental health facilities and programs that provide comprehensive mental health counseling and resources for participants with mental health issues.

**R017 Economic Self Sufficiency Services:**

Use this code to document referral services to the local Department of Children and Families (DCF) office to provide economic aid services including cash assistance and food stamps.

**R018 Transportation Services:**

Use this code to document referral services to local transportation agencies and programs that provide free or reduced price transportation services to community members.

**R019 Medicaid Services:**

Use this code to document referral services to local Medicaid agencies to provide health

care services to participants and their dependents.

**R020 Child Support Enforcement:**

Use this code to document referral services to local child support enforcement agencies that provide resources to obtain past and current child support payments.

**R021 Daycare Resources:**

Use this code to document referral services to local free or reduced priced daycare programs that provide children with supervision from trained and qualified staff members.

**R022 Domestic Violence:**

Use this code to document referral services to local domestic violence programs that provide counseling services or shelters to battered women and their family members.

**R023 Family Planning:**

Use this code to document services to a local agency or county health department that provides family planning services.

**R030 Baby Items:**

Use this code to document referral services to local businesses or agencies that provide baby items such as cribs, diapers, formula, car seats and clothing.

**R031 Household Items:**

Use this code to document referral services to local businesses or agencies that provide household items such as furniture, bedding, and dishes.

**R032 Early Steps/Developmental Evaluations:**

Use this code to document referral services to CMS Early Steps or other developmental evaluation programs.

**R033 Dental Health Clinics:**

Use this code to document referral services to local dental health clinics providing prenatal and infant care services.

**R034 Maternal, Infant, and Early Childhood Home Visiting Program Services:**

Use this code to document referrals for home visiting services provided as a result of funding from the Department of Health's Maternal, Infant, and Early Childhood Home Visiting Program.

**R999 Other Referrals:**

Use this code to document referral services to local businesses or agencies that provide general services or supplies to women and families not listed in the "Healthy Start Referral Services" section of Chapter 14 of the Healthy Start Standards and Guidelines.

**Note:** Use the comments field to document the specific type of "other" referral made

**6622 Substance Use:**

Use this code to document referral services to local substance abuse treatment facilities that provide counseling and rehabilitation services for participants with drug and alcohol addiction issues.

**6620 Tobacco Use:**

Use this code to document referral services for tobacco cessation and counseling conducted by a qualified professional who provides education and support services to prevent or reduce tobacco use in participants or family or household members.

**Note:** This code is for referral services provided by an outside agency **not** utilizing Healthy Start funding. Please refer to the Healthy Start Standards and Guidelines Chapter 10 for additional information on provider qualifications.

**6621 Alcohol Use:**

Use this code to document referral services for alcohol cessation and counseling conducted by a qualified professional who provides education and support services to prevent or reduce alcohol use in participants or family or household members.

**SPECIAL SERVICES**

**3950-8026**



**PARTICIPANT IDENTIFICATION**

**3950**

Participant identification activities are those that identify specific individuals and groups who are in need of comprehensive prenatal, interconception, or child health care; provide culturally sensitive, family-centered, educationally and demographically appropriate information regarding prenatal, interconception, and child services available within the community and the importance of accessing services early; and facilitate access to needed services.

On the direct level of participant identification, service provision would include sharing family-centered information regarding prenatal, interconception, or child services available within the community and stressing the importance of accessing services. Direct services include the facilitation of access to needed services. Identification may be done door-to-door or at specific sites such as community health fairs, soup kitchens, migrant camps, migrant day care centers, homeless shelters, and neighborhood centers in low-income neighborhoods). This process may include ongoing direct follow-up with individuals that have been identified as potential recipients of Healthy Start services.

**Note:** If the service is delivered to an identified Healthy Start participant, the participant's identification number would be coded. Code one service for every 15 minutes spent in this activity.

See Chapter 2, "Outreach – Participant Identification, Provider Recruitment, and Community Education," for more information on participant identification and provider qualifications.



**PARTICIPANT RELATED ACTIVITIES  
HEALTHY START CARE COORDINATION  
ADMINISTRATION**

**3951**

**Healthy Start Standards & Guidelines 2009**

This service entails providing administrative activities related to screening and administrative activities related to care coordination for Healthy Start participants.

Participant related activities are administrative functions that assure the Healthy Start process and include:

1. Receiving and reviewing screening reports.
2. Reconciling discrepancies in screening data.
3. Transferring screening forms to the county health department in the county of residence.
4. Performing other Healthy Start care coordinator **administrative** functions that assure the Healthy Start process is organized and coordinated.
5. Performing other Healthy Start care coordination **administrative** functions that may be participant specific.
6. Performing Healthy Start quality management and program improvement functions.

**Note:** If the service is delivered to an identified Healthy Start participant, the participant's identification number would be coded. Code one service for every 15 minutes spent in this activity. This code should not be used when services are provided on one day, and documentation of those services occurs on the next day or another day. If you provide a service on one day and cannot document it until the following day, you should code all the services on the day you provided the actual service. For example, you saw a client today on a home visit but cannot document the service until tomorrow. You would capture the travel time, visit time, and the projected time it will take you to document the service tomorrow and code that for today. This keeps all the "services" together and will accurately reflect the amount of time it took to provide the care coordination. Use your EARS to reflect the actual "time" you spent doing HS services each day. So, on your EARS you would enter the appropriate program component, and in the program service field you would enter "0000" and your 480 minutes will be distributed between all program components for that day. Remember HS service recording captures "services" and EARS capture "time".



**COMMUNITY ACTIVITIES**

**HEALTHY START CARE COORDINATION  
ADMINISTRATION**

**3952**

This service entails providing information to the community related to Healthy Start and collaboration with other community groups who provide services to pregnant and interconception women, children, and families. Outreach should be a local systematic and community-based approach to promote improved pregnancy and infant health outcomes. Use this code when promoting the Healthy Start program.

Healthy Start care coordination administrative community activities include information sharing with community agency representatives or presentations at local places of worship, or to business organizations or other community groups, or recruitment of public and private providers. The process of information sharing includes the provision of information on the Healthy Start initiative. This process may include facts on the need for linking services, drafting interagency agreements, and discussion of ways to identify participants who may need ongoing support to secure services. It may also assist

providers in identifying individuals who are potential recipients of Healthy Start services.

**Note:** Code one service for every 15 minutes spent in this activity.

See Chapter 2, “Outreach – Participant Identification, Provider Recruitment, and Community Education,” for more on these activities.



## **NUTRITION ASSESSMENT/COUNSELING HEALTHY START SERVICES**

**4501**

This service entails providing face to face intensive therapeutic nutrition assessment and counseling to the at-risk Healthy Start pregnant/interconceptional woman or family/caregiver of the at-risk Healthy Start child who is threatened by conditions for which medical nutrition therapy is a critical component of management. Nutrition counseling must be tailored to the unique needs, interests, experiences, educational level, environmental limitations, cultural patterns, capabilities, and lifestyle of the participant.

Nutrition assessment and counseling is a face to face contact with the participant and/or family/caregiver that includes the process of gathering and assessing anthropometric and biochemical data from the medical record, performing a diagnostic nutrition assessment, and evaluating the dietary intake. The plan of care is developed with the participant and/or family/caregiver. It is based on the findings of the nutrition assessment and includes goals and methods to monitor or evaluate the participant's progress toward goal attainment. Do not use this code for WIC services, which are not considered an “other Healthy Start services.”

Individual and family nutrition counseling is based on the nutrition assessment and must be consistent with the nutrition care plan. Counseling will be provided at an appropriate level of understanding for the individual and family members. Therapeutic dietary counseling for diseases may be provided upon receipt of a written physician prescription.

This process may involve one or a series of sessions to address the specific health outcome nutrition goals identified. Follow-up counseling sessions must monitor the participant's progress toward goal attainment, involve the participant or family/caregiver in their own care, and coordinate care with other members of the interdisciplinary treatment team. This service is appropriate for participants who are threatened by conditions for which medical nutrition therapy is a critical component of medical management. Nutrition services must be documented on appropriate forms in the participant's medical record.

**Note:** Nutrition assessment and counseling services provided on behalf of Healthy Start participants are coded to the Healthy Start participant's identification number, even though it is family or household members who receive the services. Code one service for every 15 minutes spent in this activity.

See Chapter 7, Nutrition Counseling, for provider qualifications and more information on nutrition counseling.



## **PSYCHOSOCIAL COUNSELING HEALTHY START SERVICES**

**8002**

This service entails providing face to face psychosocial counseling to Healthy Start participants to address emotional, situational, and developmental stressors. The goal is to reduce identified risk factors to achieve positive pregnancy outcomes and optimal infant/child health and development.

Psychosocial counseling is the process of counseling an individual, family, or group during one or more sessions to support the process of overcoming environmental, emotional, or social problems that are affecting the health and well-being of the Healthy Start participant and/or the child's family members.

Psychosocial counseling emphasizes the interaction between the individual's and/or family's emotions, behaviors, social relationships, and environment. This process helps the family to access resources and modify behaviors, relationships, and/or circumstances in order to enhance health and social functioning within the community. The psychosocial assessment process includes the development of a plan of action that addresses the family's identified goals and provides a mechanism by which progress toward goal attainment can be measured.

**Note:** Psychosocial counseling services provided on behalf of Healthy Start children are coded to the Healthy Start child's identification number, even though it is family or household members who receive the services. Code one service for every 15 minutes spent in this activity.

See Chapter 9, Psychosocial Counseling, for provider qualifications and more information on psychosocial counseling.



## **PARENTING EDUCATION AND SUPPORT HEALTHY START SERVICES**

**8004**

This service entails providing face to face activities that educate and inform the family and parents/caregivers about care of the newborn, infant, and older child; normal growth and development; anticipatory guidance; encouragement and support; changes in family dynamics; attachment behaviors; nutrition; safety; child injury prevention; and child abuse prevention.

Parenting education and support activities are any of those activities described above that are provided by trained and qualified health-related professionals and paraprofessionals who use locally approved protocols, procedures, competencies, and a curriculum with learning objectives. The curriculum content should have a prevention-based and /or an intervention-based focus to reduce factors that are associated with placing children at health, social, or behavioral risk.

**Note:** Parenting education and support services provided on behalf of Healthy Start children are coded to the Healthy Start child's identification number, even though it is family or household members who receive the services. Code one service for every 15 minutes spent in this activity.

See Chapter 8, Parenting Education and Support, for provider qualifications and other information on parenting education.

**Note:** This enhanced service can be provided on the same day of the initial contact or initial assessment after determination of service needs.



**CHILDBIRTH EDUCATION  
HEALTHY START SERVICES**

**8006**

This service entails providing face to face activities that inform and educate the pregnant woman and her family, both during early and late pregnancy, and promote healthy outcomes for the woman and her infant. These services are intended to provide information to pregnant women in order to assure the most positive birth experience and outcomes possible for her and her family.

Childbirth education includes the following topics: anatomy and physiology of pregnancy and birth; physical and emotional changes related to pregnancy; nutrition and feeding including breastfeeding promotion, barriers, and benefits; prenatal care; self-empowerment; stress management; danger signs of pregnancy; signs and symptoms of preterm labor; preparation for labor and delivery; parent-infant attachment; breastfeeding initiation and management; normal newborn growth and development; newborn care and safety; postpartum changes; interpersonal support; and family planning.

Code one service for every 15 minutes spent in this activity.

See Chapter 6, Childbirth Education, for provider qualifications and other information on childbirth education.



**BREASTFEEDING EDUCATION & SUPPORT  
HEALTHY START SERVICES**

**8008**

This service entails providing comprehensive information, education, and counseling to prenatal and postpartum participants or to the Healthy Start infant's mother, including assistance in overcoming barriers to breastfeeding, postpartum hospital and home visits, encouraging the initiation of breastfeeding, and providing anticipatory guidance and support in order to prevent breastfeeding problems.

Breastfeeding education and support activities are any of those activities described above that are provided by individuals who have received particular, specialized lactation promotion and support training and are able to provide breastfeeding education and support and assist in providing direct services under the supervision of a care coordinator, health care provider, or other health-related professional.

Breastfeeding education and support includes at least one face to face contact, an assessment of current infant feeding status, counseling consistent with breastfeeding plan of care and documentation based on goals, and referrals to local breastfeeding support groups or other support sources.

**Note:** Breastfeeding education and support services provided on behalf of Healthy Start



participants are coded to the Healthy Start participant identification number, even though it is family or household members who receive the services. Code one service for every 15 minutes spent in this activity.

See Chapter 5, Breastfeeding Education and Support, for provider qualifications and other information on breastfeeding.

**Note: This enhanced service can be provided on the same day of the initial contact or initial assessment after determination of service needs.**



## **INTERCONCEPTION EDUCATION AND COUNSELING HEALTHY START SERVICES**

**8013**

Interconception education and counseling provides activities that educate and inform any Healthy Start woman, or parent on behalf of the Healthy Start child, about interconception care, access to health care, baby spacing, nutrition, physical activity, maternal infections, chronic health problems, substance abuse, smoking, mental health, and environmental risk factors.

Interconception education and counseling activities are any of those activities described above that are provided by trained and qualified health-related professionals and paraprofessionals using approved protocols, procedures, competencies, and a curriculum with learning objectives. Interconception education and counseling services should be initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

Code one service for every 15 minutes spent in this activity.

**Note: This enhanced service can be provided on the same day as the initial contact or initial assessment after determination of service needs.**

See Chapter 21, Interconceptional Education and Counseling, for provider qualifications and other information on interconceptional education and counseling.



## **TOBACCO EDUCATION AND CESSATION COUNSELING**

**8026**

This service entails providing comprehensive information, education, reinforcement, and support throughout pregnancy and postpartum to participants, parents/caregivers of Healthy Start children, their families, and other household members related to the importance of tobacco cessation for both maternal and child health. Tobacco education and cessation counseling includes addressing barriers to tobacco cessation, benefits of quitting, counseling when relapse occurs, and behavior modification.

Tobacco education and cessation counseling services are any of the above activities that are provided by individuals who have received particular, specialized training to provide tobacco education and cessation information, education, and support.

**Note:** Tobacco education and cessation counseling services provided to or on behalf of

Healthy Start women or children are coded to the Healthy Start participant identification number, even though it is family or household members who receive the services. Code one service for every 15 minutes spent in this activity.

**Note: This enhanced service can be provided on the same day of the initial contact or initial assessment after determination of service needs.**

See Chapter 10, Tobacco Education and Cessation, for provider qualifications and other information on tobacco education and cessation.

## Frequently Asked Questions

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- Q.** *When I code an attempt to contact as two services (meaning 30 minutes), isn't this coding time?*
- A.** No. An attempt to contact is a participant service that is coded to a participant ID number/Social Security number. The number of services coded tells how long you spent providing that service. County Health Department providers are required by department policy to account for all of their workday time to program components, which are recorded via the DOH employee EARS form. Therefore, in addition to coding the services, county health department providers would also code *time* to a Healthy Start program component using 0000 as the service code. When you code time, no participant ID number (Social Security number) is coded—only the amount of time spent in each program component is coded.
- Q.** *I am a county health department employee, and I provide care management activities for SOBRA/Non-Healthy Start women. How do I code my time? Do I code on a Healthy Start encounter form?*
- A.** Do not code on a Healthy Start encounter form for services provided to a SOBRA/Non-Healthy Start women. Coding for time on EARS should be coded to program component 27, using the service code 9010.
- Q.** *If the family of a substance exposed child needs to be followed for more than three years, do we close the family to Healthy Start after the child's third birthday?*
- A.** Close the participant to Healthy Start at the child's third birthday using the ongoing care coordination code 3315, Ineligible for Services, but you may continue providing services to the child and family as a county health department. Code these services with child health, adult health, family planning, or other relevant program service codes, as appropriate. Non-county health department providers would transition the family to the county health department for continuation of services.
- Q.** *Can substance exposed infants be considered to be Healthy Start eligible, even if we do not have the signed infant risk screens yet?*
- A.** Yes. There are three ways to become an infant Healthy Start participant: a screening score of 4 or more, referral by a provider, or self-referral all justify an invitation to participate. If you deem services are warranted, then you may refer the potential participant and provide Healthy Start services.

**References**

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Department of Health Coding Pamphlet 50-20

***NOTES:***

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**Self Study Questions:** (Answers to these questions may be found in Appendix H)

1. Why is Healthy Start coding important?
2. What kinds of information does Healthy Start coding provide?
3. How does Healthy Start coding assist local decision makers?