

Chapter 31: Transition and Interagency Agreements

Introduction

Transition is movement or change from one environment to another. Transition activities are a critical component of care coordination when participants are approaching closure to Healthy Start services, but they may also be a component of ongoing care coordination. As the needs and eligibility of Healthy Start participants change, the intensity of a particular program's involvement may also change.

Seamless transition of care includes continuity of services and strives for minimal interruption of and/or duplication of services. This may be achieved through formalized relationships that include interagency agreements among programs and the facilitation of regular meetings among providers.

This chapter contains two sections. The first provides guidance for transition of care and the development of interagency agreements. The second provides guidance for the development of written procedures for Healthy Start care coordination of infants in neonatal intensive care units (NICUs) and infants and toddlers served by Early Steps in Children's Medical Services.

Standards and Criteria

Standard 31.1 The Healthy Start Coalition will assure a seamless transition of care for pregnant/interconception women and infants/children within their community through the development of interagency agreements.

Criteria:

31.1.a Healthy Start coalitions and care coordination providers have formal written agreements with programs with which they share mutual clients. At a minimum, interagency agreements should be developed with the following:

- Early Steps, Children's Medical Services;
- Neonatal Intensive Care Units for NICU clients;
- Regional Perinatal Intensive Care Centers (RPICCs) and other Level III Centers;
- Children's Medical Services for Children with Special Health Care Needs;
- Department of Children and Families for pregnant, substance abusing women and substance exposed children;
- County health departments in the event the county health department is not the sole provider of care coordination;
- Healthy Families Florida projects;
- Lead care coordination agency changes from one provider to another provider.

31.1.b Comprehensive written agreements between agencies and programs contain the following elements:¹

- Purpose of the agreement;
- Description of agencies involved in the agreement, including agency roles and responsibilities;
- Requirements impacting the agreement, as appropriate;
- Definition of terms pertinent to the agreement;
- Working procedures and timelines;
- Implementation plan for the agreement;
- Monitoring and evaluation of the agreement;
- Interagency dispute process;
- Duration of the agreement;
- Signatures and dates.

Section One: Guidance for Transition and Interagency Agreements

Guidelines

Coordinating the Transition. Seamless transition requires an interagency system that ensures that women and children receive the appropriate blend and intensity of services needed to reduce the risk of poor birth outcomes and infant mortality. It is the responsibility of the Healthy Start coalitions to maximize community resources by assuring a system of care, through the development of interagency agreements, that strives for minimal interruption of and/or duplication of services.

Successful transition considers the following:

- Children and their families;
- Direct service staff; and
- Administration.

Service delivery activities for each of these groups are described below:

Children and their Families: Family involvement is a key factor for the successful transition of Healthy Start participants. Planning for transition begins at initial contact with the child and family. Throughout the care coordination relationship, participants and/or families update their goals and jointly plan their interventions through the process of family support planning. If another agency can better provide care coordination services for the family, the family should be involved in planning for the transition to the other provider.

Direct Service Staff: Direct service staff are responsible for assuring ease of transition among programs. All staff involved in transition should have a basic understanding of the following:

- Knowledge of community agencies including their programs, service eligibility criteria, and program strengths and limitations;
- Knowledge of transition policies including release of confidential information, procedures, and timelines;
- Knowledge of community agencies' administrative structures including contact persons, staff roles and responsibilities.

Administration: The administrative component includes the assurance of effective transition (process) as well as the assurance of effective community relationships (interagency coordination). The latter creates an atmosphere of cooperation needed for transition. Interagency coordination facilitates the involvement of the family and/or participant and staff. This interagency coordination is critical to effective transition.

An effective administrative structure includes:

- Administrative support that sets the tone for interagency partnership;
- Guidance necessary for an effective and organized transition process including operational procedures;
- The facilitation of ongoing communication and problem-solving among agencies;
- The development of timelines for the transition process;
- The development of interagency compatible forms and other documentation;
- The development of staff training and participant or family involvement.

In these ways, the administrative structure is able to respond and adapt to various legal, funding, and programmatic changes that impact transition. Thus, transition becomes a continually evolving process, helping to insure its appropriateness and relevance to local needs.

Writing Interagency Agreements

Clearly written and regularly updated interagency agreements are the cornerstone of a seamless transition of care system. Healthy Start coalitions are well situated in the community to act as the catalyst for the development of effective interagency agreements. Table 31.1 lists programs that are required and programs that may be considered for interagency agreements.

Table 31.1

Interagency

Agreements

Minimum Interagency Agreements	Additional Considerations for Interagency Agreements
<ul style="list-style-type: none"> • Early Steps, Children’s Medical Services or other contracted provider for Early Steps. • Neonatal Intensive Care Units for NICU clients. • Regional Perinatal Intensive Care Centers (RPICC) and other Level III Centers. • Children’s Medical Services for Children with Special Health Care Needs. • Department of Children and Families for pregnant, substance abusing women and substance exposed children. • County health departments in the event the county health department is not the sole provider of care coordination. • Healthy Families Florida projects. 	<ul style="list-style-type: none"> • Department of Children and Family Services. • Teen Pregnancy Programs. • Domestic Violence Centers. • HIV Case Management Programs. • First Start, Even Start, Early Head Start. • Substance Abuse Treatment Programs. • YWCA, YMCA. • FDLRS (Florida Diagnostic and Learning Resources System). • Early Learning Coalitions. • Lead care coordination provider changes to another care coordination provider.

Comprehensive written agreements between agencies and programs contain several components and need to address the following questions:

- **Purpose or goal of the agreement?** What are the basic goals or commitments of this agreement? How will programs interact at a systems level and a direct service level? What are the reasons for the agreement? What should the agreement accomplish? Define your parameters, populations, ages, etc.
- **Agencies involved in the agreement?** Who are the interacting agencies serving mutual clients and how will information be shared?
- **Agency roles and responsibilities?** Who will do what? Who will be designated lead care coordinator? What services does each agency provide to which population? Who needs to be involved to accomplish stated goals for purpose of the agreement? Is agency representation required at interagency meetings?
- **Requirements impacting the agreement?** What specific requirements need to be addressed by each agency named in this agreement? Use these requirements for reference or attach to agreement, if needed. Examples are legislation, rule, program operation standards and guidelines, and other individual agency requirements.
- **Definition of terms pertinent to the agreement?** How are the specific agency terms used in this agreement defined? Examples of terms are “care coordination,”

“service coordination,” and “lead agency.”

- **Procedures (activities to take place, who will do what)?** Which of the following will take place and who will provide it: Providing the pregnant/interconception woman or family with options for services, determining a lead care coordinator and specifying this person’s role, participating in family support plan meetings, gathering and sharing information (determining forms to be used), supporting the pregnant/interconception woman or family through transition, making provisions for family to be primary service coordinator with assistance from the agency, dealing with participants’ changes (residence, phone number, family-related changes, health status, family composition), establishing processes for changing or terminating the agreement, and providing post- transition communication and follow-up. Establish predictable guidelines. Delineate administrative procedures necessary for staff to be trained to prepare the family for transition and guide the family through a seamless system of care.
- **Timelines for the above activities?** When will each activity be accomplished?
- **Implementation plan for the agreement?** How will it be disseminated? How will families and agency staff be informed and trained? What will make this a valid, functioning part of the transition system?
- **Monitoring and evaluation of the agreement?** Is the agreement working? How can you tell? Are modifications needed? If so, do you identify needed changes and how do you re-evaluate after changes are made? What is the formal process and timeline for monitoring and evaluating? How will feedback be obtained from consumers?
- **Interagency dispute process?** What process will parties use to resolve conflicts that arise as a result of implementation of the agreement?
- **Time period covered by the agreement?** On what exact day does the agreement begin and end? If a specific duration period is not specified, then the agreement should specify how, when, and by whom the agreement will be updated.
- **Signatures/date?** Who has authority to sign the agreement? What is the process to obtain authorizing signatures? Who gets copies?

Additional points of consideration include:

- What is the time frame to plan for a participant’s transition?
- What confidentiality issues may need to be resolved?

Community Collaboration

Communities can help ensure an effective transition system through the development of formal transition policies and procedures among providers of services to pregnant women and children up to age 6. There are various ways for communities to ensure the collaboration needed for effective transition. These may include consideration of regular community meetings, the

development and maintenance of a community resource directory, and the participation of agencies in the family support planning process and transition training, as described below.

- **Community Meetings:** The Healthy Start coalition or its designee may participate in interagency meetings between service providers and funders of services to plan strategies to better serve families. These meetings may be used to create, review, and revise interagency agreements as necessary.

Interagency meetings should include direct service providers, administrative staff, and family representatives. These meetings may be used to achieve a variety of goals including interagency training, the provision of updated program information among agencies, and the coordination of services to mutual clients. Communities may choose to hold interagency meetings in conjunction with other already established community meetings.

- **Provider Resource List:** A local resource list for providers should be written and updated periodically. The Healthy Start coalition should be designated to update the resource list and distribute a copy to each program that interacts with Healthy Start. This list is intended for providers who serve mutual clients as opposed to a list of resources within the community given to participants. The resource list should include agencies that serve mutual clients, service information, and contact persons' names and phone numbers, and could be written in the form of a page for each program.
- **Family Support Plans:** The Family Support Plan (DH 3136), which includes a transition page, can be used by families and agencies as a collaborative planning document that supports the transition process. Families should be well informed and included in all aspects of the transition and family support planning process. In addition, all agencies involved with the family should be included in family support plan meetings. The lead care coordinator should use available data base systems to determine who is involved with the family and should then invite those agencies, as well as the agency to which the family is transitioning, to the family support plan meeting. (Interagency access to a database that contains information regarding services planned for and received by mutual clients is an ideal.) Agencies should establish a mechanism for sharing client information, family support plans, and updates. Assuring that each program participant signs a release of information form will allow for the sharing of confidential information.
- **Transition Training:** Communities should consider participation in formal transition training and the establishment of a transition team. Formal transition training ensures an understanding of the components of transition and the process for developing a system for transition.

The Florida Transition Project promotes comprehensive, community driven systems to transition children and their families from one service provider to another by providing training using the Sequenced Transition to Education in the Public Schools (STEPS) Model. This model incorporates team building, assessment of current practices, barrier identification, recommended transition practices, prioritization of goals, work plan development, and implementation of a process that will lead to a community-wide transition system. (See References below for website information.)

Documentation

Interagency agreements are themselves the signed documentation of the agreement. Document transition activities using DOH forms or records as appropriate or comparable forms for the non-CHD provider:

- Authorization for release of information signed by the participant for any information that is to be shared among payers, providers, or others
- Family Support Plan for Single Agency Care Coordination (DH 3151)

Coding

Transition activities on behalf of individual participants are coded with care coordination codes. (See Chapter 23, Healthy Start Coding) Provider time spent in writing interagency agreements is accounted for with the following codes and the appropriate time.

COMMUNITY ACTIVITIES HEALTHY START CARE COORDINATION ADMINISTRATION

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Providing information to the community related to Healthy Start and collaboration with other community groups providing services to pregnant and interconception women, children, and families.

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, other community groups, or public and private providers. The process of information sharing would include the provision of information on the Healthy Start initiative. This process can 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 to identify individuals who are potential recipients of Healthy Start services.

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

Quality Management/Program Improvement Performance Measures

The Healthy Start coalition is responsible for assuring the development and maintenance of local interagency agreements that involve Healthy Start participants.

A community's transition system can be evaluated by examining the transition experiences of participants. This may be accomplished through client satisfaction surveys and record reviews that address the following: Was their transition process smooth? Were duplicative services provided? Were necessary services provided in a timely manner? Do families have specific suggestions for system improvements?

The following performance measures may be used to evaluate the transition system:

- Signed interagency agreements which are reviewed and updated on a routine basis, with Neonatal Intensive Care Units for NICU clients; Regional Perinatal Intensive Care Centers; Children’s Medical Services for Early Steps clients; Children’s Medical Services for Children with Special Health Care Needs; the Department of Children and Families for pregnant, substance abusing women and substance exposed children; Healthy Families Florida projects and other programs that share Healthy Start participants;
- Evidence of a provider resource list including updates;
- Documentation of community meetings (minutes);
- Documentation of interagency training;
- Evidence of seamless transition;
- Family satisfaction information.

Section Two:

Guidelines for developing written procedures for Healthy Start care coordination of infants in intensive care units (NICUs) and infants and toddlers served by Early Steps.

Guidelines for developing written procedures for Healthy Start care coordination of infants in neonatal intensive care units (NICUs)

Agreed upon written procedures between the Healthy Start care coordination provider and NICU staff are necessary to ensure that infants admitted to a NICU receive the services they need in the least intrusive, most family-centered manner. Additionally, service transition among these programs must assure families continue to receive appropriate services as their concerns, priorities, and resources change.

Not all NICU infants become Early Steps clients, and many Early Steps clients are referred from places other than the NICU. The NICU and Early Steps are two separate entities. Sometimes the Early Steps staff are allowed in the NICU to help in the referral process, but this does not occur in every hospital.

It is very important that the Healthy Start care coordination provider be aware of these vulnerable infants, and if there are concerns that need to be addressed through Healthy Start care coordination. The Healthy Start care coordination provider should meet with the NICU provider to assure a written procedure is developed, implemented, and periodically evaluated and updated.

Implementing a procedure for coordinating the initial contact and transition of Healthy Start participants and their families from NICU to Healthy Start care coordination services will help assure these most vulnerable infants and their families receive the services they need in a

continuous, family-centered manner.

Suggested components: Suggested components of the written procedure include:

1. A mechanism whereby the initial contact requirement is provided in the most family-sensitive manner possible.

Families of infants admitted to a NICU are experiencing much stress. Aware of their newborn's risk status, they typically are receiving services to fulfill immediate needs. In order to be sensitive to the needs of these families already receiving care through the NICU, the Healthy Start initial contact can be provided by the Healthy Start coordinator and "tracking" initiated until the infant is discharged from the hospital.

2. A mechanism assuring that the Healthy Start care coordination provider in the county of birth, with written parental consent, receives by telephone a list of names of all infants admitted to the NICU within two working days of admission.

This list is based on a "yes" answer in the demographic section of the Healthy Start infant (postnatal) risk screening instrument to the question: *Was the infant admitted to Neonatal Intensive Care?*

3. A mechanism whereby the care coordination provider in the county of birth is made aware of the impending discharge from the hospital of all NICU infants referred to Healthy Start. This notification assures that all eligible infants and their families will receive the Healthy Start care coordination services they need.
4. A mechanism whereby a copy of the family support plan and other pertinent records needed to allow for a smooth transition of Healthy Start care coordination will be provided to the Healthy Start care coordination provider within five working days of the infant's discharge from the NICU.
5. Assurance that Healthy Start care coordination services will be initiated by the Healthy Start care coordination provider for an infant referred by the NICU staff.

Guidelines for developing written procedures for Healthy Start care coordination of infants and toddlers served by Early Steps in Children's Medical Services.

Written procedures between the Healthy Start care coordination provider and Early Steps are necessary to ensure that infants and toddlers receive the services they need in the least intrusive, most family-centered manner. Additionally, service transition among these programs must assure families continue to receive appropriate services as their concerns, priorities, and resources change.

It is very important that the Healthy Start care coordination provider be aware of the closure of an infant or toddler from Early Steps if there are concerns that need to be addressed

through Healthy Start care coordination.

The Healthy Start care coordination provider will meet with the Early Steps representative to ensure a written procedure is developed, implemented, and periodically evaluated and updated.

In some hospitals Early Steps has access to the NICU and may have staff located in the NICU. In these situations, it is important to implement a procedure for coordinating the services and transition of participants referred to Healthy Start among NICU, Early Steps, and Healthy Start care coordination services. This will help assure these most vulnerable infants and their families receive the services they need in a continuous, family-centered, and non-duplicative manner.

Suggested components:

1. A mechanism whereby intent of the initial contact requirement is provided in the most family-sensitive manner possible.

Families of newborn infants followed by Early Steps are usually experiencing much stress. Aware of their newborn's risk status, they typically are receiving services to fulfill immediate needs. In order to be sensitive to the needs of these families already receiving care through Early Steps, the Healthy Start initial contact can be provided by Early Steps staff as long as the care coordination provider is contacted when the infant is closed from the Early Steps program.

This initial contact can be accomplished at the same time the family is informed of their newborn infant's positive risk screen. This requires staff of the Early Steps to assure the following is discussed with the family:

- The meaning of the positive risk screen;
- Service needs based on the ability of the family to access comprehensive services for their infant;
- The family's concerns, priorities, strengths, and resources;
- How the risk factors can be addressed and what types of services are available through Healthy Start and the community;
- Referrals to community resources;
- Name and phone number of a contact person at the Healthy Start care coordination agency who can be contacted for future concerns;
- Level of care on the Healthy Start State Leveling System Criteria;
- Complete an Individualized Family Support Plan

For more details on the service delivery activities of the initial contact, see Chapter 4: Coordinated Intake and Referral.

2. Assurance that the Department of Health Management System (HMS) data are

entered by the care coordination provider whenever there is written agreement that Early Steps staff provide the initial contact to the families of infants with positive Healthy Start risk screens.

3. A mechanism whereby the Healthy Start care coordination provider in the county of birth is made aware of the impending discharge from the hospital of all NICU infants who received the Healthy Start initial contact through the Early Steps program staff. This notification assures that all eligible infants and their families will receive the Healthy Start care coordination services they need.
4. A mechanism whereby, with written parental consent, the Healthy Start care coordination provider in the county of residence will be notified of any infant or toddler closed from Early Steps who is in need services through Healthy Start.
5. A mechanism whereby, with written parental consent, a copy of the family support plan and other pertinent records needed to allow for a smooth transition of Healthy Start care coordination will be provided to the Healthy Start care coordination provider within five working days of the closure of the infant or toddler from Early Steps.
6. Assurance that Healthy Start care coordination services will be initiated by the Healthy Start care coordination provider for an infant or toddler referred from Early Steps.

References

A Guest in My Home: A Guide to Homevisiting Partnerships that Strengthen Families and Communities, Florida Department of Health and Rehabilitative Services, Ounce of Prevention Fund of Florida, & Florida Department of Education Bureau of Student Services and Exceptional Education (1996).

Chapter 64F-3, Florida Administrative Code.

www.floridatransitionproject.com

¹ Taken from Florida's Transition Project for Infants, Young Children and their Families based on Project STEPS (Sequenced Transition to Education in the Public Schools)

Frequently Asked Questions

- Q. *Who ensures that a seamless transition of care system for Healthy Start participants is developed, implemented, evaluated, and revised?***
- A.** The Healthy Start coalitions have primary responsibility, with assistance from the service providers and the Department of Health.
- Q. *Why is it necessary to have formal written agreements with local programs when***

we have an excellent referral process already?

- A.** Due to changes in program policies and eligibility as well as staff turnover, it is necessary to have written agreements to ensure the continuation of a smooth transition system.

Q. *What are expected Healthy Start transition points?*

- A.** The following list indicates some, but not all, potential points for collaboration to provide transition.

- Prenatal screen to prenatal care;
- When a pregnant woman or mother is identified with a drug problem;
- Routine prenatal care to high-risk prenatal care;
- Hospital to home;
- Prenatal to postpartum care;
- Prenatal to well-baby care;
- Delivery to NICU;
- NICU to step-down care (less intensive nursery);
- NICU to home;
- Step-down care (less intensive nursery) to home;
- Prenatal to medical specialty care for the baby;
- When mother declines Healthy Start participation for her child;
- Child turns 3 years old;
- When a developmental or medical concern is identified;
- When child enters developmental, medical, or other community daycare;
- When child is identified as substance exposed;
- When child or family needs more intensive services;
- Change in (any) providers (e.g., medical, social service, education, etc.);
- Placement out of home (e.g., foster care, special nursing facility, relative, etc.);
- Child reunited with biological family;
- Family moves to another location;

- Lead care coordination provider changes to another care coordination provider.

Q. *Who is responsible for ensuring that interagency agreements that involve Healthy Start participants are written?*

A. Healthy Start coalitions or an established county interagency transition team. Healthy Start coalitions were formed to bring community providers together to build cohesive service delivery systems for pregnant women and young children. They are well situated to facilitate the development of interagency agreements that ensure unduplicated and uninterrupted services are provided.

Q. *How is the responsibility for developing and monitoring interagency agreements shared by the Healthy Start coalition when a county has an organized county transition team that has been trained in the STEPS (Sequenced Transition to Education in the Public Schools) model and is being supported by the state interagency transition team?*

A. The Healthy Start Coalition representative or designated care coordination provider on the county transition team will assure that transitions involving Healthy Start women and infants are addressed in all transition policies and will take the lead in developing and monitoring interagency agreements involving Healthy Start participants.

Q. *Who writes interagency agreements that concern Healthy Start participants?*

A. Local Healthy Start programs, including providers of care coordination and the Healthy Start coalition, should write agreements with all local programs with whom they share clients. Administrators who have decision-making authority and direct line staff from each program should participate in the writing of interagency agreements. In addition, a family or client representative can provide valuable insights in the development of a written interagency agreement.

Q. *Since NICUs are not part of the state system, they cannot be mandated to enter into interagency agreements. So how can the standards be met?*

A. NICUs and other providers that are not state funded are part of the service delivery system for which the coalitions develop service delivery plans. In order for the service delivery system to assure ease of transition among various providers, formal linkages are necessary. In the event a provider in the community is unwilling or unable to enter into an interagency agreement, documentation of efforts to enter them into an interagency agreement will suffice.

Q. *What is Healthy Start's obligation for referring children with risk factors to Early Steps?*

A. After assessing the needs, resources, and level of risk of infants eligible for Healthy Start (either through screening score or referral), a determination is made by the Healthy Start care coordinator regarding necessary referrals. If it is suspected that an infant is developmentally delayed or if the infant has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, then that infant would be referred to Early Steps for a diagnostic evaluation or assessment. If the infant is determined to be Early Steps eligible, then the infant is transferred to Early Steps, which will become the lead agency for service coordination. If the infant is not found to be Early Steps eligible, then services for that infant will continue to be coordinated by Healthy Start until closed. The Healthy Start coalition is responsible for assuring that an interagency agreement is signed both with Early Steps and the NICU that outlines responsibilities and procedures for transitioning infants.

Q. *After initial assessment by Healthy Start, what is the obligation to refer?*

A. Again, as in the previous question, if the assessment reveals a need for referral to another agency or agencies, then Healthy Start is obligated to make those referrals. The Healthy Start care coordinator is also obligated to determine whether another agency should assume the lead for care coordination and to ensure a smooth transition if another agency does take over the lead for coordination.

Q. *What is the role of well baby clinics and Well Child Check-Up for referral?*

A. Whenever an infant is potentially eligible for Early Steps, that infant should be referred to the local Early Steps program within two business days of identifying the potentially eligible child. This referral can take place as a result of any well- baby visit or Well Child Check-Up. There is always the obligation to refer within two business days when any suspicion of developmental problems occurs.

Q. *Whose responsibility is screening for a potential developmental delay in children?*

A. Any provider of health, education, or social services to infants and toddlers is responsible for the periodic screening and assessment (according to American Academy of Pediatrics schedule of periodicity) of health and developmental problems among the patients and clients that they serve. Part of this responsibility is to be aware of community resources including Florida Diagnostic and Learning Resources System (FDLRS) and Early Steps, and to make proper referrals.

Q. *How is identification and service coordination provided after the infant leaves the*

hospital?

- A.** If the infant is discharged from the NICU, then service coordination is the responsibility of Early Steps if the infant has been referred or determined eligible for Early Steps. Once the local Early Steps has received a referral, a service coordinator will be appointed as soon as possible. Ongoing service coordination will be the responsibility of Early Steps if the child is determined eligible for Early Steps. This must be covered in the interagency agreement between Healthy Start and the local Early Steps. If the infant is not referred to Early Steps, then the Healthy Start screening process takes over and the infant is identified either by score on the postnatal screen or referred to Healthy Start by a provider or the infant's parents as needing Healthy Start services. Once the infant is identified as a Healthy Start participant, service coordination becomes the responsibility of the Healthy Start care coordinator unless further assessment reveals the need for transition or no further need for services.

Q. *When a child is both Healthy Start and Early Steps eligible, who handles service coordination? Who handles transition? Who pays for services?*

- A.** Early Steps handles service coordination and transition. Healthy Start funds cannot pay for Early Steps services. Providing Early Steps services is a matter of coordination between agencies and funding sources. Payment is determined by the family support plan team. Early Steps is the payer of last resort.

Q. *When the child turns three, what is the procedure for transition? Who initiates the process? Do you have to re-evaluate?*

- A.** Once the child turns three, Healthy Start is not officially obligated to continue care coordination; however, the Care Coordinator may decide to continue care coordination with resources other than Healthy Start funds or transfer in-house the lead for care coordination. A re-evaluation of service needs and client resources should occur. The child should be closed to Healthy Start. A determination should be made regarding whether care coordination should be transferred to another agency. The Healthy Start care coordinator should initiate the transition process. Periodic screening and assessment should occur at normal intervals as the child ages (according to periodicity schedule). If at any time health or developmental problems are detected, then referrals to other agencies should be made as appropriate. If the child is determined not to need any services other than routine care, then the transition is an informal one to routine care. (Also, see Chapter 12, "Substance Abusing Pregnant Women, Substance Exposed Children and Their Families," concerning substance exposed newborns and children.)

Q. *How should public awareness and outreach be coordinated?*

- A.** Coordination should be decided among all agencies/organizations that provide services to children ages 0 to 5. The Project STEPS team or the Healthy Start coalition can be

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the convener of the relevant parties to address this issue. This is a critical component of the Interagency Agreements. It would be advisable to designate a lead agency or group for public awareness on services available to the 0 to 5-year-old population.

Q. *What are the Healthy Start data systems?*

A. There are three major Healthy Start data systems: (a) the vital records system for births, (b) the prenatal screening module and health management component module within the Health Clinic Management System, and (c) the prenatal screening module, infant screening module, and health management component module within the Health Management System.

NOTES:
