Appendix H
Answers to Study Questions

Chapter 1:

1. What are the ultimate goals of Florida's Healthy Start program?

The ultimate goals of Florida's Healthy Start program are a reduction in infant mortality, reduction in the number of low birth weight babies, and improved health and developmental outcomes.

2. What are the key components of Florida's Healthy Start program?

The key components of Florida's Healthy Start program are:

1. Universal prenatal and infant risk screening
2. Healthy Start care coordination and services
3. Community based prenatal and infant health care coalitions
4. Children's Medical Services Expansions
5. Increases in Medicaid eligibility and reimbursement

3. How are potential participants identified for entry into the Healthy Start program?

Potential participants for entry into the Healthy Start program are identified in the following ways:

- All pregnant women are to be offered a Healthy Start risk screen
- All newborn infants are to be offered a Healthy Start risk screen
- Providers may refer pregnant and postpartum women and children aged birth to age 3 for reasons "based on other factors (than score on the risk screen)"
- Women and parents of children birth to age 3 years who feel they have a need for Healthy Start services may self-refer for assessment
- Community based providers may refer patients/clients to Healthy Start services

4. What is the process for determining who will benefit from Healthy Start care coordination?

Once screening or referral (referral may be from a medical provider, another community-based service provider, or self-referral by the patient) has identified a potential participant, initial contact is made by the Healthy Start program. At the initial contact, Healthy Start personnel and the potential participant discuss the participant's risk status and available resources and come to a mutual decision regarding the participant's

further needs. These needs may include simply being provided with information, "tracking" for future follow-up, or a more in-depth assessment to identify whether and/or how ongoing care coordination and/or other Healthy Start services may benefit the participant.

5. Who is ultimately responsible for coordination of the Healthy Start system at the local level?

Responsibility for coordination of the Healthy Start system resides with the local Healthy Start prenatal and infant health care coalitions. The coalition is responsible for establishment and oversight of the Healthy Start system once the Department of Health has approved their service delivery plan. (The county health department is responsible for establishment and oversight of the Healthy Start system when there is not a local coalition service delivery plan approved by the Department of Health).

6. What are the Children's Medical Services expansions that help to further the goals of Florida's Healthy Start program?

- Expansion of high-risk obstetrical care in areas without access to specialty care
- Expansion of pediatric primary care for children with special health care needs and their siblings
- Increased number of developmental evaluation and intervention programs

7. What are the current Medicaid eligibility levels for pregnant women and infants in Florida?

- Up to 185 percent of the poverty level for pregnant women
- Up to 200 percent of the poverty level for infants

8. How is the Healthy Start program funded?

Healthy Start is funded with state general revenue and a portion of the federal funds from the Maternal and Child Health Block Grant. In addition, a 1915(b) Medicaid Managed Care waiver provides Medicaid funding for Healthy Start services for pregnant women and children up to age three enrolled in Medicaid.

9. What is the SOBRA component of Healthy Start?

The SOBRA (Sixth Omnibus Budget Reconciliation Act) Component of Healthy Start 1915(b) waiver provides for outreach and care management for women who are presumptively eligible or are eligible under expanded eligibility for Medicaid due to pregnancy. The Healthy Start coalitions are responsible for providing outreach to SOBRA women in selecting their health care provider from a panel of Medicaid prenatal care providers.

10. What is the role of a MomCare advisor?

Medicaid's fiscal agent sends all presumptively eligible and newly enrolled SOBRA pregnant women notice that they have to choose a provider to manage their care while

pregnant and they will be contacted by a trained person, called a MomCare Advisor, to assist them in facilitating appointments, referrals, and in obtaining any services needed during their pregnancy. Concurrently, the fiscal agent notifies the relevant Healthy Start coalition's MomCare Advisor of the new enrollment. The MomCare Advisor then is responsible for attempting to contact the pregnant woman within five working days to begin care management.

Chapter 2:

1. How is outreach defined as it relates to Florida's Healthy Start program?

Healthy Start outreach includes activities related to participant identification, public and private provider recruitment, and community education. Outreach should be a local, systematic, family centered, and community based approach to promote improved pregnancy and infant health outcomes.

2. How does outreach enhance Healthy Start participant identification?

Outreach helps to identify at-risk pregnant and interconceptional women and children from birth to age 3 who might not otherwise be identified as potentially benefiting from Healthy Start. Through outreach to areas where underserved populations cluster (e.g., community health fairs, soup kitchens, migrant camps, migrant day care centers, homeless shelters, and neighborhood centers in low-income neighborhoods), at-risk individuals who might not otherwise come into contact with the health care system (and thus would not receive a Healthy Start screen) may be identified.

3. What key components should be in place to demonstrate that a Coalition has cultivated a successful provider recruitment and retention program?

If the Healthy Start Coalition has cultivated a successful provider recruitment and retention program, the following components should be in place within the community:

1. There is a designated provider who is accessible for screening, assessment, and determination of Presumptive Eligibility for Pregnant Women (PEPW).
2. Collaboration between the Coalition and the Department of Children and Families district offices has resulted in the development and maintenance of a local operating procedure for the Simplified Eligibility process.
3. There is a system in place for providing prenatal care outreach (MomCare) to SOBRA women and ensuring participant entry into prenatal care.
4. A strong community network of service providers exists to seamlessly meet the needs of at-risk pregnant and interconceptional women and children from birth to age 3.
5. Through such activities as providing ongoing feedback, timely response to provider inquiries, and technical assistance and training as needed, providers are retained over time and provider turnover is minimized.

4. What is the purpose of community education as it relates to Florida's Healthy Start program?

Community education activities promote improved public awareness of risk behaviors associated with adverse health outcomes for mothers and children and facilitate access to services designed to address those risks. When the public is more aware of the benefits of Healthy Start screening, care coordination, and services, at-risk individuals are more likely to be given referrals to and assistance in obtaining Healthy Start services to help improve health outcomes.

5. What are the provider qualifications for Healthy Start outreach?

All individuals who hold in common Healthy Start goals and philosophy and provide Healthy Start services should be considered potential outreach providers. The Healthy Start service delivery system includes coalition members and staff, local health care providers, hospital staff, employees of qualified community based service agencies, and Healthy Start care coordinators and staff who provide direct services.

6. How is evaluation of the effectiveness of outreach activities assured?

The Healthy Start coalition's service delivery plan update must include evaluation of the effectiveness of outreach activities.

7. What are some key data indicators that may demonstrate an effective Healthy Start outreach program?

1. An increase in the percentage of pregnant women and infants offered screening
2. An increase in the percentage of pregnant women and infants screened
3. An increase in the percentage of pregnant and interconceptional women and infants consenting to the program
4. An increase in the number of women entering care during their first trimester
5. An increase in the ratio of completed screens compared to total births
6. An increase in the number of private providers participating in screening
7. An increase in the percentage of infants receiving timely well-baby care
8. Results of provider and participant surveys and focus groups
9. Other local information that reflects outreach goals

8. What are some examples of other activities that may assist in evaluation of a Healthy Start outreach program?

- Peer record reviews to determine if follow-up is adequate
- Feedback from participants, such as customer satisfaction surveys
- Tracking the number of referral resources provided for Healthy Start participants
- Information from coalition members regarding the outcomes of their outreach efforts in their local communities

Chapter 3:

1. What is the definition of Healthy Start risk screening?

Healthy Start risk screening is the collection of information on the designated prenatal and infant screening forms. The forms are scored to assess risk and to identify those women and infants most at risk for adverse health outcomes. Screening differs from assessment in that screening only identifies those most likely to be at increased risk; an assessment is necessary to determine service needs.

2. What are the adverse outcomes for pregnant women and infants that the Healthy Start program was designed to reduce?

For pregnant women the adverse outcome is pre-term labor and/or delivery of a low birth weight infant and for infants the adverse outcome is infant death between 28 and 364 days after birth.

3. When does Florida statute require that Healthy Start risk screening be offered?

Florida statute requires that Healthy Start risk screening is offered to all pregnant women at their first prenatal visit by their prenatal health care provider. In addition, Florida statute requires that Healthy Start infant (postnatal) risk screening is offered by the birthing facility to parents or guardians of all infants born in Florida before leaving the facility. Although women and infants/children who do not initially enter the program after their Healthy Start risk screen may be referred into or may self-refer into the program at a later date, ***they do not need another screen at that later date in order to enter the program.***

4. What are some possible factors requiring priority care coordination other than a score of 4 or more?

Knowledge or suspicion of current:

1. Domestic violence
2. Sexual abuse
3. Child abuse or neglect
4. Substance abuse
5. Diagnosed mental illness (such as severe depression episodes, bipolar, personality disorder, schizophrenia, etc.)
6. HIV positive status
7. Hepatitis B positive status
8. Inappropriate growth and development (small for gestational age)
9. Safety concerns noted by the health care provider on the Healthy Start screening form
10. Language barriers
11. Other, using professional judgment

5. What are the basic responsibilities of prenatal health care providers and delivery facility staff involved with Healthy Start screening?

- Explain Healthy Start Program and the benefits of Healthy Start Screening

- Complete risk screen instrument
- Score risk screen instrument
- Explain score
- Offer program services/referral as appropriate
- Forward screening instrument to local county health department.

6. What are the basic responsibilities of county health departments related to Healthy Start screening?

- Provide blank Healthy Start screens to prenatal healthcare providers and delivery facilities
- Receive completed screens
- Check screens for accuracy and obtain corrections as necessary
- Enter prenatal screen data into the Healthy Start prenatal screening module and forward Healthy Start prenatal and infant screens to care coordinator in county of residence within five working days.
- Maintain an administrative file for all screening forms on which the client declined to be screened, was not referred, or declined the program.

7. What are the benefits associated with the identification of patterns of positive risk screens?

The identification of patterns of positive risk screens will assist providers and Healthy Start coalitions in planning service delivery that targets resources to populations and locations most in need of services. Areas or clusters of positive risk screens (or particular risk factors) can be identified by ZIP code, census tract, or population characteristics.

8. What elements should be included in documentation of training of prenatal care providers and birth facilities staff that provide Healthy Start screening?

Documentation of training regarding Healthy Start screening is included in the coalition progress reports. The documentation includes training dates, participants (individual or group), and the curriculum determined by the coalition.

9. At a minimum, what should be included in the CHD's and Healthy Start Coalition's QM/PI program relating to Healthy Start screening?

The QM/PI component relating to Healthy Start screening consists of, at a minimum, an annual review and assessment of screening reports identifying critical screening issues and plans to address problems.

Chapter 4:

1. The order of priority for care coordination service delivery to Healthy Start participants is based on what factors?

- Safety concerns and immediate needs identified in Table 4.2a of Chapter 4 of the Healthy Start Standards and Guidelines
- Severity of risk and need
- Participant's motivation to address risk/need
- Ability to provide services that link to participant's risk and are likely to have a positive impact on outcomes
- Participant's ability to access other community resources available to offset the risk/need

2. What types of care (at a minimum) should the care coordination provider evaluate the participant's ability to access and, if necessary, facilitate access to?

1) Medicaid and Title XXI eligibility determination including Presumptive Eligibility for Pregnant Women (PEPW) and Simplified Eligibility for Pregnant Women (SEPW), KidCare and Medicaid Family Planning wavier
2) Prenatal and postpartum care
3) Primary health care for children including Child Health Check Up for Medicaid eligible children
4) Immunization services
5) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
6) Other Healthy Start services, and
7) Family planning services if the mother is postpartum or being served interconceptionally

3. At a minimum, care coordination providers should comply with which interagency agreements in order to assure collaborative networks of care within the community?

1.) Early Steps, Children's Medical Services;
2.) Neonatal Intensive Care Units for NICU clients;
3.) Regional Perinatal Intensive Care Centers (RPICC) and other Level III Centers;
4.) Children's Medical Services for Children with Special Health Care Needs;
5.) Department of Children and Families for pregnant, substance abusing women and substance exposed children;
6.) County health departments in the event the county health department is not the sole provider of care coordination; and
7.) Healthy Families Florida projects

4. What is an Individualized Plan of Care?

The Individualized Plan of Care (IPC) is a written plan of identified needs, goals, interventions, and progress towards meeting the goal(s) based on the care coordinator's evaluation of the participant's risks and needs.

The IPC is initiated at the initial contact, and is re-evaluated at each subsequent encounter.

5. What factors determine the intensity and duration of Healthy Start care coordination services?

The intensity and duration of Healthy Start care coordination are determined by:

1) The presence of risk factors affecting participants;
2) The availability of participant or family assets, strengths, and resources to offset the risk factors;
3) Participant and family desires, concerns, and priorities; and
4) The resources of the Healthy Start care coordination provider and the community.

6. What are the safety concerns and immediate needs that require priority care coordination services (ie. minimum 3 attempts to contact with at least one being a face-to-face visit)?

Knowledge or suspicion of current:

- Domestic violence
- Sexual abuse
- Child abuse or neglect
- Substance abuse
- Diagnosed mental illness (such as severe depression episodes, bipolar, personality disorder, schizophrenia, etc.)
- HIV positive status
- Hepatitis B positive status
- Inappropriate growth and development (small for gestational age)
- Safety concerns noted by the health care provider on the Healthy Start screening form
- Language barriers
- Other concerns or need based on professional judgment

7. What are the concerns and needs that require a minimum of 3 attempts to contact (ie phone and/or letter)?

Knowledge or suspicion of:

1. Tobacco use
2. Known history of abuse (i.e. child, domestic, sexual) and/or neglect in family/household
3. Lack of basic needs such as housing and food
4. Lack of health care including prenatal care
5. If the participants answer yes to screening question for tobacco, drug/alcohol, depression and history of mental health counseling
6. Other concerns or need based on professional judgment

8. What is the purpose of the Family Support Plan?

The purpose of the Family Support Plan is to involve participants/families in activities that will reduce their identified risk factors and therefore improve birth outcomes for their child's health. A Family Support Plan is not a plan of care. It is a participant-centered

plan that helps participants and families plan the steps needed to achieve their own goals.

9. For which level of participant must a Family Support Plan be developed and coded into the HMS?

Use of the family support planning process is required for all level 3 participants receiving ongoing care coordination. All participants have the potential to benefit from the family support planning process, and there are times when a family support plan may be developed for a participant who is level 1 or 2; however, family support planning services should only be coded in the Health Management System for level 3 participants. Family support planning services for a level 1 or 2 participant should be coded in the HMS as care coordination.

10. How often must the Family Support Plan be updated?

The Family Support Plan (FSP) must have periodic reviews and be updated every three months to ensure that it is meeting the needs of the participant/family and to determine progress toward achieving outcomes. The Family Support Plan update must be developed during a face-to-face encounter. During the FSP update, the care coordinator and the participant/family will jointly assess the continuing appropriateness of selected interventions, strategies, and activities toward meeting goals. The care coordinator will date and identify whether the goal is still active, is inactive, or has been resolved. (The FSP update is different from the periodic evaluation of progress which can be done via phone contacts or during face-to-face encounters as part of ongoing care coordination).

Chapter 5:

1. What is the optimal amount of time that an infant should be exclusively breastfed?

An infant should be exclusively breastfed for the first six months of life. In addition, continued breastfeeding through at least the first year of life with appropriate complementary foods should be encouraged.

2. What is the definition of "exclusively breastfed?"

Exclusive breastfeeding is defined as an infant's consumption of human milk with no supplementation of any type (no water, no juice, no non-human milk, and no foods) except for vitamins, minerals, and medications.

3. What are the health risks associated with not exclusively breastfeeding for an infant's first six months?

Infants and children who are not exclusively breastfed for at least the first six months are at increased risk to become overweight or obese; to suffer from recurrent ear infections; to develop severe diarrhea; to develop certain childhood cancers and type 1 diabetes; to be hospitalized for respiratory illness; and for infant mortality. Mothers who do not

breastfeed are at increased risk to develop breast and ovarian cancer; to retain pregnancy weight; and to develop postmenopausal osteoporosis.

4. In Florida's Healthy Start program, what comprises breastfeeding education and support services?

Breastfeeding education and support services are:

- Those services provided to pregnant women to encourage breastfeeding in the early postpartum period;
- Those services that provide anticipatory guidance and support in order to prevent breastfeeding problems and to address barriers to breastfeeding; and
- Those services provided to postpartum women to encourage the continuation and exclusivity of breastfeeding and to enable them to overcome any perceived or actual breastfeeding problems.

5. What are the qualifications necessary to provide breastfeeding education and support to Healthy Start participants?

Breastfeeding support and education must be provided by international board-certified lactation consultants or qualified health care professionals/paraprofessionals who have completed a comprehensive breastfeeding educator course and who meet the competencies listed in Chapter 5 of the Healthy Start Standards and Guidelines.

In many instances, personnel who do not meet the criteria/competencies for breastfeeding education and support as outlined in Chapter 5 offer general information about breastfeeding in a supportive manner as health promotion, education, or anticipatory guidance. This type of support is considered care coordination and must be coded as such.

6. Once a provider receives a referral for breastfeeding education and support services, how quickly should she make contact with the client?

It is important to make contact with the client in a timely manner.

For prenatal participants, services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

For postpartum participants, services are initiated within three days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

7. What are the targeted outcomes which should be examined and addressed by the QI/QA process?

1. Increase the number of Healthy Start participants who breastfeed in the early postpartum period;

2. Increase the continuation of breastfeeding among Healthy Start participants who breastfeed in the early postpartum period;

3. Increase the number of Healthy Start participants who exclusively breastfeed in the first six months postpartum;

4. Increase the number of Healthy Start participants who continue breastfeeding through at least one year of age;

5. Increase the number of African-American Healthy Start participants in all the above targeted outcomes in order to move towards eliminating health disparities;

6. Increase overall community support and encouragement of breastfeeding.

Chapter 6:

1. What is the definition of childbirth education as it relates to Florida's Healthy Start program?

Childbirth education refers to those activities that provide information and education to the pregnant woman and her family, both during early and late pregnancy, which promote healthy outcomes for the woman and her infant. Childbirth education can be provided at any location in the community. The location should meet the needs of the participant by encouraging and supporting attendance.

2. Once a provider receives a referral for childbirth education, how quickly should she/he make contact with the client?

It is important to make contact with the client in a timely manner.

Providers of childbirth education will contact participants at least 90 days before the estimated delivery date or at the time of the referral or identified need if during the third trimester of pregnancy to initiate a plan of care for receipt of services.

3. What components should be included in the curriculum for childbirth education, whether it is for group classes or one-to-one/individual instruction?

- It should have outcome based learning objectives
- It should address characteristics of the target population, such as providing materials for culturally diverse participants
- The educator should be trained to work with an adult, low-literacy population

4. Why are group sessions preferred over one-to-one/individual instruction?

Group sessions are preferred because this format provides for group interaction, support for the pregnant women, and is cost effective.

5. What topics should be covered in childbirth education?

- Healthy Start prenatal and infant screening
- Anatomy and physiology of pregnancy and birth
- Physical and emotional changes related to pregnancy
- Basic nutrition and breastfeeding
- Prenatal care
- Self-empowerment
- Stress management
- Danger signs of pregnancy and the postpartum period
- Signs and symptoms of preterm labor
- Preparation for labor and birth
- Parent/child attachment
- Normal newborn growth and development
- Newborn care and safety
- Immunizations
- Postpartum changes
- Family planning
- Sibling preparation

Different cultural beliefs and ethnic differences should be considered when presenting the childbirth education curriculum. An interpreter may be necessary when education is provided to non-English speaking participants.

6. Is it necessary for a women enrolled in childbirth education through Healthy Start to be concurrently receiving ongoing care coordination?

No. Childbirth education should be provided to the pregnant woman and her support persons when determined to be necessary by the care coordinator (and the participant) during initial contact or assessment. It is not necessary for these participants to receive ongoing care coordination if they are able to access other support services independently.

7. Who may provide childbirth education?

Childbirth educators must meet at least one of the following criteria:

1. Certification by a nationally recognized childbirth education organization
2. Completion of the Florida Outreach Childbirth Education certification requirements
3. Approval by the Healthy Start prenatal and infant health care coalition in the service delivery area

In addition, it is recommended that all childbirth educators have knowledge or experience in working with participants from culturally diverse backgrounds.

8. What competencies should the Healthy Start childbirth education provider possess?

- Experiences with childbearing women and practical knowledge of the birth process
- An understanding of learning styles, literacy levels, and learning aptitudes or disabilities
- Skills for the identification of a support person, if one is not readily available
- Ability to attend and facilitate a group class

9. What performance measures should be reviewed as part of the QI/QA process for childbirth education?

- The pregnant woman and her support person, whether provided in a group session or individually, should evaluate childbirth education classes. Written evaluations should be maintained by the provider, and should be reviewed at least annually by the Healthy Start Coalition as part of the QI/QA of the childbirth education service.
- Instructor credentials and curricula should be reviewed.
- A questionnaire should be used to verify that the educator has continued her training in childbirth education and has taught childbirth education classes within the past 12 months. Details of continuing education units, workshops, and training relevant to childbirth education should be recorded.
- A sampling of participant evaluations from each educator should be reviewed.
- Attendance records should be reviewed to determine if participants are attending and what percentage of the target population is being reached.
- Data on the following should be reviewed: information on the participant's length of labor, type of delivery, infant birth weight, gestational age of infant, and whether or not the participant initiated breastfeeding. This data should be compared with that for individuals who did not receive childbirth education.

Chapter 7:

1. What is the goal of Healthy Start nutrition counseling?

The goal of Healthy Start nutrition counseling is to assist participants in their ability to make informed health decisions affecting their nutrition status. Nutrition counseling must be tailored to the unique needs, interests, experiences, language, educational level, environmental limitations, cultural patterns, capabilities, and lifestyle of the participant.

2. What is the definition of nutrition counseling as it relates to Florida's Healthy Start program?

Healthy Start nutrition counseling is in addition to the nutrition counseling that is provided to Women, Infants, and Children (WIC) participants. It is intensive therapeutic nutrition assessment and counseling for populations found to be at high risk for adverse health outcomes.

3. Once a provider receives a referral for nutrition counseling, how quickly should she/he make contact with the client?

It is important to make contact with the client in a timely manner.

Nutrition counseling is initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

4. What are the provider qualifications for Healthy Start nutrition counseling?

Nutrition counseling must be provided by professionals with one of the following credentials:

1. Registered Dietitian (R.D.), registered with the Commission on Dietetic Registration
2. Licensed Dietitian/Nutritionist (L.D.), licensed by the state of Florida
3. Public Health Nutritionist employed by a federal, state, or county agency

5. What are the competencies for providers of Healthy Start nutrition counseling?

1. Knowledge of principles of normal and therapeutic nutrition and drug and nutrient interactions during pregnancy, postpartum, and childhood stages;

2. Knowledge and skill in nutrition and dietary assessment techniques and interpretation of data;

3. Skill in writing clear, concise entries in the participant's record using the local protocol for progress notes;

4. Knowledge and skill in providing nutrition counseling to identified at-risk pregnant women, postpartum women, children, and their families;

5. Ability to provide nutrition counseling in accordance with the constraints of the professional's practice act; established protocols; and the individual practitioner's nutrition counseling education, training, and experience;

6 Knowledge, skills, and ability to provide nutrition education to participants of varied socioeconomic, cultural, language, and educational backgrounds;

7. Knowledge of developmental stages of the human life cycle;

8. Knowledge of nonverbal communication cues;

9. Ability to utilize creative approaches in the delivery of nutrition services.

6. What are some examples of possible targeted outcomes related to nutrition counseling to be measured through the QM/PI process?

1. Achievement of weight goals and other nutrition related goals as stated in the nutrition care plan.

2. Knowledge of the underlying nutrition problem and the effects eating habits will have on health outcomes.

3. Increased knowledge of the effects of eating habits upon nutrition and other health problems.

4. Knowledge and skills in planning, buying, and preparing nutritious foods.

5. Regular participation in the WIC program and other food assistance programs when eligible.

6. Reduction or elimination of negative behavioral food habits.

Chapter 8:

1. What is the definition of parenting education and support as it relates to Florida's Healthy Start program?

Parenting education and support is a partnership relationship between a parent, parents, or a caretaker and professionals to support healthy family development. Parenting support and education provides comprehensive information and education related to the care of the newborn, infant, and child. This service includes information on normal growth and development, anticipatory guidance, changes in family dynamics, attachment behaviors, nutrition, resource management, safety, child injury prevention, immunizations, and child abuse prevention.

2. What are the three options available for the method of service delivery for parenting education and support?

1. One-to-one support using service sites such as the clinic, home, school, or work place
2. Support and information groups that empower parents. Leaders should have parenting knowledge and expertise and promote group sharing of experiences and knowledge. The leader provides education and information based on curricula and the needs of participants. These groups meet on a regular basis, with the frequency and length of time decided by the participants.
3. A formal or educational group format. A formal or educational group format differs from the support and information format in that the group has a more fixed curricula and a set number of sessions.

3. What components should be present in the curriculum when a formal or educational group format is used?

The curriculum should be:

- culturally sensitive and applicable for the participant receiving the service

- offered in the participant's native language whenever possible (or an interpreter should be provided)
- prevention-based and/or intervention-based to reduce factors that are associated with placing children at health, social, or behavioral risk
- adult education-based and designed to reflect the needs of parents relevant to their recent, current, and near-future parental role responsibilities

4. What are some examples of incentives that may be offered to encourage participation in parenting education and support classes?

Incentives such as transportation, childcare, or certificates may be necessary to encourage consistent participation in classes. Additionally, a list of resources on parenting offered in the community should be available for all participants. Two statewide resources for information are the Family Health Line at 1-800-451-2229 and the Parent HelpLine at 1-800-FLA-LOVE

5. Once a provider receives a referral for parenting education and support services, how quickly should she/he make contact with the client?

It is important to make contact with the client in a timely manner.

Parenting education and support services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

6. What are the provider qualifications for parenting education and support services?

Parenting support and education are provided by trained and qualified health-related professionals and paraprofessionals using locally-approved protocols, procedures, and a curriculum with learning objectives, as specified in rule 64F-3 F.A.C.

Individuals with, at a minimum, the following credentials, knowledge, and skills are recommended to provide parenting support and education:

1. A high school diploma or equivalent GED
2. Knowledge of local community resources for health, education, and social services
3. Knowledge of infant care and family relationships
4. Knowledge of the basics of a healthy lifestyle
5. Knowledge of basic child development, management, health, and safety
6. Training and experience in using an education-based parenting curriculum

7. What outcomes should be assessed through the QM/PI evaluation process of parenting education and support?

The QM/PI evaluation process should be designed to measure and improve the extent to which parenting education and support services have led to:

1. Better health and developmental outcomes for children, including factors such as

increased immunization rates, progressive developmental growth, decreases in child protection services involvement, and decreases in childhood injury rates.

2. Acquired new skills that enable parents to access community resources and build on their own strengths.

3. Parental ability to apply new parenting and resource management skills in the home environment.

Chapter 9:

1. What is the definition of psychosocial counseling used by Florida's Healthy Start program?

Psychosocial counseling is a service provided by a skilled professional counselor to an individual, family, or group for the purpose of improving well-being, alleviating distress, and enhancing coping skills.

2. Once a provider receives a referral for psychosocial counseling, how quickly should she/he make contact with the client?

It is important to make contact with the client in a timely manner.

Providers of psychosocial counseling will contact participants within 10 days or less after receipt of referral or identified need to schedule an appointment for a psychosocial assessment unless the need for more immediate initiation of services is evident.

3. What are the necessary components of psychosocial counseling?

1. Screening: The initial process of identifying potential psychosocial problems that may require further intervention and/or assessment. The "Tell Us About Yourself" psychosocial questionnaire (DH 3131) is a useful tool to begin the screening process.

Note: Not all counseling will include the screening component, as some counties assign this activity to another professional.

2. Psychosocial assessment: An interview that includes an assessment of environmental, emotional, behavioral, and social factors as well as resources and strengths that impact the individual's health and ability to function.

3. Planning: A joint process of counseling and goal selection between the service provider and the participant which results in the development of the counseling service plan. The Healthy Start services participant will be given primary responsibility for selecting goals. Helping the individual to take ownership of the problem creates an incentive to begin working on the acknowledged problem. Commitment to actively participate in the problem solving process will be enhanced by using goals that are of essential importance to the individual. The family support plan can be a powerful tool for supporting this process.

4. Intervention: 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 individual or her family members. Intervention includes a follow-up session to assure resolution of issues, reduction of risks, completion of tasks, and/or referrals.

5. Closure: The process of determining with the participant what progress has been made toward the goals and evaluating the need for further counseling services. Upon discontinuing psychosocial counseling services, a closing summary will be completed indicating the reason for closure, the progress achieved, and any continuing service needs.

4. What credentials must a professional possess in order to be qualified to provide psychosocial counseling?

Professionals with one of the following credentials are qualified to provide psychosocial counseling:

1. Social worker with a Master's degree or a Ph.D in Social Work from a Certified Social Work Education-accredited school of social work.

2. Registered Nurse with advanced specialized counseling education and training as a clinical nurse specialist or certified psychiatric nurse.

3. Professional licensed to provide clinical, counseling, and psychotherapy services by the Florida Department of Health, Division of Medical Quality Assurance.

4. Counselor with a Master's degree in Counseling.

5. Psychologist with a Master's or Ph.D in Psychology.

6. A Master's or Doctoral level graduate student intern from an accredited school of Social Work or a Psychology or Counseling program, under the supervision of a licensed practitioner qualified to supervise such interns.

Chapter 10:

1. What are the goals of Healthy Start tobacco education and cessation counseling?

Tobacco education and cessation counseling is provided to Healthy Start families in order to reduce the incidence of prenatal smoking and to reduce the harmful effects to the mother and developing fetus when the mother ingests chemicals from tobacco or is exposed to environmental tobacco smoke.

Healthy Start services are also offered to reduce the impact of environmental tobacco smoke which is damaging to all household members. Infants and young children are particularly vulnerable to upper and lower respiratory disease caused by tobacco smoke.

2. Who can receive Healthy Start tobacco education and cessation counseling?

The service is available to pregnant, postpartum, and interconceptional women and/or for a partner, family member(s), or household member(s) of a pregnant, postpartum, and interconceptional woman. The service is also available to parent(s), family members, and household members of Healthy Start infants and children.

3. What are the components that must be a part of tobacco education and cessation services?

The components that must be a part of tobacco education and cessation services are:

1. Ask about tobacco use.
2. Advise to quit.
3. Assess willingness to quit.
4. Assist in quit attempt.
5. Arrange follow-up.

This is called the "5A's" approach.

4. List two popular smoking cessation models that utilize the 5 A's approach.

"Make Yours a Fresh Start Family" and The American College of Obstetricians and Gynecologist's (ACOG) "Smoking Cessation During Pregnancy": A Clinician's Guide to Helping Pregnant Women Quit Smoking" are two models that utilize the 5 A's approach.

5. Once a provider receives a referral for tobacco education and cessation counseling, how quickly should she/he make contact with the client?

Tobacco cessation services are initiated within 30 days of referral or within a time frame negotiated between the provider and the coalition.

6. Where can tobacco education and cessation services be provided?

Tobacco education and cessation services can be provided at the site or sites most appropriate for meeting the participant's needs. Services can be provided in the clinic, during home visits, at a managed care office, informal settings such as parks or restaurants, or wherever classes are held in tobacco education and cessation.

7. What outcome measures should be used to help assess the success of tobacco education and cessation counseling efforts?

1. Increased knowledge of the dangers of smoking and using smokeless tobacco by all members of the family, as well as knowledge of how to quit smoking when one is ready to try.

2. Percent of participants who move into contemplation stage.

3. Percent of participants who change smoking behavior (those who do not quit) to eliminate environmental tobacco smoke (ETS) exposure to children.

4. Percent reduction of smoking in families with young children.

5. Increased quit rates among pregnant and postpartum women.

6. Percent of participants who relapse post delivery.

7. Participants' awareness of availability of nicotine replacement therapy (NRT) in conjunction with tobacco education and cessation classes (not available to all participants in all counties).

Chapter 11:

1. What are the main advantages of home visiting versus providing services in a clinical setting?

The issues facing many families often can best be addressed by reaching out to the family in a non-clinical setting. As a method of delivering services, home visiting is popular because it is flexible and allows the family to interact in a setting that is often most comfortable for them. Home visiting or care provision in other non-clinical settings has been used as an effective mechanism for delivering specific interventions and has been shown to improve outcomes, improve care giving and child development, decrease child abuse, and increase maternal attachment and personal development.

2. What are the main disadvantages of home visiting versus providing services in a clinical setting?

Home visiting is an expensive method of service delivery, so its use must be weighed in the context of community and individual assets and needs. Additionally, home visiting is not feasible when the participant does not feel comfortable with the arrangement, or if the participant and/or home visitor do not feel safe in the home.

3. What factors can be used to predict the success home visiting?

The success of home visiting depends upon:

- Developing clear goals and objectives with the participant for the home visit;
- Understanding the goals and objectives of the program;

- Carefully planning and focusing the services to be offered (offering those services in the home that will truly make a difference because they are offered in the home); and
- Offering services using a mix of staff with varied backgrounds (professionals, paraprofessionals, volunteers) to meet the goals and objectives of the home visit.

4. What is the mix of staff recommended to provide optimum success in a home visiting program?

A mix of health professionals, health paraprofessionals, and family outreach workers of varied backgrounds helps to meet the goals and objectives of the home visit as a method of service delivery in the most cost effective and time efficient manner.

5. What questions should the reviewer be able to answer when reviewing progress notes as part of the QM/PI assessment for home visiting?

- Did the home visit focus on the achievement of goals and objectives?
- Was the home visit provided by the most appropriate individual (paraprofessional, professional, family outreach worker) in order to achieve the goals and objectives?
- Was the participant satisfied with the home visit service?
- Did the supervisor follow-up to confirm the home visit was actually made?
- Is it necessary to continue making home visits?

Chapter 12:

1. For the purposes of Florida's Healthy Start program, how is identification of use/abuse of alcohol and/or illegal substances determined?

EITHER a woman has abused schedule I or II drugs during pregnancy or postpartum, as documented by

- Her own admission
- A positive drug screen
- A staff member witnessing the use
- A report from a reliable source such as a trusted family member or professional
- Response to screening questions indicating use or abuse
- Further observations or assessment of substance abuse history and patterns of use

OR an infant was prenatally exposed to schedule I or II drugs, as documented by the above criteria.

(A list of schedule I and II drugs can be found in §893.03, F.S.)

2. Who is eligible for substance abuse- related Healthy Start services?

- Pregnant women who have abused drugs during a previous pregnancy;

- Pregnant women who have abused drugs within one year of current pregnancy;
- Pregnant women who abused drugs during current pregnancy including prescription and non-prescription drugs;
- Pregnant women who used alcohol during current pregnancy;
- Pregnant women with a history of alcohol abuse;
- Children prenatally exposed to or demonstrably adversely affected by alcohol abuse;
- Children prenatally exposed to or demonstrably adversely affected by schedule I or II drugs;
- Other caregivers of those children; and their families.

3. How is a pregnant substance abusing woman usually leveled for care coordination purposes?

A pregnant substance abusing woman is to be considered as a care coordination level three until information received indicates otherwise.

4. Who assures that the county health department is notified by hospitals and other birthing facilities of all infants prenatally exposed to abuse of prescription and non-prescription drugs?

The coalitions will ensure hospital and other birthing facility staff are aware of the responsibility in accordance with s. 383.14, F.S. **(**http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0383/SEC14.HTM&Title=->2006->Ch0383->Section%2014#0383.14**),** to identify and refer for Healthy Start services all infants prenatally exposed to abuse of prescription drugs and illegal substances.

5. When shall a home assessment for a substance exposed newborn be completed?

A home assessment will be completed prior to hospital discharge of a substance exposed newborn, or the record will show why the assessment was not completed at that time.

6. If the infant or home assessment reveals that the mother or caregiver is not able to care for the child, what is the responsibility of the professional conducting the assessment?

The professional conducting the assessment must make a report to the Abuse Hotline by calling 1-800-96 ABUSE.

This should take place if:

1) The provider felt that the mother or caregiver was unable to care for the child, or
2) There was concern about neglect or abuse

Documentation of the report and rationale for the report should be included in the infant's record.

7. What is the age for care coordination case closure for almost all substance exposed children?

Because of the nature of substance abuse addiction and the possibility of relapse, care coordination of substance exposed children usually continues until the child is three. Rarely, there are unusual circumstances which warrant an earlier termination of services.

8. What is the "5 A's" approach that is recommended by the Maternal and Child Health Bureau of the Health Resources and Services Administration for use in assisting clients with substance abuse?

- **A**sk about substance use
- **A**dvise to quit
- **A**ssess willingness to quit
- **A**ssist with quit (or abstinence) efforts
- **A**rrange follow-up

9. What is the "4 P's"?

The 4 P's is a screening device that can be used to begin discussion about drug or alcohol use. A "yes" answer to questions 1 or 2 or an indication of previous or current substance use signifies the need for further assessment.

4 P's

- **Parents**. Has either of your **parents** ever had a problem with alcohol or drugs? (This question is asked during the portion of the interview when addressing other parental medical problems.)
- **Partner.** Does your **partner** have a problem with alcohol or drug use?
- **Past.** Have you used drugs or alcohol in the **past**? If yes, what did you drink/use and how much?
- **Pregnancy.** Have you used alcohol or other drugs during **this pregnancy**? If yes, what did you drink/use and how much did you drink/use?

If the answer to question 4 is "yes," ask the following question in addition.

In the month before you knew you were pregnant how much beer, other alcohol, marijuana or other drugs (or tobacco) did you use?

10. What are the guidelines regarding breastfeeding by women with a history of drug use?

The Child Study Center at http://www.childstudy.org/csc/breastfeeding.php provides the following Breastfeeding Protocol for Women with a History of Drug Use.

A woman with a history of substance abuse may breastfeed if:

1. The woman's urine toxicologies and historical evaluations are negative for use of alcohol and/or illicit drugs throughout the third trimester.
2. Urine toxicologies on the woman and the newborn are negative at the time of delivery.
3. The methadone dose for women on methadone is below 40 mg per day.
4. The woman is HIV negative.
5. The woman is not using alcohol.
6. Subsequent monitoring through interviews and urine toxicologies confirm that the woman is drug and alcohol free.

Chapter 13:

1. Why is it important to plan for transition through the development of interagency agreements?

Planning for transition ensures continuity of services and minimal interruption of and/or duplication of services.

2. What three major components must be considered to assure successful transition planning?

Successful transition must consider the following:

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

3. When should the family become involved in planning for transition?

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.

4. What three areas of competency should all staff involved in the transition process possess?

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.

5. What are the components of an effective administrative structure?

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.

6. What are the performance measures that may be used to evaluate a 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.

Chapter 14:

1. Why is Healthy Start coding important?

Coding entails accurate data entry into the Health Management System (HMS). The 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.

2. What kinds of information does Healthy Start coding provide?

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.

In addition, 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.

3. How does Healthy Start coding assist local decision makers?

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.

Chapter 15:

1. What is the basic basis of approval for a Healthy Start Coalition to begin operating?

There is only one coalition approved by the Department of Health (DOH) for a coalition's service area. This approval is based on receipt of an acceptable application from all interested individuals and organizations in the area that have joined together to submit one application for a common service area.

2. Once a Healthy Start Coalition has been in operation, continued approval is contingent upon what factors?

Continued approval of a Healthy Start Coalition is contingent on coalition performance and on compliance with the department's contract with the coalition. Requests for Proposals (RFPs) may be issued by the DOH requiring coalitions to re-apply for approval.

3. What is the purpose of the Healthy Start Coalition's Service Delivery Plan, and how often must it be developed and/or updated?

A data-driven and evidence-based service delivery plan is developed and updated by the Healthy Start coalition at least every five years that includes a comprehensive assessment of maternal and child health indicators, prenatal and infant health care services, Healthy Start activities and services, identification of service gaps and needs, local funding priorities, and a quality management and program improvement strategy. The service delivery plan shall provide the basis for contracting with local Healthy Start providers.

4. What is the purpose of the annual action plan update?

An annual action plan update is developed, approved by the coalition, and disseminated to the community and the Department of Health regarding the Healthy Start system and services, which indicates the status of the service delivery plan and documentation of progress toward achievement of coalition goals.

5. What is the definition of a Healthy Start Provider?

A Healthy Start provider is a service provider funded by a Healthy Start Coalition to deliver Healthy Start services specified in the coalition service delivery plan. The Healthy Start Standards and Guidelines govern the services provided with Healthy Start funds.

6. What factors should be considered by a Healthy Start Coalition embarking on the task of identifying the target population and prioritizing services?

Prioritization requirements are reflected in the coalition service delivery plan and contracts/memoranda of agreements. Service prioritization and identified target population are based upon:

- Assessment of maternal and child health indicators, risk factors, and need within the service delivery area;
- Consideration of public health priority populations such as substance abusing pregnant women, substance exposed children, and HIV and/or Hepatitis B positive mothers and children;
- Availability of other community resources to offset the risks and needs;
- Services corresponding to identified risk factors that are likely to have a positive impact on targeted outcome indicators.

7. How shall Healthy Start providers account for the use of the Healthy Start funds that are awarded to them?

Providers must maintain ledgers, records, and documents that sufficiently and accurately reflect all expenditures of Healthy Start funds. Additionally, providers must submit expenditure reports to the coalition at a minimum annually, or as specified under contract.

Chapter 16:

1. What are the two components covered by the Section 1915 (b)(1) Medicaid Managed Care Healthy Start waiver under the Medipass Program?

- Care management of women eligible for Medicaid due to their pregnancy (MomCare program)

- Payment for an increase in the duration and intensity of services to Healthy Start women and children

2. When is it acceptable to use Healthy Start funds to pay for prenatal and child health care?

A statement that prenatal and child health care should be provided with Healthy Start funds only if there are no other sources of payment (e.g., Medicaid, insurance, county funds) should be included in each coalition performance based contract or memorandum of agreement (MOA).

3. How often does the contracted Healthy Start service provider need to report internal QM/PI findings to the Healthy Start coalition?

A statement must be included in each coalition performance based contract or MOA assuring that the contracted Healthy Start service provider has an internal QM/PI system in place. The provider will report these findings to the coalition on a quarterly basis.

4. What is the minimum number of times, annually, that a coalition performance based contract or MOA should be monitored and evaluated?

Language must be included that describes the manner in which the contract or MOA will be monitored and evaluated and which reports, records, and documents will be used in conducting the evaluation. There must be a statement that describes Quality Management/Performance Improvement (QM/PI) activities to be conducted, how often they will be conducted, and by whom. It is recommended that on-site monitoring be done no less frequently than once a year. The coalition will assure that each provider has a functioning QM/PI process by conducting programmatic monitoring at least once a year and more frequently if deemed appropriate.

Chapter 17:

1. How is "quality maintenance" defined for the purposes of Florida's Healthy Start program?

Quality maintenance is defined as assuring the continuation of services and processes that are meeting high quality standards. Ongoing monitoring of factors that positively or negatively influence a service or process is important to sustain high quality standards.

2. How is "program improvement" defined for the purposes of Florida's Healthy Start program?

Program improvement is defined as the process by which services not meeting quality measures or processes that could be streamlined or improved are evaluated and changed to obtain better results.

3. How is "quality management" defined for the purposes of Florida's Healthy Start program?

Quality management is a continuous and dynamic process that encompasses both quality maintenance and program improvement.

4. Why is the implementation of an ongoing, program-specific QM/PI process necessary?

The implementation of an ongoing, program-specific QM/PI process is necessary to assure that services are:

- provided in a manner that meet the needs of participants, and the requirements of the program, including negotiated performance measures,
- of high quality and consistent with current standards of practice,
- accessible and acceptable to the community and to the participants, and
- delivered in a timely manner.

5. At a minimum, what must all contracts executed by Healthy Start coalitions for Healthy Start services include?

All contracts executed by Healthy Start coalitions for Healthy Start services will include a statewide core set of outcome and performance measures based on the current Healthy Start Standards and Guidelines. Coalitions and their subcontracted providers shall incorporate at a minimum the applicable core outcome and performance measures for the contracted services. Additional outcome and performance measures may be negotiated between the provider and the local Healthy Start coalition and included in the contract.

6. What needs to happen in the event that core outcome or negotiated performance measures are not being met?

A Performance Improvement Plan (PIP) will be developed by the provider and approved by the local Healthy Start coalition, or initiated by the coalition based on review of quarterly deliverables in the event that core outcome or negotiated performance measures are not being met.

Chapter 18:

1. What percent of their service dollar allocation may Healthy Start coalitions request for administrative functions?

Healthy Start coalitions can request up to 10% of their service dollar allocation for the below listed administrative functions:

- Quality Assurance/Quality Improvement
- Contract Management
- Fiscal accountability

2. How shall each Healthy Start provider account for the use of Healthy Start funds to its local Healthy Start Coalition?

All contracts and/or Memoranda of Agreement for Healthy Start funded services are in the form of performance-based agreements that:

- Specify components of fiscal reporting
- Specify frequency of fiscal reporting
- Specify Healthy Start performance measures

3. What does it mean to say that Healthy Start funds will be used as "payer of last resort?"

Healthy Start funds are expended only when all other community or insurance resources have been exhausted. The Healthy Start coalition and the contracted provider should negotiate a system that verifies that all payor sources, including assisting the client to apply for Medicaid, have been exhausted.

4. What is the scope of Healthy Start funds over which the coalitions have authority?

Healthy Start funds over which the coalitions have authority include federal and state maternity funds (IPO), a prorated portion of the state and federal child health funds to cover infants through their first birthday (or third birthday if part of the coalition's targeted focus), funds specifically allocated by the state legislature to cover other Healthy Start services, and the Medicaid Managed Care Section 1915(1)(b) Healthy Start waiver funds. Funds can only be used for specified purposes.

5. What factors must coalitions address in order to assure fiscal accountability?

Fiscal accountability requires coalitions to address:

- Whether Healthy Start clinical funds are only spent for clients without another third-party payer (Medicaid, private insurance, indigent care funds) or explain other systems created using clinical funds
- Whether Healthy Start dollars are being spent only on authorized services specified in these guidelines
- How many services or encounters were provided during the period covered by the report, and to how many individual clients
- Either expenditures for personnel or a unit cost rate, based on how each contract or MOA is written

Chapter 19:

1. What guidelines are used to assure proper compliance in the retaining, archiving, and destroying of records that contain participant-related information?

All participant-related information is retained, archived, and destroyed according to the Records Retention Schedule, Department of State, Division of Library and Information Services, Bureau of Archives and Records Management.

2. In order to help assure information security, what language must be included in each Healthy Start contract?

Each Healthy Start contract includes standard contract language that requires the contractor to comply with current departmental information security policies, protocols, and procedures.

Chapter 20:

1. Once the maternity care advisor has been made aware of a SOBRA eligible woman by the Medicaid fiscal agent, how much time does he/she have to make an attempt to contact the woman by telephone?

The maternity care advisor shall be responsible for attempting to contact by telephone all SOBRA eligible women identified on the weekly Medicaid fiscal agent list within five working days.

2. What is the intent of the initial contact between the maternity care advisor and the SOBRA eligible woman?

During the initial contact with the SOBRA eligible woman, the maternity care advisor shall:

- Explain the program and program benefits;
- Provide a list of provider choices;
- Assist the recipient in her choice of a provider;
- Document her choice in the SOBRA Information System (SIS);
- Facilitate the initial or next appointment and any subsequent missed appointments;
- Explain and facilitate the completion of the Healthy Start screen if not already completed;
- Determine if the recipient is enrolled in the WIC Nutrition Program and facilitate enrollment.
- Inform the recipient of the right to change her prenatal care providers and the mechanism to do so.

3. Once the maternity care advisor has been made aware of a SOBRA eligible woman by the Medicaid fiscal agent, how much time does she/he have to register the enrollee with her selected prenatal care provider and facilitate the completion of the Healthy Start screen?

Within 30 days of notification from the fiscal agent, the maternity care advisor shall register the enrollee with her selected prenatal care provider and facilitate the completion of the Healthy Start screen. The maternity care advisor shall make at least

three attempts to contact within the first 30 days of notification of eligibility by the fiscal agent.

Of those enrollees that the maternity care advisor is unable to reach by phone within the thirty-day period, at least 25% will receive an attempted face-to-face contact. Priority will be given to enrollees who have no phone but have a street address for this attempted face-to-face contact.

4. Describe the process of auto-assignment of a prenatal care provider for a SOBRA eligible woman.

If the enrollee has not made a decision within 30 days, the maternity care advisor shall assign a prenatal care provider by selecting from providers within a thirty-minute drive of the enrollee's residence. Coalitions with more than one prenatal care provider who meet this requirement shall assign a prenatal care provider to the enrollee based upon a locally-established unbiased protocol. The selection process shall be weighted for those group practices with more than one prenatal care provider.

5. How many more times is the coalition obligated to attempt to communicate information regarding enrollment services for those recipients that have been auto-assigned?

For all recipients that have been auto-assigned, (meaning they have not been verbally contacted but their provider choice has been registered), the coalition shall provide one additional attempt to communicate.

Communication with the recipient can be by a letter, telephone call, or a face-to-face encounter. The maternity care advisor will make this one additional attempt to communicate to women who have been auto-assigned or not verbally contacted between day 31 and the end of month 5.

6. Describe some examples of follow-up services that the maternity care advisor shall provide, as needed, to recipients.

- Ensuring that the coalition's prenatal care counselors work closely with prenatal care providers for notification of no-shows or problems;
- Contacting the recipient to determine the reasons for reported no-shows and facilitating rescheduling;
- Assisting the recipient in accessing recommended prenatal care and WIC enrollment services and resolving problems in receipt of care;
- Facilitating continuity of prenatal care in case of provider termination, loss of Medicaid coverage, or other problem;
- Ensuring that the coalition's prenatal care counselors facilitate making appointments for recipients for other health services if needed;

- Conducting periodic surveys with samples of recipients concerning their access to all services.

7. What post-enrollment services shall be made available to SOBRA eligible women?

After enrollment, between the sixth and ninth month of her pregnancy, the coalition shall provide post-enrollment services to recipients, including recipients that are auto-assigned. These services shall include:

- Facilitate accessing family planning services;
- Facilitate accessing health care coverage for the infant;
- Facilitate choosing a pediatric care provider for the infant

Chapter 21:

1. Who is eligible for Healthy Start interconception education and counseling?

An eligible woman is defined as any woman who is capable of becoming pregnant in the future who has risk factors that may lead to a poor pregnancy outcome and is also a Healthy Start prenatal client, a mother who is being provided services on behalf of her Healthy Start infant, a prenatal Healthy Start client who has gone beyond the 8 week post-partum period, or any woman who had a pregnancy and 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, stillbirth, or infant death. Women may be eligible for Healthy Start services during the interconception period for up to three years postpartum.

2. What components should be included in the interconception education and counseling provided to a Healthy Start client?

Interconception education and counseling services include the following components:

• Assessment,
• Development of a plan of care,
• Counseling and education consistent with the plan of care and approved curriculum that includes presentation, follow-up, and feedback, and
• Evaluation of progress.

3. Once a provider receives a referral for interconception education and counseling services, how quickly should she/he make contact with the client?

It is important to make contact with the client in a timely manner.

Interconception education and counseling services are initiated within 30 days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

4. In what three ways may the method of service delivery for interconception education and counseling be provided?

The method of service delivery can be provided in the three following ways:

1. One-to-one education and counseling using service sites such as the clinic, home, school, or work place.
2. Interconception education and counseling support groups that empower parents. Leaders should have interconception education and counseling knowledge and expertise and promote group sharing of participant experiences and knowledge. The leader provides education and counseling based on approved curricula and the needs of participants. These groups meet on a regular basis, with the frequency and length of time decided by the participants.
3. A formal or educational group format. A formal or educational group format differs from the support and information format in that the group has a fixed curricula provided in a set number of sessions.

5. Interconception education and counseling should provide information on what subject areas?

Interconception education and counseling includes information on, but is not limited to:

- access to care,
- baby spacing,
- nutrition,
- physical activity,
- maternal infections,
- chronic health problems,
- substance abuse,
- smoking,
- mental health, and
- environmental risk factors

6. What structural components should be included in interconception education and counseling services?

Interconception education and counseling services include the following structural components: presentation, demonstration activity with participant, follow-up, and feedback to assess understanding by the participant. It is essential that the provider of interconception education and counseling services share information with the Healthy Start care coordinator and other members of the team to reinforce the process of successful learning.

7. What are the provider qualifications for interconception education and counseling services?

Interconception education and counseling services are provided by trained and qualified health-related professionals and paraprofessionals using locally-approved protocols, procedures, and a curriculum with learning objectives. Individuals with, at a minimum, the following credentials, knowledge, and skills are recommended to provide interconception education and counseling services:

- A high school diploma or equivalent GED.
- Knowledge of local community resources for health, education, and social services.
- Knowledge of interconception health concepts.
- Knowledge of the basics of a healthy lifestyle.
- Knowledge of cultural health beliefs.
- Training and experience in using an education-based curriculum.

8. QM/PI evaluation protocols for interconception education and counseling should include outcomes that address what issues?

Evaluation of services should include outcomes that address:

1. Access to and utilization of preventative health services by the family.
2. Ability to access community resources and build on their own strengths.
3. Subsequent pregnancy intervals.
4. Reduction of unhealthy health behaviors.
5. Reduction of environmental risk factors.

9. What are the methods that should be used to evaluate process outcomes for effectiveness of interconception education and counseling services?

Methods to evaluate process outcomes for effectiveness of interconception education and counseling services include the following:

1. Verification of improvement of original Healthy Start risk factors or their underlying causes.
2. Chart review for documentation of presentation, demonstration activity with participant, follow-up, and communication with the Healthy Start care coordinator.
3. Observation of service provision.
4. Random interviews with class participants.
5. Individual surveys for participants to evaluate their educational gain from this service (post-test evaluation).
6. Review of rates of participation and program completion by families.
7. Review of participant satisfaction surveys.
8. Review of curriculum content and service delivery methodology.
9. Review for needed improvements to the service delivery format.

Chapter 22:

1. What are some key benefits of sustained community involvement in developing effective MCH programs?

Studies have found that sustained community involvement is extremely beneficial to local communities and effective MCH programs and results in:

- Community understanding of the trends in infant mortality
- More effective interactions with at-risk families
- Positive behavioral change
- Assistance with identification of key issues impacting infant mortality and other MCH issues
- Development of innovative programs that are more acceptable to program participants and the community
- Partnerships that remain viable and continue to address poor perinatal outcomes

2. According to Chapters 383.216, F.S., what are the requirements for consumer membership on local Healthy Start Coalitions?

Chapters 383.216, F.S., mandates that the membership of local Healthy Start Coalitions include consumers of family planning, primary care or prenatal care services, and that at least two consumers be low-income or Medicaid eligible. The statute further stipulates that the membership of each prenatal and infant health care Coalition shall represent "the recipient community, and the community at large; and shall represent the racial, ethnic and gender composition of the community."

3. How can the Coalition allocation process be used to increase community involvement in improving perinatal outcomes?

When the Coalition, through their allocation process, subcontracts (when appropriate) with community-based grassroots organizations, an important link between the Coalition and the community is developed and built into the service delivery process.

4. How often should the Coalition provide a formal orientation to new members?

The Coalition should provide a formal orientation for new members at least annually. When new members join the Coalition more than 90 days in advance of the next scheduled orientation, an informal process for their orientation should be provided by staff and/or Board members.

5. What is cultural competency?

Cultural competency is a lifelong process, which includes the examination of personal

attitudes (desire), the acquisition of relevant knowledge, and the development of skills, which facilitate working effectively with individuals and groups from diverse cultures.

6. What are the Coalition's responsibilities in terms of cultural competency training?

The Coalition must also assure that the subcontracted providers, coalition board, and staff receive cultural competency training within the first six months of contract execution, appointment, or hire. The coalition shall assure the provision of cultural competency training to each board, coalition, and staff member at a minimum of every three years. The community at large should be invited to trainings that are being held for staff, board, Coalition members, and subcontracted providers.

7. In addition to issues related to maternal and infant health and access to healthcare, what other considerations must be made when attempting to positively impact perinatal health outcomes?

Research has shown that a web of biological, environmental, economic, social, and psychosocial factors have influence on perinatal health outcomes. In order to effectively understand, address, and affect these potential casual factors, Healthy Start Coalitions should continuously identify and assess the varied factors within the catchment areas that impact systems of perinatal care and perinatal health outcomes. While Healthy Start Coalitions will not be able to resolve all issues that influence perinatal health, particularly factors that are outside of the scope of healthcare, the acknowledgement and analytical assessment of the impact of these risk or protective factors can lead to effective strategic actions in partnership with local government entities and community organizations that have an influence in these subject areas.

8. What elements should be included in a coalition's plan for obtaining community and consumer feedback?

Healthy Start Coalitions must provide feedback mechanisms for the community and subcontracted providers to provide constructive comments and suggestions on Coalition functions, membership, and staff representation. To cover the community's entire spectrum, the feedback mechanisms chosen should be accessible to the community and subcontracted providers. In the same respect, a feedback mechanism should be established for consumers of services provided by Healthy Start subcontracted providers that allows easy, friendly access. The process for this feedback and response system should be specified in the Coalition's service delivery plan, as part of its Quality Management/Performance Improvement (QM/PI) process.