

Chapter 4: Healthy Start Care Coordination and Risk Appropriate Care

Introduction

The Healthy Start goal of improving pregnancy, health, and developmental outcomes is facilitated through care coordination services that provide the knowledge, encouragement, linkages, and support necessary to maximize families' health, well-being, and self-sufficiency.

Healthy Start care coordinators achieve this goal by helping participants and their families receive the appropriate interventions they need to improve situations that place them at risk.

A Healthy Start participant may be:

- A pregnant women who scores at-risk (6 or greater) on the Healthy Start risk screen;
- A pregnant woman who self-refers or is referred to the program by a health care provider, a care coordinator or a community organization;

- An infant who scores at risk (4 or greater) on the Healthy Start risk screen;
- An infant or toddler whose parent self-refers or is referred to the program by a health care provider, a care coordinator or a community organization to provide services to the child, or to the parent on behalf of the child;

- A woman between pregnancies (interconception) who has a loss, either through miscarriage/abortion, stillbirth/fetal death, infant death or has a baby adopted or removed from the home. This woman has risk factors that may benefit from Healthy Start care coordination and other risk reduction services;
- Pregnant women, interconception women (up to 3 years after most recent delivery) or children (birth to age 3 years) who are referred to Healthy Start.

Length of Healthy Start program eligibility:

- Pregnant women can be served up to 8 weeks post partum.
- Infants, toddlers and their families can be served up to when the child reaches three years of age.
- Interconception women can be served up to three years post their most recent delivery.

Healthy Start care coordinators strive to assure each participant's continued involvement in prenatal and child health care as well as other needed community and Healthy Start services as described in Chapters 5-10 and 21, through actively engaging the participant and building on the families' strengths, assets and goals.

Standards and Criteria

Standard 4.1 Healthy Start services will be delivered according to identified risk

and need.

Criteria:

4.1.a The extent of services is based on available local resources.

4.1.b Services are provided at varying levels of intensity based on identified risk and need for services.

4.1.c Provision of services reflects sensitivity to cultural, language, educational/literacy, and accessibility needs.

Standard 4.2 Healthy Start care coordination service delivery and caseload management will be prioritized in a manner that addresses the immediacy of the participant's needs and identified risks to improve outcomes.

Criterion:

The order of priority for care coordination service delivery to Healthy Start participants is based on:

- 1) Safety concerns and immediate needs identified in Table 4.2 a of this chapter
- 2) Severity of risk and need
- 3) Participant's motivation to address risk/need
- 4) Ability to provide services that link to participant's risk and are likely to have a positive impact on outcomes
- 5) Participant's ability to access other community resources available to offset the risk/need

Standard 4.3 Providers of Healthy Start funded care coordination services will accurately code service information within 72 hours into the Health Management System (HMS). If a coalition utilizes a local data system to capture all the required components of Healthy Start care coordination efforts, the coalition must also ensure input of the data into HMS (dual entry). In order for the dual entry to occur, the coalition must have a signed data entry agreement with the department. The subcontracted care coordination agency is required to accurately enter all pertinent coding data into the local coalition data system within 72 hours (three working days). These agencies shall be allowed an additional 72 hours (three working days) from the time data was entered into the local coalition data system to accurately transcribe coding information into HMS.

Criterion:

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

<http://www.doh.state.fl.us/family/mch/hs/hstraining/hstraining.html>

Standard 4.4 Healthy Start care coordination providers will document services in the participant's HMS record.

Criteria:

4.4.a Content of services are documented in the participant record. Services that are provided to another person, on behalf of a Healthy Start program participant (such as in

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the case of services to a mother of a Healthy Start child participant) are documented in the child participant's record. In the event that a request is signed to release a Healthy Start child's record, all information that does not pertain to the child's medical condition must be redacted prior to release of the record.

4.4.b The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practice outlines the privacy practices of the county health department, informs clients how their information may be used and disclosed and what rights they have if their privacy is breached. Every participant must sign a form that authorizes disclosure of personal health information (PHI) for purposes of health operations, payment or treatment. This form may be the Department of Health's Initiation of Services form, DOH 3204 (11/08), or the Healthy Start Prenatal and Infant Risk Screens or DH 3134 (4/08) and 3135 (1/04), respectively. If a non-DOH form, authorizing disclosure of PHI is used, this form must permit disclosure or exchange of PHI between, the treating physician, Healthy Start coalition or the Florida Department of Health for purposes of healthcare operations, payment or treatment. The original of either or all of these forms must be maintained in the participant's file once executed. If a participant refuses to authorize disclosure, their PHI will not be disclosed and the refusal documented in the participant's file.

4.4.c The following services and activities, when provided, are documented in the participant's record:

- 1) The participant's Healthy Start risk screening form, or documentation of Healthy Start risks, if referred by community provider or self referred
- 2) All attempts, successful and unsuccessful, to contact the potential program participant
- 3) All interactions with the program participant, the family, or with others impacting their receipt of services
- 4) Identified risks, needs, and individualized plan of care for addressing, or rationale for not addressing, the risks and needs
- 5) Activities related to initial contact, initial assessment, and ongoing care coordination, including tracking, provision of referrals and follow-up activities, Individualized Plan of Care (IPC) updates, and health related education
- 6) A family support plan for all Level 3 Healthy Start participants.
- 7) All closure activities
- 8) Follow-up with the participant's health care provider

4.4.d Healthy Start care coordination providers with data systems approved as "grandfather-in" by the department, will document services in the participant's record in the grandfathered-in system for upload to the department.

Standard 4.5 In conjunction with the participant, the care coordination provider will facilitate access to adequate health care.

Criterion:

At a minimum, care coordination providers will 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)

- 2) Prenatal and postpartum care
- 3) Child primary health care including Child Health Check Up for Medicaid eligible children
- 4) Up-to-date immunization services
- 5) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- 6) Other Healthy Start services
- 7) Family planning services
- 8) Adult primary care services

Standard 4.6 Care coordination providers will participate in the development of collaborative networks of care within the community and will refer and/or transition care to specialized community providers with whom they have interagency agreements.

Criterion:

At a minimum, care coordination providers comply with the following interagency agreements:

- 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
- 7.) Healthy Families Florida projects

Standard 4.7 The Healthy Start care coordinator will facilitate the participant's access to other health care funding options and resources through provision of appropriate referrals.

Criteria:

4.7.a The care coordinator is knowledgeable about eligibility requirements and fees for other services.

4.7.b The care coordinator is knowledgeable about other funding sources, such as county service dollars, local agency services or funding, grant sources, private funds, and insurance services, such as Medicaid services.

4.7.c The care coordinator is knowledgeable about Florida's Family Health Line, a statewide toll-free number (1-800-451-2229) for basic information and referrals for prenatal, infant and family health.

Standard 4.8 Healthy Start care coordination services will be provided by qualified and trained providers. Each agency providing care coordination will have a written orientation plan with checklist sign off for their personnel file.

Criteria:

4.8.a Qualifications and competencies are met as specified in this chapter or as

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specified in Chapter 64F-3, F.A.C.

4.8.b Paraprofessionals work under the direct supervision of a qualified professional and adhere to the additional requirements as specified in the provider qualifications section of this chapter.

4.8.c All providers of care coordination services receive a minimum of two weeks pre-service training on the Healthy Start program and home visiting and/or demonstrate competencies as specified in this chapter.

4.8.d Competency and up-to-date knowledge related to Healthy Start care coordination are maintained. Training certifications shall be placed in personnel files.

4.8.e Training materials that are provided by the department and locally adapted resources are utilized.

4.8.f All providers will be knowledgeable of Department of Health (DOH) Information Security Privacy Policies including confidentiality, managing the security and confidentiality of data, and other security requirements.

4.8.g All providers participate in ongoing locally provided training.

4.8.h All providers receive pre-service training to include the following: risk screenings, child abuse, domestic violence, etc. on recognizing and reporting abuse and neglect.

Standard 4.9 Care coordination service providers will develop and implement an internal quality management (QM) and program improvement (PI) process.

Criterion:

The QM/PI process is developed in concert with the local Healthy Start coalition and includes an assessment of strengths and weaknesses to identify areas for quality maintenance and program improvement, as specified in the standards in Chapter 17, "Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions."

Standard 4.10 Healthy Start participants will receive an initial contact.

Criteria:

4.10.a Participants receive an initial contact or attempt at initial contact within five working days of the receipt of the screen or the referral to Healthy Start care coordination services. If the initial attempt to contact is not successful, an additional attempt to contact will be made within ten working days of the first attempt. The third attempt to contact will be made within ten working days of the second attempt.

4.10.b At a minimum, the initial contact includes all initial contact service delivery activities specified in this chapter (Chapter 4).

4.10.c Written notification of the status of the initial contact and plan for further services or closure are provided to the prenatal care provider or child's primary care provider within 30 calendar days of the first attempt to contact. If the child's primary care provider

is not known, document in the case file why written notification is not possible.

4.10.d If a referral has been made to Healthy Start due to risk of child maltreatment, written notification of the status of the initial contact and plan for further services or closure are provided to the referral source within 30 calendar days of the first attempt to contact.

Standard 4.11 All Healthy Start participants will be assigned a level based on their service needs.

Criteria:

4.11.a At the completion of an initial contact, a level of care defined as level E, level 1, level 2, or level 3 will be assigned to the participant. The participant who has not had a completed initial contact will be assigned a level pending (P) status. The level shall reflect the risk and severity of service needs. The greater the risk and service need, the higher the level assigned to the participant.

4.11.b Levels are assigned based on professional judgment using risk appropriate care principles. Levels are fluid and fluctuate based on changes in the participant's status. The initial level and changes in level must be supported by documentation.

Standard 4.12 All Healthy Start participants will have an Individualized Plan of Care.

Criteria:

4.12.a. 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.

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

Standard 4.13 A Healthy Start initial assessment will be provided to all participants determined as needing an assessment at the initial contact.

Criteria:

4.13.a A face to face initial assessment of service needs is completed or attempted within 10 working days after the date of the completed initial contact on every pregnant/interconception woman, infant, and child who are identified as needing an initial assessment.

4.13.b At a minimum, the initial assessment includes all service delivery activities specified in the initial assessment section of this chapter (Chapter 4).

4.13.c Each pregnant or interconception woman or infant/child who has been assessed to be in need of other Healthy Start and/or community services is referred to a qualified provider within five working days.

4.13.d Initial assessment evaluates risk factors, corresponding needs, resources, and potential for change.

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4.13.e A phone call or written note is provided to the prenatal care provider or infant's/child's primary care provider within 30 calendar days of the initial contact and the initial assessment regarding findings, request for collaboration, and outline for the disposition of the case.

Standard 4.14 Healthy Start ongoing care coordination services will be provided to all participants who are determined to need them.

Criteria:

4.14.a Ongoing care coordination services are provided according to risk appropriate criteria.

4.14.b Family support planning is done with all participants in need of high risk ongoing care coordination based on the criteria of the leveling system.

4.14.c Ongoing care coordination:

- 1) Addresses risk factors and their underlying situations,
- 2) Is based on identified needs and resources as outlined in the Individualized Plan of Care and the Family Support Plan if applicable, and
- 3) Includes all related service delivery activities specified in this chapter (Chapter 4).

4.14.d The care coordination provider addresses each risk factor identified as having potential for change through goal setting and plan development with the participant or family of the child. When the participant or family chooses not to address a risk factor, this will be documented in the participant's record.

4.14.e Notification of significant change (i.e. safety needs, mental health issues) in the participant's status or plan is provided to the prenatal care provider or infant's/child's primary care provider.

Standard 4.15 All Healthy Start participants assigned a level 3 will have a Family Support Plan.

Criteria:

4.15.a The family support plan will be required for level 3 participants and will be updated at least every three months. The initial family support plan will be facilitated through a face to face interaction with the participants (see narrative page 69).

4.15.b. The family support planning process may be utilized with all Healthy Start participants; however, this activity may only be coded in the HMS system for level 3 participants.

4.15.c. As noted in Chapter 12, a family support plan is required for all pregnant substance abusing pregnant women and substance exposed infants.

Standard 4.16 Participants may be closed to HS care coordination when determined to no longer need or desire care coordination services or are receiving care coordination services from another agency. Other HS services (breastfeeding, parenting, psychosocial counseling, smoking cessation, and interconception education) may continue to be provided to the HS participant who

no longer requires HS care coordination. Participants may be reopened to Healthy Start care coordination if their needs change.

Criteria:

4.16.a At a minimum, three attempted contacts are made before closing as “lost to contact” any participant who has scored positive (6 or greater for prenatal; 4 or greater for infant) on the Healthy Start screen or who has been referred for safety concerns and immediate needs as defined in Tier 1, Table 4.2a of this chapter. At least one of these attempts will be a face to face contact attempt on these participants. This criteria also applies to participants leveled 2 and 3 prior to closing as lost to follow-up after having had an initial contact and assessment completed.

4.16.b For participants with safety concerns and immediate needs as described in this chapter, every effort to locate the participant is made and documented, including letters, telephone calls, attempts to make face to face contact, and the following:

- 1) Contact with the participant’s health care provider to verify his/her address and telephone number;
- 2) Contact with Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) staff;
- 3) Contact with county health department (CHD) immunizations staff; and
- 4) Contact with FLORIDA Medicaid Management Information System (FMMIS) or MomCare as appropriate.

4.16.c Care coordination closure activities include:

- 1) Assessment of the need for referrals to other Healthy Start services, community services, primary care, family planning, interconception counseling, and assisting in accessing these services;
- 2) Notification of the prenatal or primary care provider of closure and collaboration in the event the provider recommends additional services;
- 3) Notification of referral source and/or Department of Children and Families when referral reason was risk of child maltreatment;
- 4) When appropriate, transition to another care coordination provider with release of information and record transfer;
- 5) Providing the participant with information regarding the ability to return as a program participant if necessary and the participant remains eligible; and
- 6) Documentation of IPC goals, birth and health outcomes, as appropriate.
- 7) Documentation of HMS Healthy Start Outcomes if the participant received services higher than initial contact and initial assessment services from the care coordinator.

Guidelines

Scope of Healthy Start Care Coordination:

Care coordination services are the foundation for the delivery of Healthy Start services. It is through care coordination that participants are contacted, assessed, provided with information, and referred for Healthy Start and other community services. Eligibility for Healthy Start care coordination begins when a pregnant woman or infant scores at-risk on the Healthy Start prenatal or infant risk screen, or a pregnant woman, interconception woman, or an infant/child is referred in by a health care provider, a community service provider, or through self-referral for reasons other than score.

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Healthy Start care coordination is based on the concept of risk appropriate care. 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
- 4) The resources of the Healthy Start care coordination provider and the community.

Care coordination plays an invaluable role, even for those participants who need care coordination only and no other Healthy Start services. By taking advantage of the "teachable moment"—that time when a family is most receptive and motivated to learn about and practice healthy behaviors—care coordination can provide the motivation, information, and encouragement many at-risk persons and families need to change the situations placing them at risk.

Throughout the delivery of care coordination services, providers of Healthy Start care coordination:

- Establish rapport and develop relationships with families (starting with initial contact)
- Identify, evaluate and assess, in collaboration with families, their strengths, resources, needs, and priorities
- Facilitate planning and problem solving with participants and families
- Address identified risks and needs
- Provide information, education, and encouragement needed to inform and/or motivate families to take steps necessary to change situations placing them at risk
- Promote self-sufficiency and healthy outcomes through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, enhancing parent-infant interaction, promoting continuation in health care, promoting health literacy, and managing behavior concerns
- Make maximum use of community resources through information and referral
- Monitor the plan of care to assure that the multiple concerns of families are addressed
- Collaborate with other providers to assure continuity and coordination of care; and
- Advocate on behalf of the participant, including communicating to the providers and the community the participant's strengths, needs, and feelings

The remainder of this chapter provides detailed information about care coordination and is organized as follows:

- I. Assuring risk appropriate care through Healthy Start care coordination
- II. Healthy Start care coordination process
- III. Care coordination provider qualifications
- IV. Healthy Start care coordination: documentation, service delivery data collection, and quality improvement/quality assurance

V. Frequently asked questions

I. Assuring Risk Appropriate Care Through Healthy Start Care Coordination

Healthy Start care coordination service delivery is based on the concept of risk appropriate care. Care coordinators evaluate the risk status of participants and determine whether services are required to help reduce the risk. Although some risk factors identified on the Healthy Start screen cannot be changed with interventions (e.g., age, race), these factors serve as markers for underlying situations that can be addressed.

The following risk factor matrix provides examples of situations that may be associated with the risk factors identified through Healthy Start prenatal and infant risk screening.

Table 4.1
RISK FACTOR MATRIX PRENATAL

<i>Risk Factor On Healthy Start Prenatal Screen</i>	<i>Possible Underlying Situations and Related Risks that Need Evaluation</i>	<i>Possible Interventions (Provided by qualified care coordinator or referred out to community provider)</i>
Age less than 18	<ul style="list-style-type: none"> • Lack of parenting skills • Fear of childbirth • < 12th grade education • Lack of financial stability • Lack of support systems (social/emotional/financial) • Lack of adequate nutrition • Possible domestic violence • Increased stress • Increased risk for child abuse/neglect issues • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Parenting education • Childbirth education • Educate on the importance of education/how to get GED • Identify support systems (social/emotional/financial) & offer support via care coordinator • Educate on proper eating habits, WIC program, and the importance of taking prenatal vitamins • Psychosocial counseling • Domestic Violence Education & how to obtain help • Stress management education • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Counseling on all available types of family planning methods • Linkages to family planning services
First pregnancy	<ul style="list-style-type: none"> • Lack of parenting skills • Fear of childbirth 	<ul style="list-style-type: none"> • Parenting education • Childbirth education

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	<ul style="list-style-type: none"> • Lack of adequate nutrition • Fear of the unknown • Lack of health insurance • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Anticipatory guidance on physical and emotional changes during pregnancy and postpartum • Nutrition education and counseling • Breastfeeding education and counseling • Educate on signs & symptoms of preterm labor • Linkages with social support • Counseling on all available types of family planning methods • Linkages to family planning services
Race	<p>(Note: Race black)</p> <ul style="list-style-type: none"> • More likely to experience poor birth outcomes • Late entry to prenatal care or no prenatal care • Increased stress • Lack of support systems (social/emotional/financial) • Poor nutrition • Lack of transportation 	<ul style="list-style-type: none"> • Educate on the importance of keeping prenatal appointments • Educate on the importance of following OB's advice & recommendations • Stress Management Education • Educate on proper eating habits, WIC program, and the importance of taking prenatal vitamins • Educate on transportation systems available/explore alternative transportation options • Identify support systems (social/emotional) & offer support via care coordinator • Educate on public assistance programs/application procedures • Educate on signs & symptoms of preterm labor • Counseling on all available types of family planning methods • Linkages to family planning services
Not married	<ul style="list-style-type: none"> • Lack of support systems (social/emotional/financial) • More likely to have low birth weight baby • Paternity issues • Increased stress 	<ul style="list-style-type: none"> • Identify support systems (social/emotional) & offer support via care coordinator • Pre-term labor education • Educate on establishing paternity/procedures • Educate on public assistance programs/application process • Stress Management Education • Counseling on all available types of family planning methods • Linkages to family planning services
Has not graduated from high school or received GED	<ul style="list-style-type: none"> • Unemployment issues • Increased stress from difficult or demanding working conditions 	<ul style="list-style-type: none"> • Educate on alternative education programs and how to enroll • Educate on job placement/skill agencies and how to access services

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	<ul style="list-style-type: none"> • Cultural/language barriers • Lack of financial support • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Educate on interpretation services available in the community • Educate on public assistance programs/application process • Counseling on all available types of family planning methods • Linkages to family planning services
Pre-pregnancy BMI less than 19.8 or greater than 35.0	<ul style="list-style-type: none"> • Poor birth outcomes • Lack of adequate nutrition • Household hunger • Lack of physical activity • Unhealthy food choices • Lack of knowledge regarding healthy food preparation • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Educate on proper eating habits, WIC program, and the importance of taking prenatal vitamins • Educate on healthy weight gain during pregnancy • Educate on fetus development and nutritional needs prior to birth • Educate on public assistance programs/application procedures • Educate on community resources for nutrition information and counseling • Breastfeeding education and counseling • Educate on signs & symptoms of preterm labor • Counseling on all available types of family planning methods • Linkages to family planning services
Children younger than 5 years old or children with special needs	<ul style="list-style-type: none"> • Lack of support systems (social/emotional/financial) • Increased stress • Lack of adequate housing • Increased risk for child abuse/neglect issues 	<ul style="list-style-type: none"> • Educate on public assistance programs/application procedures • Identify support systems (social/emotional) & offer support via care coordinator • Stress management education • Psychosocial counseling • Educate on subsidized housing programs and how to apply • Educate on community resources to assist with housing and special needs. • Referral to Children's Medical Services
Inability to keep appointments	<ul style="list-style-type: none"> • Lack of transportation • Domestic violence issues 	<ul style="list-style-type: none"> • Educate on transportation systems available/explore alternative transportation options • Provide OB calendar for client to track appointments • Educate on the importance of keeping prenatal appointments • Provide outreach for missed OB appointments and assist in rescheduling • Domestic violence education & how

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		<p>to obtain help</p> <ul style="list-style-type: none"> • Counseling on all available types of family planning methods • Linkages to family planning services
<p>Trouble paying bills</p>	<ul style="list-style-type: none"> • Lack of prenatal care • Lack of support systems (social/emotional/financial) • Increased stress • Domestic violence issues • Alcohol/substance abuse issues • Lack of adequate housing • Increased risk for child abuse/neglect issues 	<ul style="list-style-type: none"> • Educate on the importance of keeping prenatal appointments • Educate on the importance of following OB's advice & recommendations • Educate on public assistance programs/application procedures • Identify support systems (social/emotional) & offer support via care coordinator • Stress management education • Psychosocial counseling • Domestic violence education & how to obtain help • Alcohol/substance abuse education • Refer to community provider for substance abuse assessment & intervention • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Educate on subsidized housing programs and how to apply • Educate on community resources to assist with housing
<p>Felt down, depressed or hopeless; Received mental health services</p>	<ul style="list-style-type: none"> • Lack of prenatal care • Lack of support systems (social/emotional/financial) • Increased stress • Domestic violence issues • Alcohol/substance abuse issues • Lack of adequate housing • Increased risk for child abuse/neglect issues • Poor fetus development • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Educate on the importance of keeping prenatal appointments • Educate on the importance of following OB's advice & recommendations • Educate on public assistance programs/application procedures • Identify support systems (social/emotional) & offer support via care coordinator • Stress management education • Psychosocial counseling • Domestic violence education & how to obtain help • Alcohol/substance abuse education • Refer to community provider for substance abuse assessment & intervention • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry

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		<ul style="list-style-type: none"> • Educate on subsidized housing programs and how to apply • Educate on community resources to assist with housing • Counseling on all available types of family planning methods • Linkages to family planning services
Has someone you know tried to hurt you or threaten you	<ul style="list-style-type: none"> • Housing unsafe for human habitation • Homeless • High crime rate/victim of crime • Increased stress • Domestic violence issues • Increased risk for child abuse/neglect issues • Environmental issues 	<ul style="list-style-type: none"> • Educate on subsidized housing programs and how to apply • Educate on community resources to assist with housing • Domestic Violence Education & how to obtain help • Educate on household safety for family • Stress management education • Educate on environmental toxins/programs available in the CHD/community • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Psychosocial counseling • Counseling on all available types of family planning methods • Linkages to family planning services
Birth interval less than 18 months	<ul style="list-style-type: none"> • Unplanned/unwanted pregnancy • Domestic violence issues • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Counseling on all available types of family planning methods • Linkage to family planning services • Domestic violence education & how to obtain help • Education on proper way to take oral contraceptives and information on interactions that may decrease the effectiveness of the pill.
Tobacco use a day	<ul style="list-style-type: none"> • Substantial increased risk for IUGR • Possible association with spontaneous abortion • Poor pregnancy weight gain • Higher SIDS incidence • Infant respiratory problems • Second hand smoke • Increased stress • Lack of motivation to quit • Increased risk of depression 	<ul style="list-style-type: none"> • Educate on smoking & IUGR • Provide smoking cessation counseling • Second hand smoke education • Educate on the need for a smoke free environment for infant and family • SIDS education • Stress management education • Provide cessation resources • Provide positive feedback for decreasing daily intake or quitting • Assess for depression
Before you got pregnant, did you want to?	<ul style="list-style-type: none"> • Late entry to prenatal care • Unplanned/unwanted pregnancy 	<ul style="list-style-type: none"> • Provide prenatal provider choice counseling • Educate on the importance of

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	<ul style="list-style-type: none"> • Access to health care • Attachment issues • Denial issues • Increased risk for child abuse/neglect issues • Behaviors inconsistent with positive birth outcome • Increased stress • Increased risk of depression • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • keeping prenatal appointments • Educate on the importance of early prenatal care • Educate on the importance of following OB's advice & recommendations • Educate on available health care services • Educate on parent child relationship/bonding issues • Shaken Baby Syndrome education • Coping with crying education • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Monitor adverse behavior patterns • Stress management education • Assess for depression • Counseling on all available types of family planning methods • Linkages to family planning services
Tobacco/alcohol use	<ul style="list-style-type: none"> • Alcohol/substance abuse effects on fetus • Fetal development issues • Increased risk for child abuse/neglect issues • Domestic violence issues • Possible legal issues • Possible developmental delays of child • Lack of adequate nutrition • Increased exposure to STDs • More likely to be depressed 	<ul style="list-style-type: none"> • Alcohol/substance abuse education • Refer to community provider for substance abuse assessment & intervention • Educate on the effects of alcohol/drug usage on unborn fetus • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Educate on proper eating habits, WIC program, and the importance of taking prenatal vitamins • Educate on STDs & pregnancy • Complete developmental assessment on infant and refer as needed • Shaken Baby Syndrome education • Coping with crying education • Psychosocial counseling • Domestic violence education & how to obtain help
Previous poor birth outcomes	<ul style="list-style-type: none"> • Hereditary risks • Increased risk for additional poor birth outcome • Loss/grief issues • Lack of access to adequate health care • Lack of preconception knowledge 	<ul style="list-style-type: none"> • Interconception care education • Grief counseling or refer to community agency (i.e. Hospice) • Educate on community health care resources/providers • Educate on the importance of keeping prenatal appointments • Educate on the importance of early

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	<ul style="list-style-type: none"> • Lack of knowledge regarding family planning methods and services 	<p>prenatal care</p> <ul style="list-style-type: none"> • Educate on the importance of following OB's advice & recommendations. • Educate on available hereditary risk indicator tests available (i.e. Triple Screen, Sickle Cell, Cystic Fibrosis, Genetic Amniocentesis, Chorionic Villus Sampling) • Counseling on all available types of family planning methods • Linkages to family planning services
Ongoing medical condition	<ul style="list-style-type: none"> • Increased chance of poor birth outcome • Need for specialized prenatal care • Late entry in prenatal care • Increased risk of maternal/fetal morbidity • Lack of access to adequate health care • Lack of chronic disease knowledge • Lack of STD education • More likely to be depressed • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Educate on the importance of keeping prenatal appointments • Educate on the importance of early prenatal care • Educate on the importance of following OB's advice & recommendations. • Chronic disease education • Preterm labor education • Educate on community health care resources/providers • Educate on STDs & pregnancy • Assess for depression • Counseling on all available types of family planning methods • Linkages to family planning services
2 nd Trimester entry into care	<ul style="list-style-type: none"> • Increases risk of poor birth outcome • Possible poor infant health outcomes • Alcohol/substance abuse issues • Domestic violence issues • Lack of adequate health care • Lack of insurance/Medicaid • Lack of transportation • Lack of knowledge regarding signs and symptoms of pregnancy 	<ul style="list-style-type: none"> • Educate on the importance of early prenatal care • Educate on the importance of following OB's advice & recommendations. • Alcohol/substance abuse education • Refer to community provider for substance abuse assessment & intervention • Educate on the effects of alcohol/drug usage on unborn fetus • Educate on community health care resources/providers • Educate on transportation systems available/explore alternative transportation options • Domestic violence education & how to obtain help • Counseling on all available types of family planning methods • Linkages to family planning services

RISK FACTOR MATRIX INFANT

<i>Risk Factor On Healthy Start Prenatal Screen</i>	<i>Possible Underlying Situations and Related Risks that Need Evaluation</i>	<i>Possible Interventions (Provided by qualified care coordinator or referred out to community provider)</i>
Maternal age less than 18 or unknown	<ul style="list-style-type: none"> • Lack of parenting skills • < 12th grade education • Lack of financial stability • Lack of support systems (social/emotional/financial) • Possible domestic violence issues • Increased risk for child abuse/neglect issues • Lack of family planning/birth control knowledge • Increased stress • Lack of transportation • Domestic violence issues • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Parenting education • Educate on the importance of education/how to get GED • Identify support systems (social/emotional/financial) & offer support via care coordinator • Educate on nutritional eating habits for infant and mother, WIC program • Psychosocial counseling • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Shaken Baby Syndrome education • Coping with crying education • SIDS education • Interconception care education • Childcare services education • Stress management education • Educate on transportation systems available/explore alternative transportation options • Domestic violence education & how to obtain help • Counseling on all available types of family planning methods • Linkages to family planning services
Maternal race is unknown, other than white, or multiple races selected	<ul style="list-style-type: none"> • More likely to experience poor birth outcomes • Increased stress • Lack of support systems (social/emotional/financial) • Poor nutrition • Lack of transportation • Higher SIDS incidence • Lack of adequate health care or access to health care • Lack of infant nutrition education 	<ul style="list-style-type: none"> • Educate on the importance of choosing doctor for infant • Educate on the importance of keeping well child check up appointments • Educate on the importance of following infant's doctor's advice & recommendations • Stress management education • Education on infant nutritional needs, feedings, and the WIC program • Educate on transportation systems

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		<p>available/explore alternative transportation options</p> <ul style="list-style-type: none"> Identify support systems (social/emotional) & offer support via care coordinator Educate on community health care resources/providers
Mother is over 18 with less than high school education or unknown	<ul style="list-style-type: none"> Unemployment issues Increased stress from difficult or demanding working conditions Cultural/language barriers Lack of financial support Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> Educate on alternative education programs and how to enroll Educate on job placement/skill agencies and how to access services Educate on interpretation services available in the community Educate on public assistance programs/application process Counseling on all available types of family planning methods Linkages to family planning services
Unmarried mother	<ul style="list-style-type: none"> Lack of support systems (social/emotional/financial) More likely to have low birth weight baby Paternity/child support Issues Increased stress Lack of financial support Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> Identify support systems (social/emotional) & offer support via care coordinator Educate on establishing paternity/procedures Educate on public assistance programs/application process Stress management education Coping with crying education Counseling on all available types of family planning methods Linkages to family planning services
The number of prenatal visits is zero, one, or unknown	<ul style="list-style-type: none"> Lack of education about the importance of medical care Lack of or access to adequate health care Transportation issues Alcohol/substance abuse issues Lack of family planning information Domestic violence issues 	<ul style="list-style-type: none"> Educate on community health care resources/providers Educate on the importance of regular health care for mom and infant Educate on transportation systems available/explore alternative transportation options Alcohol/Substance abuse education Refer to community provider for substance abuse assessment & intervention Interconception care education Domestic violence education & how to obtain help
Infant birth weight <4 lbs. 7ozs. (2000 grams)	<ul style="list-style-type: none"> Increased risk for developmental delays Increased risk of infant morbidity/mortality Increased stress Increased risk of child 	<ul style="list-style-type: none"> Complete developmental assessment on infant (2 months for Ages & Stages) and refer as needed SIDS/Shaken Baby Syndrome education Coping with crying education

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	<p>abuse/neglect issues</p> <ul style="list-style-type: none"> • Increased risk of domestic violence issues • Lack of support system • Lack of proper nutrition for infant • Immunization compliance issues • More likely to be depressed • Higher risk for SIDS • Increased risk of depression 	<ul style="list-style-type: none"> • Stress management education • Educate on parent child relationship/bonding issues • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Domestic violence education & how to obtain help • Identify support systems (social/emotional) & offer support via care coordinator • Breastfeeding education and support • Educate on the importance of all immunizations and monitor compliance • Assess for depression
Maternal tobacco use more than 9 cigarettes per day or unknown amount	<ul style="list-style-type: none"> • Increased risk for SIDS • Infant respiratory problems • Second hand smoke issues • Increased stress • Lack of motivation to quit • More likely to be depressed 	<ul style="list-style-type: none"> • Provide smoking cessation counseling • Second hand smoke education • Educate on the need for a smoke free environment for infant and family • SIDS education • Stress management education • Provide cessation resources • Assess for depression • Provide positive feedback for decreasing daily intake or quitting
Maternal alcohol use or maternal alcohol use is unknown	<ul style="list-style-type: none"> • Increased risk for Fetal Alcohol Syndrome (FAS) • Increased risk for child abuse/neglect issues • Increased risk of domestic violence issues • Increased risk for developmental delays • Possible attachment issues • Increased risk of SIDS • Increased risk for low birth weight • Alcohol/substance abuse issues • More likely to be depressed 	<ul style="list-style-type: none"> • Educate on parent child relationship/bonding issues • Shaken Baby Syndrome education • Coping with crying education • Educate on the effects of alcohol on the infant and mothers capacity to care for her infant • SIDS education • Monitor developmental growth and assess as needed • Alcohol/Substance abuse education • Refer to community provider for alcohol/substance abuse assessment & intervention • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Domestic violence education & how to obtain help
Newborn with abnormal conditions: hyaline membrane disease / respiratory distress	<ul style="list-style-type: none"> • Increased risk for child abuse/neglect issues • Increased risk of domestic violence issues 	<ul style="list-style-type: none"> • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Domestic violence education & how to

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<p>syndrome (RDS), assisted ventilation for 30 minutes or more, or assisted ventilation for 6 hours or more</p>	<ul style="list-style-type: none"> • Psychosocial issues for the family • Increased risk of developmental delays • Increased need for specialized medical care • Increased risk of infant mortality • Increased stress • Immunization compliance issues • Lack of knowledge regarding family planning methods and services 	<p>obtain help</p> <ul style="list-style-type: none"> • Psychosocial counseling • Complete developmental assessment on infant (2 months for Ages & Stages) and refer as needed • Educate on specialized medical providers and refer to necessary medical case management services (Children's Medical Services) • SIDS/Shaken Baby Syndrome education • Coping with crying education • Stress management education • Educate on the importance of keeping well child check up appointments • Educate on the importance of following infant's doctor's advice & recommendations. • Educate on the importance of all immunizations and monitor compliance • Counseling on all available types of family planning methods • Linkages to family planning services
<p>Infant with one or more congenital anomalies</p>	<ul style="list-style-type: none"> • Increased risk for child abuse/neglect issues • Increased risk of domestic violence issues • Psychosocial issues for the family • Increased risk of developmental delays • Increased need for specialized medical care • Increased risk of infant mortality • Increased stress • Immunization compliance issues • Lack of knowledge regarding family planning methods and services 	<ul style="list-style-type: none"> • Monitor abuse/neglect incidents and report any suspected abuse or neglect to the Abuse Registry • Domestic violence education & how to obtain help • Psychosocial counseling • Complete developmental assessment on infant (2 months for Ages & Stages) and refer as needed • Educate on specialized medical providers and refer to necessary medical case management services (Children's Medical Services) • SIDS/Shaken Baby Syndrome education • Stress management education • Educate on the importance of keeping well child check up appointments • Educate on the importance of following infant's doctor's advice & recommendations. • Educate on the importance of all immunizations and monitor compliance • Counseling on all available types of

		family planning methods • Linkages to family planning services
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A. Determining Who Needs Healthy Start Care Coordination Services and Other Healthy Start Services:

It is through the care coordination process that the care coordination provider builds on and evaluates the strengths and assets of the participant and family to determine if these offset the risk the participant experiences. The care coordinator and family will then mobilize interventions to address the risk, as necessary. Because Healthy Start resources are limited, it is up to the care coordination provider to determine during the initial contact and/or assessment which services would be most beneficial for the participant's needs. Consequently, when determining who will receive care coordination services and the intensity of those services, the care coordination provider must **prioritize** services based on awareness of the participant's or family's safety concerns and immediate needs as listed in but not limited to the following tables.

All referred participants who are identified in Tier 1 Table 4.2a must have a minimum of at least 3 attempts to contact. At least one of the attempts must be a face to face attempt.
 (Refer to Decision Matrix.)

Tier 1 Table 4.2a

<p>Safety Concerns and Immediate Needs Requiring Priority Care Coordination Services (ie minimum 3 attempts to contact with at least one being a face to face visit)</p> <p>Knowledge or suspicion of current:</p> <ul style="list-style-type: none"> • 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 • Inadequate growth and development (e.g. small for gestational age) • Safety concerns noted by the health care provider on the Healthy Start screening form
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- Language barriers
- Other, using professional judgment

All referred participants who are identified in Tier 2 Table 4.2b must have a minimum of at least 3 attempts to contact. The attempts to contact may be made by letter and/or phone. Phone attempts must be made on different times and days.

Tier 2 Table 4.2b

Concerns and Needs that require a minimum of 3 attempts to contact (ie phone and/or letter).

Knowledge or suspicion of:

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

In addition to identifying participants with safety concerns or immediate needs, care coordination providers must also determine which participants are most in need of other Healthy Start services. Participants most in need are identified by determining whether their assets (e.g., strengths and resources) are adequate to offset their risk factors. When the assets available to the family are adequate to offset the risk identified without Healthy Start intervention, Healthy Start services are not required.

Assets to Offset Needs Exceed Risk → No Healthy Start Services Needed:

When the assets available to the individual or family do not offset those risks, Healthy Start services are required.

Risk Exceeds Assets → Healthy Start Services Needed:

The figure below illustrates this risk appropriate concept. In this chart, only the population falling into the blackened square—that is the population whose actual risk outweighs the availability of personal assets to counter the risk—would need to be targeted for Healthy Start services.

		Individual Has Risk	
		YES	NO
Individual Has Assets to Offset Risk	NO		
	YES		

Need Healthy Start Services
 No need for Healthy Start Services

Additionally, the following principles should be considered when providing Healthy Start care coordination.

GUIDING PRINCIPLES FOR ASSURING RISK APPROPRIATE CARE COORDINATION
<p><i>Providers of Healthy Start care coordination should:</i></p> <ul style="list-style-type: none"> • Remain objective and be aware of their own biases and prejudices • Establish, in a family-centered way, long- and short-term goals with Healthy Start participants • Be willing to and know how and when to refer a participant • Be prepared to report child abuse or neglect when suspected, as required by law and/or Healthy Start services contract • Accept the participant's and family's choices in a non-judgmental manner • Celebrate small successes with the participant, family, and other providers • Strive to establish trust and credibility with families and participants • Always reinforce the positive when providing care coordination • Be up-to-date and aware of the available community resources • Actively engage and motivate families • Deliver care coordination in partnership with the family • Gear intervention toward reducing risk and movement from chronic dependence on the "system" to self-sufficiency • Pace intervention and be aware of the family's readiness to learn, to change, or to attend to what is offered • Understand and gear interventions accordingly for crisis vs. chronic issues for the family • Strive to support "the positive side of ambivalence" in Healthy Start participants (e.g. if the participant is not sure if she wants to quit smoking, try to see this as a positive factor, because it means she is thinking about it - use this as an opportunity to promote all the benefits of quitting and the available resources to help her). • Build upon and praise strengths demonstrated and identified by the participant and family • Find the focal point that has meaning from the participant's perspective and relate consequences to it; it might not be a health-related outcome, but you can relate health to it (e.g. maybe a participant's top priority is obtaining a car – if there is a community program that provides donated cars to families in need, she should be referred to it – while obtaining a car is not <i>directly</i> a health-related outcome, perhaps having a car will enable her to attend her prenatal care appointments more reliably)

B. Strategies for Managing Healthy Start Care Coordination Workload:

Care coordination providers use triage, prioritization, Individualized Plans of Care, and leveling systems to assure that those who receive services obtain the services needed, and to manage workload in a risk appropriate manner. Intensity and type of service delivery may vary, from letter only, to phone follow-up only, to face to face contact or visits in the participant's home or another preferred site. Participants with safety concerns and immediate needs require more direct methods of contact and will require a face to face initial assessment, family support plan, and ongoing care coordination in addition to individualized plans of care.

Throughout the care coordination process, care coordinators adjust services to address the risks, needs, and priorities of participants. At any point, care coordination services may be discontinued if the care coordinator and participant agree care coordination services are no longer required, or if the participant, or family of child, declines services. (See Chapter 12 for guidelines for terminating services to families involved with substance abuse; see Chapter 4, page 79 for guidelines for terminating services to families involved with child abuse or neglect.)

Triage/Prioritization of Caseloads

Once the Healthy Start participant is involved with a provider, the provider will use his/her professional judgment and assessment skills to determine, in collaboration with the participant/family, the level of care coordination needed based on evaluation of service needs. This is done through triage (setting priorities in service delivery).

Triage is a decision-making method whereby priorities in service delivery are determined. Triage enhances the ability of the care coordination provider to provide risk appropriate care by enabling providers to focus their resources on those participants most in need.

After taking into consideration safety concerns, immediate needs, and the strengths and assets participants bring to the relationship, decisions related to which services to provide and how intensely to follow participants are based on professional judgment, with consideration of the following:

- Participant's motivation to address the risk and/or need
- Severity of the risk and need
- Care coordination provider's ability to provide services that link to the participant's risk and are likely to have a positive impact on outcomes, and
- Participant's ability to access other community resources available to offset the risk/need.

The care coordination provider uses these considerations to help set priorities in service delivery. Following is a list of considerations for prioritizing Healthy Start workloads.

Considerations When Prioritizing Workload:

- The purpose of Healthy Start service-need evaluation, face to face assessment, and intervention is to appropriately address participants' identified risks in conjunction

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with the assets and strengths they bring with them.

- Healthy Start is but one provider available to provide care coordination and other Healthy Start services.
- Many times, linking families with other community agencies is adequate and appropriate intervention.
- Discussing risk status, providing information and referral on service options, and throwing out a lifeline in the form of how families can contact you may be adequate and appropriate Healthy Start service.
- A screen is only a screen; it does not always correlate to risk, and it is not a diagnostic tool. A screen looks at the general population and narrows the total to a group that is statistically in need of further evaluation.
- If an explicit system of prioritizing is not in place, it may result in using a first-in/first-out system that does not allow targeting of services to those most in need of intervention. Implementing services without using risk appropriate care principles may result in the exhaustion of human and financial resources.
- Situations change, and reopening families to Healthy Start, closing to care coordination, or changing the level of intervention at any time is expected and appropriate if the families' circumstances and service needs warrant that change.
- Research has demonstrated that increased intensity and duration of intervention is directly related to improved outcomes, especially for those families with the highest identified levels of risk and the least availability of strengths/assets to offset the risk.
- Families may live in ways in which the care coordinator may not want to live or may not want them to live, but the job of the Healthy Start care coordinator is to use his or her judgment to determine whether the situation poses a serious threat to the safety and well-being of the family or child.

Levels of Care Coordination

High priority situations, where both risk and need are high and there are safety concerns, typically require greater investment of staff time to address need. Conversely, situations that do not involve safety concerns or immediate needs typically do not require as much staff involvement. In prioritizing service delivery, many providers find it helpful to assign participants to levels of care that correspond to service needs and the amount of staff involvement required to reduce the participant's risk.

A leveling system is essential to help care coordination providers manage Healthy Start workloads. Each level has certain characteristics or principles that guide the provider to effectively and optimally address the participant's needs as well as balance staffing caseloads. The leveling system has the following core characteristics and principles:

- Levels are fluid; they are **not** static. A participant is designated a level during the initial contact; however, a participant or family's level can change as their risk and

service needs change.

- An effective leveling system reflects the intensity of staff involvement. Therefore, the higher the level of care to which a participant is assigned, the more the care coordinator is involved with that participant.
- An effective leveling system reflects the severity of risk and Healthy Start service needs, so that the greater the risk and need, the higher the level of care to which the participant is assigned.
- Participants at each level, E, 1, 2, and 3, are required to have a certain number of direct services. A direct service encounter is direct contact with a participant or the participant's provider via the telephone or face to face.
- A direct service encounter is unduplicated by date of service. For example, if care coordination and several enhanced services are completed during one home visit, this is still considered as just one direct service encounter.
- The number of direct service encounters that a Healthy Start participant should have while enrolled in Healthy Start care coordination must correlate with the level and risk/need of that participant at any given time. **At a minimum**, encounters must occur at the frequency stated on the Healthy Start Leveling matrix.
- Levels are based on:
 - ✓ Professional judgment through systematic assessment of risk factors and determination of the type and amount of intervention required to offset the risk situation
 - ✓ The availability of participant's/family's assets and strengths to offset the risk situation
 - ✓ The participant's Healthy Start service needs and amount of care coordinator involvement. Levels are not based solely on a participant's characteristics. For example, a pregnant teenager who is receiving extensive services from other agencies and has a strong family support system would not automatically be assigned to a level 3 because she is a pregnant teenager.

Perhaps the greatest challenge facing providers of Healthy Start services and Healthy Start coalitions alike is determining who can benefit most from Healthy Start services and how to best deliver services to maximize healthy birth, health, and developmental outcomes. Considerations when determining how to best reduce risks of communities, as well as individuals, include:

- Demonstrated efficacy of Healthy Start services
- Coalition-identified target populations and desired population-based outcome objectives
- Collaboration with and/or transition to other community resources (postpartum home visitors, teen pregnancy programs, substance abuse treatment providers, Florida First Start, Healthy Families Florida, etc.)
- Professional judgment assisted by systematic assessment and interventions focusing on reducing risks

HEALTHY START STATEWIDE LEVELING SYSTEM

Level	Definition	Minimum frequency of direct services encounters	Services
P Pending	+Participants without a completed initial contact.	N/A	<ul style="list-style-type: none"> Attempt to contact, unable to complete initial contact, or unable to locate
E Education and referral	+ Participants require only the service components of an initial contact and closure.	One encounter for the duration of participation	<ul style="list-style-type: none"> Initial contact (IC) complete with referrals, if needed, to other Healthy Start services or community agencies and case closure. +This participant may have an initial assessment provided at the same time as the IC, Individualized Plan of Care Case closure
1 Low need	+ Participants require short term follow-up on the ability to successfully access services. +Participants do not stay in this level longer than 4 months before a determination is made to close to HS services or re-level to a higher level if services continue to be necessary. +Education, counseling, and referrals to community resources are given as needed.	1 minimum encounter per 60 calendar days	<ul style="list-style-type: none"> Initial contact or Initial contact & initial assessment (as determined by outcome of IC.) Care coordination not face to face as needed Care coordination face to face as needed Individualized Plan of Care Other Healthy Start services as needed Case closure or re-leveled within 4 months of IC Family Support Plan (optional and should not be coded at this level. Time spent should be coded as care coordination.)
2 Medium need	+Participants typically do not function independently, and do not have adequate knowledge about community services or may have additional barriers accessing, participating in, or coordinating services for themselves or their child. +Education, counseling, and referrals to community resources are given as needed.	1 minimum encounter per 30 calendar days	<ul style="list-style-type: none"> Initial contact or Initial contact & initial assessment (as determined by outcome of IC.) Care coordination not face to face as needed Care coordination face to face as needed Individualized Plan of Care Other Healthy Start services as needed Family Support Plan (optional and should not be coded at this level. Time spent should be coded as care coordination)
3 Intensive need	+ Participants / families are experiencing multiple concerns and need frequent service coordination. Safety concerns and crisis intervention are often characteristics of participants in this level. +Education, counseling, and referrals to community resources are given as needed	2 minimum encounters per 30 calendar days	<ul style="list-style-type: none"> Initial contact or Initial contact & initial assessment (as determined by outcome of IC.) Large percentage of care coordination is provided face to face Care coordination not face to face as needed Individualized Plan of Care Family Support Plan (be sure to code FSP correctly. It is required at this level). Other Healthy Start services as needed

Risk Appropriate Factors to be Considered When Referring for Other Healthy Start Services:

All pregnant women, interconception women, infants/young children, and their families can benefit from Healthy Start funded services (e.g., breastfeeding education and support, parenting education and support, childbirth education and support, psychosocial counseling, tobacco cessation education and counseling, nutrition counseling). Unfortunately, because funds are limited, these services can not be provided to all. Consequently, care coordinators must provide referrals to Healthy Start funded services selectively, while referrals to other community resources may be made at any time.

In determining who should be referred for Healthy Start funded services, care coordinators must consider:

- Who is at greatest risk for poor outcomes,
- How effective the service is in addressing the risk, and
- Whether the participant or family is able to obtain the service through another service delivery system.

Note: Care coordinators should refer for other Healthy Start services those pregnant women or families of infants/children who have positive scores on the Healthy Start risk screens or those pregnant or interconception women or infants/children who have been referred to Healthy Start for reasons other than score and are determined to be at high risk for poor outcomes.

The following table provides examples of participants who will most benefit from referral for other Healthy Start funded services. (These services are described in Chapters 5 – 10.)

Table 4.3

Healthy Start Service	Participants Most Likely to Benefit from Service
Breastfeeding Education	Pregnant, interconception, and/or postpartum women who are determined to be at high risk for poor birth outcomes or whose children are at risk of poor health or developmental outcomes, including: <ul style="list-style-type: none"> • Teenagers • First time mothers • Mothers of multiple births • Women whose pregnancies were unplanned (for bonding) • Other participants at risk for parenting challenges (except drug abusing and HIV+ participants) • Premature or sick babies • Mothers with past history of child abuse or neglect Note: Drug abusing and/or HIV+ participants should be educated on the risks of breastfeeding.
Childbirth Education and Support	Pregnant women who are determined to be at high risk for poor birth outcomes or whose children are at risk of poor health or developmental outcomes, including: <ul style="list-style-type: none"> • First time pregnant women who are also at high risk for poor outcomes

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	<ul style="list-style-type: none"> • Teenagers • Women who verbalize fear of childbirth and are also at high risk for poor outcomes • Women who were sexually abused • Women who are mentally challenged
<p>Nutrition Counseling</p>	<ul style="list-style-type: none"> • Pregnant women, interconception women, or infants/children with metabolic disorders such as diabetes, gestational diabetes, maternal or child Phenylketonuria (PKU), or other inborn errors of metabolism, and thyroid dysfunction • Pregnant women, interconception women, or infants/children with chronic medical conditions such as cancer, heart disease, hypertension, sickle cell anemia, cystic fibrosis, gastrointestinal disorders, epilepsy, cerebral palsy, neural tube defects (NTD), liver and renal disease, and lead poisoning • Pregnant women, interconception women, or infants/children with chronic or prolonged infections that have a nutrition treatment component such as HIV/AIDS, hepatitis, or tuberculosis • Pregnant women, interconception women, or infants/children with developmental disabilities • Pregnant women, interconception women, or infants/children with increased nutritional needs due to major surgery, trauma, or burns requiring a hospital stay • Pregnant women with conditions that impact the length of gestation or birth weight where nutrition is the underlying cause, such as underweight preconceptionally ($\leq 90\%$ of ideal body weight [IBW] or Body Mass Index [BMI] < 19.8) complicated by inadequate weight gain during pregnancy, severe anemia (Hgb < 10 gm/dl; Hct $< 30\%$), and intrauterine growth retardation • Pregnant women who are overweight (prepregnancy weight $> 120\%$ IBW or BMI ≥ 26.1) or obese (prepregnancy weight $> 135\%$ IBW or BMI > 29.0) • Pregnant women with multiple gestation • Pregnant and interconception women with eating disorders such as severe pica, anorexia nervosa and bulimia • Pregnant and interconception women with extensive dental problems such as severe tooth decay or gum disease • Pregnant and interconception women on vegan diets • Pregnant and interconception women who are homeless, depressed, or abusing drugs or alcohol • Pregnant and interconception teens (age < 16 years at last menstrual period) • Infants with conditions that impact the growth and development of children in which nutrition is the underlying cause, such as failure to thrive, prematurity greater than 4 weeks, low birth weight, or severe growth retardation • Infants/Children with cleft lip and palate • Substance exposed infants • Infants/Children below the 5th percentile weight for length

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<p>Tobacco Cessation Education and Counseling</p>	<ul style="list-style-type: none"> • Pregnant, interconception and/or postpartum women and or families of children who are determined to be at high risk for poor birth outcomes or whose children are at risk of poor health or developmental outcomes, or tobacco using members of their households who have been assessed as ready to change their tobacco using behavior modification
<p>Parenting Education and Support</p>	<ul style="list-style-type: none"> • Victims of child abuse or sexual abuse or dysfunctional parenting • Families with history of child abuse and neglect • Families with history of domestic violence • Highly stressed or chaotic families (multiple children, unemployment, disadvantaged, etc.) • Individuals lacking appropriate role models for parenting • Individuals inexperienced in parenting and lacking in in-home support systems • Parents who lack maturity • Families living in unsafe environments • Substance abusing families • Individual with violent tempers or lack of impulse control • Parents expressing fear/insecurity of parenting
<p>Psychosocial Counseling</p>	<ul style="list-style-type: none"> • Participants living with substance abuse • Families with family or partner violence • Pregnant women and interconception women with depression • Participants with a history of childhood physical, sexual, or emotional abuse • Families with high stress • Families with inadequate coping skills • Women with premature or unwanted pregnancy • Interconception women dealing with loss • Families with issues related to parental roles and responsibilities • Families experiencing difficulties accessing essential services • Depressed partner or spouse • Participants with relationship problems with a partner or spouse or other family • Participants in highly stressful situations with poor coping skills <p>Note: Healthy Start services are not designed to be long term psychotherapy services. Participants presenting issues beyond the scope of the program or the provider's training and experience should be referred to either a licensed professional with more extensive training, a professional with expertise in a particular area such as domestic violence, OR a mental health agency that can provide long term treatment.</p>
<p>Interconception Health Educational Counseling</p>	<ul style="list-style-type: none"> • All participants who are determined through the care coordination process to need this service • Any eligible woman of reproductive age to help improve the birth outcome of a potential pregnancy

II. Healthy Start Care Coordination Process

A. Initial Contact:

Introduction:

Initial contact after screening is the point-of-entry into Healthy Start care coordination. Women and families of children up to age 3 identified as at risk for undesirable outcomes through screening or referral are required by the Healthy Start legislation to receive notification of their risk status and services available to them.

The Healthy Start care coordination provider receives a copy of all Healthy Start screens within five working days of the receipt of the screen by the county health department. An initial contact is made, risks are addressed, and assets available to the participant to offset the risks are discussed. Triage (prioritizing) based on the severity of risk begins at initial contact; a written Individualized Plan of Care (IPC) is completed that indicates whether the participant needs further intervention or simply needs information about community resources and the name of a Healthy Start contact in the event circumstances change. In this way, initial contact provides an opportunity for the Healthy Start care coordinator to make preliminary decisions related to prioritizing service delivery. An IPC is a written plan of identified needs, goals, interventions, and progress towards meeting the goal(s) based on the care coordinator evaluation of the participants' risks and needs. While the IPC may be documented by various methods, the documentation should clearly identify the IPC.

Service Delivery Activities of Initial Contact:

1. Explain to the participant or family the meaning of a positive Healthy Start risk screen or why the referral was made. It is important to stress to the participant or family that a positive risk screen means the woman or child MAY experience more problems during pregnancy or infancy.
2. Determine the participant's ability to access comprehensive prenatal and child health care services. Comprehensive prenatal and child health care includes those maternal and child health care services that are provided in the community to enable pregnant women to maintain good health and have positive birth outcomes and their children to experience optimal growth and development. Comprehensive prenatal and child health care should be available to all women and children through their routine prenatal or preventive child health care and includes:
 - Eligibility determination for financial assistance including PEPW, Medicaid and Title XXI;
 - Prenatal, postpartum, and family planning care;
 - Periodic health and developmental screening, diagnosis, and treatment in accordance with professionally recognized periodicity schedule for the child;
 - Routine laboratory testing;
 - Appropriate immunizations;
 - Basic nutrition services including the Special Supplemental Nutrition Program

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- for Women, Infants, and Children (WIC);
- Basic health promotion, counseling, and education;
- Acute care; and
- Referral to developmental, social, and economic services.

Note: If the participant is unable to access comprehensive prenatal and child health care services, further involvement with the family is warranted. Referral will be made for eligibility determination and/or the needed service and, at a minimum, one follow-up contact after referral is required to determine that the participant has been able to access the needed services.

3. Evaluate the participant's service needs by determining the participant's or family's assets, strengths, and resources to reduce risk status using risk appropriate care principles. During the initial contact and after each subsequent contact an Individualized Plan of Care (IPC) shall be completed or updated. An IPC is a written plan of identified needs, goals, interventions, and progress towards meeting the goals based on an evaluation of the Healthy Start participant's risks and needs. An IPC functions as a communication tool for everyone involved in participant care. Articulating the plan of care in writing and making it clear to all those involved in the provision of care promotes continuity and consistency of service. An IPC at initial contact will contain documentation of all the service delivery activities designated during the initial contact period. For example, the IPC will contain the care coordinator's determination as to whether a face- to- face assessment is needed based on evaluation of service needs. If the participant has one of the above-mentioned safety concerns or immediate needs, a priority assessment will be made or it will be documented in the care coordination record why this priority assessment was not provided (e.g., the participant is already involved in a comprehensive system of care that is addressing the risk).
4. Provide information about how the risk factors can be addressed and what types of services may be available in the community and through Healthy Start to improve the chances of a healthy outcome.
5. Provide referrals to community resources. For many participants, adequate intervention is provided by giving information about community resources or making referrals to community services.
6. Provide a name and phone number of a contact person at the agency providing Healthy Start care coordination who can be contacted for assistance if the participant or family is unable to access needed prenatal, intrapartum, postpartum, family planning, pediatric or family support services.
7. Initiate the participant's Healthy Start care coordination record;
8. Initiate an Individualized Plan of Care;
9. Assign a level of care based on the Healthy Start leveling system criteria.
10. Provide follow-up to the prenatal health care provider, the child's primary care provider, or the referral source within 30 calendar days of the 1st attempt to

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contact. This contact is to inform the provider of the results of the initial contact and the name and phone number of a contact at the agency providing the initial contact. In the event the screen was not provided by the prenatal care provider or the child's primary care provider, with appropriate release of information, a copy of the risk-screening instrument should also be forwarded to that provider.

Time Frames of Initial Contact:

The Healthy Start care coordination provider will contact or attempt to contact, within five working days of the receipt of the screen or referral, all pregnant women, interconception women, and families of newborns/children who have been referred to the program and agree to program contact.

Method of Contact:

Contact attempts may be face to face, by phone or by mail. An initial contact may be completed face to face or by phone. The chosen method(s) will depend on the participant's level of risk and need for prompt care coordination services.

First attempt to contact must be within 5 working days of the receipt of the referral by the care coordinator. A second attempt to contact must be made within 10 working days of the first attempt and may be made by letter, by phone, or face to face, depending on the severity of risk. (For example, a second contact attempt for a participant who is a substance abuse risk would best be made by a home visit or phone call rather than by letter. The method of attempt to contact should correlate to the participant's risk and should be based on professional judgment.) The third attempt to contact will be made no later than 10 working days of the second attempt.

Special criteria for substance exposed newborn:

Chapter 12, standard 12.7 specifies that a home assessment will be completed prior to hospital discharge of a substance exposed newborn. The criteria in standard 12.7 may be consulted for complete details.

Standard 12.7.b requires a home visit within three days of referral of a substance exposed newborn in the event a pre-discharge visit is not possible due to brevity of hospital stay, failure to be notified of infant prior to discharge, inability to locate, or other reasons for failure to comply with the standard criterion.

Standard 12.8 requires an infant and home assessment within three days of notification of the infant's discharge. If a prior home and family assessment was conducted and satisfactory conditions were found, then the three-day requirement is extended to five days.

The following are prioritized methods of initial contact attempts for providing care coordination in a risk appropriate manner.

Initial contact attempt by letter only. Participants referred to Healthy Start for factors other than score which do not include concerns and needs outlined as Tier 1 and Tier 2 in this chapter may be contacted by a letter for the initial contact attempt.

- The letter will 1) explain the Healthy Start program, 2) explain how to obtain Healthy Start services, and 3) provide the participant with a contact in the event assistance in obtaining Healthy Start services is desired.

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- These participants may be closed to care coordination 30 days after the letter is sent unless they notify the care coordinator, who will then make an evaluation of service needs. These participants may be reopened to care coordination as a self-referral in the event they notify the provider for services at a later date.

Initial contact attempt by letter plus phone call or face to face interview. All participants referred for positive scores on their Healthy Start screen and those referred for factors other than score who have one or more concerns and needs as outlined in as Tier 1 and Tier 2 of this chapter will receive another attempt to contact within 10 working days.

A minimum of three attempts to contact must be completed for these participants before they may be closed as unable to be contacted, as outlined in the Care Coordination Closure Section of this chapter. Only one attempt may be by regular mail or by registered mail if the participant has a safety risk or some other immediate need. Guidelines for method of contact are summarized in the matrix on the following page.

**Decision Matrix
Reason for Referral and Method of Initial Contact Attempts**

Reason for Referral	Letter Only (mailed within 5 working days) If no response, may close as unable to complete IC after 30 days	1 st attempt by Letter (mailed within 5 working days) 2 nd attempt by letter, phone call or, home visit within 10 working days of first attempt 3 rd attempt by phone call or home visit within 10 working days of the second attempt	1 st attempt by by phone, face to face or letter within 5 working days 2 nd attempt by phone call or home visit within 10 working days of first attempt 3 rd attempt by phone call or home visit within 10 working days of the second attempt	Minimum of three attempts to contact before closure. (Only 1 attempt may be by letter if there is a safety risk or immediate need as identified in Tier 1 Table 4.2a. A face to face attempt must be completed)	Minimum of one attempt at face to face contact before closure
Score on HS screen <4 infant; <6 prenatal or self-referral with no safety concerns	√				
Score on HS screen <4 infant; <6 prenatal or self-referral with no safety concerns but have other important concerns such as those listed in Tier 2 Table 4.2b		√			
Score on HS screen <4 infant; <6 prenatal or self-referral with safety concerns			√	√	√

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Score on HS ≥ 4 infant; ≥ 6 prenatal with no safety concerns and immediate needs but have other important concerns such as those listed in Tier 2 Table 4.2b		√		√	√
Score on HS ≥ 4 infant; ≥ 6 prenatal with safety concerns and immediate needs (also reference Tier 1 Table 4.2a)			√	√	√

Plan of Action for Assuring Risk Appropriate Care:

After the initial contact, the provider will determine what additional resources the participant needs based upon professional judgment, family priorities, safety concerns, and immediate needs. Participants may:

- Receive only an initial contact and then be closed to care coordination with or without referral to other Healthy Start or other community-based services, including more appropriate care coordination providers.
- Receive tracking.
- Receive an in-depth face to face initial assessment.

B. Initial Assessment of Service Needs:

Introduction:

Initial assessment of service needs is a face to face evaluation done in collaboration with the participant and, as appropriate, the family. The initial assessment or an attempt at an initial assessment needs to be done within 10 working days after the initial contact has been completed and the care coordination provider has determined there is need to further identify and explore:

- Factors that may adversely affect the pregnancy, the mother's health status, or the child's health and/or developmental outcome
- Participant and family concerns, priorities, strengths, and resources
- Barriers to health care and other services
- Home environment

Initial assessment of service needs takes place in the clinic, the community, or the home. (Note: If the initial contact is provided during a face to face encounter and an assessment is needed, the initial assessment of service needs may be completed during the same encounter. Please refer to Chapter 14, Coding, for accurate documentation.)

When determining which participants need further assessment and intervention, the role of the care coordinator is to recognize and facilitate the family as the authority on their own concerns, priorities, strengths, and resources. Participants with the safety concerns and immediate needs outlined in this chapter receive priority assessments.

Service Delivery Activities of Initial Assessment:

Initial assessment activities will be documented and an Individualized Plan of Care will

be re-evaluated or initiated if initial contact and initial assessment are completed at the same encounter. The service delivery activities of the initial assessment include the following:

1. A face to face interview with the pregnant participant or infant's/child's family with the participant present to assess interaction.
2. Completion of an authorization for release of medical information, as appropriate.
3. Joint determination of participant and family service needs in conjunction with the participant or family. Determination of service needs includes evaluation of:
 - All unresolved risk factors, corresponding need(s), and potential for change
 - Participant's and family's concerns, priorities, and resources
 - Child's or woman's physical and emotional well-being, safety, and general appearance
 - Ability to continue regular participation in ongoing health care, including past appointment regularity
 - Ability to comply with recommended treatments, such as obtain and take medicines or stay on bed rest
 - Housing and household occupants
 - The home environment (with or without a home visit). A home visit is required for those children prenatally substance exposed (see Chapter 12, "Substance Abusing Pregnant Women, Substance Exposed Children and Their Families," for guidelines for services to substance exposed newborns)
 - Woman's and family's knowledge and attitudes about pregnancy, childbirth, parenting, and family life
 - Maternal and child interaction
 - Characteristics of the parent at risk for child maltreatment which include:
 - ✓ having a personal history of abuse, neglect, or violence
 - ✓ lack of knowledge of parenting skills
 - ✓ unrealistic expectations of the child
 - ✓ unmet emotional needs of the parent
 - ✓ substance abuse
 - ✓ social isolation
 - If unmarried, plans for establishing paternity, child support, and involvement of father in child's life
 - Availability of a social support system
 - Current situation with regard to:
 - ✓ Housing
 - ✓ Food, including current eligibility for WIC
 - ✓ Transportation
 - ✓ Family planning services
 - ✓ Health services
 - ✓ Eligibility and limits for Medicaid or other insurance and ability to access it
 - ✓ Knowledge of Medicaid services available
 - ✓ School enrollment and participation
 - ✓ Family and self-sufficiency goals/economic stability
 - Alcohol, tobacco, or other drug use.
4. Risk factors in addition to those identified through the initial contact, access to

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care, and need for referrals. The care coordinator should evaluate the participant's understanding of their risk factors and how to address them (refer to Table 4.1, Risk Factor Matrix, in this chapter). Evaluation includes:

- Ability to access needed services
 - Need for additional referrals
 - Need for additional information, encouragement, and monitoring.
5. Evaluation of participant's level of care and document any change in level of care as needed
 6. Provide verbal or written follow-up to the prenatal care provider or child's primary care provider within 30 calendar days regarding assessment and progression of Healthy Start care coordination service delivery.

Plan of Action for Assuring Risk Appropriate Care:

After the initial assessment, the care coordinator will determine, based upon professional judgment, family priorities, safety concerns and immediate needs, what additional care coordination services are needed. Participants may:

- Receive tracking care coordination of receipt of services.
- Receive ongoing face to face care coordination and a family support plan.
- Be closed to care coordination with or without referral to other Healthy Start or community-based services, including more appropriate care coordination providers.

C. Family Support Planning:

Introduction:

After or during the initial assessment, family support planning should be initiated for level 3 participants, substance involved families, and other high-risk participants. If a participant refuses to sign a Family Support Plan (FSP), the care coordinator will place the unsigned Family Support Plan in the chart and will document the refusal in addition to any other supporting information. Starting family support planning at the initial assessment allows the care coordinator to help participants begin to set goals to reduce their identified risk factors or meet basic needs. 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 create and live their own goals/dreams.

Family support planning is useful for problem solving with the family. The family support planning process helps families develop strategies, interventions, and support systems that will best help them address the situations that are putting them at risk for poor outcomes. After a thorough assessment, each unresolved risk is discussed, and participants determine the goal they are attempting to achieve. Through collaboration, the participant/family and provider determine appropriate strategies to address risks and write these strategies into the Family Support Plan. This plan is the road map for interaction with the participant and family. The plan enables anyone working with the participant to easily see how identified concerns, priorities, and resources are being addressed. If providers identify priorities and immediate needs and the participant does not want to address them on the Family Support Plan, documentation should reflect

those participant decisions. It is important to remember that the Family Support Plan reflects the participant's or family's goals, not the care coordinator's goals for the participant or family. The initial Family Support Plan is completed face to face. At each encounter, evaluation is made of progress toward achieving the stated goals. The care coordinator will periodically discuss goals, activities, and achievements related to the FSP with the participant; these discussions will sometimes take place face to face and sometimes may take place over the phone. The plan is modified as needed and updated at least every three months in a face to face visit. The participant is given a copy of the FSP, and the original is kept in the participant's record.

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 HMS for level 3 participants. Family support planning services for a level 1 or 2 participant should be coded in the HMS under care coordination.

Providers may use the Family Support Plan for Single Agency Care Coordination or another plan that is clearly participant centered. The type of plan will depend on the participant's needs and concerns and/or the involvement of other agencies, but there should be only one family support plan for each participant. Only at the family's request will there be more than one family support plan for different individuals in the same family. Some other service delivery programs may require multi-page family support plans. In most cases where a multi-page family support plan is required (e.g., Part H/C service coordination), the Healthy Start care coordinator will not be the lead coordinator.

Service Delivery Activities of Family Support Planning:

The family support planning process is used to accomplish and document the following activities.

1. Setting Goals/Dreams

The care coordinator facilitates goal setting with the family. The date and the goals are recorded. Goals are statements of what participants or families want to see happen on their behalf. For example, a goal might be: "I want to stop using tobacco."

2. Developing Next Steps - Action Plan

Care coordinators and families discuss the plan of action for the identified goals. For the participant whose goal is to stop using tobacco, the action plan will need to include specific steps to help her stop using tobacco, such as: "Healthy Start care coordinator will provide participant referral information for tobacco cessation class and bus pass for transportation to class. Participant will call and sign up for class by the end of this week." It is very important for goals to include WHO will do WHAT by WHEN and include responsibilities of the participant, family members, and agencies related to achieving the goal. Identify and record the family and individual resources that will be used to achieve each outcome as well as the location, start date, frequency, and duration of services. Identify funding sources as appropriate.

3. Follow-up/Evaluation (How is it working?)

An evaluation of the participant's goals, accomplishments, and progress (ongoing care coordination). For instance, "The participant has attended first class session and reports that she has decreased number of cigarettes she smokes per day by half. Will attend another class next week, and plans to reduce number of cigarettes by half again by the end of next week."

4. Completing the Family Support Plan

The participant, or family member of the infant/child, should be offered the opportunity to sign the plan indicating their understanding of the plan and acknowledging their participation in its development. If a participant refuses to sign a Family Support Plan, the care coordinator will place the unsigned FSP in the chart and will document the refusal in addition to any other supporting information.

The care coordinator and other service providers participating in the planning process must sign and date the plan.

The FSP is the family's plan. It should be written in language easily understood by the family. A copy should be given to the family and the original kept in the record.

5. Updating the FSP

The 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). (See Chapter 14, Coding, for Family Support Plan coding guidelines).

D. Ongoing Care Coordination:

Introduction:

Ongoing care coordination is a process by which families are assisted with locating, coordinating, and monitoring needed services and learning what they can to maximize their health and well-being. Ongoing care coordination includes direct contact with the participant and family, as well as indirect contact on the participant's and family's behalf. Intensity and duration of ongoing care coordination are based on the concerns, priorities, resources, and desires of the family; their risk factors; and the availability of other community resources. Activities range from tracking to intensive coordination of services addressing complex problems to family support planning. Participants can be moved back and forth from tracking to intensive ongoing care coordination and back to tracking based on their needs. A Family Support Plan may be used with all Healthy

Start participants; however, this activity may only be coded in the HMS system for level 3 participants.

Ongoing Healthy Start care coordination services may be provided through:

- Face to face contact with the participant and family
- Telephone contact with the participant or family
- Communication with other providers
- Review of participant's clinical record for update on participant's status/receipt of services as part of the participant or provider direct contact

Ongoing care coordination can be provided in the home, the neighborhood, school, workplace, clinic, or wherever the needs of the participant can best be met. While the home may be the preferable place of service for Healthy Start care coordination services, resources should be targeted to those participants in greatest need. In order to prioritize who should receive a home visit, providers must consider potential risk; the family's concerns, priorities, strengths, and resources; availability of provider resources; professional judgment; and local targeting practices (see Chapter 11 on Home Visiting and Service Delivery Sites).

Service Delivery Activities for Ongoing Care Coordination:

Ongoing care coordination will be documented and an Individualized Plan of Care is evaluated. Ongoing care coordination may include any of the following activities:

1. Developing a caring and trusting relationship
2. Tracking the participant's receipt of services

Tracking activities may include:

- Establishing an agreement with the prenatal or postpartum provider (including family planning or child health care provider) to notify the Healthy Start care coordination provider of missed appointments or failure to comply with recommended treatment (e.g., Medicaid's Child Health Check Up program)
- Periodic follow-up with the participant, family, or prenatal or child health care provider to determine continued ability to access and follow-through with needed services and recommended treatments.

At least quarterly, care coordination providers will track and document the receipt of prenatal and postpartum/interconception care, WIC services, child health care and immunizations for all participants receiving ongoing care coordination.

3. Ongoing systematic assessment of participant or family assets, risks, concerns, and priorities

Ongoing assessment allows providers and participants/families to determine if needs have been met, risk situations addressed and/or resolved, and if additional concerns have arisen. If child abuse or neglect is known or suspected, an immediate report should be made to the Florida Abuse Hotline at 1-800-962-2873, as required by law (s.39.202, F.S.) and Healthy Start contract.

4. Prioritizing, planning, and evaluating, in conjunction with the family, the actions

required to address their concerns, risks, and priorities

5. Developing and updating a family support plan

Note: While family support planning is one component of ongoing care coordination, there are special coding requirements for time spent developing the initial and updating the FSP. (See Chapter 14, Coding, for Family Support Plan coding guidelines.)

6. Providing referrals and following up on referrals

Referral and follow-up are provided for any services needed to address outstanding risks and needs. Referral follow-up **must** be documented in the participant's record for any participant not closed at IC.

7. Providing anticipatory guidance and health promotion information, and reinforcing the health care regimen, at each contact

An important part of ongoing care coordination is providing information and education at each contact with the participant or infant's/child's family. Due to resource limitations, all participants cannot receive all Healthy Start services. However, depending on the risk and what the participant and family need to reduce their risk, the care coordinator can provide valuable information such as information related to pregnancy, child birth education, infant care, safety, child growth and development, positive parenting, tobacco education and cessation, and breastfeeding. Other examples of information that is, depending on risk, useful for families include:

- The importance of compliance with the prescribed treatment plan
- Signs and symptoms of complications and how to access emergency care
- Appropriate weight gain during pregnancy and/or during infancy
- Kick count
- Benefits of breastfeeding
- Avoidance of substances and exposure to second-hand smoke
- The appropriate sleeping position (on back) for an infant
- The safe sleeping environment
- Nutrition and physical activity
- Household safety tips and information
- Family dynamics including techniques related to parents adjusting to role as care giver, appropriate discipline, parental/caregiver self-care and managing stress (activities geared toward preventing child abuse and neglect and family violence)
- Techniques to prevent shaken baby syndrome/coping with crying
- Baby nurturing and soothing techniques
- Necessary baby supplies and equipment to obtain before birth
- Planning for parenthood and the impact on other family members
- Family planning methods and recommended birth interval information
- Interconception counseling
- Emergency /disaster planning

Care coordination activities of providing health promotion information,

anticipatory guidance, and information reinforcing the health care regimen are distinguished from other Healthy Start services (such as tobacco education and cessation, psychosocial counseling, childbirth education, and parenting education and interconception education and counseling) by criteria in the individual HSSG chapters for these services.

8. Advocating on behalf of the participant and family for needed services

If the participant or the family lacks the skills to advocate for themselves or their efforts were unsuccessful, the care coordinator will need to intervene on their behalf (having assured that proper releases for sharing information have been signed by the participant). Some examples of when the care coordinator may need to advocate for the participant are listed below:

- Participant's condition warrants treatment, such as when a pregnant participant who is having warning symptoms (such as bleeding, headaches, or severe pain) or a child who is vomiting, having diarrhea, or has a fever can not access medical care in a timely manner
- There is a long waiting list for obtaining services related to safety or immediate needs such as food, housing, transportation, quality child care, counseling, and treatment for substance abuse
- Care provider services are not meeting participant expectations or are not accessible to the participants

The care coordinator should follow locally developed policies and protocols when advocating for participants and their families. A mechanism should be established so that trends, bad practices, and system problems can be identified and strategies can be developed to resolve them.

9. Empowering the participant and family towards self-sufficiency and economic stability

If the participant is in school or has a job, information and encouragement should be provided to motivate her to continue these activities during and after pregnancy. Direct advocacy with the employer or school (once proper releases for sharing information have been signed by the participant) may be needed for the participant to receive needed work or school flexibility related to schedule or working conditions. Rights under federal and state leave laws should be discussed.

If the participant has not finished school or lacks an adequate job, information and counseling should be provided and referrals should be made to available resources.

10. Promoting employability and life management skills

Information will be given to the participant about tools to promote job and organizational skills, such as calendars and appointment books. Problem-solving with participants can help them develop skills in seeking assistance and support from family and friends, and in developing work and career plans in relationship to bearing children/family planning.

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11. Monitoring progress of services

Services will be monitored and plan adjustments will be made as the participant's situation changes. At each contact the care coordination provider will address risk factors or goals documented on an Individualized Plan of Care and evaluate the participant's progress.

12. Transition of ongoing care coordination to other providers, when appropriate

Transition includes exchange of records (with proper authorization for release of records from the participant). The care coordinator's decision to provide the services versus referring the participant or family to another source should be based on the following criteria:

- Is it more cost effective for the care coordinator to provide the needed services than to refer? A consistent caregiver with an established relationship may be able to educate and motivate the participant better than a separate provider of specialized services.
- Will the participant or family access quality, affordable, risk-appropriate services if referred to a program or separate provider?
- Are quality services available?

13. Maintaining ongoing communication with other providers, especially the prenatal and child health care provider (obtain proper releases for sharing of information if referral to Healthy Start was not from prenatal or child health care provider)

14. Evaluating the participant's level of care

15. Provide education on disaster preparedness for the family

E. Care Coordination Closure:

Introduction:

Closure to Healthy Start occurs when services are declined, transitioned to another provider, no longer needed because risks are resolved, the participant is no longer eligible for services, or the participant is lost to contact.

Closure to care coordination services is the point at which the participant exits the Healthy Start care coordination system. Healthy Start care coordination services are discontinued when:

- The family and professional agree there is no longer a need for services
- The prenatal participant completes her postpartum and family planning appointment
- The interconception participant reaches three years post delivery
- The child reaches his or her third birthday
- The participant/family requests to discontinue participation
- The participant/family is receiving or going to receive services from Early Steps
- The participant/family is receiving or going to receive services from another provider of care coordination, other than Early Steps
- The participant cannot be located after three documented attempts have been made to locate, including one face to face attempt for level 2 and 3 clients

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(Participants at level 1 may be closed as unable to locate after a minimum of 3 attempts to contact by letter or phone)

For substance involved families or families with suspected or known child maltreatment, care coordination services can only be terminated following **consultation with the supervisor** and when one of the following occurs:

- a) The environment is assessed to be reasonably safe for the child with low risk of danger or harm to the child; or
 - b) A permanent or long-term placement for the child has been established separate from the biological mother's or substance abusing parent's home; the permanent or long-term family has been educated about the child's special needs and no longer desire care coordination services; and the biological mother no longer can benefit from services; or
 - c) The mother/caregiver with whom the child is living refuses services and there is no court-ordered supervision of the child or family (services may be re-offered at a later time); or
 - d) Persistent attempts to locate have failed and the appropriate Family Safety agency has been notified
- Documentation of closure in the participant's record must be co-signed by the supervisor.
 - Information is left with the family describing the process for reinitiating services should the family determine a need later.
 - Other service providers are notified prior to care coordination closure as appropriate.

Service Delivery Activities of Care Coordination Closure:

Healthy Start care coordination closure activities will be documented and an Individualized Plan of Care may be re-evaluated. Care coordination closure activities include the following:

- Assessment of the participant or family for unresolved need, and assistance in locating a primary care provider for ongoing health care needs including family planning (e.g., up-to-date immunizations or Child Health Check Up visits)
- Completion of referrals to other service providers if continuing or additional services are needed and desired
- Notification of the participant's prenatal and/or primary service provider of the date of and reason for care coordination closure
- Immediate written notification to referral source and/or Department of Children and Families if participant was referred due to substance abuse or child maltreatment concerns
- Transition to another care coordination provider with appropriate release of information and record transfer. (See Chapter 13, "Transition and Interagency Agreements.")
- Completion of HMS Healthy Start Outcomes for each participant who has received ongoing care coordination services higher than initial assessment.

Before declaring a participant lost to contact, at least three documented attempts to locate should be made, including one face to face attempt for level 2 and 3 participants. These attempts will be according to the following guidelines: Attempts may be by letter, telephone call, or attempted face to face visit. Before closing a participant with a Tier 1

safety concern, the care coordinator should check the following resources for updated information regarding address or follow -through with care:

- Participant's health care provider
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) staff and WIC Information Project (WIP) System
- Immunizations staff and computer
- FLORIDA Medicaid computer (FMMIS)

Participants at level 1 may be closed as unable to locate after a minimum of 3 attempts to contact by letter or phone.

III. Care Coordination Provider Qualifications:

Care coordinators are health care providers, health-related professionals, or qualified paraprofessionals working under the supervision of a professional, who function in partnership with the participant or family in providing care coordination. The care coordinator may work one-on-one with the family or as the lead on an interdisciplinary team, depending on his or her qualifications. Any Healthy Start care coordinator who provides enhanced services must have expertise in that specific field, as outlined in Chapters 5-12 and 21.

Care coordinators should meet one or more of the following educational requirements and have received all of the required training:

1. Minimum of four-year college degree in one of the following areas:
 - a) Social sciences
 - b) A health related field such as nursing, health education, health planning, or health care administration
 - c) Social work
2. Licensure as a Registered Nurse with three years of public health/community development experience or licensure as a Licensed Practical Nurse with 4 years of public health/maternal child health experience
3. Two years of college with three years of public health/community development experience
4. Paraprofessional care coordinators have a high school education or its equivalent and must meet additional requirements as follows:
 - a) Paraprofessionals providing care coordination services must receive ongoing supervision by a Healthy Start program staff professional who meets the educational requirements specified in the qualifications in 1, 2, or 3 above.
 - b) Paraprofessionals providing care coordination services must meet the state job specifications for a family support worker or have equivalent experience.
 - c) Paraprofessionals work under locally approved written protocols.
 - d) All Healthy Start care coordination activities conducted by a paraprofessional must be reviewed every two weeks by a qualified Healthy Start program staff professional as described above in section 4.a. A case summary review sheet signed by the paraprofessional and his or her supervisor may be used to document this process. The case summary review sheet will be kept in the participant's record.
 - e) Paraprofessionals providing an initial contact must use a systematic process as

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- outlined in this chapter and utilize thorough documentation, to include an Individualized Plan of Care and a level based on the participant's service needs. All the documentation must be reviewed and co-signed within two working days by the supervisor. If the participant or family has safety concerns or immediate needs that the paraprofessional has not been trained to handle, the paraprofessional should contact the supervisor immediately for guidance. If an initial assessment is determined to be necessary after an initial contact is completed, it is recommended that this face to face assessment be performed by a care coordinator who meets the qualifications in 1, 2, or 3 above.
- f) Paraprofessionals who do conduct an initial assessment must use a systematic process as outlined in this chapter and utilize thorough documentation, to include an Individualized Plan of Care and a level based on the participant's service needs. All the documentation must be reviewed and co-signed within two working days by the supervisor. If the participant or family has safety concerns or immediate needs on Tier 1 Table 4.2a that the paraprofessional has not been trained to handle, the paraprofessional should contact the supervisor immediately for guidance.
 - g) Paraprofessionals may not assume the role of lead care coordinator.
 - h) Although paraprofessionals are important members of an interdisciplinary team, they may not function as interdisciplinary team leaders.

Competencies for Care Coordination Providers:

1. Demonstrated knowledge of community resources for at-risk pregnant and interconception women, infants, young children, and their families and procedures for accessing them;
2. Demonstrated practice of family-centered communication skills;
3. Demonstrated knowledge of available Healthy Start services;
4. Demonstrated knowledge of all components on the Healthy Start prenatal or postnatal risk screen;
5. Demonstrated knowledge of evaluation of service needs and assessment;
6. Demonstrated cultural sensitivity to and competency in working with participants from a variety of cultural backgrounds;
7. Demonstrated knowledge of maternal and child health principles, including:
 - a) Normal pregnancy anatomy, physiology, comfort measures, breastfeeding, danger signals, and what to do if danger signals occur;
 - b) Normal infant and child growth and development and corresponding anticipatory guidance to promote optimal physical and emotional health, safety, and well-being for participant and family;
 - c) Basic content of prenatal and well-child care;
 - d) Importance of appropriate interpregnancy interval and basic knowledge of family planning methods;
 - e) Child Health Check Up periodicity schedule and the components for each visit;
 - f) Impact of and interventions related to the special needs of substance abusing families and families with potential for or histories of domestic violence and/or child abuse;
 - g) Recognition of stage of readiness to stop tobacco and other substance abuse and appropriate intervention; and
 - h) Family dynamics including principles related to parents adjusting to role as care giver, appropriate discipline, parental/caregiver self-care, and managing stress.
8. Demonstrated knowledge of child abuse or neglect indicators and the responsibility to report to the Florida Abuse Hotline 1-800-962-2873;

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9. Demonstrated knowledge and ability to communicate verbally and in writing with health care providers and other community resource people;
10. Demonstrated knowledge and ability to advocate on the participants' behalf;
11. Demonstrated knowledge of the family support planning process;
12. Demonstrated knowledge of home environment and safety assessment;
13. Demonstrated knowledge of funding resources such as local funding options, eligibility and limits of Medicaid, and local workforce development resources;
14. Demonstrated knowledge of chart documentation to include but not be limited to Individualized Plans of Care and Family Support Plans;
15. Demonstrated knowledge of Healthy Start coding procedures; and demonstrated knowledge of situations in which it is necessary to contact a supervisor immediately regarding the participants' immediate needs and/or safety concerns.
16. Knowledge and adherence to pregnancy and postpartum non-directive information and counseling for prenatal care and delivery, infant care, adoption and pregnancy termination options. (See Appendix I)

IV. Healthy Start Care Coordination: Documentation, Service Delivery Data Collection, and Quality Management /Performance Improvement

Documentation:

Healthy Start care coordination providers will document services in the participant's HMS record within 72 hours from the service delivery date. (unless otherwise directed in Ch. 4, Standard 4.3 of the Healthy Start Standards and Guidelines).

Content of services are documented in the record of the participant receiving the services. Services that are provided to another person, on behalf of a Healthy Start program participant (such as in the case of services to a parent for a child participant) are documented in the Healthy Start participant's record. **NOTE: In the event that a request is signed to release a Healthy Start child's record, all information that does not pertain to the child's medical condition must be redacted prior to release of the record.**

The participant's confidential Healthy Start care coordination record is opened at the time of the first initial contact attempt or at the time of initial contact.

All Healthy Start care coordinators will receive ongoing quality assessment of their record documentation competencies.

B. Service Delivery Data Collection:

Data on service delivery is entered into the Health Management System

HMS Coding

For complete information, see Chapter 14, Coding.

C. Quality Management/Program Improvement Performance Measures:

Every woman, infant, or child who scores positive on the Healthy Start prenatal or infant risk screen, or is referred by a health care provider, a community service provider, or self referred for Healthy Start care coordination based on factors other than score, receives a

timely initial contact and documented attempts to contact according to their risks, immediate needs, and safety concerns as outlined in Tiers 1 and 2.

Evaluation to ensure that all care coordination activities have been completed can be accomplished by a quarterly peer review of a selected sample of records. The Healthy Start Care Coordination Record Review Check List can be used to document this activity (see appendix B).

The Healthy Start Executive Summary Reports, compiled monthly by the Department of Health, Division of Health Statistics and Assessment, provide aggregate data useful for determining whether the processes of initial contact and service delivery are being implemented effectively.

Documentation of adequate ongoing care coordination is evidenced as follows:

- A written Individualized Plan of Care (IPC) that is initiated at initial contact should be clearly documented in the record. Documentation should reflect the re-evaluation of the IPC during ongoing care coordination.
- Follow-up for all participants receiving coordination of routine services, including but not limited to addressing risk factors conducive to intervention
- Update of progress made toward goal(s) of plan
- A formal FSP for all participants and families with complex needs and intensive coordination of services should be clearly documented in the record. The family support planning process may be used for all participants but may only be coded in the HMS system for level 3 participants.
- Documentation of all contacts or attempts to contact,
- Documentation of the status and progression of pregnancy and normal infant/child growth and development
- Documentation of information, referrals, and interventions provided when the progression of the pregnancy and/or infant/child growth and development deviate from what is considered optimal
- Routine prenatal or infant/child primary health care (including Child Health Check Up for Medicaid eligible children) received at the appropriate periodicity
- Appropriate immunizations received
- Recording of mother's family planning contraceptive method of choice
- Documentation of health information and education provided
- Follow-up on other Healthy Start services and other community referrals to determine if the family is receiving services needed to promote wellness should be clearly documented in the record. Follow-up on services and referrals is an important component to assure a seamless approach to care.
- HMS Healthy Start Outcomes for each participant who has received ongoing care coordination services higher than initial assessment.

Periodic participant satisfaction surveys can assist Healthy Start care coordination providers to identify areas in need of service expansion or improvement. Suggested questions to include on participant satisfaction surveys include:

- Have Healthy Start care coordination services been beneficial?
- Was staff courteous and helpful?
- Did the participant experience any barriers to services?
- Was the participant able to get the services needed?

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Record reviews by care coordinators and care coordination supervisors are done at least quarterly to determine the effectiveness of ongoing care coordination. A randomly selected sample of records from all Healthy Start participants, ranging from newly enrolled participants to those who have been closed to care coordination or are near closure, will provide necessary information for determining the effectiveness of intervention. Based on the information documented in the participant's record, including but not limited to information from the Individualized Plan of Care, Family Support Plan, and notes, consider the following key questions when conducting a record review:

- What are the basic identified risk factors of the participant selected for record review, including information from the Healthy Start risk screen, the Individualized Plan of Care, and Family Support Plan?
- What are the stated goals and objectives agreed upon by the participant/family?
- What are the critical risk factors documented in the record?
- Were indicators of child maltreatment recognized and reported appropriately?
- What are the action steps (interventions) to address the risk factors/concerns of the participant?
- Did the participant follow the plan of care action steps? If not, what kind of follow-up was done to support participation?
- Were the goals and objectives met by the participant, and if so, to what extent?
- If the goals and objectives were met, what critical factors contributed to the success?
- If the goals and objectives were not met, what critical factor(s) or barrier(s) contributed to the failure?

Answers to these questions should be documented thoroughly. As the record reviews are conducted over time, the answers will begin to indicate the effectiveness of the care coordination system as well as patterns of action and behavior that may provide a great deal of information about which components or critical factors of care coordination have the greatest impact on outcomes.

References

Reporting Abuse, Neglect, and Exploitation of Children and Vulnerable Adults, Florida Abuse Hotline (call 850-478-6100 for the most current edition of this document)

CF Operating Procedure No. 175-28 Family Safety and Preservation Allegation Matrix

Videotape training of May 21, 2002 entitled "Common Sense and the Assessment of Child Abuse Injuries"

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Institute of Medicine (IOM). Report Brief: Preterm Birth: Causes, Consequences, and Prevention. Washington, D.C., National Academies Press, 2006.
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Notes:

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

1. The order of priority for care coordination service delivery to Healthy Start participants is based on what factors?
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?
3. At a minimum, care coordination providers should comply with which interagency agreements in order to assure collaborative networks of care within the community?
4. What is an Individualized Plan of Care?
5. What factors determine the intensity and duration of Healthy Start care coordination services?
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)?
7. What are the concerns and needs that require a minimum of 3 attempts to contact (ie phone and/or letter)?
8. What is the purpose of the Family Support Plan?
9. For which level of participant must a Family Support Plan be developed and coded into the HMS?
10. How often must the Family Support Plan be updated?