

Chapter 3: Healthy Start Risk Screening

Introduction

Healthy Start legislation requires that all pregnant women and infants be offered screening for risk factors that may affect their pregnancy, health, or development. The prenatal and infant (postnatal) Healthy Start risk screens assess risk factors for adverse health outcomes so that identified individuals may then be referred more expeditiously to the appropriate services for their needs. This process makes for a holistic approach to the patient's care and encourages continued participation in prenatal and infant health care. (Healthy Start risk screening instruments may be found in Appendix C.)

Successful targeting of Healthy Start resources requires establishing and maintaining a network of providers who participate in prenatal and infant (postnatal) risk screening and are well-informed about screening procedures and knowledgeable about the services available to participants referred to the Healthy Start program.

It is also imperative that every pregnant woman and parent of a newborn understand the value of risk screening and ask their prenatal care provider and birthing facility staff, respectfully to complete the Healthy Start screening form. Health care providers need to receive ongoing education regarding the benefits of the Healthy Start program as it relates to their patients and have an understanding of the importance of offering each patient the risk screen in a manner that encourages consent. Furthermore, the providers must understand how to make appropriate referrals to community resources for factors other than score.

Consequently, it is critical that Healthy Start care coordinators provide feedback to providers who refer participants to Healthy Start. Providing this feedback reinforces the value of the program to providers and encourages good screening practices.

Definition of Service

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

Standards and Criteria

Standard 3.1 The Healthy Start coalition will assure that providers receive training on how to present the Healthy Start screen in a manner that encourages consent, and how to explain the concept of Healthy Start as well as the benefits of Healthy Start screening.

Criteria:

3.1.a Healthy Start coalition designates responsibility for training prenatal care providers and birth facilities staff who provide Healthy Start screening.

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

Standard 3.2 Each Healthy Start coalition will assure the development and implementation of a public relations strategy designed to achieve universal Healthy Start prenatal and infant risk screening.

Criteria:

3.2.a All providers of Healthy Start care coordination participate in the development and implementation of the strategy.

3.2.b All training and education related to Healthy Start screening is provided with consideration to cultural, language, educational/literacy, and accessibility needs of the participant.

Standard 3.3 All prenatal care providers and delivering facilities will use the Healthy Start prenatal and infant risk screening instruments designated by the Department of Health and provided by the county health department.

Criteria:

3.3.a Each provider forwards the completed Healthy Start risk screening form within five working days of completion of the screen to the county health department in the county where screening occurred.

3.3.b Each county health department where the screening occurs checks the screens for accuracy, obtains corrections as necessary, and then forwards the appropriate copies of the Healthy Start screen to the county health department in the participant's county of residence or enters the screening form data into the Health Management System (HMS) as appropriate, within five working days.

3.3 c. The county health department in the participant's county of residence enters the screening form data into HMS, and then forwards all screens with appropriate patient consent and referral to the Healthy Start care coordinator within five days.

Additionally, each county Healthy Start program forwards a copy of all Healthy Start screens on which the participant responds "yes" to consent for release of information to the Healthy Families Florida (HFF) provider unless otherwise determined by local agreement with Healthy Families. Healthy Start staff does not calculate HFF risk scores. Procedures for sharing the cost of providing copies of the screening forms shall be based on local agreement between Healthy Start and Healthy Families Florida.

Standard 3.4 Each Healthy Start coalition's and county health department's quality management/program improvement (QM/PI) system will include a Healthy Start screening component.

Criterion:

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

Standard 3.5 Each Healthy Start care coordinator and coalition will receive updated technical assistance and/or training related to Healthy Start screening.

Criterion:

Information provided through technical assistance and/or training is disseminated to each Healthy Start care coordinator and coalition through a locally determined mechanism.

Guidelines

Background: The Healthy Start screening instruments were initially developed in 1992 by a workgroup that included physicians, nurses, social workers, researchers, program specialists, and other professionals knowledgeable in the field of maternal and child health. The purpose of the screening instruments is to identify pregnant women and infants who are more likely to experience adverse outcomes. For pregnant women the adverse outcome is pre-term labor and/or low birth weight, and for infants the adverse outcome is infant death between 28 and 364 days after birth.

The instruments were created after extensive research and analysis of risk factors, and a statewide workgroup then approved the forms. The risk screens are evaluated annually to determine their success in identifying those women and infants most at risk for adverse outcomes. Studies that have linked birth outcomes to Healthy Start infant screening data indicate that infants who score 4 or more on the Healthy Start screen are six times more likely to experience postneonatal infant mortality than those who score less than 4.

Risk Ratios: Each risk factor scored on the Healthy Start screening tool is associated with higher risk for poor health outcomes. The strength of the association is expressed as a "risk ratio." For example, if a pregnant woman has experienced a previous poor pregnancy outcome, she is 2.02 times more likely to experience preterm birth or to deliver a low birth weight infant than a woman who has not experienced a previous poor pregnancy outcome. In this analysis, preterm birth is defined as a birth before 37 weeks of gestation and low birth weight is defined as less than 2500 grams. The risk ratio for each factor is provided in the chart below.

Healthy Start Prenatal Risk Screen:¹

Screen	Risk Factor	Estimated
3	Previous Poor Pregnancy Outcome	2.02
3	Race = Black	1.52
3	Previous Birth <2500 grams	1.47
2	Illness Requiring Ongoing Care	1.47
2	Body Mass Index (BMI) >35	1.11
2	First Pregnancy	1.09
1	Body Mass Index (BMI) < 19.8	1.27
1	Tobacco Use	1.13
1	Age less than 18	1.06
1	Unintended Pregnancy	1.04
1	Depression	1.03
1	Unmarried	1.02
1	Birth Interval < 18 months	1.02
1	Trimester Care = 2 nd	.99
1	Less than High School Education	.95
1	Alcohol Use ³	0.92

Healthy Start Infant (Postnatal) Risk Screen:⁴

Screen	Risk Factor	Risk Ratio ²
1	Mother's Age < 18	1.25
1	Mother's Race = Unknown, Nonwhite or	1.45
2	Mother's Education < High School and Mother	1.20
1	Mother Is Not Married	1.71
4	Number of Prenatal Visits is zero, one or unknown	1.42
4	Birth Weight < 2000 grams (4lbs 7oz)	10.74
1	Mother Used > 9 Cigarettes Per Day	1.77
1	Mother Used Alcohol	1.18
4	Abnormal Conditions of Newborn	2.07
4	Congenital Anomalies	7.04

Healthy Start services are provided with risk reduction in mind. Because some risk factors cannot be changed with interventions (e.g., single marital status, race, or age), it is necessary to assess the situations that underlie the risk factor or are caused by the risk factor. (For example, if a single woman does not have the social supports needed to ensure the best outcomes for her pregnancy, care coordination services may be critical to ensure her access to services.)

Population Served: Florida statute requires that Healthy Start risk screening is offered to all pregnant women at their first prenatal visit by their prenatal health care provider. In addition, Florida statute requires that Healthy Start infant (postnatal) risk screening is offered by the birthing facility to parents or guardians of all infants born in Florida before leaving the facility.

Services Provided: The assurance of a comprehensive Healthy Start risk screening system includes the following components.

Health Care Providers and Delivery Facility Staff:

- Explain Healthy Start Program and the benefits of Healthy Start Screening
- Complete risk screen instrument
- Score risk screen instrument
- Explain score, as appropriate
- Refer for program services as appropriate
- Forward screening Instrument to local county health department

County Health Departments:

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

Parameters: Pregnant women and infants are screened only once for Healthy Start. Prenatal risk screening and referral for positive score should occur at the first prenatal visit or the earliest time thereafter. Referrals for reasons other than score are sometimes necessary but must be made judiciously. (See Table 3.1) Potential program participants may, however, enter the program at any time subsequent to their negative screening and/or referral by a self-referral or a referral from a community resource.

Note: When entry into the Healthy Start program occurs based on factors other than screen score, pregnant women and infants are not re-screened.

Infant risk screening and referral for positive score should occur at the time of delivery. Referrals for reasons other than score are sometimes necessary but must be made judiciously. Potential program participants may, however, enter the program at any time subsequent to their negative screening and/or referral by a self-referral or a referral from a community resource.

(See Table 3.1)

Table 3.1

**Safety Concerns and Immediate Needs Requiring Priority Care Coordination Services
(i.e. minimum 3 attempts to contact with at least one being a face to face visit)**

Knowledge or suspicion of current:

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

Service Delivery Activities Related to Establishing and Maintaining a Provider Network for Healthy Start Screening: The first step in establishing and maintaining a provider network for screening is to identify the agency responsible for this activity. This may be the coalition, the county health department, or another designated agency.

Activities Include:

1. Identifying and informing local providers about the Healthy Start program and risk screening
2. Reviewing and monitoring their screening practices, including providing feedback on their screening practices on a quarterly basis.

1. Identifying and Informing Local Providers:

The agency designated by the local coalition for establishing and maintaining the provider network for Healthy Start screening will contact providers of prenatal and infant health services to inform them of their responsibility related to Healthy Start risk screening. Providers of prenatal care and birthing facilities are required by the Healthy Start legislation (§383.14, F.S.) to offer Healthy Start prenatal or infant risk screening, respectively.

Information To Be Shared with the Provider Network for Healthy Start Screening:

Healthy Start Standards & Guidelines 2007

Information	Explanation/Comments
1. Overview of the Healthy Start initiative.	All providers of prenatal care and all birthing facilities must receive an overview of the Healthy Start initiative and periodic updates on screening requirements including; the screening process; how to obtain forms, brochures, and other marketing aids; and the benefits to prospective
2. Requirement to screen.	All pregnant women are to be offered a screen at the time of their first prenatal visit. The families of newborn infants are to be offered screening before the infant leaves the facility in which he or she was born. The purpose of the screening instruments is to identify pregnant women and infants who are more likely to experience adverse outcomes. For pregnant women the adverse outcome is pre-term labor and/or low birth weight and for infants the
3. How to obtain screening	Screening forms may be obtained through the local county health
4. How to conduct screening.	Prenatal and infant risk screening forms include complete instructions related
5. How to score screening forms.	Prenatal screening forms include instructions for scoring the form on the back of the patient's medical record (pink) copy of the form, while infant screening forms have a scoring worksheet on the back of each page of the screen. (Creole and Spanish versions do not have the scoring worksheet on all
6. Requirements related to getting completed prenatal and infant screens to the local county health department.	<p>Prenatal risk screens are to be sent to the county health department in the county where the prenatal screen was completed within five working days of completion of the screen.</p> <p>Risk factor information for the infant (postnatal) screen is taken from the</p>
<p>7. How to refer a pregnant woman or infant, regardless of risk screen score, for Healthy Start care coordination services if in the community resource's, woman's, or family's judgment the woman or infant needs the services.</p> <p>(* Referrals for reasons other than score should be used judiciously and with consideration of risk factors, available interventions, participant's ability to</p>	<p>Pregnant women or infants can be referred for Healthy Start care coordination services regardless of their score on the Healthy Start risk screen in the following ways:</p> <ol style="list-style-type: none"> 1) If the referral is to be made at the same time the risk screen is administered, the health care provider may indicate on the risk screening form that the woman or infant is referred and "specify" reasons for referral on the screening instrument as indicated. 2) If the determination is not made at the time of the screening, the community resource may directly refer the woman or infant to the Healthy Start care coordination provider upon assessment of actual or potential factors associated with high risk. 3) If a pregnant woman or the family of an infant needs and desires Healthy Start care coordination regardless of screening score, they may request a

Information to be Shared with the Provider Network for Healthy Start Screening
(Continued):

Information	Explanation/Comments
8. Information related to how the county health department's quality management/program improvement process maintains quality of screens.	The county health department, upon receiving the Healthy Start risk screen, monitors whether the screen was mailed within the specified time and was completed and scored accurately. If incomplete or scored inaccurately, the county health department in the county where the screen was completed will contact the provider for corrections. The provider should be aware that this quality control mechanism is in place. When entered into HMS, screening forms with missing data elements go into "query" status until those elements are obtained and entered. Query screens are not calculated in county
9. Information related to reimbursement for prenatal screening.	Private providers who bill Medicaid fee-for-service are eligible to receive reimbursement for provision of the Healthy Start prenatal risk screen. This reimbursement includes an additional amount for screening that is completed during the first trimester of pregnancy. The reimbursement is handled the same as other Medicaid reimbursable services. <i>(Use code H1001 TG (modifier) for screening conducted in the first trimester and H1001 for screening conducted subsequent to the first trimester.)</i>

2. Reviewing and Monitoring Screening Practices of Local Providers:

Systematic monitoring of screening practices by the designated responsible agency will help identify strengths and weaknesses associated with Healthy Start risk screening.

Activities to be reviewed	Explanation/Comments
1. Screening patterns observed in the community: <ul style="list-style-type: none"> • Identify positive risk screens • Identify low number of completed screens • Identify number of inaccurate screens • Identify interval between screening date 	The identification of patterns of positive risk screens will assist providers and Healthy Start coalitions in planning service delivery that targets resources to populations and locations most in need of services. Areas or clusters of positive risk screens (or particular risk factors) can be identified by ZIP code, census tract, or population characteristics.
2. Quarterly feedback to providers related to quality and accuracy of the providers'	Regular feedback to providers will reinforce appropriate screening practices and provide a mechanism for correcting
3. Ongoing training and implementation regarding Healthy Start risk screening to meet the needs of all Healthy Start service	Periodic updates related to screening requirements will reinforce screening practices of providers and help maintain open lines of communication.
4. Providing information and presentations related to Healthy Start and receiving feedback from providers.	Presentations at meetings of professional organizations, hospital staff, and medical societies and at conferences will provide information about the importance of Healthy Start risk

Service Delivery Activities of the County Health Department Related to Screening Infrastructure

The Department of Health county health department is responsible for establishing an internal system to process and monitor the accuracy of Healthy Start risk screening forms. This responsibility is retained in the county health department even if other components of the system reside with another designated agency.

Activities Include:

1. Providing screens
2. Receiving and monitoring screens
3. Entering prenatal screens into the Health Management System
4. Distributing screens
5. Completing screens in query

1. Providing Screens:

The county health department will provide blank Healthy Start risk screening forms to providers responsible for Healthy Start risk screening, including birthing facilities and all providers of prenatal care.

2. Receiving and Monitoring Screens:

Upon receipt of the completed risk screen, the county health department in the county where the screen was completed will monitor risk screening instruments for completeness, obtain corrections as needed, and then forward all screens to client's county of residence when the client resides in a different county.

The County Health Department in the participant's county of residence will:

- enter screens into HMS
- distribute screens to care coordinator
- file screens in an administrative file as appropriate
- share a copy of screens with Healthy Families Florida, where client consented to release of information

3. Entering Prenatal Screens into the Health Management System (HMS):

The county health department in the participant's county of residence enters the data on the screening form into the HMS. Prenatal screening data should be uploaded to the Healthy Start Central Registry within 14 calendar days of screening date. If any required data elements are missing from data entry, the screen will go into "Query" status and the system will not upload the data from "Query" screens to the Healthy Start Central Registry. See below Completing Screens in Query.

4. Distributing Screens:

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Within five working days of the receipt of the screen the county health department in the county where the screening was completed will:

- Batch and send a copy of the screening forms to the county health department in the participant's county of residence, if different, who will forward to the Healthy Start care coordinator. If the screen is in "Query" status, a copy of the screen should be kept by the county health department to continue efforts to obtain the missing elements from the provider and a copy should be forwarded to the care coordinator to begin providing program services to the participant.
- Forward a copy of the *Healthy Start Prenatal Clients by Screening Month* and the *Healthy Start Infant Clients - Alphabetical Within Birth Month* reports to contracted Healthy Start care coordination providers outside of the health department. The reports will be updated on the Healthy Start Reports website to be accessed via password by the county health department, Healthy Start care coordination provider or other staff designated by the health department. (All clients who have said "No" to release of information must be redacted (removed) from the list prior to sending the report to an outside care coordination provider.
- Maintain an administrative file for forms on which the client declined screening, was not referred, or declined the program.
- Forward prenatal and infant screens on which the client consents to program participation and release of information to the care coordinator, if care coordination is provided outside of county health department.

5. Completing Screens in Query:

When any required data elements are missing from data entry and the screen goes into "Query" status, the (care coordinator/data entry operator/designated CHD staff) will contact the provider to obtain missing information to insure completeness of screen for upload to the Healthy Start Central Registry.

Provider Qualifications

At least one person in the agency responsible for establishing and maintaining a provider network for Healthy Start risk screening will meet the following education and competency requirements.

Education Requirements:

Four-year college degree in one of the following areas:

- Social sciences
- A health related field such as nursing, health education, health planning, or health care administration
- Social work

or

Licensure as a Registered Nurse with three years of public health/community development experience

or

Two years of college with three years of public health/community development experience.

Competencies:

- Knowledge of local obstetrical, pediatric, and hospital providers and organizations;
- Knowledge of community assessment and community development concepts and practices;
- Demonstrated communication skills and ability to work with the providers of maternal, infant, and family services;
- Administrative and management systems expertise;
- Knowledge of maternal and child health principles;
- Ability to understand, analyze, and explain data related to public health assessments and service provision.

Documentation

Copies of the Healthy Start screening form should be placed in the participant's medical provider's record and the Healthy Start care coordination record and given to the participant. In the event that the woman or infant is not a Healthy Start participant or is not expected to become one, it is allowable to file the screen in an administrative file within the county health department in the participant's county of residence.

HMS Coding

Time spent in administrative activities related to screening is accounted for with the following codes and the appropriate time or service unit.

PARTICIPANT RELATED ACTIVITIES HEALTHY START CARE COORDINATION ADMINISTRATION

3951

Providing administrative activities related to screening and care coordination for Healthy Start participants.

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

1. Receiving and reviewing screening reports.
2. Reconciling discrepancies in screening data.
3. Transferring of screening forms to the county health department in the county of

residence.

4. Entering screens into the Health Management System.
5. Performing other Healthy Start care coordinator **administrative** functions that assure the Healthy Start process.
6. Other Healthy Start care coordination **administrative** functions that may be participant specific.
7. Healthy Start quality management/program improvement functions.

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

COMMUNITY ACTIVITIES HEALTHY START CARE COORDINATION ADMINISTRATION

3952

Providing information to the community related to Healthy Start and/or Healthy Start screening and collaboration with other community groups to provide services to pregnant women, children, and families.

Healthy Start care coordination administrative community activities include information sharing with community agency representatives or presentations at local places of worship or to business organizations, other community groups, or public and private providers. The process of information sharing should include the provision of information on the Healthy Start initiative. This process can include providing facts about the need for linking services and ways to identify participants who may need ongoing support to secure services. It may also assist providers to identify individuals who are potential recipients of Healthy Start services.

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

Quality Management/Program Improvement Performance Measures

The establishment and maintenance of an adequate provider network for Healthy Start screening is evidenced by improvement in screening rates based on Department of Health and Vital Statistics screening reports.

Effective processing of risk screening instruments is evidenced by:

- Timely delivery of accurate risk screens to the county health department,
- Timely entry of screening forms into HMS,
- Timely upload of screening forms from HMS to the HS Central Registry,
- Timely obtainment and entry of missing data items for screening forms that are in "Query" status for upload into the Healthy Start Central Registry,
- Timely delivery of accurate risk screens to the provider of Healthy Start care coordination,

and

- Timely forwarding of completed screens to county of residence.

Additionally, the *Healthy Start Executive Summary Report* can be used to evaluate the following outcomes related to Healthy Start screening:

- Percentage of potential participants offered screens (compared to estimated number of pregnant women/number of births for same time period).
- Percentage of potential participants consenting to and receiving screens.
- Total percentage of positive screens and screens referred for other factors.
- Percentage of potential participants (or their families) consenting to participate.

References

Florida's Healthy Start Prenatal Risk Screen (DH 3134)

Florida's Healthy Start Infant (Postnatal) Risk Screen (DH 3135)

Chapter 64F-3, Florida Administrative Code, Healthy Start Care Coordination

Chapter 64C-7, Florida Administrative Code, (formerly 10J-8), Prenatal and Postnatal Risk Screening and Infant Screening for Metabolic, Hereditary, and Congenital Disorders

Section 383.011, F.S., Administration of maternal and child health programs

Section 383.14, F.S., Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors

American College of Obstetricians and Gynecologists Educational Bulletin, Number 255, November 1999, Psychosocial Risk Factors: Perinatal Screening and Intervention

¹ Risk screening score from Prenatal Screening form #DH 3134, 4/08.

² Based on 113,502 births in 2005 linked to prenatal screening data.

Each risk ratio is adjusted for associations with all other risk factors in the table.

³ Risk screening score from Infant Screening form #DH 3135, 01/04.

⁴ Based on 313,791 births in 2005 and 2006 linked to 855 postneonatal death records.
Each risk ratio is adjusted for associations with all other risk factors in the table.

Frequently Asked Questions

Q. *Who is responsible for training providers?*

A. The delineation of responsibility should be clearly evident in the memorandum of

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agreement or contract negotiated between the Healthy Start coalition and the care coordination provider.

- Q.** Can the screening form be completed over the phone?
- A.** If the screening form has been signed by the participant, but lacks some other required items, then the screening form can be updated over the phone. The updated information needs to be initialed and dated by the county health department or Healthy Start staff member when obtained.
- Q.** *Do we screen infants who will potentially be placed for adoption?*
- A.** Yes, the screen should be offered to the legal guardian at the time of delivery.
- Q.** *A pregnant woman scores as not at risk on the screening form and a few weeks later her situation changes. Now she would score differently if she were to be re- screened. Should we have her complete another screening form?*
- A.** If you believe that a person is at risk, you may offer Healthy Start services no matter what her risk score is. An additional screening is not needed to justify providing services to the participant.
- Q.** *Who is eligible for reimbursement for the Healthy Start screens?*
- A.** Medicaid provides reimbursement for the Healthy Start prenatal risk screen to private providers who bill fee-for-service. A higher rate is reimbursed if the screening occurs during the first trimester of pregnancy. The financial infrastructure of county health departments is operated on a cost-based reimbursement methodology; therefore, they are not eligible to receive Medicaid reimbursement for individual screens.
- Q.** *The county health department has 5 working days to batch and send screens to the Healthy Start care coordinator. The Healthy Start care coordinator has 5 working days to attempt an initial contact. Are these the same 5 days or a total of 10 days altogether?*
- A.** The intent of the 5-day timeline is to assure that pregnant women and the families of infants are notified of their risk status and invited to participate in Healthy Start as soon as possible. With this in mind, it is conceivable, depending on the unique make-up of a local system, that it could take 10 days for the screen to make it through the health department and to the care coordinator, especially if the care or delivery takes place out of county. However, it is always desirable that the woman or family be contacted just as soon as is reasonably possible, and within 5 working days, unless there are circumstances beyond the system's control that preclude this. In that instance, a quality

management/program improvement process may be helpful in identifying and resolving problems in meeting the timeline.

Q. *What is the purpose for the Healthy Start Prenatal Client's by Screening Month and the Healthy Start Infant Clients – Alphabetical Within Birth Month reports?*

A. Healthy Start care coordination providers should use the reports during regularly scheduled quality management/quality improvement activities to insure that Healthy Start has followed up with all clients who were referred to the program.

Q. *What are strategies for increasing screening rates?*

A. Ongoing training and education of providers, provision of feedback to providers, and the involvement of providers in ongoing Healthy Start activities have all been reported by communities as successful strategies for increasing screening rates.

Q. *Although we do not provide prenatal care, we do provide PEPW and other maternity assessments. Should we be providing the prenatal screen?*

A. The screening system is designed to encourage screening at the initial prenatal appointment or as soon as possible thereafter. The goal is to identify high risk women and ensure their access to prenatal care and other services. It is recommended that in order to prevent duplicate prenatal screening, you work to ensure the ongoing education of your prenatal care providers rather than offering the screen; however, the woman may be referred at this point to Healthy Start.

Q. *Who can administer the Healthy Start prenatal screening instrument?*

A. Screening should be done by staff of prenatal care providers and birth facilities as a component of an initial prenatal health care visit, or as part of the pre- discharge care of a newborn. This systematic approach will ensure that all pregnant women and infants are offered a screen in a manner that encourages screening consent, and that they are screened only once.

Q. *What should happen if a provider is unsure if a woman had a risk screen done with a previous prenatal health care provider?*

A. In this instance, if the woman is unsure if a risk screen was completed and the prenatal care records were not transferred to the new provider, a risk screen should be completed at this visit.

Notes:
