Chapter 11: Healthy Start Care Coordination

Introduction

Care coordination is provided within the context of the program to ensure participants receive prenatal, interconception, and pediatric care, as well as other services available in the community to mitigate identified risks as well as social determinants of health that contribute to adverse birth outcomes and developmental delay. Healthy Start workers strive to assure each participant is linked to needed services through actively engaging the participant and building on the families' strengths, assets and goals.

Definition of Services

Care Coordination is connecting women and families to community resources in order to address risk factors associated with poor pregnancy and infant outcomes.

Provider Qualifications

At a minimum, the Healthy Start workers must meet the qualifications and demonstrate the competencies outlined in Chapter 6, The Healthy Start Program.

Healthy Start Care Coordination must be provided in accordance with the constraints of the professional's practice act, established protocols and the individual's prenatal education, training, and experience. **Paraprofessionals must provide services under the supervision of a professional supervisor.** If a participant is referred for additional services such as substance abuse treatment, mental health counseling, or clinical medical services, the Healthy Start worker must ensure the participant is being referred to entities or individuals with the appropriate credentials or licensing to provide the service.

Standards and Criteria

Standard 11.1 All Healthy Start Program participants will receive ongoing care coordination.

Criteria:

11.1.a 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, and
3. Includes all related service delivery activities specified in this chapter.

11.1.b Care coordination services are provided according to risk appropriate criteria.

11.1.c The Healthy Start worker 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.

11.1.d 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.

11.1.e Healthy Start services are provided in a manner that adheres to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care https://www.thinkculturalhealth.hhs.gov/clas.

Standard 11.2 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
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 11.3 All Healthy Start participants will have an Individualized Plan of Care.

Criteria:

11.3.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 Healthy Start worker's evaluation of the participant's risks and needs.

11.3.b The IPC is initiated at the Initial Assessment, and is re-evaluated at each subsequent encounter.

Standard 11.4 All Healthy Start participants will have a Family Support Plan.

Criteria:

11.4.a The Family Support Plan is initiated at the Initial Assessment.

11.4.b If the Family Support Plan was not initiated at the Initial Assessment, the Family Support Plan will be initiated at the first Healthy Start Program face-to-face visit.

11.4.c The Family Support Plan is required for all participants and will be updated at least every three months.

Standard 11.5 In conjunction with the participant, the Healthy Start worker will continue to facilitate the participant's access to adequate health care, other health care funding options and resources through provision of appropriate referrals.

Criteria:

11.5.a At a minimum, Healthy Start workers will evaluate the participant's ability to access and, if necessary, facilitate access to:

1. Medicaid and Title XXI eligibility determination
2. Prenatal and postpartum care
3. Child primary health care
4. Immunization services
5. Family planning services
6. Adult primary care services including mental health and drug treatment
7. WIC
8. Housing
9. Transportation
10. Food
11. Child care
12. Managed Care Organization

11.5.b Each pregnant or interconception woman or infant/child who has been assessed to be in need of community services is referred to a qualified provider within five working days.

Standard 11.6 Healthy Start workers 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, Healthy Start workers comply with the following interagency agreements:

1. Early Steps, Children's Medical Services

2. Regional Perinatal Intensive Care Centers (RPICC) and other Level III Centers
3. Department of Children and Families for pregnant, substance abusing women and substance exposed children
4. County health departments in the event the county health department is not the sole provider of care coordination

Standard 11.7 Healthy Start services will be provided by qualified and trained providers who meet education, training, and competency standards for their position.

Criterion:

Qualifications and competencies are met as specified in Chapter 6, The Healthy Start Program.

Standard 11.8 Healthy Start workers will document care coordination services in the approved data management system in a format determined by the local coalition and service provider within three business days of service completion.

Criteria:

11.8.a Services and attempts to provide services are documented in the approved data management system in the electronic record of the individual receiving the services.

11.8.b In the event that services are provided to another person on behalf of a Healthy Start participant (such as the parent of a referred infant), the services are only referenced in the participant's electronic record. The actual detailed documentation occurs in the record of the individual receiving the service.

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

1. All attempts, successful and unsuccessful, to contact the potential program participant.
2. All interactions with the program participant, the family, or with others impacting their receipt of services.
3. Identified risks and needs and how these are addressed or rationale for not addressing the risks and needs.
4. Follow-up with the participant's prenatal or primary health care provider.
5. Activities related to the tracking, provision of referrals and follow-up activities, Individualized Plan of Care (IPC) updates, Family Support Plan updates, and health related education

Standard 11.9 Providers of Healthy Start services will accurately code service information in the approved data management system within three business days of service completion.

Criterion:

Coding complies with the requirements of the Department of Health publication DHP 50-20 and as specified in Chapter 23, Healthy Start Coding, of these Healthy Start Standards and Guidelines.

Standard 11.10 Healthy Start service providers will develop and implement an internal continuous quality improvement (CQI) process.

Criterion:

The CQI process, developed in collaboration with the local Healthy Start coalition, includes an assessment of strengths, an assessment of areas needing improvement and a plan for assuring maintenance of program quality and improvement.

Guidelines

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.

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

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 worker 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, Healthy Start workers 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 Family Support Plan. (See Chapter 23, Healthy Start 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 the Initial Assessment.

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 Enhanced Services. However, depending on the risk and what the participant and family need to reduce their risk, the Healthy Start worker 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 Healthy Start Standard and Guidelines 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 Healthy Start worker 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 Healthy Start worker 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 cannot 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 Healthy Start worker 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.

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 Healthy Start worker 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 Healthy Start worker'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 Healthy Start worker 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. Provide education on disaster preparedness for the family

Risk Appropriate Care

Care coordination plays an invaluable role. 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.

Healthy Start care coordination service delivery is based on the concept of risk appropriate care. Healthy Start workers evaluate the risk status of participants and determine whether services are required to help reduce the risk. Although some risk factors identified on the Prenatal and Infant Risk Screen cannot be changed with interventions (e.g., age, race), these factors serve as markers for underlying situations that can be addressed. The Prenatal and Infant Risk Factor Matrix Tables provide examples of situations that may be associated with the risk factors identified through risk screening, the Initial Intake, the Initial Assessment, or during Healthy Start Program services (see Appendix D).

GUIDING PRINCIPLES FOR ASSURING RISK APPROPRIATE CARE COORDINATION

Providers of Healthy Start care coordination should:

- 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 *directly* a health- related outcome, perhaps having a car will enable her to attend her prenatal care appointments more reliably)

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

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

In determining who should be referred for Healthy Start funded Enhanced Services, Healthy Start workers 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.

Table X.X Participants Most Likely to Benefit from an Enhanced Service provides examples of participants who will most benefit from referral for Enhanced Healthy Start funded services. (These services are described in Chapters 7-22.)

Table X.X Participants Most Likely to Benefit from an Enhanced Service

Healthy Start Services	Participants Most Likely to Benefit from an Enhanced Service
Breastfeeding Education & Support	Pregnant 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: • 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	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: • First time pregnant women who are also at high risk for poor outcomes • Teenagers • Women who verbalize fear of childbirth and are also at high risk for poor outcomes • Women who were sexually abused • Women who are developmentally disabled

Nutrition Counseling	• 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 $\geq$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 four 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
Psychosocial Counseling	• 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 **Note:** Healthy Start psychosocial counseling 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.
Tobacco Cessation Counseling	• Pregnant, interconception and/or postpartum women, and families of children who have been assessed as ready to change their tobacco using behavior modification. • Members of the participant's household who have been assessed as ready to change their tobacco using behavior modification

Family Support Planning:

Introduction:

During the Initial Assessment, family support planning should be initiated for all participants who will receive the Healthy Start Program (services beyond the Initial Assessment). If a participant refuses to sign a Family Support Plan (FSP), the Healthy Start worker 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 Healthy Start worker 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 and 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.

Note: If the participant/family will not receive the Healthy Start Program (services beyond the Initial Assessment), then a family support plan will not be initiated.

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 Healthy Start worker's goals for the participant or family. The initial Family Support Plan is completed face-to-face. At each face-to-face encounter, evaluation is made of progress toward achieving the stated goals. The Healthy Start worker 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 during a face-to-face visit. The participant is given a copy of the FSP, and the original is kept in the participant's record.

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.

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 Healthy Start worker 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 in the next 60 days."

2. Developing Next Steps - Action Plan

   Healthy Start workers 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 worker 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 Healthy Start worker will place the unsigned FSP in the chart and will document the refusal in addition to any other supporting information.

   The Healthy Start worker 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 at a minimum 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 Healthy Start worker and the participant/family will jointly assess the continuing appropriateness of selected interventions, strategies, and activities toward meeting goals. The Healthy Start worker 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 23, Healthy Start Coding, for Family Support Plan coding guidelines).

Documentation

Healthy Start care coordination services, or the provision of Healthy Start care coordination services, must be documented in the participant's electronic record in the approved data management system within three business days of service. Healthy Start care coordination documentation in the participant's electronic record must include:

- Authorization for release of information, signed by the participant, or on behalf of the participant, for any information that is to be shared among payers, providers, or others
- Individualized Plan of Care
- Family Support Plan
- Documentation of information, referrals, and interventions provided

Coding

Healthy Start services for care coordination should be coded in accordance with approved protocols and procedures for coding. Healthy Start care coordination services require specific codes for service delivery. 3300-series codes should be entered into the approved data management system, by participant name, within three business days of service completion. The provider of the service should code one unit for every 15 minutes of services provided to the appropriate program component.

No group coding is allowed. This is necessary to provide for tracking, analysis, and program evaluation of client specific data.

Refer to Chapter 23, Healthy Start Coding, in the Healthy Start Standards and Guidelines for more specific information on coding, including coding for referrals and follow-ups.

Continuous Quality Improvement (CQI)

The CQI process should be designed to measure and help improve the extent to which women and families receive care coordination services to eliminate barriers that prevent women from receiving services and to reduce risk factors identified through the Risk Screen, referral, Initial Intake, and Initial Assessment.

The Healthy Start coalition should verify that the Healthy Start worker continues to meet provider qualifications and has continued their training keeping up-to-date with resources in the community.

Examples of targeted outcomes to be measured through the CQI process include:

1. Reduction or elimination of the original Healthy Start risk factors or their underlying situations.
2. Percentage of participants who received referrals during Healthy Start and were able to access services.
3. Percentage of participants who receive the required number of face-to-face visits at the designated times.
4. Percentage of referrals with documented follow-up.
5. Adequate training opportunities regarding area resources for Healthy Start workers.

Record reviews by Healthy Start supervisors are completed at least quarterly to determine the effectiveness of Healthy Start care coordination. A randomly selected sample of records from all Healthy Start participants will provide necessary information for determining the effectiveness of Healthy Start care coordination. Based on the information documented in the participant's record, including but not limited to the Initial Assessment 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 Risk Screen, Initial Intake, Initial Assessment, Individualized Plan of Care, and Family Support Plan?
- What are the critical risk factors documented in the record?
- Were indicators of child maltreatment recognized and reported appropriately?
- What are the protective factors of the participant/family?
- What are the action steps (interventions) to address the risk factors/concerns of the participant?
- Was the intervention appropriate for the risk factors and needs of the participant?
- Was the Individualized Plan of Care appropriate for the risk factors and needs of the participant?
- What are the stated goals and objectives agreed upon by the participant/family on the Family Support Plan?
- 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?
- Did the home visit focus on the achievement of goals and objectives?
- Was the home visit provided by the most appropriate individual (paraprofessional,

professional, family outreach worker) in order to achieve the goals and objectives?

- Was the participant given appropriate referrals?
- Was the participant able to access services?

Documentation of adequate ongoing care coordination is evidenced as follows:

- A written Individualized Plan of Care (IPC) that is initiated at the Initial Assessment 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
- A formal Family Support Plan
- Update of progress made toward goal(s) of Family Support Plan and the Individualized Plan of Care
- 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
- Routine prenatal or infant/child primary health care (including Child Health Check Up for Medicaid eligible children) received at the appropriate periodicity
- 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.
- Healthy Start Outcomes for each participant who has received ongoing care coordination services higher than Initial Assessment.

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.

See Chapter 30, Continuous Quality Improvement, for additional information.

Resources and References

Department of Children and Families	www.myflfamilies.com/service-programs/abuse-hotline/howtoreport

Early Steps	www.floridahealth.gov/programs-and-services/childrens-health/early-steps/index.html
Florida WIC	http://www.floridahealth.gov/programs-and-services/wic/
Florida's Head Start State Collaboration Office	http://floridaheadstart.org/
U.S. Department of Health & Human Services	https://homvee.acf.hhs.gov/Default.aspx
Zero to Three	https://www.zerotothree.org/resources/series/home-visiting-supporting-parents-and-child-development

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