

Chapter 6: The Healthy Start Program

Introduction

The Healthy Start Program is a home visiting program that delivers education, care coordination, screening and interventions/referrals, follow-up in accessing prenatal care and other needed services, anticipatory guidance and ongoing support to participants who have risk factors associated with an increase in preterm delivery, low birth weight delivery and/or infant mortality. Services are provided in an effort to mitigate or eliminate these risk factors and address social determinants of health that contribute to adverse birth outcomes and developmental delay. Key components of the program include:

- Prenatal and parenting education using standardized, research informed curricula;
- Interconception education using a standardized curriculum;
- Screening for perinatal depression, intimate partner violence, tobacco/substance use and child development using validated tools at key intervals in pregnancy and following delivery;
- Intervention pathways that ensure risk appropriate care is provided by the Healthy Start worker or through referrals to community providers to address screening results;
- Follow-up, through care coordination, to ensure participants access prenatal and other health services, and other needed community services; and,
- Anticipatory guidance and support to engage participants and build on their assets, strengths and goals.

Eligibility

A Healthy Start Program participant may be:

- A pregnant woman who scores at-risk (6 or greater) on the Prenatal 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 Infant Risk Screen;
- An infant or toddler whose parent self-refers or is referred 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 recently had a loss (such as a miscarriage, stillbirth, or infant death) or recently had an infant placed out of the home (adoption or removed from the home);

While the goal is to keep women in Healthy Start during their pregnancy and through their infant's first year of life, the length of time a participant is eligible for Healthy Start Program services are:

- Pregnant women can be served up to 8 weeks postpartum.
- Infants, toddlers and their families can be served up to when the child reaches three years of age if the family is in need of continued services and there is no other program in the area that the family can be referred to in order to meet their needs.
- Interconception women can be served up to 18 months post their most recent delivery.

Definition of Services

Healthy Start Core Services – standardized services that are provided to Healthy Start participants regardless of county of service.

Healthy Start Enhanced Services – services that are provided to Healthy Start participants when funding is available and there is a need for Healthy Start to provide the service. Service availability varies from county to county.

Home Visiting – When the term “home visiting” is used throughout the Healthy Start Standards and Guidelines, the reader should apply a broader definition to include any face-to-face visit taking place in a location that is convenient and preferred by the participant. This can include school-based visits, neighborhood center visits, or visits to the offices of other service providers.

Provider Qualifications

Healthy Start workers 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 Healthy Start services. The Healthy Start worker 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 worker who provides Healthy Start Core Services and/or Enhanced Services must meet the qualifications and demonstrate competencies as outlined in Chapters 7-22 in order to provide those specific services.

Healthy Start workers must meet one or more of the following educational requirements and have received all 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. Associate degree and licensure as a Registered Nurse with three years of public health/maternal-child health experience or licensure as a Licensed Practical Nurse

with four years of public health/maternal child health experience

3. Two years of college with three years of public health/maternal-child health experience
4. Paraprofessional Healthy Start workers have a high school education or its equivalent and must meet additional requirements as follows:
 - a) Paraprofessionals providing Healthy Start services must receive ongoing supervision by a professional supervisor who meets the educational requirements specified in the qualifications in 1, 2, or 3 above.
 - b) Paraprofessionals providing Healthy Start 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 worker activities conducted by a paraprofessional must be reviewed every two weeks by a qualified professional supervisor as described above in section 4.a. Electronic documentation of the case review will be kept in the participant's record.
 - e) Paraprofessionals providing Healthy Start services including care coordination must use a systematic process as outlined in this chapter and utilize thorough documentation, to include an Individualized Plan of Care based on the participant's service needs. All the documentation must be reviewed and co-signed within two business days by the supervisor.
 - f) 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.
 - g) Paraprofessionals may not assume the role of lead Healthy Start coordinator.
 - h) Although paraprofessionals are important members of an interdisciplinary team, they may not function as interdisciplinary team leaders.

Competencies for Healthy Start Program Providers:

The Healthy Start worker is expected to demonstrate:

1. Cultural sensitivity to and competency in working with participants from a variety of cultural backgrounds;
2. Practice of family-centered communication skills;
3. Ability to advocate on the participants' behalf;
4. Ability to communicate verbally and in writing with health care providers and other community resource people;

5. Knowledge of:
 - a. Community resources for at-risk pregnant and interconception women, infants, young children, and their families and procedures for accessing them;
 - b. Available Healthy Start services;
 - c. All components on the Department's Prenatal and Infant Risk Screen;
 - d. Evaluation of service needs and assessment;
 - e. Maternal and child health principles, including:
 - 1) Normal pregnancy anatomy, physiology, comfort measures, breastfeeding, danger signals, and what to do if danger signals occur;
 - 2) 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;
 - 3) Basic content of prenatal and well-child care;
 - 4) Importance of appropriate interpregnancy interval and basic knowledge of family planning methods;
 - 5) Child Health Check Up periodicity schedule and the components for each visit;
 - 6) Impact of and interventions related to the special needs of families with substance abuse and families with potential for or histories of intimate partner violence and/or child abuse;
 - 7) Recognition of stage of readiness to stop tobacco and other substance abuse and appropriate intervention; and
 - 8) Family dynamics including principles related to parents adjusting to role as care giver, appropriate discipline, parental/caregiver self-care, and managing stress.
 - f. Effects social determinants of health and barriers to health equity have on birth outcomes and overall health;
 - g. Child abuse or neglect indicators and the responsibility to report to the Florida Abuse Hotline 1-800-962-2873;
 - h. Home environment and safety assessment;
 - i. Funding resources such as local funding options, eligibility and limits of Medicaid, and local workforce development resources;
 - j. Family support planning process;
 - k. Chart documentation to include but not be limited to Individualized Plans of Care and Family Support Plans;
 - l. Healthy Start coding procedures;
 - m. Situations in which it is necessary to contact a supervisor immediately regarding the

participants' immediate needs and/or safety concerns; and

6. Knowledge and adherence to pregnancy and postpartum non-directive information and counseling for prenatal care and delivery, infant care, adoption and pregnancy termination options.

Healthy Start services must be provided in accordance with the constraints of the professional's practice act, established protocols and the individual's education, training, and experience.

Paraprofessionals must provide services under the supervision of a professional supervisor. If a referral is made 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 6.1 All prenatal women, families with children under the age of three, women who have experienced a recent loss (miscarriage, stillbirth, infant death) and women who recently had an infant placed out of the home (adoption or removal by DCF) who are determined through the Initial Assessment to need Healthy Start ongoing services will receive the Healthy Start Program.

Criteria:

6.1.a Participants receive their first Healthy Start Program home visit within 30 calendar days of the completion of the Initial Assessment.

6.1.b The Healthy Start Program 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.

6.1.c 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.

6.1.d 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 6.2 Healthy Start Program participants will receive Core Healthy Start Program services.

Criterion:

During the appropriate time frames, participants will receive the following Healthy Start services as outlined in the Healthy Start Standards and Guidelines:

- Prenatal Education

- Parenting Education
- Interconception Education and Counseling
- Stress Management Education
- Care Coordination
- Screenings for Perinatal Depression, Intimate Partner Violence, Tobacco Use, Substance Use and Child Development
- Individualized Plan of Care
- Family Support Plan

Standard 6.3 All Healthy Start Program Participants will have an Individualized Plan of Care.

Criteria:

6.3.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.

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

Standard 6.4 All Healthy Start Program participants will have a Family Support Plan.

Criteria:

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

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

6.4.c The Family Support Plan is required for all participants and will be updated at least every three months through a face-to-face interaction with the participants (see Chapter 11, Healthy Start Care Coordination, for more information.)

Standard 6.5 In conjunction with the participant, the Healthy Start worker will facilitate the participant's access to adequate health care, other health care funding options and resources through provision of appropriate referrals.

Criteria:

6.5.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

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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

6.5.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 6.6 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 6.7 Healthy Start Enhanced Services will be delivered according to identified risk and need.

Criteria:

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

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

Standard 6.8 Healthy Start services will be provided by qualified and trained providers who meet education, training, and competency standards for their position.

Criteria:

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

6.8.b Any Healthy Start worker who provides Core Services and/or Enhanced Services must have expertise in that specific field and meet the qualifications and competencies of the corresponding chapter, as outlined in Chapters 7-22.

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

6.8.d Prior to providing services to Healthy Start participants, all Healthy Start workers receive pre-service training on Healthy Start Program services and eligibility requirements, the CI&R process, home visiting, Prenatal and Infant Risk Screening, child abuse, intimate partner violence, recognizing and reporting abuse and neglect, area resources and demonstrate competencies as specified in this chapter.

6.8.e Each agency providing Healthy Start will have a written orientation plan with checklist sign off for their personnel file.

6.8.f Competency and up-to-date knowledge related to Healthy Start services and care coordination are maintained. Training certifications shall be placed in personnel files and made available upon request.

6.8.g 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.

6.8.h All Healthy Start staff will receive ongoing training about all service options and regular supervision to help ensure positive client engagement and effective referral strategies.

6.8.i The Healthy Start worker is knowledgeable about eligibility requirements and fees for other services.

6.8.j The Healthy Start worker 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.

6.8.k The Healthy Start worker 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 6.9 Participants may be closed to the Healthy Start Program when it is determined services are not desired, not needed, the participant is receiving services from another home visiting program, the participant is no longer eligible for Healthy Start, or the participant has been lost to contact.

Criteria:

6.9.a Participants “graduate” from the Healthy Start Program when the participating infant reaches one year of age.

6.9.b Families who need services beyond their infant’s first year should be referred to a care coordination program that serves children one to three years. If no care coordination programs for children ages one to three are available, the participant will remain in Healthy Start until services are no longer warranted, a care coordination program who can meet the needs of the family becomes available, or the child reaches their third birthday.

6.9.c The Healthy Start Program is a voluntary program and the participant may choose to end services at any time.

6.9.d At a minimum, three attempts to contact are made before closing as “Unable to Locate” with one attempt being a face-to-face attempt to contact. In addition, prior to closure as “Unable to Locate”, the Healthy Start worker should check resources for updated information regarding phone number and address or follow-through with care. Suggestions of resources include:

- Participant’s health care provider
- WIC staff and WIC Information Project (WIP) System
- Immunizations staff and Florida SHOTS database
- FLORIDA Medicaid database (FMMIS)

6.9.e Healthy Start 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;
6. Documentation of IPC goals, birth and health outcomes, as appropriate; and
7. Documentation of Healthy Start Outcomes if the participant received services higher than Initial Assessment services from the Healthy Start worker.

6.9.f Participants may be reopened to the Healthy Start Program if they remain eligible for the program.

Standard 6.10 Providers of Healthy Start services will document 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:

6.10.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.

6.10.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.

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

1. The participant's risk screening form, or documentation of risks, if referred by a community provider or self-referred.
2. Authorization for release of information, signed by the participant, or on behalf of the participant.
3. All attempts, successful and unsuccessful, to contact the potential program participant.
4. All interactions with the program participant, the family, or with others impacting their receipt of services.
5. Identified risks and needs and how these are addressed or rationale for not addressing the risks and needs.
6. Activities related to Initial Assessment and ongoing Healthy Start services, including tracking, provision of referrals and follow-up activities, Individualized Plan of Care (IPC) updates, and health related education.
7. A Family Support Plan.
8. Follow-up with the participant's prenatal or primary health care provider.
9. All closure activities.

Standard 6.11 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 6.12 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

The goal of the Healthy Start Program is to keep families engaged during the pregnancy and through the infant's first year of life. During their time in Healthy Start, families receive Healthy Start Core Services to assist in reducing risk factors that may result in poor outcomes such as preterm birth, low birth weight delivery and infant mortality.

Core Services are provided to all Healthy Start participants, regardless of county of service. These services include:

- a. Prenatal Education – provided during the participant's pregnancy using the Partners for a Healthy Baby curriculum. See Chapter 7, Healthy Start Prenatal Education, for standards, guidelines, and additional information.
- b. Parenting Education – provided to the parent/guardian of an infant participant using the Partners for a Healthy Baby curriculum. See Chapter 8, Healthy Start Parenting Education and Support, for standards, guidelines, and additional information.
- c. Interconception Education – provided during the prenatal participant's third trimester and continues through six months postpartum using the *Interconception Care Curriculum for the Healthy Start Program*. See Chapter 9, Healthy Start Interconception Education and Counseling, for standards, guidelines, and additional information.
- d. Stress Management Education – provided using the Mothers & Babies curriculum. See Chapter 10, Healthy Start Stress Management Education, for standards, guidelines, and additional information.
- e. Screenings occur throughout a participant's time in Healthy Start.
 - 1) Perinatal Depression Screening – provided to participants during pregnancy and postpartum. See Chapter 13, Healthy Start Perinatal Depression Screening, for standards, guidelines, and additional information.
 - 2) Intimate Partner Violence Screening – provided during pregnancy and postpartum. See Chapter 14, Healthy Start Intimate Partner Violence Screening, for standards, guidelines, and additional information.
 - 3) Substance Use Screening – provided to participants during pregnancy and postpartum. See Chapter 15, Healthy Start Substance Use Screening, for standards, guidelines, and additional information.

- 4) Smoking Use Screening – provided to participants during pregnancy and postpartum. See Chapter 16, Healthy Start Tobacco Use Screening, for standards, guidelines, and additional information.
 - 5) Child Development Screening – provided to the Infant Participant throughout the service delivery period. See Chapter 17, Healthy Start Child Development Screening, for standards, guidelines, and additional information.
- f. Individualized Plan of Care
 - g. Family Support Plan – a written plan to assist the family in setting and reaching goals. See Chapter 11, Healthy Start Care Coordination, for standards, guidelines, and additional information.
 - h. Care Coordination – provided throughout the service delivery period to connect families to community services. Care coordination also accounts for time spent providing general education that is not captured by other service codes, travel time, time to complete paperwork, contacting resources on behalf of the client, etc. See Chapter 11, Healthy Start Care Coordination, for standards, guidelines, and additional information.

In addition to Core Healthy Start services, other Enhanced Healthy Start Services may be provided. These services are offered by Healthy Start when there is a lack of resources for these services in the community and funding is available. The availability of these services may vary from county to county. Enhanced services include:

- a. Breastfeeding Education – may be provided during the prenatal and postpartum period. See Chapter 18, Healthy Start Breastfeeding Education and Support, for standards, guidelines, and additional information.
- b. Childbirth Education – may be provided to pregnant women generally in their third trimester. See Chapter 19, Healthy Start Childbirth Education, for standards, guidelines, and additional information.
- c. Nutrition Counseling – may be provided for the pregnant woman, interconception woman or infant/child. See Chapter 20, Healthy Start Nutrition Counseling, for standards, guidelines, and additional information.
- d. Psychosocial Counseling – may be provided to participants of Healthy Start. See Chapter 21, Healthy Start Psychosocial Counseling, for standards, guidelines, and additional information.
- e. Tobacco Counseling – may be provided to the participant, anyone who lives with the participant and anyone who cares for the infant/child. See Chapter 22, Healthy Start Tobacco Education and Cessation Counseling, for standards, guidelines, and additional information.

Home Visiting

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Healthy Start Core Services and Enhanced Services are provided during home visits. Below is a schedule of when Healthy Start home visits should occur:

Healthy Start Home Visitation Frequency	
Visit 1	Initial Assessment/Engagement Visit
Visit 2 and 3	Trimester 1
	Trimester 2
Visit 4 and 5	Trimester 3
Visit 6 and 7	Postpartum Month 1
Visit 8 and 9	Postpartum Month 2-3
Visit 10 and 11	Postpartum Month 4-6
Visit 12	Postpartum Month 7-9
Visit 13	Postpartum Month 10 to 13

Unsuccessful home visit attempts should be rescheduled as quickly as possible.

Between the 11th and 12th visit and between the 12th and the 13th visit, no more than 90 days should pass between home visits.

Along with home visits, at a minimum, the Healthy Start worker makes telephone contacts with the participant/family monthly. Telephone contacts consist of more than scheduling the next home visiting appointment. This should be an opportunity to assess the family's needs, ensure that the family has access to care, and provide general information, as needed.

If the family continues with Healthy Start beyond 13 months postpartum, phone contacts will be made to the family every month and home visits will occur at a minimum of every three months until the case is closed or the child reaches their third birthday.

A Note on Home Visiting:

It is important to remember that the home visitor is a guest in the participant's home. A home is a place where people go to feel safe and to retreat from the stressors of the outside world. The home visitor should remember the importance of treating participants with courtesy, kindness,

and respect—especially when meeting with them in the home setting. This helps to foster a sense of trust and can ultimately lead to improved outcomes.

Unfortunately, some Healthy Start clients live in home environments that are less than ideal—this may include housing that is cramped/overcrowded, cluttered, foul-smelling, noisy, too hot/too cool, etc. While such conditions may be temporarily unpleasant for the home visitor, they do not pose a safety risk for the home visitor, and should not discourage the home visitor from attempting to work with the client in the home setting if it has been mutually determined by the home visitor and the participant that home visits are a desired mode of service delivery. Even in less than ideal surroundings, home visiting can prove to be a very pleasant experience for both the home visitor and participant when overtures of courtesy, kindness, and respect lead to achievement of goals and improved health outcomes for pregnant and interconception women and their children.

Safety concerns include those issues related to the safety of both the participant receiving the home visit as well as the home visitor. See Appendix F for a list of items to consider when making a home visit.

Healthy Start Program Closure:

Introduction:

Closure to Healthy Start occurs when the participant completes the Healthy Start Program or when services are no longer desired, no longer needed, transitioned to another provider, the participant is no longer eligible for services, or the participant is lost to contact.

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

- The child turns one year, needs no further services and the family completes the program
- The family and professional agree there is no longer a need for services
- The prenatal participant completes her postpartum and family planning appointment and she declines services for her infant
- The interconception participant reaches 18 months 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 another provider of care coordination such as Early Steps
- The participant cannot be located after three documented attempts have been made to locate, including one face-to-face attempt

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For substance involved families or families with suspected or known child maltreatment, Healthy Start services should continue past one year postpartum unless there is a **consultation with the supervisor** and 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 Healthy Start services; and the biological mother no longer can benefit from services; or
 - c) The mother/caregiver with whom the child is living refuses services (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 Healthy Start case closure as appropriate.

Service Delivery Activities of Closure:

Healthy Start closure activities will be documented and an Individualized Plan of Care may be re-evaluated. 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 case 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 31, "Transition and Interagency Agreements.")
- Completion of Healthy Start Outcomes for each participant who has received services higher than the 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. 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, the Healthy Start worker should check resources for updated information regarding phone number and address or follow-through with care. Suggestions of resources include:

- 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)

(See Chapter 12 for guidelines for terminating services to families involved with substance abuse.)

Documentation

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

- Prenatal Risk Screen, Infant Risk Screen or Referral
- Initial Intake
- 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
- Initial Assessment
- Individualized Plan of Care
- Family Support Plan
- Progress Notes

Coding

Healthy Start services for the Healthy Start Program should be coded in accordance with approved protocols and procedures for coding. Service codes should be entered into the approved data management system, by participant name, within three business days of service completion. The Healthy Start worker or the provider of the service should code one unit for every 15 minutes of services provided.

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 Healthy Start 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 are determined to need the Healthy Start Program at the Initial Assessment and complete one Healthy Start Program Visit.
3. Percentage of participants who remain engaged in Healthy Start at three months, six months, and one year.
4. Percentage of participants who complete the Healthy Start Program.
5. Adequate training opportunities for Healthy Start workers.

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

- Was Healthy Start beneficial?
- Was staff courteous and helpful?
- Did the participant experience any barriers to services?
- Was the participant able to get the services to which they were referred?

Periodic satisfaction surveys of health care providers, community organizations and Healthy Start program representatives may also be beneficial by showing where improvements in outreach and working with community partners can improve.

Record reviews by Healthy Start supervisors are completed at least quarterly to determine the effectiveness of the Healthy Start Program. A randomly selected sample of records from all Healthy Start participants will provide necessary information for determining the effectiveness

of the Healthy Start Program. Based on the information documented in the participant's record, 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, referral, 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?
- If the case was closed as Unable to Locate, were the number of attempts and type of attempts to contact adequate based on risk factors and safety concerns?
- 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 satisfied with the Healthy Start Program service(s)?
- Did the supervisor follow-up to confirm the home visit was actually made?

Documentation of adequate ongoing Healthy Start services 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

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- A formal Family Support Plan
- Update of progress made toward goal(s) of plan
- 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 services higher than the 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 Healthy Start system as well as patterns of action and behavior that may provide a great deal of information about which components or critical factors have the greatest impact on outcomes.

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

Resources and References

American Academy of Pediatrics	www.aap.org
American Congress of Obstetricians and Gynecologists	www.acog.org/
CDC	www.cdc.gov/pregnancy/
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/
Healthy People 2020	www.healthypeople.gov/
March of Dimes	www.marchofdimes.org

Office of Women's Health	www.womenshealth.gov/pregnancy
Safe Haven for Newborns	https://asafehavenfornewborns.com/
U.S. Department of Health & Human Services	https://homvee.acf.hhs.gov/Default.aspx
U.S. Preventative Services Task Force	www.uspreventiveservicestaskforce.org/
Zero to Three	https://www.zerotothree.org/resources/series/home-visiting-supporting-parents-and-child-development

Johnson, Kay. (2009.) *State-based home visiting: Strengthening programs through state leadership*. Retrieved from http://www.nccp.org/publications/pdf/text_862.pdf.

Notes
