Healthy Start Coalition of Miami-Dade

Risk Assessment Leveling Guidelines

The Healthy Start Standards and Guidelines (HSSG) state:
Leveling: An approach to care coordination and caseload management whereby participants are assigned a level of service delivery that corresponds to the intensity and duration of service required to address the participant's risks and need for services. Levels are fluid; they are not static. A participant is designated a level during the initial attempt to contact; however, a participant/family can change between levels whenever risk and service needs change.

Levels are based on:

- Professional judgment through systematic assessment of risk factors and determination of the type and amount of intervention to offset the risk situation.
- The availability of participant's/family's assets and strengths to offset the risk situation.
- The participant's Healthy Start service needs and amount of care coordinator involvement. Levels are not based solely on a participant's characteristics. For example, a pregnant teenager who is receiving extensive services from other agencies and has a strong family support system would not automatically be assigned a level 3 because she is a pregnant teenager.
- At a minimum, encounters must occur at the frequency stated on the Healthy Start Leveling matrix

The standardized level definitions are:

Level E: Participants require only the service components of an Initial Contact. Education, counseling, and referral to community resources are given as needed.

Level 1: Participants typically function fairly independently, but may not have adequate knowledge about community services or may have additional barriers accessing, participating in or coordinating services for themselves or their child. Participants require short term follow-up on the ability to successfully access services. Participants do not stay in this level longer than 3 months before a determination is made to close to Healthy Start services or re-level to a higher level if services continue to be necessary. Education, counseling and referrals to community resources given as needed.

Criteria for Level 1 Assessment:
After IC has been completed and it is determined that the participant has more strengths than needs, close care plan as no further services needed. Invite and provide participants with a schedule of Healthy Start classes that are of interest to them. At a minimum, Level 1 participants will be contacted once every other month.

Level 2: Participants typically function fairly independently, but may not have adequate knowledge about community services or may have additional barriers accessing, participating in or coordinating services for themselves or their child. Education, counseling and referrals to community resources given as needed.

Criteria for Level 2 Assessment:
Families should be assessed a level 2 risk when they have risk factors that potentially pose risks for the health and safety of the pregnant woman, baby, or caregiver. A combination of risks may be present, but the woman may have reported adequate supports and strengths to deal with the current situation. Family / network support is assessed as present, and the woman can access such to assist her in coping with the presenting problem situation. Long term health and psycho-social outcomes for the woman are positive. The woman and family can benefit from care coordination services and she agrees to make necessary changes in her life and her family's.

There are some risk factors which may warrant initial leveling of 2. These include:

- Teen pregnancy (less than 18 years old)
- Mother whose age is more than 39 years
- Reporting of financial stress and difficulty with finances
- Single woman without a support system
- Concerns expressed about providing care for the newborn baby regarding parenting, health care, breastfeeding, etc.

At a minimum, Level 2 participants will be contacted once per month. If the participant is unable to be contacted after 3 attempts (phone/letter, no home visit), for ongoing care coordination, close the case as unable to locate. Mail a closure letter with a schedule of Healthy Start classes that are relevant to the participant.

Level 3: Participants/ Families are experiencing multiple concerns and need frequent service coordination. Safety concerns and crisis intervention are often characteristics of participants in this level. Education, counseling and referrals to community resources given as needed.

Criteria for Level 3 Assessment
Families should be assessed a level 3 risk when they have at least one significant risk factor that poses an imminent risk to the health of the pregnant woman, baby, or caregiver or demonstrates a number of lower level concerns that when combined put the child at-risk of harm. Safety concerns and crisis interventions are often characteristics of participants at this level.

There are some risk factors which warrant initial leveling of 3. These include:

- Significant safety concerns that pose an imminent threat to the health of child(ren) or caregiver
- Suspicion of domestic violence and/or past abuse issues
- Current DCF involvement or DCF involvement in the past year or repeated history of DCF involvement in the past
- Child is medically at-risk (NICU stay in the neonatal period, chronic health condition, failure to thrive, multiple hospitalizations in the first year of life, low birth weight (less than 4 lb, 7 oz/2000 g), congenital anomalies)

- Teen pregnancy/teen parent (less than 18 years old), in combination with any other risk factors
- Indications of maternal substance use during pregnancy/history of parental substance use during first year of life
- More than 4 children in the house (especially if family has low economic resources and low education)
- Significant parental mental health concerns that interfere with parent's ability to care for the child
- Parent smokes in the home or around child (due to an increased risk of SIDS, low birth weight, and second hand smoke)
- A reported history of past traumatic events (i.e. domestic violence, fetal loss during second/third trimester, infant loss, etc)
- Reported depression and/mental health concerns
- Inadequate role modeling from a parent or caregiver for parenting in the past, present, or future (i.e., teen parent)
- Chronic health condition of the mom or the baby
- Homelessness and/reports of not having adequate housing that affect the psychosocial conditions of the pregnant woman, baby, and family

At a minimum, Level 3 participants will be contacted on a bi-weekly basis to be in compliance with the HSSG. If participant is unable to be contacted after 3 attempts (including a face to face attempt) for ongoing care coordination, close case as unable to locate. Mail a closure letter with a schedule of Healthy Start classes that are relevant to the participant.

Additional Recommendations:

- Prenatal Screens with score less than six and are referred based on other factors shall be assessed by the Florida Department of Health in Miami-Dade County, Healthy Start Data Management Office and assigned if there is an indication maternal illness (chronic health condition), HIV status, homelessness, domestic violence, substance use, prior fetal loss during second/third trimester, infant loss, depression, or pregnant teen less than 18 years old.
- Postnatal Screens with score of less than four and are referred based on other factors shall be assessed by the Florida Department of Health in Miami-Dade County, Healthy Start Data Management Office and assigned if there is an indication of maternal illness (chronic health condition), HIV status, homelessness, domestic violence/child abuse, substance use/exposed infant, postpartum depression, parenting teen less than 18 years old.
- Self-referrals indicating maternal illness (chronic health condition), HIV status, homelessness, domestic violence/child abuse, substance use/exposed infant, prior fetal loss during second/third trimester, infant loss, depression, or pregnant/parenting teen less than 18 years old will be assigned.
- Florida Department of Health in Miami-Dade County, Healthy Start Data Management Office will be responsible to mail letters with a schedule of Healthy Start classes to participants who do not qualify for Healthy Start services.