Healthy Start System of Care Guidelines for IC, IA, Care Coordination

These are general guidelines as established by the Healthy Start Standards and Guidelines. The Provider must ensure that any local requirements set forth by the Healthy Start Coalition of Miami-Dade are adhered to which supersedes the basic guidelines found in this document and the Healthy Start Standards and Guidelines.

A. **Initial Contact**

1. The Provider shall contact or attempt to contact all potential participants within 5 business days of the receipt of the Healthy Start referral or positive risk screening. The initial contact may be telephonic or face-to-face. The Provider shall choose the most appropriate method(s) based upon the participant's level of risk and need for care coordination services. The Provider shall document the contact chosen method(s) and the participant's level of risk based, if known shall be documented in the participant's record.

2. During the initial contact with the participant, the Provider shall:

a) Provide information on the Healthy Start Program and the reason for the referral (positive risk screening, etc.);

b) Prioritize severity of risk and determine the ability to access health care through the managed care plan;

c) Evaluate service needs;

d) Provide information on how to address risk factors;

e) Provide referrals as needed;

f) Provide contact information for the Healthy Start care coordinator;

g) Initiate the Healthy Start care coordination record; and

h) Initiate and complete the Plan of Care.

3. If the Provider is unable to reach the participant after the first contact attempt, the Provider shall make two additional attempts to contact the participant. Subsequent contact attempts may be face-to-face, telephonic, or by mail, unless otherwise specified in the Contract. The second contact attempt shall be made within ten (10) business days of the first attempt. If unsuccessful, the third attempt to contact will be made within ten (10) business days of the second attempt.

The continued method of attempt to contact should correlate to the participant's risk and should be based on professional judgment. Phone attempts must be made at different times on different days.

4. The Provider shall ensure that one of the contact attempts is face-to-face if the participant has one or more of the following safety concerns. Knowledge or suspicion of current:

- Domestic violence;
- Sexual abuse;
- Child abuse or neglect;
- Diagnosed mental illness;
- HIV positive status;
- Hepatitis B positive status;
- Inadequate growth and development;
- Safety concerns noted by the health care provider on the Healthy Start screening form; or
- Language barriers.

5) The Provider shall ensure that written notification of the status of the initial contact and plan for further services or closure are provided to the prenatal care provider, child's primary care provider, or the managed care plan within thirty (30) calendar days of the first attempt to contact, if appropriate. If the child's primary care provider is not known, there must be documentation in the case file stating why written notification is not possible.

The Provider shall ensure that closure to Healthy Start occurs when services are declined, transitioned to another provider, no longer needed because risks are resolved, the participant is no longer eligible for services, or the participant is lost to contact. Before declaring a potential participant lost to contact, the Provider shall ensure that at least three documented attempts to locate are made.

B. **Initial Assessment**

1) The Provider shall provide a Healthy Start initial assessment to all participants meeting certain criteria during the initial contact. The initial assessment must be conducted face-to-face and performed in collaboration with the participant and the family, as appropriate. At a minimum, the Provider shall ensure:

a) An initial assessment or an attempt at an initial assessment will be done within ten (10) business days after the initial contact has been completed and determined that the participant meets the criteria for the assessment.

b) Participants have an Individualized Plan of Care (IPC) that includes the identified needs, goals, interventions, and progress towards meeting the goal(s).

c) Participants are assigned a level of service delivery, Healthy Start Leveling Matrix (found in Chapter 4 of the Healthy Start Standards and Guidelines) based on their needs.

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

e) The initial assessment takes place in a clinic, the community, or the home, and the location of the initial assessment is documented in the IPC.

f) Every pregnant woman or infant/child in need of other Healthy Start and/or community services is referred for those services within five (5) business days of receipt of the initial assessment.

g) A written report is provided to the prenatal care provider or the infant's/child's primary care provider, within thirty (30) calendar days of the initial contact and the initial assessment regarding findings, request for collaboration, and outline for the disposition of the case.

C. **Care Coordination and Risk Appropriate Care**

1) Care coordination services are the foundation for the delivery of Healthy Start services. Participants receiving care coordination are contacted, assessed, provided with information, and referred for Healthy Start and other community services. Eligibility for Healthy Start care coordination is determined by the pregnant woman or infant score on the Healthy Start prenatal or infant risk screening. A pregnant woman or an infant/child may also be referred for care coordination services by a health care provider, a community service provider, or through self-referral for reasons other than their Healthy Start prenatal or infant risk screening score.

2) Care coordination services may be provided face-to-face and/or telephonically, and can include direct contact with the participant and family, as well as indirect contact on the participant's behalf (e.g., communication with provider). Activities range from family support planning to intensive service coordination addressing complex problems. Care coordination may be provided to the participant on an ongoing basis, for the duration of enrollment in the program.

3) The Provider shall offer care coordination services to the following populations:

a) A pregnant women who scores at-risk (6 or greater) on the Healthy Start risk screen.

b) A pregnant women who self-refers or is referred to Healthy Start by health care provider, a care coordinator, or a community organization.

c) An infant who scores at risk (4 or greater) on the Healthy Start risk screen.

d) An infant or toddler whose parent self-refers or is referred to Healthy Start 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.

4) The Provider shall ensure the intensity and duration of care coordination services are determined by:

a) The presence of risk factors affecting participants.

b) The availability of participant or family assets, strengths, and resources to offset the risk factors.

c) Participant and family desires, concerns, and priorities.

d) Healthy Start care coordination provider and resources within the community.

5) The Provider shall ensure that services are delivered according to identified risk, and are not duplicative of those services provided by the participant's managed care plan.

6) The Provider shall ensure that the care coordination service delivery and caseload management are prioritized in a manner that addresses the immediacy of the participant's needs and identified risks to improve outcomes.

7) The Provider shall ensure that care coordination services are accurately coded into the Agency approved tracking system within three business days of delivery.

8) The Provider shall ensure that care coordination services are documented in the participant's record.

9) The Provider shall ensure that the following services and activities, when provided, are documented in the participant's record:

a) The participant's Healthy Start risk screening form or documentation of Healthy Start risks, if referred by community provider or self-referred.

b) All attempts, successful and unsuccessful, to contact the potential participant.

c) All interactions with the participant, the family, or with others impacting their receipt of services.

d) Identified risks, needs, and individualized plan of care for addressing, or rationale for not addressing the risks and needs.

e) Activities related to initial contact, initial assessment, and ongoing care coordination, including tracking, provision of referrals and follow-up activities, Individualized Plan of Care (IPC) updates, and health related education.

f) A Family Support Plan (FSP) for participants/families who have multiple concerns. (See Exhibit III)

g) All closure activities.

h) Follow-up with the participant's health care provider and managed care plan if appropriate.

10. For substance abusing pregnant women and substance exposed children and families, the Provider shall ensure that:

a) If the care coordinator has a concern that the mother or caregivers is not able to care for the infant or child, a report will be made to the Florida Abuse Hotline and documented in the participant's record.

b) The care coordination services are provided for the birth mother, regardless of whether the mother has or will retain custody of her child.

c) Appropriate services will also be offered to the caregiver when the mother is not the primary caregiver.

11. The Provider shall ensure that the care coordination providers participate in the development of collaborative networks of care within the community and refer and/or transition care to specialized community providers with whom they have interagency agreements.

12. The Provider shall ensure that care coordination services are provided by qualified and trained providers.

13. The Provider shall ensure that the care coordinator facilitates the participant's access to other health care funding options and resources through provision of appropriate referrals, which include:

a) Medicaid and Children's Health Insurance Program eligibility determinations;

b) Primary care services (pediatric and adult);

c) Immunization services;

d) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);

e) Other Healthy Start services; and

f) Family planning services.

14. The Provider shall ensure that care coordination services are discontinued when:

a) The participant exits the Healthy Start care coordination system.

b) The family and health care professional agree there is no longer a need for services.

c) The prenatal participant attended her postpartum visit, received family planning education and if not, reasons are documented in the participant's record.

d) The child reaches his or her third birthday.

e) The participant/family requests to discontinue participation.

f) The participant/family is receiving or going to receive services from Early Steps.

g) The participant/family is receiving or going to receive services from another provider of care coordination, other than Early Steps.

h) The participant cannot be located located/served after three documented attempts have been made to locate/serve, including one face-to-face attempt for level 2 and level 3 clients. (Participants at level 1 may be closed as unable to locate/serve after a minimum of three attempts to contact by letter or telephone.)

D. **Family Support Planning**

1) The Provider shall ensure family support planning is initiated for families with a history of substance abuse, and other high-risk participants. If an participant refuses to sign a Family Support Plan (FSP), the unsigned FSP will be placed in the participant record and the chart shall be documented that the participant refused to sign the FSP, along with any other supporting information. A FSP is not a plan of care.

2) The Provider shall ensure that the initial FSP is completed face-to-face during the initial assessment or if initial assessment is not completed on participant the FSP is completed during the first face-to-face encounter and updated every three months.

3) The Provider shall ensure that each encounter and/or evaluation of an participant's progress toward achieving the stated FSP goals is documented. This activities may take place face-to-face or over the phone.

4) The Provider shall ensure that the FSP is modified, as needed, and updated at least every three months during a face-to-face visit with the participant.

5) The Provider shall ensure that the participant is give a copy of the FSP and the original is kept in the participant's record.

E. **Breastfeeding Education and Support**

1) The Provider shall ensure that Healthy Start breastfeeding education and support services are provided by qualified and trained providers and are offered to all participants who need breastfeeding education and support services, as determined through assessment.

2) At a minimum, breastfeeding education and support shall include:

a) At least one face-to-face contact, for prenatal participant within thirty (30) calendar days or within three business days for postpartum participant after receipt of referral or identified need (unless more immediate initiation of services is evident), an assessment of current infant feeding status, counseling consistent with the breastfeeding plan of care and documentation based on goals, and referrals to local breastfeeding support groups or other support sources.

b) Documentation of all services in the participant's record, including a follow-up within thirty (30) calendar days of the referral and plan for services.

F. **Childbirth Education**

1) The Provider shall ensure that Healthy Start childbirth education services are provided by qualified and trained providers and offered to all participants who are determined to need childbirth education services as determined through assessment.

2) The Provider shall ensure that childbirth education services are provided at the site or sites most appropriate for meeting the participant's needs.

3) The Provider shall ensure that written follow-up documentation of referral and plan for initiation of services is provided to the Healthy Start care coordinator within thirty (30) calendar days.

4) The Provider shall ensure that providers of childbirth education will contact participants to initiate a plan of care for services at least ninety (90) days before the estimated delivery date, or at the time of the referral or identified need, if during the third trimester of pregnancy.

5) The Provider shall ensure that all services are documented in the participant's record.

G. **Nutrition Counseling**

Healthy Start nutrition counseling is in addition to the nutrition counseling that is provided to Women, Infants, and Children (WIC) participants. Healthy Start nutrition counseling is an intensive therapeutic nutrition assessment and counseling for populations found to be at high risk for adverse health outcomes.

1) The Provider shall ensure that Healthy Start nutrition counseling services are provided by qualified and trained providers and offered to all participants who need nutrition counseling services, as determined through assessment.

2) The Provider shall ensure that nutrition counseling services are provided at the site or sites most appropriate for meeting the participant's needs.

3) The Provider shall ensure that nutrition counseling includes a diagnostic assessment, development of a plan of care (POC), a plan to provide counseling consistent with the POC, and an evaluation of progress to meet the POC.

4) The Provider shall ensure that written follow-up documentation of referral and plan for initiation of services is provided to the Healthy Start care coordinator within thirty (30) calendar days.

5) The Provider shall ensure that nutrition counseling is initiated within thirty (30) calendar days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

6) The Provider shall ensure that all services are documented in the participant's record.

H. **Parenting Education and Support**

1) The Provider shall ensure that Healthy Start parenting education and support services are offered to all participants needing parenting and education support, as determined through assessment.

2) The Provider shall ensure that parenting education and support services are provided at the site or sites most appropriate for meeting the participant's needs.

3) The Provider shall ensure that parenting education and support includes the following components:

   a. Assessment
   b. Development of a plan of care
   c. Counseling and education consistent with the plan of care that includes presentation, a demonstration activity, and follow-up and feedback

   d. Evaluation of the participant progress

4) The Provider shall ensure that written follow-up documentation of referral and plan for initiation of services is provided to the Healthy Start care coordinator within thirty (30) calendar days.

5) The Provider shall ensure parenting education and support services is initiated within thirty (30) calendar days after receipt of referral or identified need unless the need for more immediate initiation of services is evident.

6) The Provider shall ensure that all services are documented in the participant's record.

I. **Tobacco Education and Cessation**

1) The Provider shall ensure that pregnant women who smoke or use other forms of tobacco are offered enrollment in Healthy Start to receive tobacco cessation services by qualified and trained providers. If enrollment is declined, it should be documented in the participant's record.

2) The Provider shall ensure tobacco education and cessation services are provided at the site or sites most appropriate for meeting the participant's needs.

3) The Provider shall ensure tobacco education and cessation services will continue once the child is born.

4) The Provider shall ensure tobacco education and cessation services will be offered to all participant's family members or household members who smoke.

5) The Provider shall ensure tobacco cessation services will be initiated within thirty (30) calendar days of referral or sooner if need there is a need for more immediate initiation of services.

6) The Provider shall ensure all tobacco education and cessation services are documented in the participant's record.

J. **Home Visiting and Other Variations in Service Delivery Sites**

1) The Provider shall ensure that participation in home or in varied service delivery sites is based upon identified level of risk, need, and participant's ability to access services.

2) The Provider shall ensure that Healthy Start services delivered in the home or in varied service delivery sites are provided by qualified and trained providers.

3) The Provider shall ensure all training materials that are used in home visiting are Coalition approved via the Network.

4) The Provider shall ensure home visits are provided in a prioritized manner, with the top priority placed upon safety concerns and the severity of the situation.

5) The Provider shall ensure all services are documented in the participant's record.