

Healthy Start Prenatal Record Review

Review Date: _____ Participant's Initials _____ DOB: _____ EDD: _____

Care Coordinator's Initials: _____ Reviewer's Name: _____

HS Care Coordination Provider: _____ Site: _____

Initial Contact (IC)	Yes	No	N/A	Comments
HS Screen Date: _____ Score: _____ Date received : by FDOHMD _____ by Coordinator _____ Self-Referral (other than screen) Date: _____ Referred by: _____ Case Transfer Date: _____ Transferred from: _____				Medicaid Information in system (if applicable) _____ Services entered within 3 days of service _____
IC attempt within five working days from receipt of screen				Date: _____ Method: Letter ___ Phone ___ HV ___
2 nd IC attempt within 10 working days of 1 st contact attempt				Date: _____ Method: Letter ___ Phone ___ HV ___
3 rd attempt within 10 working days of the 2 nd attempt				Date: _____ Method: Letter ___ Phone ___ HV ___ Total # of IC attempts: _____
IC contact actually completed				Date: _____ Method: Phone ___ HV ___ Level at IC: P E 1 2 3 (circle one)
Each risk factor assessed for intervention				
Each intervention appropriate for risk				
Follow-up with provider within 30 calendar days of 1 st attempt to contact				Date: _____
IPC completed on IC				Plan : Tracking Initial Assessment Closure
All IC components present in record				
MomCare Search Requested				<i>Only Required to close UTL</i>
Appropriate # of attempts made prior to closing UTL				
Appropriate Closure and Date: _____ (Choose ONLY One)				Declined Unable to Complete IC Unable to Locate No Services Needed Receiving Services Elsewhere
RISK FACTOR IDENTIFIED BY SCREEN or ASSESSMENT	RISK BASED INTERVENTION Documentation must reflect that each risk factor was assessed for intervention			
	Yes	Info	Referral	F/U
				Was Intervention Appropriate?
Education less than 12 th grade				
Unmarried				
Poor pregnancy timing (9a.earlier /9b. later)				
Feeling depressed/hopeless/alone				
History of mental health counseling				
Someone tried to hit or hurt participant				
Race black				
Used drugs or alcohol				
Uses tobacco				
Wishes not to be pregnant at all				
First pregnancy				
Previous pregnancy problems (baby not born alive, premature, under 5lbs., 8oz.)				
Age < 18				
BMI < 19.8 or > 35				
Pregnancy interval is < 18 months				
2 nd trimester entry into care				
Illness requiring ongoing medical care				
Current stress: low medium high				
Other risk factors identified (Specify)				

Initial Assessment (IA)		Yes	No	N/A	Comments	
Home Visit attempt within 10 working days of IC					Date: Total # of IA attempts:	
IA actually completed					Date: Level at IA: E 1 2 3 (circle one)	
IA assessment of risk and need done						
Each risk factor assessed for intervention						
Each intervention appropriate for risk						
Consent Forms signed						
Follow-up with provider within 30 calendar days of IA					Date:	
IPC for IA follow-up done					Plan: Care Coordination/Tracking Closure	
Appropriate Closure and Date: _____ (Choose ONLY One)					Declined Unable to Complete IA Unable to Locate No Services Needed Receiving Services Elsewhere	
Care Coordination (CC)		Yes	No	N/A	Date: Level at 1 st CC encounter: E 1 2 3	
Tracking Contacts Completed		#			Total # of CC Tracking Attempts:	
Face-to-Face Contacts Completed		#			Total # of CC Face to Face Attempts:	
Appropriate Referrals & Education						
Follow-up on Referrals						
Family Support Plan (required for Level 3 participants)						
Family Support Plan Updated (every 90 days)						
IPC Reevaluated at Each Encounter						
Number of Encounters is Consistent with Level					If 'no', note reason:	
Appropriate Closure at CC					Date:	
Closure Activities Documented at CC						
Outcomes Documented (if client received CC)						
Lost to Follow up					Date:	
CC level of need and risk		Level 1	Level 2	Level 3		
Dates of any change in level from 1 st CC encounter (dd/mm/yy)					Reason for Change:	
"Other Healthy Start Services" Provided by CC	Offered Yes/No	Accepted Yes/No	Provided Yes/No	# of Contacts	CC Qualified Per HSSG	Was the Curriculum/Plan Followed and Documented in the Record?
Parenting Education						
Childbirth Education						
Psychosocial Counseling						
Tobacco Cessation						
Nutrition Counseling						
Breastfeeding Education						
Interconceptional Counseling						
Summary of Activity			Yes	No	N/A	Comments
All risk factors were addressed						
Information given on WIC						
Information given on Medicaid & federally funded health clinics						
Information given on Safe Haven for newborns						
Birth Summary Report Documented						
Pregnant teen received parenting education						
Pregnant teen encouraged to attend home school or an alternative program						
ICC education offered if participant delivered						
Wraparound Service(s) provided at the first face to face						
Miscarriage/infant loss, SHARE Group offered						
Detailed Description of home/neighborhood (if applicable)						
Home Visit/Face-to-Face Signature Log Present in File						
Appropriate closure (IC, IA or Care Coordination)						

INSTRUCTIONS FOR THE HEALTHY START PRENATAL CARE COORDINATION RECORD REVIEW CHECKLIST

NOTE: The Healthy Start Care Coordination Record Review Checklist contains confidential information and should only be used by authorized personnel as a quality assurance/quality improvement tool. The checklist is designed to provide the record reviewer with a format for recording care coordination services provided. Items expected to be found in the record are consistent with Healthy Start standards and provide the reviewer with information needed to determine whether appropriate and adequate risk-based interventions (i.e., risk appropriate care) were provided. The checklist may be used by supervisors, in-house peer reviewers, or external auditors.

The checklist includes sections for 1) descriptive information; 2) initial contact; 3) recording of risk factors identified by screen and/or assessment; risk-based intervention provided to address the risk factors; 4) initial assessment and ongoing care coordination services provided 5) other Healthy Start services received and 6) summary of activities. Note that not every service will be provided to each participant since the provision of services is based on the presence of risk and a corresponding need for intervention. However, in the event the participant has a risk factor that does not require intervention from the provider or for which the participant refuses intervention, documentation should always reflect that the risk was addressed. In addition, if there are no resources available to address the risk factor, this too should be discussed with the participant.

1. **DESCRIPTIVE INFORMATION:** Record the review date, participant's initials and DOB, EDD, reviewer's name, the care coordination provider and location.
2. **INITIAL CONTACT:** The left column contains services and activities related to the participant's HS Screen and initial contact. The next three columns to the right provide space to check "YES", "NO", or "N/A" (not applicable) for each service or activity in the left column. The far right column in this area gives space for comments, dates, and indication of whether the record reflected, after the completion of the initial contact, a plan of care that included "Declined", "Receiving care coordination", "No services needed," or "Unable to Contact". The IPC should be found in the record and describes the HS care coordinator's plan and the HS participant's intensity of need at the time of initial contact. If the case is closed at IC then one of the following case closures must be recorded: "Declined", "Receiving care coordination", "No services needed," "Unable to Complete IC" or "Unable to Contact".
3. **RISK FACTOR IDENTIFIED BY SCREEN/ASSESSMENT & RISK-BASED INTERVENTION:** The left column contains a list of risk factors from the Healthy Start screen and blank spaces to specify any other risk factors that may have been identified during interactions with the participant. The second column provides a space to check "YES" to specify all risk factors that apply to the participant whose record is being reviewed. The third and fourth columns provide spaces to indicate whether information and/or referrals were made related to the particular risk factor. The fifth column provides a space to check whether appropriate follow-up for the risk factor was provided and requires the reviewer to assess the seriousness of the risk factor and the interventions provided. **Each identified risk factor must be adequately addressed for appropriate follow-up to have occurred.** Adequacy of intervention depends on the seriousness of the risk, the desires of the participant, and the resources of the provider and community, and is therefore, a subjective determination on the part of the reviewer. Providers and record reviewers must take these factors into consideration when determining whether appropriate intervention was provided. The last column is for comments.
4. **INITIAL ASSESSMENT and CARE COORDINATION:** The left column lists items that correspond to standards and criteria for initial assessment and ongoing care coordination. The next three columns to the right provide space to check "YES", "NO", or "N/A" (not applicable) for each service or activity in the left column. The far right column in this area gives space for comments, dates, and indication of whether the record reflected, after the completion of the initial assessment and ongoing care coordination, a plan of care that included a participant level, and plans for future encounters. The last column provides space to document comments and attempts made to provide telephone or face-to-face contacts. **Were referrals, participation in prenatal/infant health care, and other services tracked to assure access to these services? If it was known that the participant missed a scheduled appointment ("no show"), did someone re-connect with the participant to explore barriers? Did all participants have an Individualized Plan of Care and a Family Support Plan in the record if the participant received level 3 care coordination? Was a rationale documented when the case was closed?**
5. **OTHER HS SERVICES PROVIDED:** Document the number of contacts made for "Other HS Services" provided by the HS care coordinator, if the care coordinator was qualified to provide the services, and if the documentation followed a curriculum approved by the Coalition.
6. **SUMMARY OF ACTIVITIES:** Document other activities provided by the care coordinator.

