Healthy Start Prenatal Screening Guide



Every Baby Deserves a Healthy Start



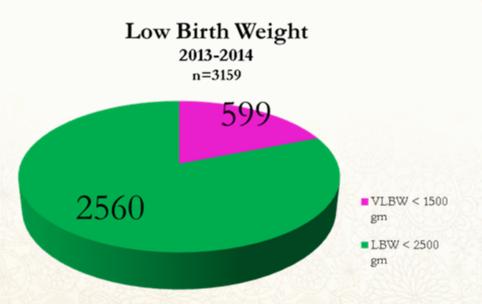


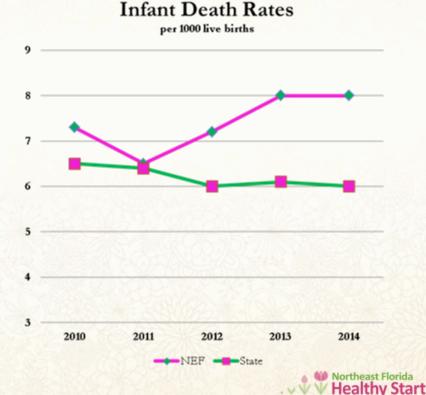
Goal of Healthy Start:

Reduce Infant Mortality

Decrease the Number of Low Birth Weight

Babies





Q: How can the office do that??





A: HEALTHY START

- In response to Florida's high infant mortality rates,
 Legislators created Healthy Start in 1991
- Healthy Start is a comprehensive program promoting optimal prenatal health and developmental outcomes for ALL pregnant women and babies in Florida.





Healthy Families

Healthy Families is an evidence-based, voluntary home visiting program that is proven to prevent child abuse/neglect and other poor childhood outcomes in high risk families.

98% of participants did not have verified incidents of child abuse or neglect 12 months after completing the program







Healthy Families Goals

- Prevent child abuse and neglect
- Increase parents' abilities to develop positive relationships with their children



- Improve family stability and self-sufficiency
- Promote child health and development
- Enhance parents' ability to create stable and nurturing homes



Healthy Start and Healthy Families

HS and HF are sister programs working together to serve the needs of ALL families.





Do we HAVE to do this?

- The state of Florida is so confident in Healthy Start that they made Prenatal Screening mandatory by law.
 - Florida Statute 383.14 requires that Prenatal Screening is offered to ALL pregnant women at their 1st prenatal visit by their Health Care Provider regardless of income level or insurance





Prenatal Risk Screen



Help your baby have a healthy start in life!



Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are <u>confidential</u>. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in its 1)*

	(Please complete in ink.)*							
Today's Date: 1. Have you graduated from high school or received a GED?		YES N	11. What race are you? Check one or more.					
2.	Are you married now?		12. In the last month, how many alcoholic drinks did you have per week?					
3.	Are there any children at home younger than 5 years old?		drinks 1 🗖 did not drink					
4.	Are there any children at home with medical or special needs?		13. In the last month, how many cigarettes did you smoke a day? <i>(a pack has 20 cigarettes)</i>					
5.			cigarettes₁ □ did not smoke					
6.	In the last month, have you felt down, depressed or hopeless?	□ 1 □	14. Thinking back to just before you got pregnant, did you want to be? □ pregnant now □ pregnant later □₁ not pregnant					
7.	In the last month, have you felt alone when facing problems?		15. Is this your first pregnancy? □₂ Yes □ No If no, give date your last pregnancy ended:					
8.	Have you ever received mental health services or counseling?		Date: (month/year)					
9.	In the last year, has someone you know tried to hurt you or threaten you?	□₃ Had a baby that was not born alive □₃ Had a baby born 3 weeks or more before due						
10.	Do you have trouble paying your bills?		☐₃ Had a baby that weighed less than 5 pounds, 8 ounces ☐ None of the above					
Nam	ne: First Last	M.I.	Social Security Number: Date of Birth (mo/day/yr): 17. Age:					
Stre	et address (apartment complex name/number):		County: City: State: Zip Code:					
Prenatal Care covered by: Medicaid Private Insurance Other			Best time to contact me: Phone #1Phone #2					
Hea	ithy Families Florida, WIC, Florida Department of	Health, a	ne Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, nd my health care providers for the purposes of providing services, paying for is authorization remains in effect until revoked in writing by me.					
Pati	ient Signature:		Date:					
Plea			ize specific health information to be exchanged as described above, which of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.					
	,	please cor	nplete the patient information section only and sign below:					
S	ignature:		Date:					

	DH 3134, 04/08, stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred							
	Provider's/Interviewer's Signature and Title Date (mo/day/yr)							
ā	Healthy Start Screening Score:	Check One: ☐ Referred to Healthy Start. If score <6, specify:						
ROVIDER ONLY			Specify illness: No	■ ₂ Yes				
	Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care?					
			20. Trimester at 1st Prenatal Visit?	■₁ 2nd				
	Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? N/A No	■ ₁ Yes				
			Wt:lbs. Height:ftin. BM:	■ ₂ > 35.0				
	LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy:	■ 1 < 19.8				
	Signature: Date:							
	# If you do not want to participate in the screening process, please complete the patient information section only and sign below:							
		includes any or	rmy mental health, 1b, alcohol/drug abuse, 51b, or HIV/Albs	iniornation.				



Which woman needs Healthy Start?



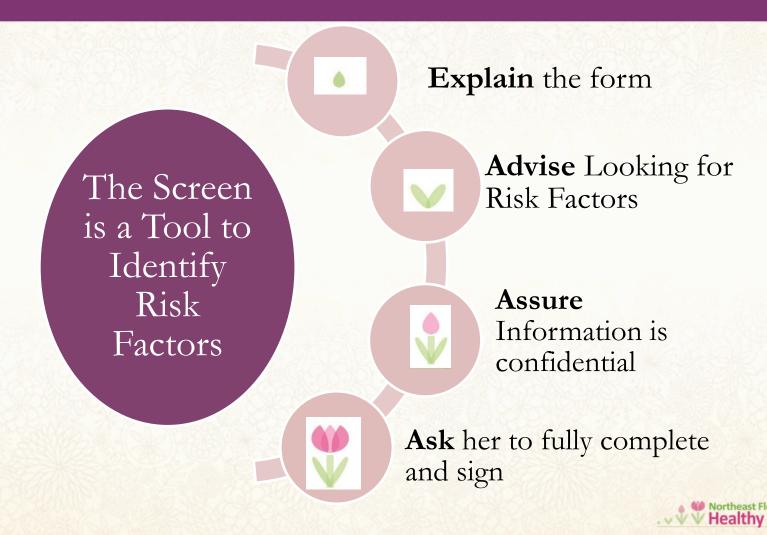








Administering the Screen



Scoring the Prenatal Screen

PRENATAL RISK FACTORS

- Less than high school education-1
- Less than 18 year old-1
- Unmarried mother-1
- Mother's race is black-3
- First Pregnancy-2
- Alcohol, tobacco and or drug use-1
- Depression, prenatal or preexisting-1

- Unwanted pregnancy or unexpected-1
- Baby Spacing less than 18 months-1
- Late (after 12 weeks) entry to prenatal care-1
- Previous poor pregnancy or birth outcomes-3
- Illness requiring ongoing medical care-2



What Does That Score Mean?

- The Healthy Start Score helps Healthy Start and Healthy Families determine what services to provide to your patient.
- Regardless of score patients will be connected with services as long as the referred box is check at the bottom of the screen.
- For a woman with a score of less than 6 note the reason for being referred so we can anticipate the services needed.

EDD (mo/day/yr):	18. Pre-Pregnancy:	■ ₁ < 19.8
	Wt:lbs. Height:ftin. BMI:	2 > 35.0
Provider's ID:	19. Pregnancy Interval Less Than 18 Months? $\ \square$ N/A $\ \square$ No	■ ₁ Yes
	20. Trimester at 1st Prenatal Visit?	■ ₁ 2nd
Provider's County:	21. Does patient have an illness that requires ongoing medical care?	
	Specify illness: No	2 Yes
	to Healthy Start. If score <6, specify: red to Healthy Start.	

The PERFECT Prenatal Screening Form

She initials "YES" to release of specific information

Providers complete the "Provider Only" section in full

	,	Help yo Please answer the or your baby's healt Healthy Start Progr (Please complete in	following question th. Your answers am or the Heat	ons to find	d out if anythin	ng in your may qua	life could lify for free	affect your h services fron	n the	
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		received a GED? 2. Are you married now?			12. In			nany alcoholic	drinks o	did you
	3. Are there any children at home younger than 5 years old? 4. Are there any children at home with medical or special needs? 5. Is this a good time for you to be pregnant? 6. In the last month, have you felt down,		-	h	have per week? drinks ,					
				13. In			many cigarett as 20 cigaret			
							🕤 🗆 did not			
					14. Thinking back to just before you got pregnant, did you want to be?					
		depressed or hopeless?					now 🗈 pr first pregna	egnant later	□₁ not p	regnant
		7. In the last month, have you felt alone when facing problems?					lo Ifno, give	date your last	prognar	
		Have you ever received mental health services or counseling?			16. Pl	ease mark		othlyear) ollowing that	/ ,	pened.
		In the last year, has someone you know tried to hurt you or threaten you?			0	, Had a ba	by that was	not born		lue date
	×	10. Do you have trouble paying your bills?				Had a ba	by that weigh	//	pounds,	
		Name: First La	at	M.I.	Social Security Nu		Date of	al day lyr): 1	17. Age:	■ •<18
	FORMAT	Street address (apartment complex name/number):			County:			State:	2	ip Code:
	Prenatal Care covered by:		- 	Best time to cont	ime to conta					
	MA	☐ Medicaid ☐ Private Insurance ☐ No Insurance ☐ Other ☐ Other					Phone #1 _ Phone #2			_//
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The patient signs and dates the screen

Mark the Referred box

Timeframes

- Screen completed at 1st prenatal appointment
- Send screens to Regional Processing Center (RPC) within 5 working days of completing it.
 - Best practice- Send off screens the same day every week.
 - A letter will be sent to you after Initial Contact is completed
 - You can call the assigned Care Coordinator for questions
- Complete screens on women that are transferred if they don't know if they had one completed at another practice.
- Call RPC if you know that a women's life circumstance changes and needs HS services



Where do the screens go?

All Prenatal Screens are submitted to:

Healthy Start Regional Processing Center MC-06 900 University Blvd. North Jacksonville, FL 32211-9203

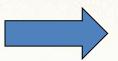
*The Prenatal Screen is utilized by both the Healthy Start and the Healthy Families programs.



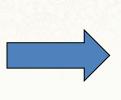


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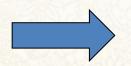






HS Regional Processing Center

1st prenatal appt.







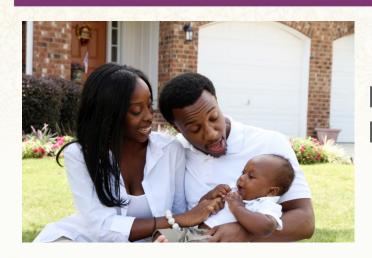
HS Care Coordination/ HF Family Support Program



Healthy Baby and Mom!



What can HS do for us and our patients?



Parenting Education



Smoking Cessation



Nutrition Education



Breastfeeding Education and Support

What can HS do for us and our patients?



Advocate on behalf of the participant



Collaborate with other providers



Face to face visits



Information and referrals to community resources



Questions?

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Mary E. Nash, Healthy Families Jacksonville 904-630-7057 mnash@coj.net

Beverly Butler, Healthy Start Regional Processing Center 904-253-2654

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