Healthy Start
Prenatal Screening Guide

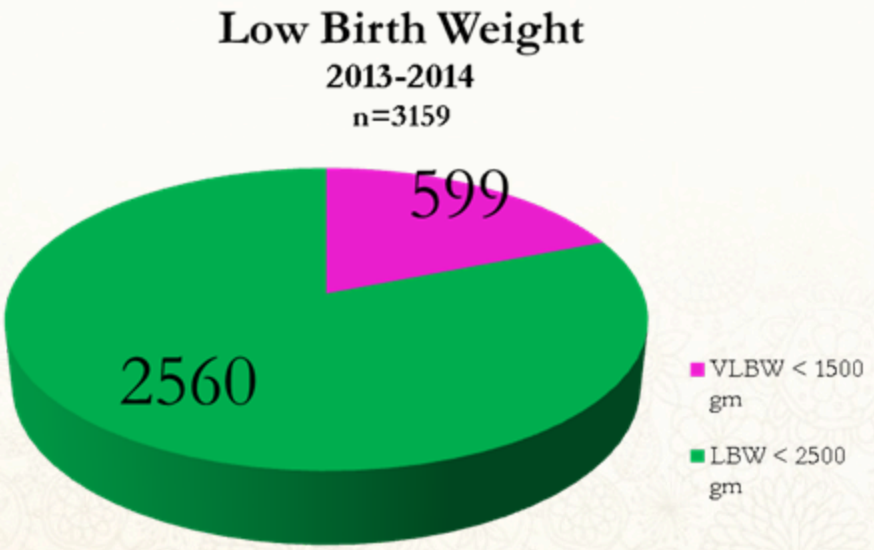
Northeast Florida
Healthy Start
COALITION, INC.

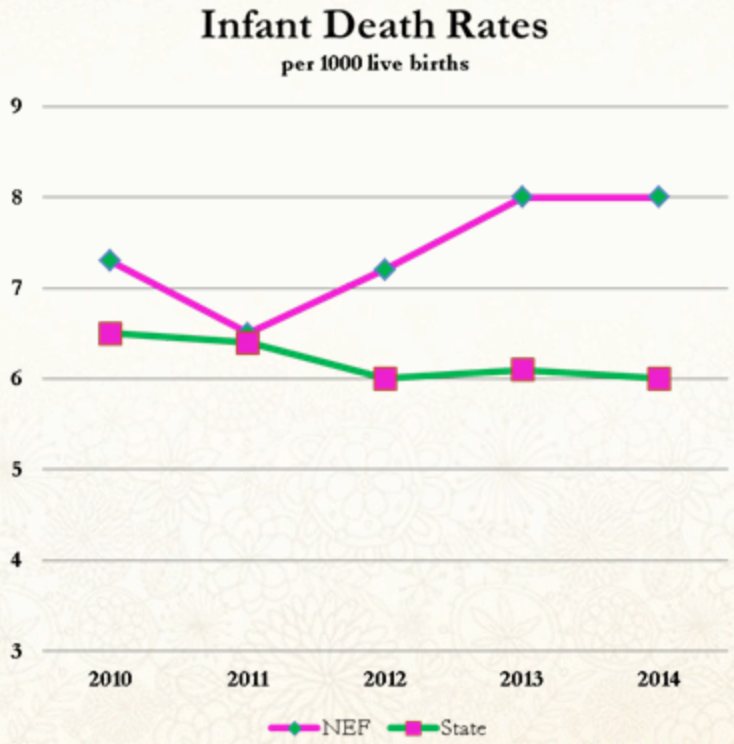
Every Baby Deserves a Healthy Start

Northeast Florida Healthy Start Coalition, Inc.

Goal of Healthy Start:

- Reduce Infant Mortality
- Decrease the Number of Low Birth Weight Babies





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Q: How can the office do that??

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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.

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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 FLORIDA

HEALTHY FAMILIES JACKSONVILLE

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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

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Healthy Start and Healthy Families

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

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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

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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 confidential. 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 ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐ 1
2. Are you married now?	☐	☐ 1
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, depressed or hopeless?	☐ 1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
☐ White ☐ 3 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks 1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes 1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ 1 not pregnant

15. Is this your first pregnancy?
☐ 2 Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.
☐ 3 Had a baby that was not born alive
☐ 3 Had a baby born 3 weeks or more before due date
☐ 3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age: ☐ 1 <18
Street address (apartment complex name/number):	County:	City: State:	Zip Code:
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐ 2 Yes
Healthy Start Screening Score: _____	**Check One:** ☐ **Referred to Healthy Start.** If score <6, specify:_____ ☐ **Not Referred to Healthy Start.**		
Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____			

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Which woman needs Healthy Start?

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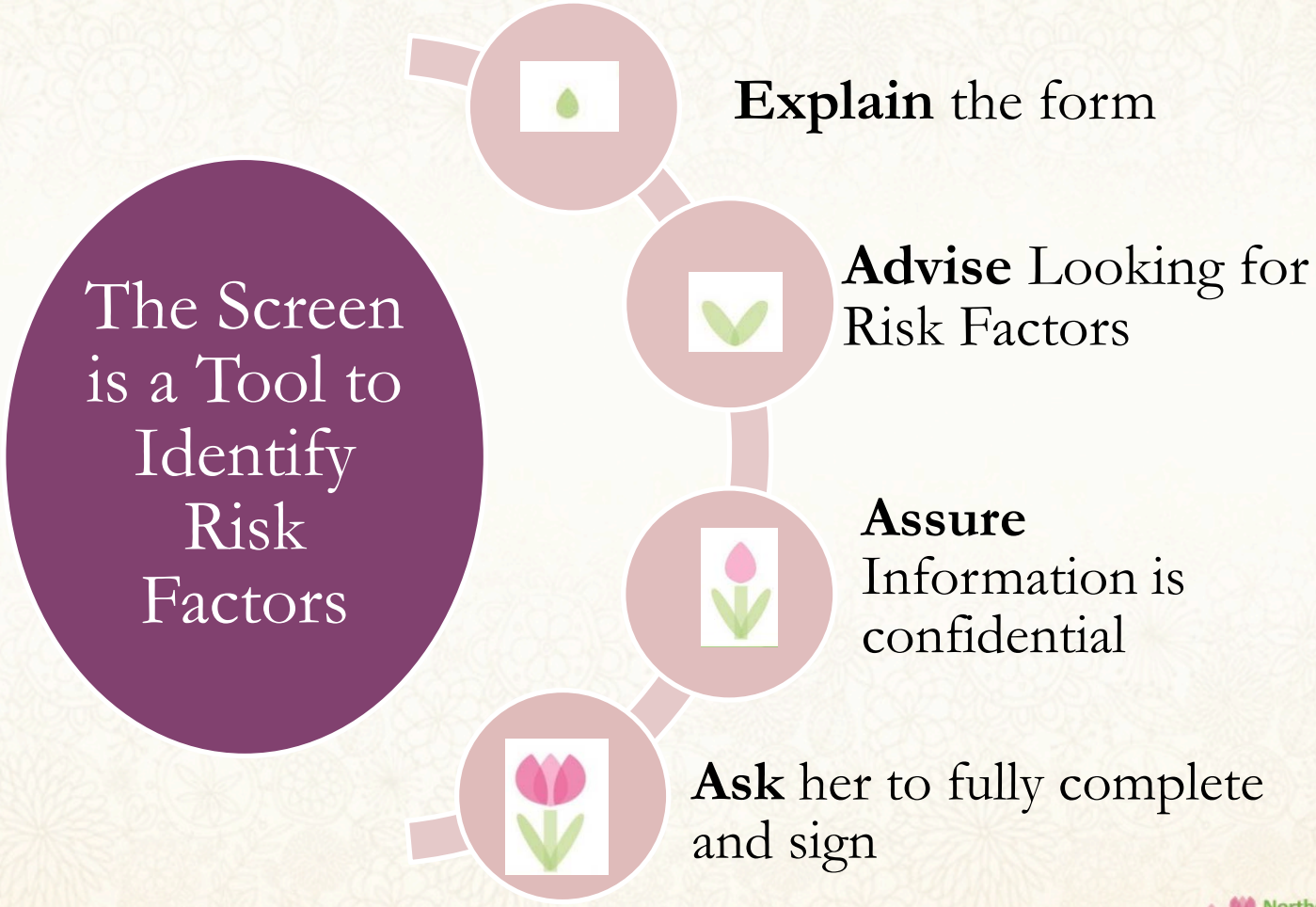
Administering the Screen



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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 pre-existing-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

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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: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐1 < 19.8 ☐2 > 35.0
Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ❑ N/A ❑ 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
Check One: ❑ Referred to Healthy Start. If score <6, specify:_____ ❑ Not Referred to Healthy Start.		

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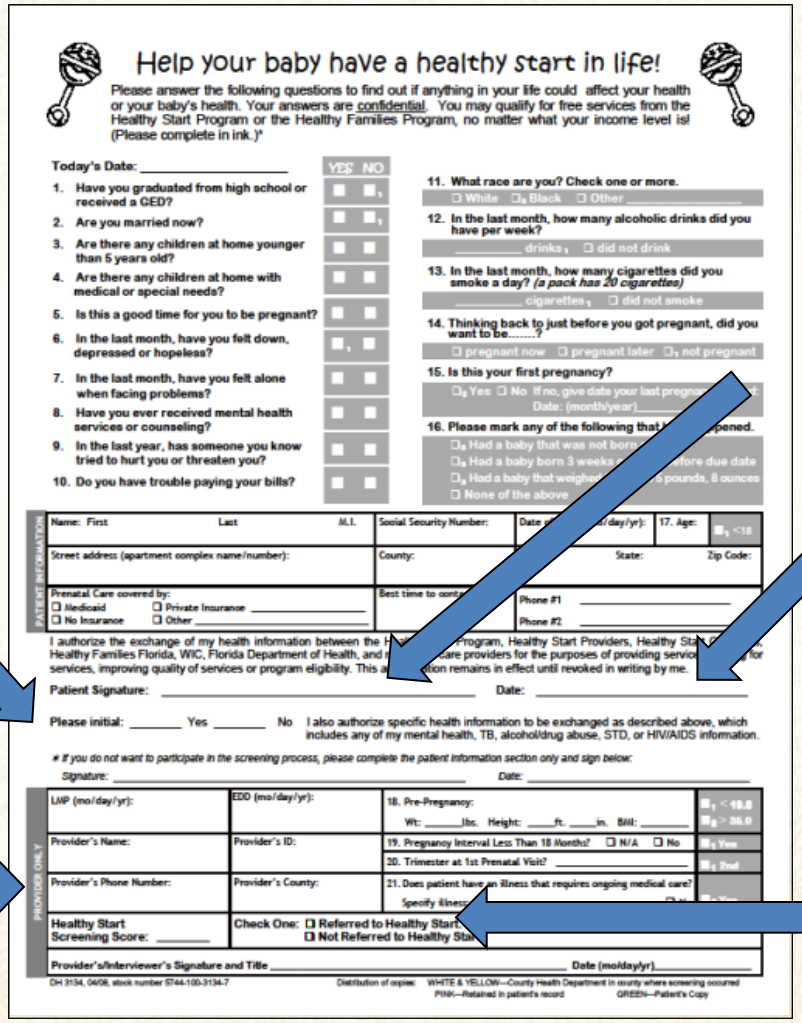
The PERFECT Prenatal Screening Form

She initials "YES" to release of specific information

Providers complete the "Provider Only" section in full



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 confidential. 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 ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?		
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7. In the last month, have you felt alone when facing problems?		
8. Have you ever received mental health services or counseling?		
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10. Do you have trouble paying your bills?		

11. What race are you? Check one or more.
☐ White ☐ Black ☐ Other _____

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13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ not pregnant

15. Is this your first pregnancy?
☐ Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that happened.
☐ Had a baby that was not born
☐ Had a baby born 3 weeks before due date
☐ Had a baby that weighed pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I. | Social Security Number: | Date of birth (mo/day/yr): | 17. Age: | <18

Street address (apartment complex name/number): | County: | State: | Zip Code:

Prenatal Care covered by:
☐ Medicaid ☐ Private Insurance _____
☐ No Insurance ☐ Other _____

Best time to contact: | Phone #1 _____ Phone #2 _____

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalition, Healthy Families Florida, WIC, Florida Department of Health, and my prenatal care providers for the purposes of providing services, referrals for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ Date: _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

*If you do not want to participate in the screening process, please complete the patient information section only and sign below:

Signature: _____ Date: _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: ____lbs. Height: ____ft. ____in. BMI: _____ ☐ <19.8 ☐ > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No ☐ Yes
Provider's Phone Number:	Provider's County:	20. Trimester at 1st Prenatal Visit? _____ ☐ 2nd
		21. Does patient have an illness that requires ongoing medical care? Specify Illness: ☐ Yes
Healthy Start Screening Score: _____	Check One: ☐ Referred to Healthy Start ☐ Not Referred to Healthy Start	

Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr)_____

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The patient signs and dates the screen

Mark the Referred box

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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

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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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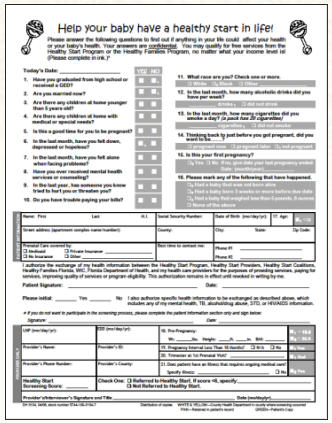
Where do the screens go?

1st prenatal appt.



Referral

HS Regional Processing Center

HS Care Coordination/
HF Family Support Program

Healthy Baby and Mom!

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What can HS do for us and our patients?

Parenting Education

Smoking Cessation

Nutrition Education

Breastfeeding Education and Support

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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

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Questions?

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