Prenatal Care Provider’s Guide To the Healthy Start Screening Process

and

MomCare Program

The Charlotte County Healthy Start Coalition, Inc.
Located at: 17940 Toledo Blade Blvd., Unit A, Port Charlotte, FL 33948
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SCREENING
Completed screens (white and yellow copies) will be collected weekly by
Tammy or Tina at Vital Statistics
Charlotte County Health Department
1100 Loveland Blvd.
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MomCare simplified Medicaid Applications may be obtained through the
Charlotte County Health Department
(941) 624-7200
or the
Department of Children & Families
19500 Cochran Blvd.
Port Charlotte, FL 33948
(941) 613-2000
Inside the Guide...

The Charlotte County Healthy Start Coalition has compiled the *Prenatal Care Provider’s Guide to the Healthy Start Screening Process* to broaden understanding of Florida’s Healthy Start Initiative and facilitate universal Healthy Start risk screening of all pregnant women in Charlotte County. A section on the MomCare program has also been included to explain the MomCare services.

**HEALTHY START**
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- Outreach Opportunities
- *Sample WIC Application*

**SCREENING**
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- Responsibilities of Providers
- Introducing the Screen to Patients
- Screening Guidelines
- About the Healthy Start Screen
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**MOMCARE**
- What is MomCare?
- Overview of the Program
- How MomCare Works
- What This Means for Providers
- *AHCA Compliance Letter*

Please contact the Healthy Start Community Liaison at (941) 764-9700 for any questions regarding the *Prenatal Care Provider’s Guide.*
What Is Healthy Start?

Healthy Start is a comprehensive program created to promote optimal health and developmental outcomes for all pregnant women and babies in Florida.

- The Charlotte County Healthy Start Coalition is a private, non-profit organization designated by the State of Florida. Its responsibilities include coordinating community partnerships dedicated to assuring a high quality, comprehensive health care system and supportive services for women and their infants, in addition to providing community involvement through education, planning services, and allocation of resources.

**The goal of Healthy Start is to reduce infant mortality, reduce the number of low birth weight babies and improve health and developmental outcomes.**

Healthy Start key components include:

- Universal prenatal and infant risk screening to identify pregnant women and infants at risk for adverse birth, health and developmental outcomes
- Healthy Start care coordination and services that support families in reducing the factors and situations that place pregnant women and infants in jeopardy for poor outcomes
- Community-based prenatal and infant health care coalitions that ensure the coordination of activities and services within a community that supports and enhances the community’s ability to promote optimal health and developmental outcomes for all pregnant women and babies born in Florida

Healthy Start services, provided by nurses, social workers, counselors and trained support workers, include:

- Care coordination, home visiting services, and outreach to help assure access to health care and provide support to families in reducing identified risk factors
- Additional services may include breastfeeding education and support, childbirth education and support, parenting education and support, smoking cessation, nutritional counseling, psychosocial counseling, and other risk appropriate care
How Healthy Start Works

STEP 1: PROVIDER’S OFFICE
- A woman seeks prenatal care for her pregnancy.
- At her first visit she fills out the risk form with her provider/nurse (see the Screening Guidelines section in this manual).
- The provider/nurse scores the risk screen using the instructions on the back of the screen and Screening Guidelines section in this manual.
- Those women receiving a score of 6 or more are automatically eligible for Healthy Start Services.
- A woman may be referred to Healthy Start based on factors other than score by the provider or self-referral (see the Screening Guidelines section in this guide for a list of possible factors).
- All completed risk screens (white and yellow copies) will be picked up each Thursday by staff from the Charlotte County Health Department, 1100 Loveland Blvd., Port Charlotte, FL. (To order more Screen Forms or report that Screen Forms have NOT been picked up, please call (941) 624-7299.

STEP 2: CARE COORDINATION
- A copy of the screen is delivered to Healthy Start Care Coordinators at the Charlotte Behavioral Health Care
- A Care Coordinator will attempt to contact the woman within 5 business days of receiving the screen.

Healthy Start care coordination provides the following throughout the delivery of services:
- Establish rapport and develop relationships with families
- Identify/evaluate/assess, in collaboration with families, their strengths, resources, needs and priorities
- Facilitate planning/problem solving with participants and families
- Address identified risks and needs
- Provide information, education and encouragement needed to take steps necessary to change at-risk situations
- Promote self-sufficiency and healthy outcomes
- Make maximum use of community resources through information and referral
- Monitor the plan of care to assure that the multiple concerns of families are addressed
- Collaborate with other providers to assure continuity and coordination of care
- Advocate on behalf of the participant, including communicating to providers and the community

The Healthy Start goal of improving pregnancy, health and developmental outcomes is facilitated through care coordination services that provide the knowledge, encouragement, linkages, and support necessary to maximize families’ health, well being and self-sufficiency.
Understanding Risk Factors

Healthy Start care coordination service delivery is based on the concept of risk appropriate care.

1. Risk factors that may indicate pregnant women or infants are at increased risk for poor pregnancy, health, or developmental outcomes are identified through universal risk screening or other health referrals.
2. Care coordinators then evaluate the risk status of participants and determine the appropriate services required to help reduce the risk.
3. Although some risk factors identified on the Healthy Start screen cannot be changed with interventions (e.g. single marital status, race), these factors serve as markers for underlying situations that can be addressed (see matrix below).

Eligibility for Healthy Start care coordination begins when a pregnant woman scores at-risk on their Healthy Start pre-natal risk screen, or a pregnant woman is referred in for reasons other than score.

The following risk factor matrix provides examples of situations that may be associated with the risk factors identified through Healthy Start prenatal and infant risk screening.

<table>
<thead>
<tr>
<th>Risk Factor Prenatal Screen</th>
<th>Possible Underlying Situations and Related Risks</th>
</tr>
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<tbody>
<tr>
<td>Age less than 18</td>
<td>- May not have experience parenting&lt;br&gt;- Has not finished high school education&lt;br&gt;- Financial support issues&lt;br&gt;- Paternity issues&lt;br&gt;- Inadequate nutrition</td>
</tr>
<tr>
<td>First Pregnancy</td>
<td>- Lack of parenting experience&lt;br&gt;- Inadequate nutrition&lt;br&gt;- Lack of health insurance&lt;br&gt;- Stress related to lack of childbirth knowledge/education</td>
</tr>
<tr>
<td>Age greater than 39</td>
<td>- Chronic medical conditions&lt;br&gt;- Complications or congenital anomalies</td>
</tr>
<tr>
<td>Race: Black</td>
<td>- More likely to have pre-term, low birth weight baby or infant death&lt;br&gt;- Difficulty accessing quality services</td>
</tr>
<tr>
<td>Unmarried</td>
<td>- Lack social, emotional or financial support&lt;br&gt;- Low birth weight baby&lt;br&gt;- Paternity and child support issues</td>
</tr>
<tr>
<td>Did not complete High School or GED</td>
<td>- Limits job opportunities&lt;br&gt;- Unemployment&lt;br&gt;- High stress from difficult or demanding working conditions</td>
</tr>
<tr>
<td>Pre-pregnancy BMI</td>
<td>- Low birthweight and poor infant health outcomes&lt;br&gt;- Inadequate nutrition and lack of knowledge on healthy eating&lt;br&gt;- Threat to health of mother and developing fetus</td>
</tr>
<tr>
<td>Risk Factor</td>
<td>Possible Underlying Situations and Related Risks</td>
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<tr>
<td>Prenatal Screen</td>
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<tr>
<td><strong>Unsafe living conditions</strong></td>
<td>• Injury due to unsafe housing conditions&lt;br&gt; • Victim of Crime&lt;br&gt; • Stress&lt;br&gt; • Injury due to domestic violence&lt;br&gt; • Threats of harm&lt;br&gt; • Emotional and/or economic abuse&lt;br&gt; • Potential child abuse and neglect of any child in household</td>
</tr>
<tr>
<td><strong>Tobacco use</strong></td>
<td>• Substantially increases risk for IUGR (intra-Uterine Growth Retardation)&lt;br&gt; • Possible association with spontaneous abortion&lt;br&gt; • Reduced weight gain during pregnancy / danger to child after birth</td>
</tr>
<tr>
<td><strong>Drug / Alcohol use</strong></td>
<td>• Endanger fetal development&lt;br&gt; • Endanger child after birth&lt;br&gt; • Legal implications&lt;br&gt; • Child abuse and neglect of all children in household&lt;br&gt; • Lifestyle factors and increased exposure to STD/violence&lt;br&gt; • Poor nutrition</td>
</tr>
<tr>
<td><strong>Timing of pregnancy</strong></td>
<td>• Delay initiation of prenatal care&lt;br&gt; • Engage in behaviors which increase risk for adverse birth outcomes&lt;br&gt; • Health care issues / barriers&lt;br&gt; • If pregnancy is unwanted, may have problems with attaching to newborn</td>
</tr>
<tr>
<td><strong>2nd Trimester entry to care</strong></td>
<td>• Low birth weight and poor infant health outcome&lt;br&gt; • May be attributable to lack of access or avoidance of system (domestic violence, substance abuser)&lt;br&gt; • Sign of problem in health care delivery system</td>
</tr>
<tr>
<td><strong>Previous negative pregnancy outcomes</strong></td>
<td>• Hereditary risks&lt;br&gt; • Red flag for increased risk</td>
</tr>
<tr>
<td><strong>Ongoing medical condition</strong></td>
<td>• Specialized prenatal care&lt;br&gt; • Maternal, fetal morbidity (i.e., diabetes, hypertension)&lt;br&gt; • Reduced access to care</td>
</tr>
<tr>
<td><strong>Access to services</strong></td>
<td>• Prenatal care improves health outcomes, provides support and health education</td>
</tr>
</tbody>
</table>
Women and children birth to age 3 years identified as at risk for undesirable outcomes by screening or referral are contacted by Healthy Start. A determination is then made as to whether the participant needs further intervention or simply needs information about community resources and the name of a Healthy Start contact in the event circumstances change.

Some participants will merely need “tracking” for future follow-up, some will need a thorough assessment to determine the full extent of interventions needed to offset their risk, and others will need additional Healthy Start services.

Healthy Start specialized services include the following:

**BREASTFEEDING EDUCATION**
Breastfeeding is primary to achieving optimal infant and child health, growth and development. Human milk feeding ensures the best possible developmental and psychosocial outcomes for the infant. Breastfeeding also benefits women, reducing the risk of pre-menopausal breast cancer, ovarian cancer, osteoporosis and obesity. Breastfeeding education services include:
- Encouragement of the initiation of breastfeeding
- Anticipatory guidance and support in order to prevent breastfeeding problems and addressing barriers to breastfeeding
- Services provided to postpartum women to increase the duration and exclusivity of breastfeeding and to enable them to overcome any perceived or actual breastfeeding problems
- Encouragement of informed decision-making related to choice of feeding method
- Access to infant feeding plans
- Provide referrals to local breastfeeding support groups and other breastfeeding educational sources
- Provide education about the risks related to substance abuse when breastfeeding

**CHILDBIRTH EDUCATION**
The childbirth education class is based on specific learning objectives and addresses characteristics of the target population, such as providing materials for culturally diverse participants. The classes are adapted to meet individual or group needs, and are provided in individual or group sessions. The following topics are included in the curriculum:
- Healthy Start prenatal and infant screening
- Physical and emotional changes related to pregnancy
- Basic nutrition and breastfeeding
- Anatomy and physiology of pregnancy and birth
- Self-empowerment and stress management
- Prenatal care
- Danger signs of pregnancy and signs of preterm labor
- Preparation for labor and birth
- Parent/child attachment
- Normal newborn growth and development
- Newborn care, safety and immunizations
- Postpartum changes and sibling preparation

**HOME VISITING**
As a method of delivering services, home visiting is popular because it is flexible and allows the family to interact in a setting that is often most comfortable for them. Home visiting or care provision in other non-clinical settings has been used as an effective mechanism for delivering specific interventions and has been shown to improve outcomes, improve care giving and child development, decrease child abuse, and increase maternal attachment and personal development.

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NUTRITION COUNSELING
The goal of Healthy Start nutrition counseling is to assist participants in their ability to make informed health decisions affecting their nutrition status. Nutrition counseling is tailored to the unique needs, interests, experiences, educational level, environmental limitations, cultural patterns, capabilities and lifestyle of the participant. Nutrition counseling includes:
- Diagnostic assessment of participant’s nutrition status
- Development of a nutrition care plan
- Monitoring and evaluation by the nutritionist of progress toward the nutrition goals

DIABETIC NUTRITIONAL COUNSELING
These services are designed to assist any pregnant woman with gestational diabetes, Type One or Type Two diabetes whose insurance does NOT pay for diabetic education.

PARENTING EDUCATION
Parenting support and education provides comprehensive information and education related to the care of the newborn, infant, and child. This service includes information on normal growth and development, anticipatory guidance, changes in family dynamics, attachment behaviors, nutrition, resource management, safety, child injury prevention, immunizations, and child abuse prevention. Parenting education topics include:
- Bonding and attachment behavior
- SIDS risk reduction
- Comforting and stimulating infants
- Recognizing a child’s distress cues
- Child growth and development, including brain research findings, play, and learning
- Appropriate expectations for age and developmental stages
- Speech and language development
- Child health including basic nutrition and safety information
- Building on family strengths and relationships
- The effects on children of witnessing violence in the home
- Non-violent discipline techniques (i.e., alternatives to spanking)
- Day-to-day problem solving techniques
- Skills for accessing resources in the community
- Techniques for developing a support network
- Family dynamics and changing roles such as sibling rivalry
- Managing stress and anger
- Positive communication to promote positive behavior
- Home environmental risk factors including environmental smoke and safety hazards

PSYCHOSOCIAL COUNSELING
Psychosocial counseling is provided to Healthy Start participants to address emotional, situational and developmental stressors. It is provided in a confidential setting to individuals, couples, groups or families. The goal is to reduce identified risk factors to achieve positive pregnancy outcomes and optimal infant/child health and development.

TOBACCO EDUCATION
Tobacco education and cessation counseling is provided in order to reduce the incidence of prenatal smoking and to reduce the harmful effects to the mother and developing fetus when the mother ingests chemicals from tobacco or is exposed to environmental tobacco smoke. The components of tobacco education and cessation services include the 5 A’s:
- Ask about tobacco use
- Advise to quit
- Assess willingness to quit
- Assist in quit attempt
- Arrange follow-up
An assessment of progress includes the provision of tobacco education and cessation brochures, specific assistance in how to quit smoking, support services and relapse services. Nicotine replacement therapy (NRT) or other pharmaceutical aids may be used in conjunction with these services.
Healthy Start encourages health care providers to participate in outreach activities that can identify pregnant women eligible for Healthy Start.

**MomCare**
Special consideration should be given to individuals in need of assistance for prenatal health care. Early prenatal care and continuous health care are more likely if there is an assurance that fees for services will be paid.

*For pregnant women, a process for determining aid eligibility is called MomCare.*

- The MomCare process assures the providers and families that there is a third-party payment system in place for eligible persons when care begins.
- To determine eligibility, pregnant women must fill out a one-page Medicaid application form available through the local Health Department office, attach a positive pregnancy test on letterhead from the doctor’s office or clinic with an estimated due date, and mail it to the closest Department of Children and Families (DCF) office – (address listed in Important Contact Information at the front of this guide.)

If you meet a potential client with financial needs, please give them the simplified Medicaid application.

For more information on the MomCare program, please review the MomCare section of this manual or call the Maternity Care Advisor for MomCare at 941-764-9900. For more information on WIC, please contact the Nutrition Program Director at 941-624-7210.

**WIC – Special Supplemental Program for Women, Infants and Children**
As a health care provider, improving maternal and child health is a common goal you share with the WIC program. By referring your potentially eligible patients to the local WIC office, you will be providing a valuable service to your patients. Patients who participate in WIC will receive free, professional nutrition services as well as supplemental foods. WIC is available to low-to-moderate income pregnant, breastfeeding and postpartum women, in addition to infants and children up to age five.

The eligibility criteria includes:
- Residency in Florida or recipient of health care in Florida
- Be at nutritional risk – such as abnormal anthropometric or hematological measurements, nutritional-related medical conditions and inadequate dietary intake
- Income eligibility - the family’s income must not exceed 185% of the US Poverty Guidelines

To refer a patient to WIC, complete a Florida WIC Program Medical Referral Form (see sample form on next page).

For more information on WIC, please contact the Nutrition Program Director at 941-624-7210

**Florida KidCare – Health Insurance for Uninsured Children**
Through Florida KidCare, children may be eligible for health insurance even if both parents are working.
- Through Florida KidCare, the State of Florida offers health insurance for uninsured children from birth through age 18
- Some of the services Florida KidCare covers include doctor visits, check-ups, shots, surgery, prescriptions, emergencies, vision hearing and mental health

For more information on Florida KidCare, call 941-624-7200
Benefits for Providers

By supporting the state-legislated Healthy Start Initiative, you and your healthcare staff can directly benefit. Making sure that every pregnant woman who enters your care fills out a Healthy Start risk screen and is encouraged to participate ensures that those who really need the help will not be missed. The benefits for providers of having patients participate in Healthy Start include:

Valuable Time Gained:
In an effort to help keep Healthy Start patients in prenatal care throughout their pregnancy, Healthy Start Care Coordinators maintain contact with the patient through home visits and telephone calls.

- Through constant contact and appointment reminders, Care Coordinators help keep the number of missed appointments low.
- Healthy Start Care Coordinators can be used as valuable contacts to community resources that will help patients maintain prenatal care between office visits, therefore reducing the time spent in the office repeating prenatal care already recommended.
- Risks may be identified through completion of the Healthy Start risk screen that would have been otherwise unnoticed until later in the patient’s pregnancy when it was either too late to resolve or very costly and time consuming for both the patient and provider.

Through Healthy Start, providers have the opportunity to be involved in reducing infant mortality and reducing the number of low birth weight babies. You can help Healthy Start achieve its goals of improving pregnancy, health and development outcomes for ALL of Florida’s babies.

Increased Support of Your Work:
Care coordination services provide your patients the knowledge, encouragement, and support to reinforce the prenatal care learned from your office, and necessary to maximize her families’ health, well-being and self-sufficiency.

- Patients may be eligible to receive free or low cost prenatal care classes and educational courses creating a reinforcement of information and continuation of prenatal care discussed in your office.
- Healthy Start Care Coordinators regularly remind patients about the importance of nutrition during their pregnancy. This will be especially important for your patients with special medical conditions.
- Through home visits and increased trust in their Healthy Start Care Coordinator, your patients will gain a support system that may have not previously existed, and as a result care more about taking the right steps in their prenatal care.

Additional Revenue:
Providers who bill Medicaid fee-for-service are eligible to receive reimbursement for completion of the Healthy Start prenatal risk screen.

- For screens completed during the first trimester of a patient’s pregnancy your office can receive $156 - Medicaid billing code W1992.
- For screens completed after the first trimester of a patient’s pregnancy your office can receive $104 - Medicaid billing code W1991.
Responsibilities of Providers

Each Provider should understand the:

1. Healthy Start Initiative
   - Attend training with Healthy Start Provider Liaison
   - Maintain communication with Provider Liaison for any questions you may have

2. Requirement to screen
   - ALL pregnant women are to be offered a screen at the time of their first prenatal visit in order to identify pregnant women who are more likely to experience pre-term labor and/or low birth weight

Each Provider should know how to:

3. Obtain screening forms
   - Contact Tammy at the Charlotte County Health Dept. courier at 941-624-7299, Vital Statistics Dept., screens will be delivered on the next Thursday.

4. Conduct screening
   - Refer to the Screening Guidelines section in this manual for a step-by-step process
   - Contact the Healthy Start Provider Liaison for an in-service if re-orientation is needed

5. Score the screening form
   - Refer to the Healthy Start Provider’s Guide and the back of each screen

6. Refer a patient to Healthy Start regardless of risk screen score if the patient needs the services
   - Indicate on the risk screening form that the woman or infant is invited to participate “based on factors other than score” - please list reasons on form
   - If a patient needs and desires Healthy Start care coordination regardless of screening score, they may request a referral to the care coordination provider, or contact the Healthy Start Coalition or care coordinator directly

Each Provider should know the:

7. Requirements related to getting completed screens to the Office of Vital Statistics
   - The white and yellow copies of the risk screens will be collected each Thursday by staff from the Charlotte County Health Department.
   - Please do not staple forms

8. Information related to how the Health Department’s quality improvement process maintains quality of screens
   - If incomplete or scored inaccurately, the Health Department will contact the provider for corrections

9. Information related to reimbursement for prenatal screening
   - Providers who bill Medicaid fee-for-service are eligible to receive reimbursement for the prenatal risk screen
   - The pink copy of the screen should remain in the patient’s medical record to document this Medicaid billable service
   - This reimbursement includes an additional amount for screening completed during the first trimester of pregnancy
   - The reimbursement is handled the same as other Medicaid reimbursable services (code W1992 for conducting screening in the first trimester and W1991 for screening conducted subsequent to the first trimester)
Introducing the Screen to Patients

Normally, the entire Healthy Start risk screen can be done in less than ten minutes. Please encourage ALL pregnant women to complete the screen and help their baby off to a great start.

Please remember Healthy Start is NOT based on income and Florida laws require every pregnant woman and infant be offered this screening.

Sample answers to questions patients may have about Healthy Start:

1. What is Healthy Start?
   Healthy Start is a state legislated program that provides care coordination while you are pregnant and after your baby is born to help you access support services available in Charlotte County. This program is designed to help ALL infants to have a healthy start in life by trying to identify any factors that may require special attention or services.

2. I heard Healthy Start is only for poor people, will I qualify?
   Healthy Start is NOT based on income – it is solely based on risk factors present during your pregnancy and when your baby is born. Every pregnant woman and infant in Florida is eligible to receive FREE Healthy Start services.

3. What are some of the services Healthy Start provides?
   Healthy Start provides information about financial assistance, child care, housing, health care and transportation. They also offer information on classes for childbirth, parenting and breastfeeding education, help to stop smoking, nutritional counseling, and confidential counseling, many of which are free or low cost.

4. Why do I have to fill this out?
   Healthy Start screening is part of your prenatal and infant assessment. The purpose of the questionnaire is to discover whether there is something about your health, current living situation, or everyday activities that could cause problems for you or your baby.

5. I don’t need any help, do I still need to fill this out?
   Florida has laws that require every pregnant woman and infant be offered this screening. Even if you feel you don’t need help, answering the questionnaire will be helpful in gathering the data that can improve health care for all of Florida’s moms and babies.

6. I don’t know if I want to give you this information.
   It only takes minutes. The answers are confidential and helpful in organizing the best possible care for you and your baby. It is very important to all of us to have healthy moms and healthy babies.

7. I just don’t want to do it, thank you.
   Please think about your decision, this is important to us and your baby. Would you mind filling out the top section and signing below so we can document that we offered you the screening?
1. Introduce Healthy Start and the screening form to the patient (see previous section on Introducing the Screen to Patients for sample answers to patient questions on Healthy Start and the risk screen).

2. Complete questions 1 – 16 with patient.
   - Question 9 – If patient answers “yes”, make appropriate referral based on Domestic Violence services available in the community (C.A.R.E).
   - Question 19 – If the patient answered “no” to question 15, provide a date…if the is less than 18 months before the current pregnancy, check “yes.” If the date is greater than 18 months or the patient answered “yes” to question 15, check “no.”
   - Question 20 – Enter the trimester at which the patient had her first prenatal visit. If the patient entered care in the second trimester, check “2nd.”
   - Question 21 – Check “yes” if patient requires ongoing medical care and specify condition or diagnosis.

3. Complete the “Patient Information” Section and “Provider Only” sections
   - Questions 18 – Use the BMI chart on the back of the yellow cop to determine the patient’s BMI score, based on height and weight information. If the patient’s BMI score is less than 19.8, or greater than 35, check the appropriate response box.
   - Question 19 – If the patient answered “no” to question 15, provide a date…if the is less than 18 months before the current pregnancy, check “yes.” If the date is greater than 18 months or the patient answered “yes” to question 15, check “no.”
   - Question 20 – Enter the trimester at which the patient had her first prenatal visit. If the patient entered care in the second trimester, check “2nd.”
   - Question 21 – Check “yes” if patient requires ongoing medical care and specify condition or diagnosis.

4. Complete the name of the Physician, Certified Nurse Midwife, or Advanced Registered Nurse Practitioner providing the prenatal care. Include the provider I.D., phone number and county for the prenatal healthcare office.

   NEXT …

5. Determine the patient’s Healthy Start screening score by adding together the subscripted numbers (along side each check box). Enter this total into the space indicated

6. Refer the patient for participation in Healthy Start care coordination if the prenatal screening score is six (6) or more, or the patient is at risk for an adverse based on factors other than score, including maternal illness, homelessness, domestic violence, HIV status, substance abuse, etc.

7. Discuss the Healthy Start screening score and status for care coordination with the patient. Sign and date the form.

8. Note that the form is to be signed by the patient and the authorization for information exchange must also be initialed by the patient.

   If the patient does NOT sign and initial where appropriate, she will NOT be eligible to be invited to participate in Healthy Start services.

   If the patient does NOT wish to participate in the screening process, she must indicate such by signing below the asterisk (*).

9. If the patient refuses to sign the form, write “patient refuses to sign” on the form.

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10. Provide ALL screens (complete and incomplete) to the Charlotte County Health Dept. Courier weekly on Thursday. Screen copies are distributed as follows:
   - White and yellow copies – picked up by the Health Dept. Courier
   - Pink copy – keep in the patient’s medical record
   - Green copy – give to the patient

Helpful tips for proper completion of the Healthy Start screen:

Section 1 – It is important that the patient fills out the birth date, marriage information, high school information, race and pre-pregnancy weight to properly score the screen.

Possible Factors requiring Priority Care Coordination other than a score of 6 or more

Knowledge or suspicion of:

- Domestic violence
- Sexual abuse
- Other threatened violence, including child abuse
- Substance abuse
- Untreated mental illness, including severe depression
- and suicidal tendencies
- Known history of abuse and neglect in family
- HIV positive
- Hepatitis B positive
- Lack of basic needs such as housing and food
- Lack of health care including prenatal care
- Inappropriate growth and development
- Other, using professional judgment
Healthy Start legislation requires that ALL pregnant women and infants be offered screening for risk factors that may affect their pregnancy, health or development. The prenatal and postnatal Healthy Start risk screens assess risk factors for adverse health outcomes so that identified individuals may then be referred more expeditiously to the appropriate services for their needs.

- The screening instrument includes a series of risk factors based on medical, environmental, and psychosocial concerns.
- The prenatal risk screen is designed to identify pregnant women who are potentially at risk to experience preterm delivery or deliver a low birth weight baby.
- The postnatal risk screen is designed to identify babies potentially at risk for adverse health and developmental outcomes or death in their first year of life.
- Florida’s Healthy Start services are available for all pregnant women and infants who are screened to be at risk for adverse health outcomes or those who are referred due to special risk factors.

**DEFINITION OF SERVICE**

Healthy Start risk screening is the collection of information on the designated prenatal and postnatal screening forms. The forms are scored to assess risk and to identify those women and infants most at risk for adverse health outcomes. Screening differs from assessment in that screening only identifies those most likely to be at increased risk; an assessment is necessary to determine service needs.

**BACKGROUND**

The Healthy Start screening instruments were developed by a workgroup that included physicians, nurses, social workers, researchers, program specialists and other professionals knowledgeable in the field of maternal and child health.

- The purpose of the screening instruments is to identify pregnant women and infants who are more likely to experience adverse outcomes.
- For pregnant women, the adverse outcome is pre-term labor and/or low birth weight.
- For infants, the adverse outcome is infant death between 28 and 364 days after birth.

Studies indicate that a woman who scores 6 or more on the Healthy Start prenatal screen is 1.8 times as likely to experience preterm labor or to have a low birth weight infant as a woman who scores less than 6.

**RISK RATIOS**

Each risk factor scored on the Healthy Start screening tool is associated with higher risk for poor health outcomes. This strength of the association is expressed as a “risk ratio.” For example, if a pregnant woman is less than 18, she is 1.38 times more likely to experience preterm labor or to deliver a low birth weight infant than is a woman who is over 18.

**POPULATION SERVED**

Florida statute requires that the Healthy Start risk screening be offered to all pregnant women at their first prenatal visit by their prenatal health care provider. In addition, Florida statute requires that the Healthy Start infant (postnatal) risk screening is offered to parents or guardians of all infants born in Florida before leaving the delivering facility.

**PARAMETERS**

Pregnant women and infants are screened only once for Healthy Start. Prenatal risk screening and referral for positive score should occur at the first prenatal visit or the earliest time thereafter. Referrals for reasons other than score are sometimes necessary but must be made judiciously. Potential program participants may, however, enter the program at any time subsequent to their negative screening and/or referral by a self-referral or a referral from a community resource.

The next 5 pages include samples of completed Healthy Start screens →
A GUIDE TO

THE
MomCare
Program

Charlotte County Healthy Start Coalition, Inc.
Pam Bicking, Maternity Care Advisor
Located at: 17940 Toledo Blade Blvd., Unit A, Port Charlotte, Fl 33948
Phone: 941-764-9900, Fax: 941-625-1690
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MomCare is a Medicaid-funded program for pregnant women in the State of Florida. It is authorized by a special waiver from the federal government.

MomCare seeks to improve birth outcomes and infant health by providing the following services to Medicaid-eligible pregnant women:

- Choice counseling for the selection of a maternity care provider
- Case Management to assist with initiation and use of prenatal care
- Healthy Start services for at-risk women

Medicaid applications are available at the Department of Health, and the Department of Children and Families.

MomCare was developed through a partnership of the Florida Association of Healthy Start Coalitions, Inc., the Department of Health, the Florida Agency for Health Care Administration (AHCA) and the U.S. Centers for Medicare and Medicaid Services.

Implemented as a pilot program by the Northeast Florida Healthy Start Coalition in 2000 that resulted in a 40% increase in the number of pregnant women receiving care, the program was adopted statewide in 2001. The addition of Healthy Start services to the program provides MomCare clients with a well-rounded prenatal care program to guide them through a healthy pregnancy.
The goal of MomCare is to improve birth outcomes and infant health by helping women who are newly eligible for Medicaid to receive early and regular prenatal care. MomCare’s objectives include:

- To assign every pregnant woman enrolled in MomCare a primary care provider within 30 days
- To increase Healthy Start screening rates
- To increase participation in WIC
- To identify client needs and link them with Healthy Start services
- To increase family planning services
- To ensure health insurance coverage for newborns

<table>
<thead>
<tr>
<th>SIMPLIFIED MEDICAID ELIGIBILITY</th>
<th>One page application</th>
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<tbody>
<tr>
<td></td>
<td>Applications processed in 5 business days by DCF</td>
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<tr>
<th>CHOICE COUNSELING</th>
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<tbody>
<tr>
<td>Providing unbiased information regarding her options for enrolling with a prenatal care provider</td>
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<tr>
<td>Assisting pregnant women in accessing early prenatal care</td>
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<table>
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<tr>
<th>CASE MANAGEMENT</th>
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<tr>
<td>Assisting pregnant women in scheduling their initial prenatal visit</td>
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<tr>
<td>Ensuring pregnant women keep their prenatal appointments</td>
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<tr>
<td>Ensuring completion of a Healthy Start screen</td>
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<tr>
<td>Providing information on Healthy Start and other community resources and to assist at-risk women in obtaining services</td>
</tr>
<tr>
<td>Working closely with prenatal care providers in locating patients who have missed appointments</td>
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<tr>
<th>FAMILY PLANNING SERVICES</th>
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<tr>
<td>Providing Family Planning services for 2 years postpartum</td>
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<tr>
<td>Reducing the number of unintended pregnancies paid by Medicaid</td>
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<tr>
<td>Decreasing repeat teen births</td>
</tr>
<tr>
<td>Improving birth outcomes</td>
</tr>
<tr>
<td>Decreasing infant mortality</td>
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</tbody>
</table>

According to statistics, without Medicaid an estimated 40 – 50% of this county’s pregnant women would go without prenatal care.

The MomCare program accomplishes these objectives through a simplified application for Medicaid, guidance, education and prenatal care counseling.
How MomCare Works

The MomCare Process

1. Patients should be encouraged to obtain the simplified Medicaid application at the local Health Department office to begin the process for presumptive eligibility determination. Otherwise, they may contact the nearest Department of Children and Families office for an application.

2. She completes the simplified one-page application and attaches proof of a positive pregnancy test on letterhead from a health care provider.

3. The application can be mailed to the nearest Department of Children and Families.

4. If accepted, MomCare registers and enrolls the patient, and Maternity Care Advisor Counseling services begin.

ELIGIBILITY:
All pregnant women whose income is between 100% - 185% of the poverty level are eligible for MomCare.

- Babies of women between 100% -185% of the poverty level have the highest infant mortality rate of all economic groups

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Income</th>
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<tbody>
<tr>
<td>(Include your unborn child)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$1669</td>
</tr>
<tr>
<td>2</td>
<td>$2246</td>
</tr>
<tr>
<td>3</td>
<td>$2822</td>
</tr>
<tr>
<td>4</td>
<td>$3399</td>
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<tr>
<td>5</td>
<td>$3975</td>
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<tr>
<td>6</td>
<td>$4552</td>
</tr>
<tr>
<td>7</td>
<td>$5129</td>
</tr>
<tr>
<td>8</td>
<td>$5705</td>
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</table>

The monthly income guidelines are based on the maximum gross monthly household income allowable to be eligible for this program. Guidelines are effective April 2002.

Most women are eligible for Medicaid in two ways:

1. PEPW – Presumptive Eligibility for Pregnant Women (also called MU)
   - Allows 45 days of Medicaid coverage for pregnant women
   - Helps women obtain early prenatal care by providing immediate coverage for medical care.

2. SOBRA – Sixth Omnibus Reconciliation Act
   - Refers to pregnant women who are eligible for Medicaid because their incomes are within 185% of poverty
   - Allows pregnant women to qualify for Medicaid for their entire pregnancy and for 60 days after the baby is born
MomCare patients are exactly the same as regular Medicaid patients with one advantage:
- MomCare patients receive assistance selecting a prenatal care provider and in accessing Healthy Start services and other community resources.

MomCare patients are Medicaid patients, so your practice will receive current Medicaid fees.
- There is no change in billing or payment practices.

MomCare patients will now have access to health insurance, through Medicaid, within days not months.
- This means earlier entry into care, less 2nd and 3rd trimester primary physician changes due to Medicaid status, and more women entering into care and remaining with a physician who accepts Medicaid.

Physicians who are currently Medicaid providers are registered on the MomCare provider list supplied by the State of Florida’s Agency for Health Care Administration (AHCA).

Physician Standards for the MomCare Program:
- Provider is a qualified Medicaid provider
- Provider signs an agreement to serve as a primary care provider
- Provider offers comprehensive services to all eligible and assigned Medicaid clients
- Provider refers clients for specialty care and other services when medically necessary
- Provider approves all non-emergency in-patient admissions
- Provider makes emergency services available 24-hours, 7 days per week
- Provider does not refuse assignment or in any way discriminate against patients due to age, sex, race, physical or mental handicap, national origin, or type of illness or condition except when that condition is better treated by another type of provider
- Provider completes Healthy Start screens in a timely manner
- Provider cooperates with provision of Healthy Start services and WIC
- Provider screens for substance abuse including alcohol abuse
- Provider screens for HIV status and treats/refers as necessary
- Provider completes all recommended tests, including tests for STDs
- Provider meets Department of Health standards for prenatal care
- Provider refers patients for genetic counseling as appropriate
- Provider transfers high risk patients to Regional Perinatal Intensive Care Centers when criteria are met
- Provider meets such other criteria as may be established by the Agency for Health Care Administration, the Department of Health, and the regional and statewide advisory groups
- Providers are limited to 150 pregnant Medicaid beneficiaries per full-time practitioner and 75 patients per full-time physician extender