

**High Risk Perinatal
Program/Newborn Intensive
Care Program (HRPP/NICP)**

**COMMUNITY NURSING
SERVICES**

**POLICY AND PROCEDURE
MANUAL**

**Arizona Department of Health Services
Bureau of Women's and Children's Health
Office of Children's Health**

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~ Leadership for a Healthy Arizona ~

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CHAPTER 1 INTRODUCTION

1.1 History of the Newborn Intensive Care Program (NICP)

Prior to 1967, Arizona had one of the highest infant mortality rates in the country. That year, in an effort to reduce the high infant mortality and morbidity rates, Arizona applied for and received a federal demonstration grant. The grant was designed to reduce infant death by transporting critically ill newborns born in rural hospitals into intensive care centers. As a result, there was a dramatic decrease in neonatal mortality. Part of that grant was to provide home based Community Nursing Services to the infants and their families. Community Health Nurses provided follow-up home visits for the NICP infants and their families up to one year of age.

In 1972, the State Legislature provided state funding for the program, which eventually became the Newborn Intensive Care Program (NICP). The system provided care to those infants transported to metropolitan hospitals (Level III's) and expanded to include infants born in Level II or Level III hospitals. Comprehensive and periodic developmental assessments were an additional component of the follow-up services provided in specific areas of the state.

In 1975, Arizona Department of Health Services (ADHS) received a Robert Wood Johnson Grant to develop regionalized perinatal care with a focus on the maternal transport system. Under this grant, the Maternal Transport Program (MTP), the Arizona Perinatal Program (APP), the Arizona Medical Association (AMA) and the University of Arizona began to develop guidelines for Level I, II, and III perinatal hospital services, a perinatal data system and the system of maternal transport.

In 1977, it was demonstrated that babies did very well if transported to hospitals closer to their homes following the acute phase of their illness. Therefore, back transport was added as a component of the NICP.

In the late 1980's ADHS Office of Women's and Children's Health (OWCH) with the county health departments identified a need for home-based community health nursing services for those infants who may not have been critically ill at birth but were diagnosed with problems at a later date.

Part C of the Public Law for Individuals with Disabilities Education Act (IDEA), provided incentive for the development of a system of early intervention services which could provide a comprehensive, culturally appropriate, multi-disciplinary, family centered approach to all families. In 1993, ADHS awarded contracts to

developmental clinics to determine eligibility for the Arizona Early Intervention Program (AzEIP).

In 2002, funding for the developmental clinic component was eliminated. Arizona physicians and therapists then had few options for the evaluation of their developmentally delayed patients. Physicians began working closely with the Arizona legislature to restore funding for this much needed service. In FY 2007 the legislature partially restored funding to allow the HRPP/NICP to provide developmental assessments to program enrollees who do not meet Arizona Early Intervention (AzEIP) eligibility criteria and are uninsured or underinsured.

The Community Health Nursing component works with families to improve their infant's developmental outcomes. Services may be provided through a child's third birthday.

Research has demonstrated that the health of the mother before she becomes pregnant plays a significant role in the wellbeing of the newborn. To address those issues the CHN also incorporates post-partum wellness assessment and guidance about intraconception wellness into her/his family centered care.

During FY 2009, the state experienced a severe budget downfall. As the result of budget reductions, and in an effort to serve the sickest infants, the Program changed eligibility to infants who have spent at least 5 days in the NICU and restricted back transports to families who live over 50 miles from the NICU. The Developmental Services component was eliminated at that time also as a result of underutilization.

1.2 Description of the Program (See flow sheet at end of chapter)

The NICP is the major part of the High Risk Perinatal Program. The transition of the program name to High Risk Perinatal Program (HRPP) is a reflection of the program mission to provide a statewide system of specialized care for high risk pregnant women and sick newborns. There are currently three program components to the HRPP/NICP.

1. Transport Services
2. Hospital Inpatient Physician Services
3. Community Nursing Services

1.2.1 Transport Services

Medical Consultation and Case Management Services

The ADHS contracts with neonatology and maternal fetal medicine/ Perinatology groups throughout the state to provide medical consultation regarding the treatment, stabilization and, if needed, approval of coordination of interfacility neonatal and maternal transport. This service is provided free of charge to all callers.

Information and Referral Services

The ADHS provides access to a toll free telephone service that serves as the crucial link between referring health care providers and consulting perinatologists and neonatologists. If, at the time of consult, a transport is deemed necessary, the contracted neonatologist or perinatologist will make transport arrangements with a contracted transport company.

**STATE WIDE TOLL FREE
INFORMATION AND REFERRAL NUMBER
1-800-552-5252**

Transport Services

Families benefit from the Transport Program by having a coordinated system in place to ensure appropriate interfacility transport and admission to high risk perinatal centers. The services are initiated without prior authorization or verification of payment source to prevent delays in service delivery.

The ADHS contracts with medical transport companies to provide air and ground transport, as well as team services, for high risk pregnant women and sick neonates. The HRPP/NICP transport providers must obtain authorization and administrative specialty program direction from a board certified perinatologist or neonatologist licensed and practicing in Arizona and contracted with the ADHS. The HRPP/NICP transport providers must be accompanied by a program contracted transport team.

1.2.2 Hospital and Inpatient Physician Services

The ADHS contracts with all Level II, II Enhanced Qualifications (EQ), and III perinatal centers (see glossary) that are certified by the APT/APRS, Inc., to provide the appropriate level of hospital care to Program babies and their families.

Contracts are in place with neonatology groups to provide appropriate medical care to program infants during the newborn intensive, intermediate or continuing care hospitalization.

In addition, the Program contracts with all Level II EQ and Level III centers to support the implementation of developmental care practices in their newborn intensive care units.

1.2.3 Community Nursing Services

The Community Nursing Services component of the HRPP/NICP delivers a statewide, coordinated system of specialized nursing services to infants who are enrolled in the Program. The Community Health Nurse (CHN) provides support to families during the transition of the infant to home; conducts physical, developmental, psychosocial and environmental assessment of the discharged infant and a post-partum wellness assessment of the mother and provides education about interconception health. Whenever possible, the CHN makes referrals to specific community services as needed. The CHN also will collaborate with the mothers on issues related to their own wellbeing in an effort to improve their ability to meet the needs of the enrolled infants and decrease the likelihood of a poor birth outcome with subsequent pregnancies.

This program is linked with the Office for Children with Special Health Care Needs (OCSHCN) to provide services to children who have a chronic medical condition and whose families express a desire for information, support, and/or coordination with multiple service providers and resources.

Currently the HRPP, CHN Services and the Office for Children with Special Health Care Needs (OCSHCN) collaborate to support home visiting for other children with special health care needs to the age of twenty-one (21).

The CHN's also collaborate with the Newborn Screening Program (NBS) to provide home visits, coordination and referral to community services as needed for infants identified by Newborn Screening Program as needing repeat testing.

1.3 Financial Assistance/Benefits to Infant and Family

The HRPP/NICP Hospital Services Program provides limited financial assistance for families who request financial participation. The Program's role is **payer of last resort**.

1.3.1 Family Liability/Billing

Hospitals, using the ADHS formulas, establish the liability for each family requesting financial assistance. All contracted hospital and physicians agree **not** to bill the family more than their established family liability. Family liability is based on one amount per family rather than per child in the event of a multiple birth delivery. The liability is established once to cover all associated inpatient costs for the infant (s). The HRPP Claims Coordinator tracks the distribution of family liability payments and notifies each provider how much they can bill the family.

The family's liability is the total amount that the family must pay to contracted providers before a bill is considered for payment by HRPP/NICP. The family liability is generally applied to hospital and physician bills accordingly: 75% to hospitals and 25% to specialty services. When a hospital does not require the entire 75%, the remaining liability is applied to physicians in the NICU, or transport. Conversely, if the specialty services do not require the 25%, the remainder will be applied to the hospital bill. The family will be responsible for the entire established family liability. **Families are not protected from costs with providers who do not have a contract with ADHS.**

1.3.2 Maternal Transports

Maternal transports by contracted providers are paid by HRPP/NICP after all other third-party payments. The HRPP Request for Maternal Transport Form must be completed and signed by the patient or responsible party and must include the name of the authorizing contracted maternal fetal medicine specialist and name of Level II EQ or III perinatal center to which the patient is transported.

1.3.3 Neonatal Transports

Neonatal transports completed by contracted providers are paid once the HRPP/NICP enrollment is complete and after all other third-party reimbursements. Families must enroll their infant in third party insurance or apply for **AHCCCS within the required timeframes and maintain insurance. Failure to do so will result in HRPP/NICP financial**

assistance being denied and the family being liable for the cost of the transport. The HRPP Request for Neonatal Transport Form must be completed and signed by the patient or responsible party and must include the name of the authorizing contracted neonatologist and name of Level II, II EQ or III perinatal center to which the patient is transported.

1.3.4 Neonatal Back Transports

Neonatal back transports by contracted providers are paid by the HRPP/NICP after all other third-party reimbursements if the a contracted neonatologist authorizes the transport and where the distance from the family home to the hospital is over 50 miles and the family is enrolled as full participants. Payment for transport to a non-contracted hospitals provided only with a prior authorization from the Transport Services Program Manager.

1.3.5 Non-Contracted Ground Transports

Non-contracted ground transport providers may participate in the Transport Program and may be reimbursed as payer of last resort. However, if they choose to participate, they must abide by the Transport Services Policy and Procedure Manual.

The HRPP/NICP does not pay for any services provided at non-contract facilities prior to the transport or for the mother's health care costs.

1.4 Mission Statement

The mission of the HRPP/NICP is to reduce maternal and infant mortality and morbidity through a regionalized statewide system of coordinated care that includes consultation, transport, hospital care and community health nursing.

1.5 Philosophy

The recipients of our services are families who live within broader systems that include extended family, friends, and communities. All services provided by this program are reflective of this philosophy.

1. Successful development and implementation of the HRPP/NICP depends on a partnership with families, members of the medical community, funding sources and policy makers.

2. Risk appropriate transport, hospital care, community home nursing, and developmental services should be available and accessible to all critically ill newborns in Arizona regardless of geographic location and ability to pay.
3. Developmentally appropriate care is mandatory for the optimal development of the infant. This philosophy of care is:
 - a. Initiated at birth
 - b. Continued during transport
 - c. Incorporated into discharge planning upon admission to the HRPP/NICP
 - d. Based on the infant and family needs
 - e. Supports an environment conducive to maximum healing and growth
4. The family is the most important resource and decision maker in a child's life; therefore, they should be active participants in the hospital care, discharge planning and the ongoing interventions of their infants.
5. Primary care providers are crucial in the medical management of all infants, both at home and during necessary hospitalizations.
6. All children have intrinsic value and the right to maximize their potential for productive independence.
7. Follow-up after discharge is critical for:
 - a. Strengthening the family unit
 - b. Assuring optimal development of the child
 - c. Identifying physical, developmental, psycho-social and environmental issues that may lead to referral for early intervention services
 - d. Assisting families to be the best advocates for their child
8. Referrals for needed services should include community-based options for families whenever possible.
9. A system should be in place to protect families from catastrophic costs that may be associated with newborn intensive care.

1.6 Goals and Objectives

1.6.1 Overall NICP Goals

The goal of the NICP is to reduce maternal and infant mortality and morbidity utilizing the following strategies:

1. Early identification of women and children at high-risk for mortality and

- morbidity
- 2. Education for health professionals, families and communities
- 3. Linkage of infants, toddlers and pregnant women to risk appropriate services
- 4. Establishment of standards of care

1.6.2 Community Health Nursing Specific Goals

1. To encourage normal developmental patterns in high risk infants and toddlers.
2. To help children function better when they reach the school system.
3. To empower families to function at the highest level by assessing their own needs in accessing community resources.
4. To ensure the highest quality risk appropriate care for infants and toddlers at risk.
5. To provide family-centered, culturally sensitive, and developmentally appropriate, coordinated services.
6. To provide families of high risk children with developmental evaluations to determine eligibility for early intervention services and/or developmentally appropriate activities for their child.
7. To provide services in a setting that best meets the needs of the family and child.

1.6.3 Objectives

1. Support families who participate in evaluation, assessment, education and/or the community referral process of their child.
2. Standardize quality of services.
3. Plan and implement an evaluation system, which includes data collection.
4. Seek funding for continued program development.
5. Encourage the participation of parents and other community advisors in policy development, business meetings, and continuous quality improvement activities.

1.7 Overview of Roles and Responsibilities

The ADHS is designated as the state agency responsible and accountable for program goals and expenditures. The HRPP/NICP is administered by ADHS, Public Health Prevention Services, and the Bureau of Women's and Children's Health (BWCH). The HRPP/NICP performs a variety of roles in the oversight of the Program: as a regulator, as a partner, monitor, facilitator, technical advisor, educator, and payer.

1.7.1 ADHS Roles and Responsibilities

1. ADHS and its contractors share a dynamic role in the development and evolution of the HRPP/NICP.
2. The HRPP/NICP collaborates with the APT/APRS, Inc., and AHCCCS for establishing standards of care and participation within the regionalized system.
3. ADHS provides the criteria, policies and requirements for developing and implementing the high quality, developmentally, risk appropriate transport, and intensive care services state wide for high-risk pregnant women and critically ill newborns. The philosophy reflects the core requirements of the HRPP/NICP Program, while also attempting to promote the family centered approach that is the cornerstone of the program.
4. ADHS contracts with perinatal centers (Levels II, II EQ, and III Hospitals) which may recruit and manage a unique group of specialized providers, such as neonatologists, perinatologists, pediatricians, nurses, paramedics, respiratory therapists, social workers, developmental interventionists, communication specialists and other ancillary personnel.
5. The ADHS Community Nursing Services program component contracts with local public and private agencies (contractors) that may recruit and manage a unique group of specialized providers, community health nurses, social workers, and early interventionists, (speech/language pathologists, physical and occupational therapists).
6. The ADHS contracts with air transport companies who meet established eligibility standards. These companies may recruit and manage a unique group of specialized providers such as perinatologists, neonatologists, specialty nurses; i.e., NICU, ER ICU or L&D, respiratory therapists, communication specialists and other ancillary personnel. In an effort to provide the most risk appropriate comprehensive care, the HRPP High Risk Transports may only be performed by these contracted companies.

1.7.2 Contractor Roles and Responsibilities

Services are contracted through providers statewide. Coordination among all service programs and rural specialists is essential for an efficient, statewide, family centered program. The contractor is expected to:

1. Provide a home based visitation program to:
 - a. Infants and toddlers meeting NICP eligibility
 - b. Infants and toddlers and children meeting “Children with Special Health Care Needs” requirements
 - c. Mothers and families of NICP enrolled infants.
2. Provide individualized family-centered, developmentally appropriate, and evidence-based coordinated home visiting services in a setting and at a time which is most appropriate for meeting the needs of the child and family.
3. Provide a program that at a minimum recruits, hires, trains and supervises community health nurses, early interventionists and social workers.
4. Provide orientation for new staff, continuing education and ongoing supervision of staff for this program as outlined in Chapter 4.
5. Provide a physical, developmental, psychosocial and environmental assessment of the enrolled infant including evidence based education, family support, and early intervention along with referral services to community resources.
6. Provide postpartum wellness screening, interconception assessment support and education to the mother.
7. Provide assistance to the ADHS Newborn Screening Program in locating families and facilitating the collection and submission of another newborn screening test for infants with a previously abnormal test result.
8. Designate a CHN to attend the weekly Discharge Planning meetings at Level II Enhanced Qualification (EQ) and Level III Newborn Intensive Care Units as appropriate.
9. Collaborate and coordinate with parents, team members and other community providers in order to offer a family centered approach to care.
10. Establish a linkage with referral sources for children and their families needing services within the Contractor’s community.
11. Provide written quarterly reports as outlined in Chapter 8.

12. Provide written reports including a Continuous Quality Improvement (CQI) plan for Community Nursing Services based on the ADHS/BWCH CQI policy. At least two components of the CQI will be determined by ADHS as outlined in chapter 8.
13. Provide orientation and ongoing updates to staff on the requirements of the Community Nursing Services Contract.

Written notification will precede any changes in Contractor responsibilities. Contractors will be given a 30 day grace period before the change is expected to be implemented.

1.8 How To Use This Manual

The purpose of this manual is to document the HRPP/NICP Program's policies for management of the Program. The manual is to be used as a reference and information resource for community nursing contractors, ADHS administration and other interested parties in fulfilling the mission of the Program.

The policies contained herein are the minimum acceptable requirements to contract with ADHS to provide community nursing services to Arizona's maternal and neonatal population.

This manual will be reviewed at least annually and revised as necessary. Suggestions for changes to the manual to clarify a policy or to update a procedure may be sent in writing or fax to the Community Nursing Services Program Manager at the address at the end of this chapter. The suggestions will be considered during the review process.

Please note that the policies and procedures are dated and numbered. As revisions occur or new policies and procedures are developed, they should be added to the manual. Old policies and procedures no longer in effect should be deleted from this manual.

Revisions to the manual will be distributed to all contractors at least thirty days prior to the effective date of any change, when appropriate. Contractors are required to adhere to the requirements and guidelines set forth in this manual, and are also responsible for incorporating any policy changes into their operations.

If this reference does not answer your questions or concerns, or if you have suggestions for additional information that should be included in the policy manual, please contact:

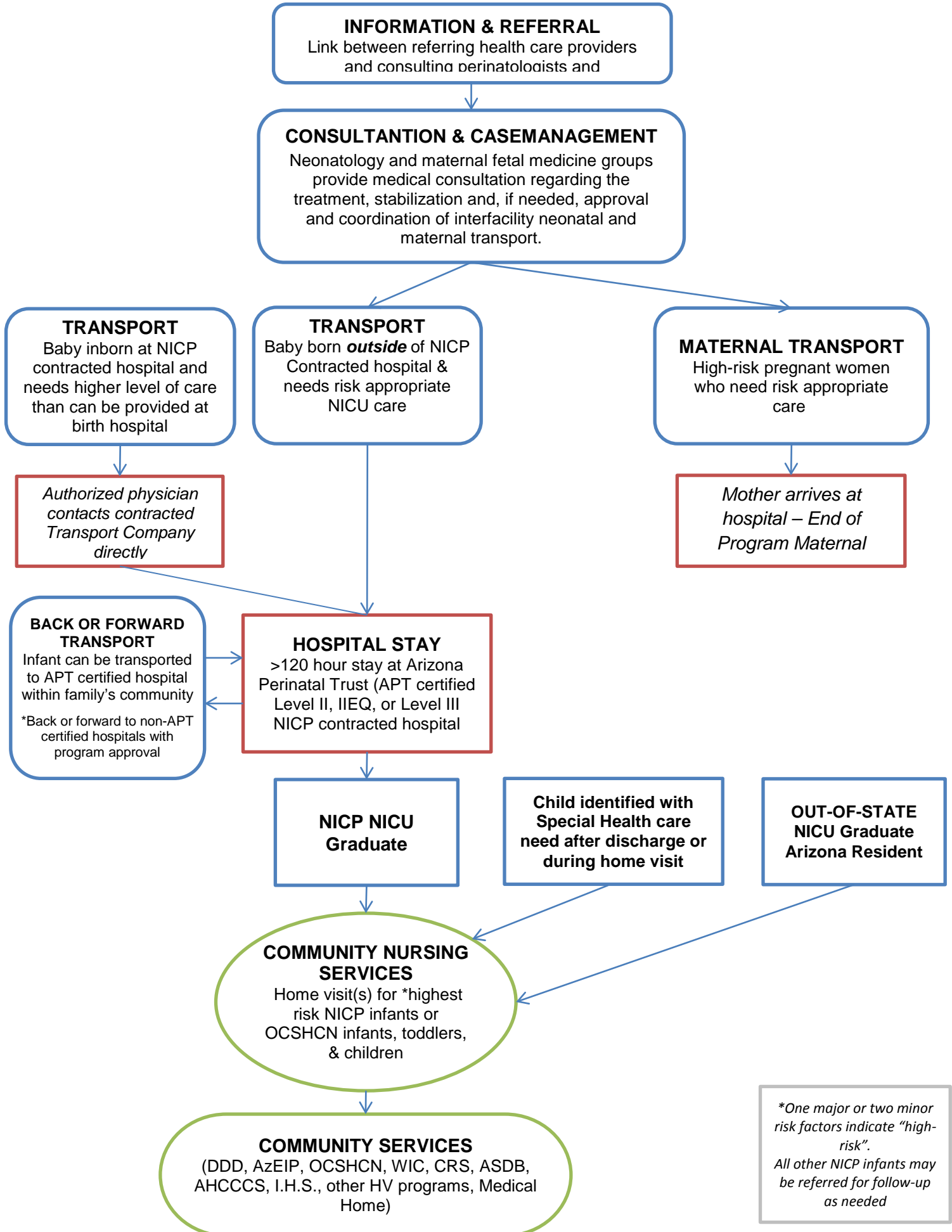
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HIGH-RISK PERINATAL PROGRAM/NEWBORN INTENSIVE CARE PROGRAM FLOWCHART



**One major or two minor risk factors indicate "high-risk". All other NICP infants may be referred for follow-up as needed*

**CHAPTER 2
GLOSSARY**

AAP

American Academy of Pediatrics. AAP is a professional organization for physicians and affiliate members involved with the care of children.

ADE

Arizona Department of Education

ADES

Arizona Department of Economic Security - Lead Agency for AZEIP

ADHS

The Arizona Department of Health Services - ADHS is the Arizona State agency responsible for administering public health services and a variety of community health programs.

AHCCCS

Arizona Health Care Cost Containment System - AHCCCS is an Arizona State agency that administers (through its managed care plans) health care benefits and services for people who are eligible for Medicaid or other low income medical assistance programs.

Anticipatory Guidance

Preparing families for changes in the growth and development of their infant(s) through counseling and education.

APIB

Assessment of Preterm Infant Behavior - APIB is a formalized and standardized method of determining the developmental and behavioral characteristics of a Preterm infant.

APRS, Inc.

Arizona Perinatal Regional System, Inc. - The performing corporation of the Arizona Perinatal Trust (defined below)

APT

Arizona Perinatal Trust - The private non-profit agency that administers the voluntary certification of Arizona hospitals for their obstetrical and neonatal care services. The agency also works to establish standards of care. The HRPP/NICP only contracts with hospitals that are certified by the APT/APRS, Inc.

ASDB

Arizona State School for the Deaf and the Blind.

ASQ Ages & Stages Questionnaire: A parent – completed child monitoring system designed to identify infants and young children who show potential developmental problems

Authorization

The ADHS process for accepting enrollment requests for eligible maternal/neonatal clients.

AzEIP

Arizona Early Intervention Program - AzEIP is Arizona's implementation of a federal law requiring that early intervention services be provided to infants and toddlers who have, or who are at risk for, certain disabling conditions.

AzEIP Eligibility Determination

This determination is made by collecting and reviewing existing information regarding the child and family in order to determine eligibility for AzEIP.

Back Transport

Any authorized transport of an HRPP/NICP infant from one HRPP/NICP contracted hospital to an equal or lower level HRPP/NICP contracted hospital. (All exceptions **must** be approved by the HRPP/NICP Transport Manager).

Brazelton Neonatal Behavioral Assessment Scale (BNBAS)

An interactive examination measuring a variety of aspects of infant behavior. Designed for the assessment of neonates (infants from Birth to 1 month of age).

BWCH

Bureau of Women's and Children's Health - Provides services and facilitates systems development to improve the health of women, children, and adolescents. This includes: technical assistance, consultation, system and community development, direct care, contracts for services and education.

Case Management

A process that provides high quality, cost effective health care by decreasing fragmentation, increasing clients' quality of life and containing costs. Case management can be provided to groups of clients, in addition to individuals and families.

Children with Special Health Care Needs (CSHCN)

Included are children birth to 21 years of age who have any of a broad range of disabilities or chronic illnesses, which necessitate adaptations for daily

functioning, prolonged or periodic hospitalizations, or special services in educational settings.

Client

An enrolled patient who receives eligible neonatal, child or maternal services.

Consent

Agreement to and acceptance of a course of action, when:

- A. the parent or parents have been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication.
- B. the parent or parents understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom.
- C. the parent or parents understand that the granting of consent is voluntary on the part of the parent or parents and may be revoked at any time.

Contractor

A public or private organization that has a contract with ADHS to develop, manage and provide HRPP/NICP services.

Council (AzEIP)

Arizona Interagency Coordinating Council (ICC)

Denver II

A formal and standardized screening tool designed to assess the developmental status of infants and young children. This is one possible instrument used by the community health nurses.

Developmental Care

An approach to providing individualized care to infants based on an individual assessment of the infant's developmental/behavioral status and capabilities. This care is based on the Synactive Theory of Development.

Developmentally Appropriate

Refers to the provision of services and activities that are designed to optimize the developmental status and capabilities of the individual to whom they are targeted.

Disabilities

In this context, it refers to a child who presents with special health care needs.

Educational Visit/Assessments (Developmental Services)

This visit is usually for NICP children. The purpose of this visit is to provide the family with educational opportunities in the areas of motor, speech, behavior, nutrition, or social services. The family will receive a written summary of the recommendations made during the visit. The summary should also include the expectation for future services. AzEIP may refer a child for a nutritional assessment under this billable unit.

Eligibility

Pertains to meeting the requirement for enrollment in the High Risk Perinatal/Newborn Intensive Care Program, AzEIP, or any other Early Intervention agency for services.

Enrollment

A process of voluntarily requesting to receive High Risk Perinatal/Newborn Intensive Care Services by the parent or legal guardian for his or her eligible infant or by the transported mother.

Established Condition (AzEIP)

Diagnosed physical or mental condition which, based on informed clinical opinion, has a high probability of resulting in a developmental delay.

Family-Centered

Recognition that the family is the constant in a child's life and that service systems and personnel must support, respect, encourage and enhance the strength and competence of the family.

Family Liability

A term used to describe the total amount of money a family will be required to pay for services provided for their HRPP/NICP enrolled infant during the infant's hospital stay in an HRPP/NICP contracted hospital(s). The services covered are inpatient and transport related only. The time period covered is from the infant's initial transport/enrollment until his or her final discharge to home or to a non-contract facility. This may cover more than one admission if there was a back or forward transport, but does not cover readmissions of enrolled infants after a discharge to home or to a non-contract facility.

Family Service Plan

Resources, concerns, priorities and outcome tool; this form is used with the family to plan goals for case management.

H.O.M.E

Home Observation for Measurement of the Environment - A standardized instrument used to assess the family's home environment.

ICC (AzEIP)

Interagency Coordinating Council for Infants and Toddlers (AzEIP)

IFSP (AzEIP)

Individualized Family Service Plan - A written plan for providing early intervention services to an eligible child and the child's family.

IFSP TEAM (AzEIP)

Group of people selected with assistance of, and including, the parents, who, through consensus, collaboration and coordination, support the family in meeting the needs of their child. Activities of this team and its subgroup include assessment, IFSP development and implementation.

Level I

A hospital certified by the APT/APRS, Inc. to provide basic obstetrical and/or newborn care.

Level II

A hospital certified through the APT/APRS, Inc. to provide basic and intermediate obstetrical and newborn care.

Level II EQ (Enhanced Qualifications)

A hospital certified by the APT/APRS, Inc., to provide all services provided by Level II hospitals plus management of pregnancy labor and delivery at 28 weeks gestational age or greater.

Level III

A hospital certified by the APT/APRS, Inc., to provide basic and intensive obstetrical and/or newborn care.

Multi-disciplinary

Refers to a service or activity carried out collaboratively between at least two separate disciplines. Each discipline involved carries out its own part, but the resulting product includes the input presented in an integrated fashion.

NANN Developmental Guidelines

This refers to the guidelines for development of an individualized infant care plan in the NICU or special care nursery based on the National Association of Neonatal Nurses' (NANN) recommendations to enhance the developmental status of the infant.

NANN Transport Guidelines

National Association of Neonatal Nurses published guidelines for the ground transport of critically ill newborns.

Natural Environments

To the maximum extent appropriate to the needs of the child, early intervention services must be provided in settings that are natural or normal for the child's age peers who have no disability, including home and community settings.

NCAST

Nursing Child Assessment Satellite Training - A formal, standardized assessment of the caregiver/child interaction.

NIDCAP

Neonatal Individualized Developmental Care and Assessment Plan - A formal and standardized assessment of an infant's developmental and behavioral status presented along with a suggested care plan to enhance the developmental status of the infant.

Primary Agency (AzEIP)

The Agency that accepts responsibility for the eligible child and family as well as, ensuring assignment of a service coordinator (typically the agency responsible for the largest portion of services to an eligible child and family).

Program Manager

The program manager is an ADHS employee who is responsible for the agency's implementation and oversight of a specific program component of the HRPP/NICP. The program manager provides consultation and technical assistance, coordinates activities among contractors and among HRPP/NICP team members, receives and reconciles invoices, manages the Program budget, and answers questions that arise. The program manager is also responsible for writing and negotiating contracts, writing and updating the CHN Policy and Procedure Manual continuous quality improvement and monitoring contractor compliance.

Referral

Refers to the concept of linking persons in need of particular services or service alternatives with services appropriate for their needs, and assisting individuals to access these services when necessary.

Risk Appropriate

Refers to the concept of providing needed services in the manner, and in an environment that most closely meets the needs of the individual.

Risk Criteria

A set of conditions or circumstances that indicate areas of risk.

Service Coordination(AzEIP)

Activities carried out to assist and enable a child eligible under Part C and the child's family to receive the rights, procedural safeguards and services that are authorized to be provided under the State's early intervention program.

Staffing

Multi-disciplinary staffing is a term used for the purpose of reimbursement for service provided by the Contractor such as CPS (Child Protective Services) or DDD (Department of Developmental Disabilities) staffing, hospital discharge staffing, IFSP, etc. The family is usually present as are other disciplines as appropriate.

CHAPTER 3 PROGRAM SERVICES

3.1 Introduction

This chapter provides a synopsis of major programmatic functions and responsibilities of the Community Health Nursing Program Contractors. This general summary is not intended to be an all-inclusive description of the Contractor responsibilities. More comprehensive detailed descriptions of these responsibilities are contained throughout this policy manual and in each Contractor's written contract with Arizona Department of Health Services (ADHS).

The purpose of the HRPP/NICP Community Health Services Program is to assist in the smooth transition of medically fragile Newborn Intensive Care Program (NICP) enrolled infants and their families from a Newborn Intensive Care Unit/Special Care Unit to home and to provide a coordinated, family centered, culturally, developmentally appropriate, evidence-based home visiting services to these infants and other children/families identified with special health care needs. This care will include collaborating with the mothers on issues related to their own wellbeing in an effort to improve their ability to meet the needs of the enrolled infants and decrease the likelihood of a poor birth outcome with subsequent pregnancies.

3.2 Program Responsibilities

Contractors shall:

- A. Follow the standards, guidelines and policies and procedures of ADHS.
- B. Provide a home based visitation program, which shall include a CHN, and may include early interventionist and/or a social worker for children enrolled in the NICP or other children with special health care needs services.
- C. Identify and enroll infants, toddlers and children meeting the Children with Special Health Care Needs (OCSHCN) criteria.

- D. Provide a program that at a minimum employs, train, supervise and evaluates sufficient and adequate staff and support services, i.e., community health nurses, social workers and/or early interventionists.
- E. Provide a program that ensures the first home visit shall be done by a CHN, and subsequent visits shall be made by appropriate professionals. All visits with children having on-going medical problems shall be done by a CHN;
- F. Complete a physical, developmental, psychosocial and environmental assessment of the enrolled infant including evidence based education, family support and early intervention along with referral services to community resources as needed (see Chapter 5)
- G. Provide postpartum wellness screening and provide interconception support and education to the mother
- H. Contact the enrolled family within one week of receiving the Discharge Form;
- I. Visit the enrolled infant/family within two weeks of receipt of the Discharge Form
- J. Visit enrolled infants a minimum of four (4) times within a year from the date of discharge as required or prioritize visitation to ensure the infants are seen as appropriate according to their risk.
- K. Coordinate service area with other contracted CHN agencies when providing services in the same metropolitan area
- L. Collaborate and coordinate with other community based agencies in order to offer comprehensive, family centered services and prevent duplication of service.
- M. Provide administrative, supervisory and evaluative services within the contractor's organizational systems, based on the needs of the child/family.
- N. Assure professional competency with high-risk infants and toddlers
- O. Develop and implement a HRPP/NICP Plan for each child/family receiving services through the home visitation program. The HRPP/NICP plan is based on individual child/family resources, priorities

and concerns and should reflect the plan and timelines for addressing identified needs.

- P. Provide assistance to the ADHS Newborn Screening Program in locating families and facilitating the collection and submission of another newborn screening test for infants with a previously abnormal test result as requested by ADHS
- Q. Within one (1) week of discharge, send a letter to families when a newborn infant may be enrolled in the program by the family, but has been determined to be low- versus high-risk and does not require an initial visit. The family may request a follow-up visit.
- R. Ensure personnel assigned to provide home visitation services receive program approved orientation, on-going supervision, education and training. Be responsible for maintaining documentation of current license number, CPR certification, education, training and self-assessment reviews for each licensed team member
- S. Ensure that all newly licensed nurses shadow an experience licensed nurse for a home visit until they are qualified to complete a visit on their own
- T. Provide and implement a plan for a continuous quality improvement process (CQI) for nursing services based on specific indicators (see chapter 8).
- U. Designate a CHN to attend the weekly Discharge Planning meetings at Level II Enhanced Qualification and Level III Newborn Intensive Care Units as appropriate
- V. Within thirty (30) days after the end of each month, submit Invoice, Client log and supporting documentation, Community Health Service Visit Forms (NICP, OCSHCN, NBS) to Community Nursing Program Manager (see Chapter 5 & 6), Enrollment Status Change Forms, NICP clients receiving letters, Trainings attended, etc.
- W. Submit annual plan and quarterly Progress Report, which includes every three (3) months (Oct., Jan., April, July) progress on all Tasks and include data
- X. Obtain approval from Community Nursing Program Manager for trainings, conferences, workshops, etc. prior to registration.

- Y. Submit written education or marketing materials prepared by the Contractor for Community Nursing Services to the Community Nursing Program Manager for approval, prior to distribution of materials.

3.3 Eligibility Requirements (NICP Infants)

In order to be considered for participation, the following initial condition must be met:

The primary caregiver/ parent of the infant must reside in Arizona when eligibility is determined and throughout HRPP/NICP service delivery. A residential street address is sufficient to prove residence for HRPP/NICP purposes. A P.O. Box address is not acceptable.

Once the above conditions are met, the infant must meet one or more of the criteria below in order to be eligible for the NICP:

- A. Infants who require **120 hours or more** of Level II, II EQ or Level III nursery care beginning within **96 hours of birth**. (Example: infant is discharged 24 hours after birth and is readmitted to NICU at 4 days of age with a neonatal condition that was present but not detected at birth.)
- B. Infants approved for transport to a Program contracted hospital by a Program contracted neonatologist, if they subsequently require 120 hours of Level II, II EQ, or Level III nursery care.
- C. Infants who require Level II, II EQ, or Level III nursery care and who subsequently expire after medical intervention has occurred are eligible.
- D. Infants with special health needs other than the above may be authorized for admission to the Program upon submission of a request from a Program contracted neonatologist. (This request may be made by signing and dating the *Request for Participation* and providing a brief reason for request. The name of the requesting neonatologist must be included on the form. The authorized hospital representative signature is still necessary). Neonatologist request does not guarantee enrollment into the HRPP/NICP. Each request will be evaluated to determine the needs of the infant and family as well as the most appropriate resource (HRPP/NICP, OCSHCN, CRS, AzEIP).
- E. Any infant who was in a NICU in another state whose parents now

reside in Arizona qualifies for HRPP/NICP follow-up services only.

- F. Infants who do not meet the established criteria for HRPP/NICP may be eligible for Community Health Nursing services through the Office for Children with Special Health Care Needs (OCSHCN).

3.4 NICP Enrollment in Contracted Hospital

The appropriate ADHS contracted hospital enrolls an infant meeting the eligibility criteria described above. If an infant is inborn and eligible under criteria 3.3a above, HRPP/NICP forms must not be completed by hospitals prior to the determination of eligibility (i.e., 120 hours in Level II, II EQ or Level III nursery care from the time of birth).

- A. Each contract hospital shall have designated and trained personnel available to explain the Program to eligible families and assist them with enrollment. The HRPP/NICP requires that hospital personnel be responsible for completion of all forms required for enrollment.
- B. **Enrollment in the HRPP/NICP occurs when data forms are received and accepted as complete by ADHS, and within the established time frames. Refer to Chapter 6 for timeframes for receipt and acceptance of forms by ADHS, and other reporting forms.**
- C. The forms to be received by the contracted hospital:
 - 1. *Request for Participation Form Page 1*
 - 2. *Request for Participation Page 2*
 - 3. *Financial Worksheet and Questionnaire (for Full Participation only)*
 - 4. *Discharge Summary*
- D. Designated hospital personnel shall interview families in order to complete the *Request for Participation Form Page 1 & 2, Financial Worksheet and Questionnaire*.
- E. The contracted Level II, IIEQ or Level III hospital of birth is usually considered the enrolling hospital, provided that, the infant spends 120 hours in their intermediate or intensive care nursery. The enrolling hospital is required to complete and distribute **ALL** NICP forms.
- F.
 - a. If the infant is transported within the first 120 hours, the contracted **receiving** hospital will be considered the enrolling hospital, and is required to complete and distribute

- all of the NICP forms.
- b. If the infant is transported **after** the first 120 hours, the contracted **birth** hospital is required to complete and distribute all of the NICP forms.
- G. After initial enrollment into the NICP, if an infant is forward or back transported from one NICP contracted hospital to another, the referring facility initiates the process and completes as much of the *Request for Neonatal Transport* form as possible. The transport carrier(s) will complete the form and distribute all copies as indicated. The referring facility also completes and distributes the *Discharge Summary Form* to document the discharge.
- a. When an infant is transported from a non-contracted hospital to a contracted hospital, the transport team initiates the process by completing the *Request for Neonatal Transport* form. A signed and completed *Request for Neonatal Transport* form is required for **each** transport and is distributed by the transport carrier.
 - b. The **parent's or legal guardian's signature** on the *Request for Neonatal Transport* form is obtained as consent to transport the infant. If the infant is transported and the *Request for Neonatal Transport* form is signed by the flight nurse because the infant must be transported immediately and a parent or guardian is not available, the transport nurse will print the parent's name, initial and date the entry, and write the reason the parent cannot sign. For back transports, if the family is not available to sign the form, a telephone call with a ***notation that consent was given via telephone including the name of the parent authorizing participation and a hospital representative signature is sufficient.***
 - c. **A witness signature is preferred when possible.**
- H. The contracted enrolling hospitals submit to the HRPP/NICP: *Request for Participation Form; Financial Worksheet & Questionnaire; and Hospital Discharge Summary Form* for each infant enrolled in the Program within the timelines specified in Chapter 6 of the Hospital and Physician Services Policy and Procedure Manual.
- I. When families enroll they may request 1) **FULL** participation, which includes financial assistance, transport, medical care and follow-up services; or 2) **PARTIAL** participation, which includes follow-up services only. Only **one** participation level should be selected. If the

family adjusted gross income, based on the Financial Worksheet, is greater than \$200,000.00, the family must be enrolled as **partial, over income**. They are still eligible for Community Health Nursing visits. (See Chapter 6 – data collection).

- J. Enrolling hospitals must submit the Request for Participation so that HRPP/NICP receives the forms within HRPP/NICP timelines. Exceptions may be made in unusual circumstances, but will require prior authorization from the Hospital Services Program Manager. The enrolling hospital must provide documentation under the Late Enrollment section on the Request for Participation form.
- K. If a hospital fails to offer the HRPP to an eligible family, the hospital cannot bill the family for more than their liability.

3.4.1 Adoption and Foster Care

- A. When an infant is to be placed in foster care, either the birth parent or representative from the guardian agency may sign the *Request for Participation* forms. If the infant is in the care, custody, and control of DES, the family liability would be zero.
- B. When a child is to be adopted but the date of the consent to adopt has not been provided by the birth parent(s), adoption agency or attorney, they may enroll the infant in the HRPP/NICP and must apply for AHCCCS or enroll the infant in other third party insurance if eligible. If the birth family has no insurance and is denied AHCCCS eligibility, the family liability shall be zero.
- C. If there is consent to adopt but no adoptive parents are identified, the birth parent(s) must apply for AHCCCS or enroll the infant in other third party insurance if eligible. The birth family's resources may be used but the family liability will be zero.
- D. If the birth parent(s) have provided the date of consent to adopt, then the date of the consent will be the date that the financial liability using the adoptive parents' income will commence. The adoptive family may then enroll the infant in the HRPP/NICP. The adoptive family must apply for AHCCCS or enroll the infant in other third party insurance, if eligible. If the adoptive family completes the *Financial Worksheet and Questionnaire*, they must also sign the *Request for Participation Forms*, even if the birth parent has already enrolled the infant.

3.4.2 Program Participation

- A. Families may request different levels of participation in the HRPP/NICP. **Full participation** includes transport, hospital inpatient services, Community Health Nursing and back transport as needed. Families marking “Full participation” on the *Request for Participation Form* must complete the *Financial Worksheet and Questionnaire*. Families shall be given a copy of the NICP Financial Worksheet and Questionnaire to help them gather all information needed for the form. A mechanism must be in place to assure that the family has the opportunity to complete the form within HRPP/NICP timelines.

If the family is not available to sign these forms, a telephone call with a notation that consent was given via telephone including the name of the parent authorizing participation and a hospital signature is sufficient. A witness signature is preferred when possible. The hospital representative is not required to obtain verification of financial information provided by the family. ADHS may require families to provide proof of this information.

- B. When full participation is selected, families must enroll their infant on their third party and/or AHCCCS plan, if eligible, within insurance guidelines to cover the infant’s medical bills. Failure to do so may result in HRPP/NICP financial assistance being denied and family will be responsible for all hospital, physician, and transport charges.
- C. Families who do **not** wish to participate in the financial portion of the Program may request **partial participation**. This level of participation may be requested by the family if they do not wish to disclose their financial information or they are willing to take a risk that their insurance will pay all inpatient and transport costs for their infant. If they request “partial participation”, they will not receive any financial assistance for transport, hospital, or physician services, but may receive community nursing and developmental follow-up as needed. **Back transport will not** be available for infants enrolled as Partial Participation.
- D. If the family has been offered the Program but does not want to participate at any level, it is in the best interest of the hospital to have the family sign the **HRPP/NICP Decline Participation Form**. This will enable the hospital to have written, signed evidence of the family’s having been offered and refused the Program, and free the hospital of adherence to the family financial liability. The hospital is required to maintain a copy of the form in the infant’s medical record.

- E. A revised *Financial Worksheet and Questionnaire* may be submitted in situations where the family's financial situation is changed within the initial 60 day time period from the infant's date of birth. Additional time is given for completion of the revised *Financial Worksheet and Questionnaire*. (For example: The family's infant remains medically fragile and mother cannot return to work or father loses his job within 60 days after the infant's birth or one parent, if unmarried, denies responsibility. The **revised** *Financial Worksheet and Questionnaire* must be submitted within **90** days of the infant's date of birth, with the reason for revision noted by hospital interviewer.)
- F. When a language barrier exists, an explanation of accommodations made shall be noted in the "Interviewer's Remarks" section of the *Financial Worksheet and Questionnaire* and in the bottom margin of the *Request for Participation Forms*. Examples of accommodations include:
- Language translation services for families who are non-English monolingual (include name and title of person providing translation services)
 - Reading the forms to families who are not able to read (include name and title of person providing this service)
- G. Families **must** be given copies of the *Request for Participation* forms and *Financial Worksheet and Questionnaire* after completion so they are aware of their financial liability.
- H. Infants who are not eligible for the HRPP/NICP may request CHN follow-up through OCSHCN. A copy of the OCSHCN referral form is located in the Appendices and should be submitted with the monthly invoice by the CHN.

3.4.3 Change in Participation Level

- A. A family may switch to "partial participation" and decline to disclose financial information on the *Financial Worksheet and Questionnaire* at any time. They will then be responsible for their infant's hospital and transport bills and will not receive any financial assistance from ADHS HRPP/NICP. Documentation of family's participation choice shall be noted on the *Request for Participation Form* in the appropriate fields, with a notation of "revised" written at the top.

- B. A family may also switch from “partial participation” to “full participation” when the Request for Participation forms and Financial Worksheet and Questionnaire are received by ADHS within **45** days of the infant’s birth. The hospital is responsible for explaining the Financial Worksheet and Questionnaire to the family, providing them with a copy of the *Financial Worksheet and Questionnaire*, and assisting them in filling out the form. This form shall **not** be mailed to the family except under unusual circumstances. In such a case, the hospital representative will speak with the family before assuming they want follow-up services only, and will review the form with the family. Any *Financial Worksheet and Questionnaire* received by ADHS that is incomplete will be returned to the Hospital NICP Liaison for correction. The *Financial Worksheet and Questionnaire* must accompany the *Request for Participation Form* for all families requesting full participation. When changing to full participation, families must have enrolled their infant on their third party and/or AHCCCS plan, if eligible, within 30 days from infant’s date of birth. If this did not occur, financial assistance from ADHS HRPP/NICP may be denied.

3.4.4 Late Enrollment

- A. Requests for participation in the program, which occur beyond 45 days of the infant’s birth, must be authorized by the Hospital Services Program Manager.
- B. Reasons for a NICP Late Enrollment:
1. Parent originally declined participation
 2. Sibling of eligible infant
 3. Child from an Out of state NICU
 4. Enrollment Hospital never offered program (contact Hospital Services Program Manager before enrolling)
 5. Other late enrollment reasons need to be authorized by the Hospital Services Program Manager.
- C. If late enrollment occurs within the hospital setting, the Request for Participation Forms shall be submitted by the enrolling hospital to the Hospital Services Program Manager and followed by the *Hospital Discharge Summary*. The *Financial Worksheet and Questionnaire* needs to be submitted as well provided full participation is authorized by the Program Manager.
- D. If late enrollment occurs through the Community Health Nurse, the

requestor shall complete the Request for Participation Forms and select the partial/late enrollment participation level. Families who are requesting late enrollment after discharge are usually eligible for follow-up services only and are not eligible to receive financial assistance for transport or hospital services.

- E. A well-baby twin whose sibling was already enrolled in NICP may be enrolled by the Community Health Nurse as a partial/late enrollment to receive follow-up services at the parent's request.
- F. The appropriate HRPP/NICP Manager will review the request and supporting documentation to determine program eligibility and will notify the Community Health Nurse of any denied requests.

3.4.5 Pre-Discharge Visits

The purpose of pre-discharge visits is for families of high-risk infants to meet with a CHN prior to discharge. CHN's are encouraged to complete pre-discharge visits at the Level IIEQ or Level III hospital where they participate in discharge planning meetings, regardless of service area. Meeting with the family and hospital staff during the child's hospital stay is beneficial for helping parents to understand the program, the home visit process, and for making that initial connection. **The CHN must have the required enrollment forms completed before conducting pre-discharge visits.** The parent/guardian must be present for a pre-discharge visit to occur; the visit is voluntary for the family.

3.7 Collaboration

An essential component of community nursing services is the collaboration with hospitals, primary care providers, and other agencies to assist infants, children and their families in accessing appropriate services. Community Nursing providers are expected to:

- A. Attend hospital discharge planning meetings at Level IIEQ or Level III hospitals within their service area. In areas with multiple nursing contractors and hospitals, one or two nurses shall attend discharge planning meetings and provide information to the individual nurses responsible for visiting those families discharged into their service area. Independent and specialty contractors may share responsibility for attending discharge planning meetings. Nurses attending those meetings must also document pertinent information on the form

provided by ADHS to assist CHN's in providing better services to families.

B. Meet with Level IIEQ and Level III hospital personnel to:

1. Develop a collaborative relationship
2. Receive discharge information
3. Provide feedback to hospital personnel
4. Provide training on NICP and other community resources as appropriate

C. Attend multi-disciplinary staffing meetings as requested by agencies and/or families. These may include:

1. Hospital discharge staffing
2. Child protective services staffing
3. AzEIP's Individual Family Service Plan (IFSP) meeting
4. DES/DDD, OCSHCN, UHC-CRS or AzEIP/ASDB staffing
5. Other staffing as appropriate

CHNs will, as is appropriate, be part of an infant's AzEIP IFSP team and work collaboratively with all other team members. This will include, at a minimum, sharing any results, findings related to the infant's health and well-being. **Sharing of information may be at a staff meeting, by fax, by phone, or any other forum, once permission to share information has been retrieved from the parent/guardian.**

3.7.1 Discharge Planning

The following policies and procedures regarding discharge planning were incorporated in both the hospital and community nursing policy and procedure manuals in order to promote continuity. Therefore, policies pertinent to hospitals only may be included, letting each CHN know policies and procedures the contracted hospitals are responsible for.

Each hospital and nursing contractor is required to provide comprehensive, family-centered discharge planning for each enrolled infant in accordance with the HRPP/NICP Discharge Planning Guidelines as follows:

Infants enrolled in HRPP/NICP shall:

- i. Receive comprehensive discharge planning initiated on admission and based on ADHS Discharge Planning Guidelines.
 - i i. Continue to receive HRPP/NICP services when transferred to special care units within the same hospital. The *Hospital Discharge Summary Form* shall be transferred with the infant and sent to the HRPP/NICP Data Manager when discharged from each hospital.
 - i i i. Be entitled to the same HRPP/NICP services when placed into foster care or adoption. Hospital personnel shall be responsible for notifying and informing the responsible agency and/or family regarding the array of services available.
- a. Contracted hospitals and CHN's shall ensure that the HRPP/NICP forms are completed and maintained as follows:
- i. A Discharge Planning notebook will be kept in a specific nursery unit location to maintain and organize the *Request for Participation* and *Hospital Discharge Summary Forms* until infant's discharge.
 - i i. All CHN contractors providing services in an area where there is a Level II EQ and III hospital shall participate in the formal discharge planning processes. The CHN attending these discharge planning meetings shall assist the hospital discharge coordinator to ensure that information is recorded on all copies of the *Hospital Discharge Summary Form*. The CHN shall also note any pertinent information on the discharge notes sheet for the CHN who will be providing follow-up services. These notes shall be kept in the Discharge Planning notebook with the NICP forms and updated by the CHN at each Discharge Planning meeting. These notes will be sent by the discharging hospital to the CHN providing follow-up services, on the day of the infant's discharge.
 - i i i. In areas where multiple Level II, II EQ and III hospitals and CHN contractors exist, it will be the responsibility

of the CHN's to meet on a regular basis to determine which nurses will visit which hospitals to assist with the discharge planning process.

- i v. Each CHN shall be responsible for maintaining ongoing collaboration with at least one level II and/or level I hospital to facilitate the discharge planning process. These hospitals are required to maintain a Discharge Planning notebook as described above.

- b. All enrolled infants are referred to Community Nursing Services. Each hospital is responsible for sending forms to the assigned CHN group within 30 days of discharge. Hospitals shall refer to the HRPP/NICP CHN Directory for the list of CHN contractors and their assigned areas. Contracted hospitals shall ensure that the completed forms will be distributed as follows:
 - i . **Level II EQ and III (local): The CHN(s) attending discharge planning meetings shall obtain the enrollment paperwork for their assigned area,** The yellow copy of the *Request for Participation Forms* (if baby is inborn, Xeroxed copy if transported), *yellow copy of the Hospital Discharge Summary Form, the nursing notes sheets* and developmental care reports shall be distributed to the CHN(s) attending weekly discharge planning meetings for their assigned area only. All other referrals shall be sent by fax, mail or secure messaging to the appropriate Community Nursing Contractor on the infant's discharge date.

 - i i . **Level II EQ and III (non-local):** The yellow copy of the *Request for Participation Forms* (if baby is inborn, Xeroxed copy if transported) , *yellow copy of the Hospital Discharge Summary Form, the nursing notes sheets* and developmental care reports shall be sent by fax, mail or secure messaging to the appropriate Community Nursing Agency immediately on the day of infant discharge to facilitate continuity of care and initiate nursing home visits.

 - i i i . **Level II:** The yellow copy of the Request for Participation Forms, *yellow copy of the Hospital*

Discharge Summary Form, the nursing notes sheets and developmental care reports shall be sent by fax, mail or secure messaging by the hospital to the appropriate CHN on the day of the infants discharge.

- i v. **Level I:** Contracted nursing personnel providing services in an area with a level I hospital shall establish a collaborative relationship with that hospital to:
 - Receive discharge information for babies needing OCSHCN follow-up
 - Provide feedback to hospital personnel
 - Provide training on NICP and other community resources as appropriate

- c. Contracted hospitals shall be responsible for assessing the child's medical risk at the time of discharge. (The HRPP Medical Risk Criteria is located at the end of this section). Infants who meet high risk criteria are infants who have at least one of the major risk factors or have two or more minor risk factors. All Program infants regardless of risk criteria are eligible for Community Nursing follow-up and will be prioritized according to the needs of the child and family.

- d. Contracted hospitals shall be responsible for ensuring accurate demographic data and other relevant information is documented on the forms. All medical and social needs must be documented on the *Hospital Discharge Summary Form*. **If the address is a P. O. Box number, directions to the family's residence must accompany the form.** If an infant is medically fragile or other concerns exist, the hospital shall make a telephone call to the CHN and/or family regarding the HRPP/NICP. **The Request for Participation Forms, *Hospital Discharge Summary Form, nursing notes and developmental summary* must be faxed with a note of urgency if a priority home visit needs to be completed.**

- e. The most recent written developmental assessment and plan shall be given to the family and the community health nurse at time of discharge.

CHAPTER 4 HOME VISITATION SERVICES

4.1 Introduction

The service planning process, while needing to hold participants accountable for decisions and actions, must also be flexible, coordinated and culturally sensitive to accommodate changes that occur within the family over time. Long term and future goals must be explored with the family as well as immediate needs or concerns. Home visiting services are based on health, development, environment and relationship risk. Risk can be determined through use of the “Resiliency and Risk Identification System for Children” (RRISC) © or other risk identification tool.

4.2 Program Responsibilities

- A. **CHN contact with the family shall occur within one week of receipt of NICP enrollment forms.** Reasons for exceptions shall be documented on the *Community Nursing Follow-Up Assessment (Visit form)*. Home visits must not occur if the CHN does not have a copy of the *Request for Participation* form for infants enrolled in the NICP. Enrollment for children with special health care needs may occur during the first home visit upon completion of the *OCSHCN Request for Participation in the Community Health Nursing Program* form.
- B. If the parent does not wish to participate in the program, the nurse shall check the appropriate box on the Change of Status form and send the form in with the monthly invoice or on the visit form if family expressed that decision during a visit. Please do not send the information on a visit form if a home visit has not been completed. If a visit has been completed, there is no need to send a *Change of Status* form in addition to the visit form.
- C. **CHN must perform the initial visit within two weeks of receiving referral** and must provide case management for children having ongoing medical problems. Services might be delayed if there are other home providers or if parents request the CHN to begin visits at a later time. The social worker and/or early interventionist should be utilized to perform the most appropriate level of service based on the needs of the child and family.

All initial home visits must be completed by a CHN, subsequent visits,

if needed, could be conducted by a social worker, or other appropriate health professional (speech therapist, physical therapist, occupational therapist, dietician, etc), as determined by the needs of the infant and family. The CHN may or may not be present at these subsequent visits. If the CHN is present and provides a complete assessment of the child this visit would be a “regular” visit and two visit forms would be submitted; the first form by the CHN and the second form by the other attending health professional. That form should clearly state the professional’s area of expertise across the top of the form. Any other paperwork generated by this professional should be copied and sent to ADHS along with the monthly invoice. If no assessment is completed by the CHN; this would be a “staffing” visit.

- E. The home visitation information shall be documented on the CHN Services visit form . Both pages are filled out legibly and completely upon completion of the home visit and submitted to the Community Nursing Program Manager with the monthly log and invoice. Any information not on the “Request for Participation” form and all white areas on the CHN Services visit form must be filled out on the initial visit. Shaded areas do not need to be filled out on subsequent visits. The mother’s name, child’s alias, etc. must be filled out each time to facilitate data query. The Request for Participation and HRPP/NICP Plans should be filed in the client’s chart, and are subject to review at site audit.
- F. The Resiliency and Risk Identification System for Children (RRISC)© may be completed for infants/children to assist the family and nurse in identifying concerns, priorities and levels of service need.
- D. The Community Health Nurse should transfer or refer families for services to appropriate programs as quickly as is appropriate. Examples of programs that families can be transferred or referred to are outlined below. Note that this list is not all-inclusive. CHN contractors should a network of providers, programs and services for families.

| Transfer | Referrals |
|--|--|
| AzEIP Arizona Early Intervention Program, DES | Arizona Department of Health Services programs |
| Arizona State School for the Deaf and Blind (ASDB) | Arizona Health Care Cost Containment System (AHCCCS) |
| Children's Rehabilitative Services (CRS) | Arizona Warm Line |
| Office for Children with Special Health | Supplemental Security Income (SSI) |

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| | |
|--|---|
| Care Needs (OCSHCN) | |
| Division of Developmental Disabilities (DDD) | WIC – Women, Infants and Children |
| Early Head Start | Child Protective Services, DES |
| Health Start | Birth to Five Helpline |
| Healthy Families | Community Information and Referral Services (CIR) |
| Strong Families Home Visiting programs | Pregnancy & Breastfeeding Hotline/Baby Arizona |
| | SNAP – Supplemental Nutrition Assistance Program |
| | Text4baby |
| | Raising Special Kids |
| | Pilot Parents of Southern Arizona |

- G. Based on discussions with the family, the home visitor will develop and complete the *HRPP/NICP Plan* form, which identifies family resources, priorities and concerns.

The *HRPP/NICP Plan* could:

1. Identify child and family desired outcomes.
2. Explore the family's natural helping network, such as extended family members, friends or neighbors.
3. Explore child and family health insurance benefits and provide information about services available in the community.
4. Identify other agencies or services for which the child may be eligible, facilitate referrals, and enrollment.
5. Assist the family in identifying needed services as appropriate.

The *HRPP/NICP Plan* form is developed during the first visit, and may be updated with each visit or as changes occur. The Plan should be signed by the family and the CHN.

The *HRPP/NICP Plan* form is not a legal document, which means that services identified as needed are not required to be provided by the CHN program. Efforts shall be taken, however, to facilitate the referral of families to appropriate service providers, and encourage enrollment.

- H. All NICP enrolled infants are identified upon discharge from the hospital as “high risk” or “at risk” for developmental delay. Families who have a child that is considered to be in the “high risk” category should be strongly encouraged to receive follow-up services through the Community Nursing Services component of the program. Infants

who have an established condition at the time of discharge should be referred, by the discharging hospital, directly to the Arizona Department of Economic Security's Division of Developmental Disabilities (DDD), or the Arizona Early Intervention Program (AzEIP). *Established conditions that have a high probability of developmental delay include, but are not limited to:

- Chromosomal abnormalities
- Metabolic disorders
- Hydrocephalus
- Neural tube defects (e.g. spina bifida)
- Intraventricular hemorrhage, grade 3 or 4
- Periventricular leukomalacia
- Cerebral Palsy
- Significant auditory impairment
- Failure to thrive
- Severe attachment disorders

*Determination that a child has an established condition will be based on diagnosis by a qualified physician or other qualified professional (e.g. audiologist) and medical records, and will include the use of informed clinical opinion. (34 CFR 303.300 State Eligibility Criteria and Procedures ARS 8-651-Definitions)

See the AzEIP website for a list of other conditions and eligibility criteria. <https://www.azdes.gov/AzEIP/Policies-And-Procedures/>

- I. The NICP home visitor (CHN, Social Worker or Early Interventionist) may also refer the family to the Arizona Early Intervention Program (AzEIP). NICP families may be referred to AzEIP for further assessment for the following reasons:
 1. "Suspicious" outcome after screening with the Ages and Stages Questionnaire
 2. One or more "failures" or two or more "cautions" on the Denver Developmental II screening tool.
 3. Neuromotor or behavioral condition concerns
 4. Parental concern regarding the child's development that is unresolved after intervention by the Community Health Nurse or Early Interventionist.

Screening information should be shared with AzEIP team members in an effort to assist with eligibility determination, identification of medical concerns, continuity of care and reduction of duplicative services.

- J. NICP and other CSHCN that require further services not provided by the CHN Program should be referred to the DES/AzEIP program, to begin the initial planning process. The DES/AzEIP will explain AzEIP services, complete needed paperwork, and refer the child and family for eligibility determination/ evaluation as needed.

Services provided by the CHN Program are part of the Arizona Early Intervention System. With appropriate release from the family (obtained at the first visit, information gathered, clinical impressions and the *HRPP/NICP Plan* form may be forwarded to the AzEIP as part of the continuum of early intervention services. The CHN documentation shall become part of the child's record. The CHN may assist the child and family in transitioning to the AzEIP, as appropriate and should do so as soon as it is medically appropriate.

- K. The home visitation information shall be documented on the CHN Nursing visit form. Both pages are filled out legibly and completely upon completion of the home visit and submitted to the Community Nursing Program Manager with the monthly log and invoice. Any information not on the "Request for Participation Page 1" form and all white areas of the CHN Visit forms must be filled out on the initial visit. Shaded areas do not need to be filled out on subsequent visits. The mother's name, child's alias, etc. must be filled out each time to facilitate data query. The Request for Participation, CHN Visit forms, and *HRPP/NICP Plan* form are filed in the client's chart, and are subject to review at site audit.

Contractors participating in the Newborn Screening Follow-Up Program contact the families after a call from the Newborn Screening Hotline. The Community Health nurse will make a home visit and provide education about Newborn Screening and a follow up blood test. All procedures in the Newborn Screening Guidelines are to be followed, See Chapter on Newborn Screening Home Visit protocol.

4.3 Guidelines for Case Closure

CHN's may close cases as follows:

- A. Infants are over 12 months adjusted age and have no medical or developmental problems or are in services. (goals met/ service complete)
- B. Infants are being seen by other service providers, medical intervention by a CHN is not necessary (Closed/discharged)
- C. When risk at birth is unclear on the hospital forms, the CHN makes one or more home visits and determines the child and family to be in the lowest risk category. (NICP closed/low risk)
- D. CHN makes contact with the family after home visitation has been established and the family states the visits are not needed. (Voluntary withdrawal)
- E. Prior to home visits being established, the CHN makes contact with the family and they verbally refuse nurse home visitation. (Declined Nursing follow up/ initial contact)
- F. When several attempts have been made to reach a family, such as a letter, phone call or home visit and there is no response. Phone is disconnected, mail undeliverable, family has left no forwarding address (Lost to Follow-up)
- G. Moved out of State
- H. Death include date of death

4.3.1 Guidelines for Closure When Families Meet Criteria for Visits but do not Respond

When a family cannot be physically located, i.e moved with no forwarding address or ability to be contacted by phone, they are considered "Lost to follow-up". The following are guidelines for documentation of closure to community nursing services.

- a. When family and infant are lower risk:
 - CHN must make at least 2 contact attempts by phone or mail with no response.
- b. When family and infant are moderate/high risk:

- CHN must make at least 2 contact attempts by phone and mail. CHN will use clinical judgment to determine whether a drop in home visit needs to be made prior to closure.

4.3.2 Guidelines for transferring cases between ADHS/NICP contractors

When a family is moving out of one service area into another service area the CHN should ask the family if they are interested in continuing services in their new community. If so, the CHN should complete the revised “enrollment status change form” with the parent/guardian’s signature as permission to release information. Once received, the change form should be submitted with the monthly billing **AND** a **copy** of the entire case file should be forwarded to the new CHN contractor (**refer to the CHN directory for appropriate contractor, or call the Program Manager for verification**)

4.4 Determining Level of Risk

Utilizing the **Medical Risk Criteria Form** (see end of chapter for sample form) determine if the infant is “high risk” or “at risk”. This should be determined by using the information contained in the discharge summary from the hospital.

Next the CHN will conduct the initial contact and home visit. During this initial visit the CHN will conduct a complete assessment of the child. The **Community Nursing Neonatal and Pediatric Assessment Form** (see end of chapter for sample) will be completed at this time.

Infants with major risk factors from **Medical Risk Criteria Form** will remain high risk. All other infants risk level will be determined as follows:

Two (or more) areas of concern in two (or more) categories from **Community Nursing Neonatal and Pediatric Assessment Form** are considered High risk.

One area of concern in two categories from **Community Nursing Neonatal and Pediatric Assessment Form** is considered Moderate Risk.

One area of concern in one category from **Community Nursing Neonatal and Pediatric Assessment Form** is considered low risk.

4.5 Minimum Visit Guidelines

The Olds model for home visitation of NICP infants recommends a frequent schedule of home visits. Once a week for the first six weeks, every other week until 21 months, and once a month from months 21-24. (David Olds, PH.D. Prenatal and Infancy Home Visitation By Nurses, 1998). Budget constraints prevent HRPP/NICP from following that model.

In FY 2007 the Arizona State Legislature awarded the High Risk Perinatal Program additional funds for the additional provision of services to at risk infants and families. These funds are provided so that all at risk infants enrolled in the NICP would have a minimum of four home visits during their first year of life. In FY 2009 that funding was reduced due to a budget reduction. CHN contractors are required to evaluate their allocated funding each fiscal year and prioritize visitation to ensure the infants are seen as appropriate according to their risk.

Additional visits are allowable based on the needs of the child and family, impressions of the CHN, or at the family's request, pending program funding, and must be well documented in the client chart.

CHAPTER 5 GUIDELINES FOR OFFICE FOR CHILDREN WITH SPECIAL HEALTHCARE NEEDS SERVICES

5.1 Introduction

This program is linked with the Office for Children with Special Health Care Needs (OCSHCN) to provide services for families who do not meet the eligibility criteria for HRPP/NICP but could benefit from these services. Currently the HRPP/NICP CHN Services and the Office for Children with Special Health Care Needs (OCSHCN) collaborate to support home visiting for other children with special health care needs to the age of twenty-one (21).

The purpose of the OCSHCN services is to provide families of children with special health care needs with support and linkage to other service systems or providers. Infants, toddlers and children may be seen for **up to 6 months under the OCSHCN CHN services**. Home visits beyond this period require prior approval from HRPP/NICP Program Manager.

5.2 Office for Children with Special Health Care Needs (OCSHCN) Eligibility Requirements: Ages Birth – 21

Eligible individuals shall reside in Arizona. These infants and children may have been born without incident but later developed health and/or developmental delays and meet one or more of the following criteria:

- A. Infants with special needs, who do not meet the criteria of a NICU/SCN stay of 120 hours, may be authorized for admission to the Program upon submission of a request from a Program contracted neonatologist. Neonatologist request does not guarantee enrollment into the HRPP/NICP. Each request will be evaluated to determine the needs of the infant and family as well as the most appropriate resource (HRPP/NICP, OCSHCN).
- B. Sibling of an infant enrolled in the NICP: Infants/toddlers not enrolled in NICP who have a chronic medical condition and whose families demonstrate a need for information, support, and/or coordination with multiple service providers and resources. This would include children from 0-3 years of age and 3-21 as authorized by the HRPP/NICP Program Manager.
- C. Children ages birth – 21 years of age not enrolled in NICP who have a chronic medical condition and whose families express a desire for

information, support, and/or coordination with multiple service providers and resources.

5.3 OCSHCN ENROLLMENT REQUIREMENTS

Infants and children meeting the above eligibility requirements may be enrolled as children with special health care needs (CSHCN) and be referred for Community Nursing Services.

A. Infants with special needs who do not meet the criteria of a NICU/SCN stay

1. Contracted hospitals (hospital NICU or Pediatrics) may refer children with special health needs who do not meet the NICP criteria. Requests should be sent to the Program for authorization
2. The *Request for Participation OR Office for Children with Special Health Care Needs Request (OCSHCN) Request for Participation in the Community Health Nursing Program form* should be signed and dated with a brief reason for request. The name of the requesting neonatologist must be included on the form. The authorized hospital representative signature is still necessary.
3. Each request will be evaluated by the ADHS CHN Program Manager and the appropriate CHN contractor to determine the needs of the infant and family as well as the most appropriate resource (HRPP/NICP, OCSHCN).
4. The ADHS CHN Program Manager will notify the hospital representative when the request has been approved and send referral to CHN contractor

B. Sibling of an infant enrolled in the NICP

1. The *OCSHCN Request for Participation in the Community Health Nursing Program form* must be completed by CHN at the home visit. The document must be signed by the parent/guardian and the Community Health Nurse.
2. The *OCSHCN Request for Participation in the Community Health Nursing Program form* must be submitted with the monthly invoice with the CHN Visit form.

Infants, Toddler, or Children referred by a community provider

1. Referrals of eligible children may be made directly to Community Health Nurse (CHN) upon family request and permission. The CHN will complete the *OCSHCN Request for Participation in the Community Health Nursing Program* form with the family during the home visit.
2. The *OCSHCN Request for Participation in the Community Health Nursing Program* form must be submitted with the monthly invoice with the CHN Visit form.

5.4 HOME VISITATION

The service planning process, while needing to hold participants accountable for decisions and actions, must also be flexible, coordinated and culturally sensitive to accommodate changes that occur within the family over time. Long term and future goals must be explored with the family as well as immediate needs or concerns. Infants, toddlers and children may be seen for **up to 6 months under the OCSCN CHN services**. Home visits beyond this period require prior approval from HRPP/NICP Program Manager.

Home visiting services are based on health, development, environment and relationship risk. Risk can be determined through use of the “Resiliency and Risk Identification System for Children” (RRISC) © or other risk identification tool. The Resiliency and Risk Identification System for Children (RRISC) © may be completed for infants/children to assist the family and nurse in identifying concerns, priorities and levels of service need.

CHN contact with the family shall occur within one week of receipt of referral from contracted hospital, community provider or ADHS Reasons for exceptions shall be documented on the *Community Nursing Follow-Up Assessment* (Visit form). If the CHN completes the enrollment in the home (ex. Sibling of eligible infant) then one week rule does not apply.

If the parent does not wish to participate in the program, the nurse shall check the appropriate box on the Change of Status form and send the form in with the monthly invoice or on the visit form if family expressed that decision during a visit. Please do not send the information on a visit form if a home visit has not been completed. If a visit has been completed, there is no need to send a *Change of Status* form in addition to the visit form.

CHN must perform the initial visit within two weeks of receiving referral and must provide case management for children having ongoing medical problems.

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Services might be delayed if there are other home providers or if parents request the CHN to begin visits at a later time. The social worker and/or early interventionist should be utilized to perform the most appropriate level of service based on the needs of the child and family.

All initial home visits must be completed by a CHN, subsequent visits, if needed, could be conducted by a social worker, or other appropriate health professional (speech therapist, physical therapist, occupational therapist, dietician, etc.), as determined by the needs of the infant and family. The CHN may or may not be present at these subsequent visits. If the CHN is present and provides a complete assessment of the child this visit would be a “regular” visit and two visit forms would be submitted; the first form by the CHN and the second form by the other attending health professional. That form should clearly state the professional’s area of expertise across the top of the form. Any other paperwork generated by this professional should be copied and sent to ADHS along with the monthly invoice. If no assessment is completed by the CHN; this would be a “staffing” visit.

The Community Health Nurse should transfer or refer families for as quickly as is appropriate. Examples of programs that families can be transferred or referred to are outlined below. Note, this list is not all-inclusive. CHN contractors should have a network of providers, programs and services for families.

| Transfer | Referrals |
|---|--|
| AzEIP Arizona Early Intervention Program, DES | Arizona Department of Health Services programs |
| Arizona State School for the Deaf and Blind (ASDB) | Arizona Health Care Cost Containment System (AHCCCS) |
| Children's Rehabilitative Services (CRS) | Arizona Warm Line |
| Office for Children with Special Health Care Needs (OCSHCN) | Supplemental Security Income (SSI) |
| Division of Developmental Disabilities (DDD) | WIC – Women, Infants and Children |
| Early Head Start | Child Protective Services, DES |
| Health Start | Birth to Five Helpline |
| Healthy Families | Community Information and Referral Services (CIR) |
| Strong Families Home Visiting programs | Pregnancy & Breastfeeding Hotline/Baby Arizona |
| | SNAP – Supplemental Nutrition Assistance Program |

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| | |
|--|--------------------------------------|
| | Text4baby |
| | Raising Special Kids |
| | Pilot Parents of Southern Arizona |

More programs and services can be found on the ADHS Office for Children with Special Healthcare Needs webpage.

Based on discussions with the family, the home visitor will develop and complete a *HRPP/NICP Plan* form, which identifies family resources, priorities and concerns.

The HRPP/NICP Plan could:

1. Identify child and family desired outcomes.
2. Explore the family's natural helping network, such as extended family members, friends or neighbors.
3. Explore child and family health insurance benefits and provide information about services available in the community.
4. Identify other agencies or services for which the child may be eligible, facilitate referrals, and enrollment.
5. Assist the family in identifying needed services as appropriate.

The *HRPP/NICP Plan* is developed during the first visit, and may be updated with each visit or as changes occur. The Plan should be signed by the family and the CHN.

The Plan is not a legal document, which means that services identified as needed are not required to be provided by the CHN program. Efforts shall be taken, however, to facilitate the referral of families to appropriate service providers, and encourage enrollment.

Infants, toddlers or children who have an established condition should be referred directly to the Division of Developmental Disabilities (DDD), or the Arizona Early Intervention Program (AzEIP). *Established conditions that have a high probability of developmental delay include, but are not limited to:

- Chromosomal abnormalities
- Metabolic disorders
- Hydrocephalus
- Neural tube defects (e.g. spina bifida)
- Intraventricular hemorrhage, grade 3 or 4
- Periventricular leukomalacia
- Cerebral Palsy

- Significant auditory impairment
- Failure to thrive
- Severe attachment disorders

*Determination that a child has an established condition will be based on diagnosis by a qualified physician or other qualified professional (e.g. audiologist) and medical records, and will include the use of informed clinical opinion. (34 CFR 303.300 State Eligibility Criteria and Procedures ARS 8-651-Definitions)

See the AzEIP website for a list of other conditions and eligibility criteria.
<https://www.azdes.gov/AzEIP/Policies-And-Procedures/>

The NICP home visitor (CHN, Social Worker or Early Interventionist) may also refer the family to the Arizona Early Intervention Program (AzEIP). NICP families may be referred to AzEIP for further assessment for the following reasons:

1. "Suspicious" outcome after screening with the Ages and Stages Questionnaire
2. Neuromotor or behavioral condition concerns
3. Parental concern regarding the child's development that is unresolved after intervention by the Community Health Nurse or Early Interventionist.

Screening information should be shared with AzEIP team members in an effort to assist with eligibility determination, identification of medical concerns, and continuity of care and reduction of duplicative services.

Children with special health care needs that require further services not provided by the CHN Program should be referred to the DES/AzEIP/IPP contractor, to begin the initial planning process. The DES/AzEIP will explain AzEIP services, complete needed paperwork, and refer the child and family for eligibility determination/ evaluation as needed.

Services provided by the CHN Program are part of the Arizona Early Intervention System. With appropriate release from the family (obtained at the first visit, information gathered, clinical impressions and the *HRPP/NICP Plan form* may be forwarded to the AzEIP as part of the continuum of early intervention services. The CHN documentation shall become part of the child's record. The CHN may assist the child and family in transitioning to the AzEIP, as appropriate and should do so as soon as it is medically appropriate.

The home visitation information shall be documented on the CHN Nursing visit form. Both pages are filled out legibly and completely upon completion of the home visit and submitted to the Community Nursing Program Manager with the monthly log and invoice. Any information not on the "Request for Participation" form and all white areas must be filled out on the initial visit. Shaded areas do not need to be filled out on subsequent visits. The mother's name, child's alias, etc. must be filled out each time to facilitate data query. The Request for Participation and HRPP/NICP Plans are filed in the client's chart, and are subject to review at site audit.

5.5 Guidelines for Case Closure

CHN's may close cases as follows:

- A. Goals met/ service complete - Infants, toddlers or children have no medical or developmental problems or are in services.
- B. Closed/discharged - Infants, toddlers or children are being seen by other service providers, medical intervention by a CHN is not necessary
- C. Voluntary withdrawal - CHN makes contact with the family after home visitation has been established and the family states the visits are not needed.
- D. Declined Nursing follow up/ initial contact- Prior to home visits being established, the CHN makes contact with the family and they verbally refuse nurse home visitation.
- E. Lost to Follow-up - When several attempts have been made to reach a family, such as a letter, phone call or home visit and there is no response. Phone is disconnected, mail undeliverable, family has left no forwarding address
- F. Moved out of State
- G. Death include date of death

5.6 Guidelines for transferring cases between ADHS/NICP contractors

When a family is moving out of one service area into another service area the CHN should ask the family if they are interested in continuing services in their new community. If so, the CHN should complete the revised “enrollment status change form” with the parent/guardian’s signature as permission to release information. Once received, the change form should be submitted with the monthly billing **AND** a **copy** of the entire case file should be forwarded to the new CHN contractor (**refer to the CHN directory for appropriate contractor, or call the Program Manager for verification**)

CHAPTER 6 GUIDELINES FOR OFFICE OF NEWBORN SCREENING FOLLOW- UP SERVICES

6.1 Introduction

This program is linked with the Office of Newborn Screening to provide follow up, coordination and referral to community services for infants identified as needing repeat bloodspot or hearing testing.

6.2 Eligibility Requirements for Office of Newborn Screening Infants

Eligible individuals shall reside in AZ, with an occurrent birth within the state. These infants will have had a bloodspot or hearing screen where there was a previous abnormal or incomplete result.

The bloodspot sample collected will need to have been analyzed by the Arizona State Laboratory. For either the hearing or bloodspot screen, the department needs to be able to verify demographic information on the baby such as DOB, birth hospital and mom's name and DOB.

6.3 Enrollment Requirements

These infants are not formally enrolled in the HRPP/NICP. The Community Health Nurse Home visit form will act as the enrollment form.

6.4 Home Visitation Services

Upon notification from the ADHS Office of Newborn Screening, contractors participating in the Newborn Screening Follow-Up Program will provide assistance in locating families and facilitating the collection and submission of another newborn screening test for infants with a previously abnormal test result.

The Community Health nurse will make a home visit and provide education about Newborn Screening and a follow up blood test. All procedures in the Newborn Screening Guidelines are to be followed.

The Newborn Screening Provider Guideline details the specifics for ordering collection kits, techniques for specimen collection, shipping and handling practices. There are also best practice recommendations for meeting hearing screening, diagnoses, and early intervention milestones. (<http://www.azdhs.gov/lab/aznewborn/documents/providers/AZ-Newborn-Screening-Provider-Guidelines.pdf>)

The website www.aznewborn.com provides free brochures in English and Spanish for dissemination to families as well as links to other clinical references, including the core panel of disorders screened for in Arizona.

Once visit is complete, CHN will provide ADHS Office of Newborn Screening status of case as well as Community Nursing Visit form which outlines areas discussed.

6.5 Case Closure

CHN's may close Newborn Screening cases as follows:

- A. Goals met/ service complete – Education provided, screen collected or infants being seen by other service providers, medical intervention by a CHN is not necessary
- B. Voluntary withdrawal - CHN makes contact with the family after home visitation has been established and the family states the visits are not needed.
- C. Declined Nursing follow up/ initial contact- Prior to home visits, the CHN makes contact with the family and they verbally refuse nurse home visitation.
- D. Lost to Follow-up - When several attempts have been made to reach a family, such as a letter, phone call or home visit and there is no response. Phone is disconnected, mail undeliverable, family has left no forwarding address
- E. Moved out of State
- F. Death include date of death

CHAPTER 7 PERSONNEL AND TRAINING

7.1 Personnel

The following are the ADHS HRPP/NICP required qualifications. Requests for exception to the qualification must be submitted in writing for review and approval by the HRPP/NICP Community Nursing Services Program Manager

Community Health Nurse: Arizona Licensed Registered Nurses with Basic Life Support Certification, experienced in pediatrics and/or NICU and a BSN Degree.

Social Worker: CISW +/-or MSW Degree, experience with children and families and have Basic Life Support certification.

Early Interventionist: Early Interventionists shall have a minimum of a Bachelor's degree in early childhood, early childhood special education, speech therapy, physical therapy, occupational therapy, hearing, nutrition or a closely related field. Early Interventionists shall also meet the professional requirements and rules of professional conduct for that discipline or profession as prescribed by the State of Arizona. The early interventionist may perform the following functions: service coordination, assessment, IFSP development, intervention and curriculum development. The early interventionist demonstrates knowledge and skill in growth and development, infant/family needs, methods of service provision and methods of assessing child performance and progress, including curriculum-based and portfolio assessments.

7.2 Overview of the COMMUNITY NURSING Team Training

The role of the Community Nursing Team is to provide assessment, education, referral, anticipatory guidance and advocacy services within his/her own community. In order for the community nursing team to perform these responsibilities safely and competently, they must receive sufficient orientation, training and information about the services.

Basic orientation must be completed by the community health nurse, social worker and/or early interventionist before they may initiate unsupervised client home visits. The essential areas of training have an * after the training topic. The balance of the orientation must be completed within six months of hire date. Additional specific training is geared to the special needs of the Contractor, community nursing team, and the community.

Home visiting personnel are required to participate HRPP/NICP/OCSHCN sponsored training annually. The specific training requirements are outlined in this manual. Contractors shall maintain records of the staff attendance at the above training/meetings and they will be reviewed at the annual contractor site visit.

7.3 Orientation

The Orientation is intended to give the Community Nursing provider an overview of the program requirements and their role and job responsibilities. The orientation program provides basic information on several critical areas of the Community Nursing Program. Through this initial orientation process, community nurses, social workers and/or early interventionists (typically used as “on call”) can demonstrate that they possess sufficient knowledge about the program, and that they have mastered the necessary skills to begin conducting client contact activities safely and competently.

The orientation for the community nurses, social workers and/or early interventionists shall include:

- HRPP/NICP/OCSHCN Overview. *
 - CHN Policy & Procedure Manual
 - CHN forms
 - HRPP/NICP Plan
- Role of the Community Nurse, Social Worker, and Early Interventionist. *
- Infant Assessment Review * and completion of Community Nursing neonatal and Pediatric Assessment form
- Use of screening tools; Ages and Stages, RRISC, Edinburgh and other appropriate tools
- Observation of NICU
- Observation of Home Visit
- Communication Process and Strategies *
- Hospital Discharge Planning Process *
- Documentation and Confidentiality *
- Identifying and Accessing Community Resources *
- Supervised Home Visit
- Maternal assessment review including post-partum wellness and orientation/education about interconception wellness.

The areas with an * must be completed before new CHN's can be assigned a

caseload. Shadowing visits for a nurse, social worker or early interventionist in training shall be billable with some very specific limitations. The other areas should be covered at least briefly and must be completed within six months.

The information in these areas must, at minimum, address the learning objectives of the orientation training curriculum and conform to ADHS Community Nursing Policy and Procedure Manual. Training must also include relevant information from the Contractor's specific community to allow community nurses, social workers and early interventionists to successfully work within that community.

7.4 Orientation/Observation/Supervision

Orientation experiences shall be designed to meet the needs and experiences of each new candidate, i.e., nurses who have worked in the NICU would be best served by more exposure to the public health nursing role whereas, nurses experienced in the public health role would benefit most from spending time observing care offered to the critically ill infant in the NICU.

All candidates would benefit from spending time observing infant evaluations by a developmental specialist. Specific questions regarding the assessment of the neuromotor development of the infant can be addressed during these opportunities.

All candidates would also benefit from the mentoring experience of following a very experienced nurse or practitioner making home visits. Each newly hired community nurse, social worker and/or early interventionist for the Community Nursing Program shall be supervised conducting home visits prior to assuming independent client contact responsibilities. The amount and duration of the supervised home visits depend on the needs and experience of each health worker, the minimum number of visits is three.

7.5 Orientation/Education Log

The orientation log is found at the end of this section. Supervised home visits include the following activities:

- The home visitor health worker is provided with the Orientation/Education Log and given information and training necessary to demonstrate the activities.
- Using the Orientation/Education Log, the community health nurse, social worker and/or early interventionist observes the supervisor/trainer or an experienced community health nurse conducting a home visit.
- The supervisor/trainer observes the community health nurse, social worker and/or early interventionist conducting a home visit and checks off the completion of the activities on the Orientation/Education Log as they are

completed.

- The completed Orientation/Education Log is placed in the workers personnel file and a copy is sent to the Community Nursing Program Manager.
- Contractors are encouraged to use the Orientation/Education Log for periodic review and assessment of the mastery of home visiting skills.

7.6 Continuing Education

All continuing education should be designed to strengthen the skills, provide updated information and support the activities of the community health nurse, social worker and/or early interventionist. A continuing education plan should be developed annually for all workers that include the training needs identified through the Orientation/Education Log. A copy of the continuing education log will be available to the ADHS Site Review Team for review during a formal site visit.

At a minimum, continuing education plans should include the following topics:

- Communication Process and Strategies
- Hospital Discharge Planning Process
- Documentation and Confidentiality
- Developmental Screening
- Injury Prevention
- Immunizations
- Safe Sleep
- Nutrition/Feeding
- Child Development
- Infant assessment
- Family planning
- Maternal assessment including post-partum and interconception wellness

Community health nurses, social workers and early interventionists in the Community Nursing Program are strongly encouraged to attend all NICP/OCSHCN conferences and workshops for continuing education. Attendance at training is based on availability of funds.

7.7 Site-Specific Training

This training is individualized to meet the specific demands of the community health nurses, social workers and/or early interventionist in the Community Nursing Program in a particular community. Contractors are responsible for developing and implementing appropriate site-specific training for community nursing personnel. At a minimum, site-specific training should:

- Consider the special health education or social needs of the clients and potential clients in the community;
- Provide relevant information about the Contractor's organization and business practices and;
- Provide specific information and procedures to community nursing personnel for developing and accessing referral networks and community resources within that community.

Site specific training is appropriate any time the Contractor, community nursing personnel or community being served has special needs that can be addressed through additional training sessions, in services or workshops. The site-specific training should reinforce basic principles of family centered case management and assist the Community Nursing Team in applying what they have learned to their own neighborhoods and communities. Suggested topics include:

- Special characteristics of the community/cultural sensitivity
- Community resources and how to access them
- How to build a community network of providers that specifically meet CHN caseload needs
- How to work with and within the system (how to make the system work for you)
- Additional training on health-related topics of particular concern to the community and individual providers.

CHAPTER 8 ASSESSMENT PROTOCOLS

8.1 HRPP/NICP Plan: Resources, Priorities, Concerns

The information contained in the **HRPP/NICP Plan** must be gathered in collaboration with the family and only the information the families wishes to share should be documented on this page. The **HRPP/NICP Plan** is designed to provide the family with a mechanism to identify their resources, priorities, and concerns. Information gathered assists both the home visitor and the family in identifying strengths, needs, resources, and provides the opportunity to establish goals and record accomplishments.

8.1.1 Guiding Principles for the HRPP/NICP Plan Process

- Infants and toddlers are uniquely dependent on their families for their survival and nurturing. This dependence necessitates a family-centered approach to early intervention.
- Each family has its own structure, values, roles, beliefs and coping styles. Respect and acceptance of this diversity is essential to family-centered early intervention.
- Early intervention systems and strategies must reflect a respect for racial, ethnic and cultural diversity of families.
- Respect for family, autonomy, independence and decision making means that families must be able to choose the level and nature of early intervention involvement.
- Family/professional collaboration and partnership is the key to family-centered early intervention and successful implementation of the planning process.
- No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families. Therefore, a team approach to planning and implementing the **HRPP/NICP Plan** is preferable, and strongly encouraged.

- A family need or concern is only a need if the family perceives it to be relevant.
- Any information the family does not want to be on the plan must not be included and must remain confidential.
- The **HRPP/NICP Plan** is a “working” document. The process must lead to outcomes that assist the family in achieving their goals for themselves and their child.

8.1.2 Key Activities of the HRPP/NICP Plan

The abbreviated HRPP/NICP Plan is required for each child enrolled in the Community Nursing Component of the HRPP/NICP. The form used is not as important as the data collected, examples of approved format are included at the end of this chapter. .

The **HRPP/NICP Plan** is usually initiated on the first visit with the family and includes assessment planning. This is not duplicating data collected elsewhere, only data important to the family and outcome goals identified.

Infant/child, maternal and family strengths and needs are identified, i.e., “What is the family most proud of with their child and what are they the most concerned about?” “How does mother view her own health in relationship to possible subsequent pregnancies?”

Outcomes to meet infant/child, maternal and family needs are identified - this is the area to put potential or actual dates.

Review **HRPP/NICP Plan** at each visit and update as needed. Anytime a concern is documented on the FSP, a corresponding outcome goal must be documented as it is met.

The family receives a copy of the FSP. The home visitor and family can decide together when that happens. They may want to wait until the form is completed and at least some outcome goals have been met or they may want a copy each visit. If the family does not want a copy after each visit, a line can be drawn and then initialed by the home visitor. The home visitor and parent shall sign and date the **HRPP/NICP Plan** when a page is completed or when copies are given to the family.

8.2 Infant Screening Tools

The Ages and Stages Questionnaire should be used to assess the child's performance on various age-appropriate tasks. This tool is valuable in screening children for possible problems, confirming suspicions with an objective measure, and in monitoring children at risk for developmental problems, such as those who have experienced perinatal difficulties. It is designed to compare a given child's performance on a variety of tasks to performance of other children the same age.

8.2.1 Ages and Stages Questionnaire

The Ages and States Questionnaires (ASQ): A Parent-Completed, Child Monitoring System includes a series of questionnaires designed to identify infants and young children who show potential developmental problems. Each questionnaire features 30 developmental items that are written in simple, straightforward language. The items are divided into five areas: communication, gross motor, fine motor, problem solving, and personal-social.

An overall section addresses general parental concerns. Children are identified as needing further testing and possible referral to early intervention services when their ASQ scores fall below designed cutoff points.

The ASQ materials consist of reproducible master questionnaires, age-appropriate scoring and data summary sheets, and the User's Guide which also contains activity sheets for parents that correspond to the ASQ age intervals. A Spanish translation master set of questionnaires is also available.

8.2.2 Risk Identification Tool

The *Resiliency and Risk Identification System for Children* (RRISC 8) was developed by Karen Van Wie through a Flinn Grant. CHN contractors may utilize the RRISC8 or another risk identification tool as a measurement of cumulative risk frequency and intensity of services. The CHN may conduct a risk assessment at the first home visit, and as family situations warrant.

8.3 Neonatal and Pediatric Assessment

All “regular” home visits by the Community Health Nurse should include an assessment of the infant/child’s physical, developmental, environmental, and family relationship status. The assessment form should be used to describe any *Concerns* of the parent or home visitor, to describe the home visitor’s *Impressions*, and to document the *Plan* for follow up. The level of risk should also be recorded here.

8.4 Maternal Screening Tools

8.4.1 Postpartum Mood Disorder*

Postpartum Mood Disorders affect millions of women worldwide, regardless of race, age, culture, or socioeconomic status. Symptoms of Postpartum Mood Disorders vary and may include feelings of sadness, anger, frustration and confusion.

A mother experiencing a Postpartum Mood Disorder may feel alone and ashamed of her symptoms. Fathers are also impacted by Postpartum Mood Disorders and have their own experience that may be very different from the mother. These differences place an enormous amount of stress on the couple's relationship and it can prove a difficult time for the entire family.

The <http://www.postpartumcouples.com> website was created to provide information and resources to mothers and fathers on Postpartum Mood Disorders. The resources there are intended to provide couples, families, and professionals with information and tools to help mothers and families heal from Postpartum Mood Disorders.

* Information taken from <http://www.postpartumcouples.com>

8.4.2 Edinburgh Postnatal Depression Scale (EPDS)**

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6 –8 week postpartum examination. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than 5 minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items. Validation studies have utilized various threshold scores in determining which women

were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be immediately referred for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel. Users may reproduce the scale without permission providing the copyright is respected by quoting the names of the authors, title and the source of the paper in all reproduced copies.

** information taken from

<http://health.utah.gov/rhp/pdf/EPDS.pdf#search='edinburgh%20postnatal%20depression%20scale'>

The Edinburgh Postnatal Depression Scale is to be completed at each first home visit of NICP enrolled children (foster/adoptive excluded). Results are to be recorded on page two of the nursing visit form. Any score equal to or higher than 10 must be referred for follow up care. This will vary in each community, but could include PPD support groups and a referral to the primary care physician and/or any other appropriate referral. The referrals must be written in on the visit form also.

8.4.3 Maternal Wellness Assessment/ Preconception Care

“Preconception care is defined as a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman’s health or pregnancy outcome through prevention and management.” Recommendations to Improve Preconception Health and Health Care-United states, A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006; 55 (No.RR-6):3-4.

The Community Health Nurse, by virtue of following NICP enrolled infants, is in the unique position of being in the home and working with the mother of a premature infant or infant with a less than optimal birth outcome. The mother who has had a preterm infant is at a statistically higher risk of having another preterm infant. The goal of this aspect of the CHN follow up visit is reduction of risk factors that can lead to preterm delivery in a subsequent pregnancy.

To this end, the CHN will use appropriate screening tools to screen and then provide education to the mother of the infant about: reproductive awareness; environmental toxins and teratogens; nutrition and folic acid; genetics; substance use including tobacco and alcohol; medical conditions and medications; infectious diseases and vaccination; and psychosocial conditions

and the help to link her to community services when appropriate. Information may be downloaded from the BWCH web site at <http://www.azdhs.gov/phs/owch/publicat.htm#EWA> under the section titled Every Woman Arizona. Interconception education may be found at at www.PowerMeA2Z.org.

8.5 Environmental Screening Tools

Home Safety Assessment – Healthy @ Home

Arizona Department of Health Services created the Healthy @ Home Assessment as part of the Association of State and Territorial Health Officials (ASTHO) and Robert Wood Johnson Foundation (RWJF) quality improvement integration project. The standardized home safety and family wellness assessment integrates environmental health and chronic disease components into the home visiting process. The early childhood home visitor will have an opportunity to optimize the time spent in the home by providing a comprehensive approach to family health. The Healthy @ Home Assessment process recognizes the importance the child's home settings has on the child's health by addressing chronic disease in family members. The assessment process helps identify concerns and provide referrals and education in order to improve the health of everyone in the household. The Healthy @ Home Assessment is also an opportunity to focus on environmental issues in the home such as lead poisoning and asthma triggers. The outcome we hope to achieve is that more children and families in Arizona are screened for health and safety concerns and are able to address health and safety concerns in the home and within the family. This process will be a great improvement to identifying home safety and other wellness issues that impact family life in Arizona.

Educational materials, resources and training tools can be found at <http://www.azdhs.gov/phs/owch/healthy-at-home/index.htm>.

CHAPTER 9
DATA AND REPORTING

9.1 Contractor Requirements

All forms and reports are used by the Community Nursing Program to collect information for program planning, development and evaluation. Information gathered, both at the ADHS and Contractor level is used to evaluate the effectiveness of the Program. In this chapter, data collection forms will be fully explained.

- A. The contractor shall notify the ADHS Community Nursing Program Manager of any new professional staff and changes to existing staff within 30 days of the change. This may be done via email or formal letter.

- B. The contractor shall maintain the following information for ADHS Site Team Review:
 - 1. Documentation of Orientation/Training for each staff member providing visits

 - 2. Proof of current Arizona Nursing Licensure

 - 3. Certification/Licensure for Social Worker or other Early Interventionist staff (includes staff and contractors)

 - 4. Continuing Education for previous year for home visiting staff

9.2 Reporting Requirements

A. Monthly Logs/Invoices

Contractors are required to provide a monthly log (Service Summary) that includes the name of the participant, date of visit and type of service. The monthly log and invoice are to be submitted within 30 days after the end of each month. If the log or invoice is incomplete or illegible, it will be sent back to the Contractor for completion before payment is authorized.

B. Quarterly Reports/Quality Improvement Indicators

A quarterly report **must** be submitted within 30 days of the end of the quarter (quarters end September, December, March and June) describing the following:

1. Program strengths, priorities and concerns
2. Goals for the next 3 months
3. Training/education activities, certifications and training needs
4. Current program staff
- 5.

Continuous Quality Improvement updates (chapter 10)
(1st quarter is July-September the report is due October 31. The 2nd quarter is October-December the report is due January 31st. The 3rd quarter is January-March the report is due April 30. The 4th quarter is April-June the report is due July 31.)

9.3 Forms Completion and Distribution

The CHN must receive a copy of the “*Hospital Discharge Summary*” and “*Request for Participation*” (RFP) forms from the hospital for all infants enrolled in the NICP prior to home visits. The “Request for Participation” (RFP) forms should be received prior to a pre-discharge visit.

9.3.1 “Request for Participation” – High Risk Perinatal Program

This form provides demographic information for the family. It also contains the family’s signature that verifies enrollment and provides permission for data sharing with other components of the program. This form must be received by the Contractor before home visits are completed.

The Community Health Nurse may be requested to enroll an infant in the program; however, this must have prior approval from the Community Nursing or Hospital Services Program Manager. This might occur when:

- The family was eligible but not signed up in the hospital
- The family initially refused enrollment into the Program and now wishes to enroll.
- The child was in an out-of-state NICU and moved to Arizona after birth.

- The family lives in Arizona but delivers out of state. Contractors in border counties serving many infants who are born out of state may have a working relationship with specific hospitals that refer NICP eligible infants directly to them. For these enrollees, the contractor would not need to get prior approval; however, the infant is eligible for follow-up service only.

(See the procedures for “Late Enrollments” in Chapter 3)

9.3.2 Request for Participation - Children with Special Health Care Needs

Permission to Participate must be signed by the parent, the hospital or on the first home visit of infants/children who are not enrolled in the NICP. (See Chapter 5 for eligibility and enrollment information.)

9.3.3 Discharge Summary

This form is used to summarize the infant’s hospitalization records and discharge data and also functions as the referral form for the CHN. A copy of this form should be given to the appropriate CHN at the time of discharge.

Referrals for out-of-town families are to be sent by hospital personnel to the appropriate community-nursing contractor within 24 hours after discharge. CHN staff attending discharge-planning meetings shall assist the responsible hospital personnel by providing updated CHN Directory as needed.

9.3.4 Community Nursing Visit Reporting Form

The Community Nursing Visit Form is a two-page report to be filled out by the home visitor after each visit. Areas shaded in gray do not need to be filled out for infants enrolled in NICP unless there is a change in data. Child’s last name, alias, DOB and mother’s name are used as an identifier and must always be completed. These forms are used for any home visit whether provided by nurses, social workers or early interventionists to a family enrolled in NICP, OCSHCN or receiving a visit for Newborn Screening. If the visit is conducted by an EI, it must be clearly indicated across the top of the visit form. *Other policies include:

- a. Copies of page 1 and 2 of the visit forms must be “stapled” together and returned to the Community Nursing Program Manager with the monthly invoice.
- b. The white copy of the Community Nursing visit form is filed in the client’s chart.

- c. Forms not filled out completely or legibly will be considered incomplete and returned to the Contractor for completion before reimbursement is approved.
- d. The entire visit form must be completed on the first visit for OCSHCN enrollees. Since the mother and infant are “linked” in the data system, the mother’s information is mandatory.
- e. “Alias” names must be provided on each nursing form as data managers do not have previous information at hand when entering a visit form. The initial forms from the hospital are the ones entered first into the data system and therefore; the child’s actual name may appear as an alias in the data system.
- f. All non-shaded fields must be filled in. Referrals and barriers must be completed using the letter coding system, see reference table at the end of this chapter. If there is no appropriate code simply use a zero with a slash through it.
- g. The data system is set up to receive specific field values selected by ADHS and OCSHCN that enable the programs to collect complete and consistent data. This data will be used to “paint a picture” of the critically ill newborns and their progress (outcomes). Please refer to reference tables at the end of this chapter.

h. **Health Status**

“Good” when they have normal growth and development parameters:

- Consistent growth, height, weight and head circumference as indicated on the growth charts and the other assessment information collected by the CHN’s.
- No trips to the ER, no medications needed except vitamins, normal physical exam and no family or CHN concerns.

“Fair” when child has had normal childhood illnesses such as ear infection or:

- A chronic condition exists that does not require frequent trips to the doctor or hospitalizations.
- Feeding problems exist but the child’s growth parameters are still on the growth chart.

- Some equipment, such as apnea monitor and/ medications are taken such as those for seizures, etc.

“Poor” when they have conditions that may be considered “life threatening” or need frequent hospitalizations or surgeries.

- i. **Medical Home** - ADHS will use the American Academy of Pediatrics (AAP) definition of medical home as ideal. However, that definition is very restrictive. Therefore, please mark “yes” for medical home if the family has a consistent source of medical care, such as:
 - A physician or practitioner they can call if their child is sick anytime within a 24-hour period of time.
 - A place they can take their child for care other than an emergency room, i.e., Doctor’s Office, clinic, community health center, etc.
- j. **Service**
Please be sure to check both where the visit was located (local, out-of-town, out of county) AND the type of visit (interim, regular, staffing, bereavement, pre-discharge) (chapter 7).
- k. **Purpose of CNS Visit**
This field should be utilized to provide additional detail regarding the purpose of the visit and is particularly important when there is a need for multiple visits within a short period of time. Using as few words as is possible; the home visitor should describe the ongoing situation. ie: uncontrolled diabetes, repeated hospitalizations, homelessness, domestic violence, et al.

9.4 Forms List

All forms may be found in the Appendix and on the HRPP/NICP webpage - <http://www.azdhs.gov/phs/owch/children/highrisk.htm>

| TYPE OF FORM | PURPOSE | ADDITIONAL USE | WHO FILLS IN | DISTRIBUTION OF FORM, BY WHOM |
|---|---|--|--|---|
| Request for Participation Forms (Page 1 & 2) | Enrollment and authorization form for HRPP/NICP Participation | <p>Collect demographic information about the mother and baby</p> <p>Record family's preference as to type or level of NICP Participation</p> | <p>Referring hospital, transport team or designated staff at the enrolling hospital</p> <p>If parents are not available to sign before transport, a new Request for Participation Form must be signed at the receiving hospital</p> | <p>White copy is sent to the ADHS Data Manager by receiving, enrollment hospital</p> <p>Yellow copy goes with CHN immediately after discharge</p> <p>Pink copy goes to family</p> <p>**Must be sent to ADHS Data Manager within 45 days of the birth, even if the baby is still in the hospital</p> |
| Hospital Discharge Summary | Discharge information | Collection of diagnoses and discharge information for infant | Designated hospital staff at discharging hospital | White copy is sent to the ADHS Data Manager by receiving, |

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| | | | | |
|---|---|---|--|---|
| | | Referral information | | discharging hospital Yellow copy goes with CHN immediately after discharge Pink copy goes to family **Must be sent to ADHS Data Manager within 30 days of discharge |
| Community Health Nursing Services Forms (Page 1 & 2) | Home visit information | Collect demographic information about the mother and baby Record visit provided by nurses, social workers or early interventionists Must be completed for infant/family receiving NICP, OCSHCN or a visit for Newborn Screening | Nurse, Social workers or Early Interventionist | White copy is kept in the client chart Yellow copy sent to ADHS with monthly invoice |
| HRPP/NICP Plan: Family Resources, Priorities and | Resources, priorities and concerns identified by family | | Nurse, Social workers or Early Interventionist | White copy is kept in the client chart |

| | | | | |
|---|---|---|--|---|
| Concerns | and CHN, Social worker or Early Interventionist | | | Yellow copy is provided to parent |
| OCSHCN Request for Participation | Permission to participation in CHN Services for children who do not meet NICP criteria | Collect demographic information about the parent and child | Nurse, Social workers or Early Interventionist | Copy is kept in client chart Copy is sent to ADHS with monthly invoice and CHN Visit form |
| Monthly Invoice | Bill for home visit services and trainings | Number of home visits and trainings per month | CHN Billing Representative | Original signed copy is sent to ADHS with visit log and CHN Visit forms Copy is kept with contractor |

CHAPTER 10
BILLING PROCESS

10.1 Billing Policy

- A. Payments are contingent on availability of funds. The NICP will notify Contractors when allocated funds are exhausted.
- B. The NICP "Request for Participation", OCSHCN Request for Participation and CHN Visit forms must be received by ADHS before any request for payment is considered.
- C. Services for infants who are not NICP must be billed as OCSHCN or NBS as appropriate.

10.2 Billing Procedures

- A. Within 30 days after the end of each month of service, the Contractor shall submit the monthly Invoice for Community Health Nursing (CHN) Services. The CHN Services invoice is located in the Appendix.
- B. A visit summary and Copies of the Community Nursing Service visit reporting forms must be submitted with the monthly invoice.
- C. Each Contractor has a unique Contract Number and Purchase Order number. The contract number must be included on all Contractor invoices and correspondence to ADHS. Contractors should reference the Purchase Order for the correct Contract Number.
- D. The billing time period, Contractor's name and address must also be entered in the stated block on the form. The invoice must contain the original signature of the Contractor's authorized representative and the date of signature.
- E. Any revisions to the invoice must be resubmitted to the Program manager with original signature of the Contractor's authorized representative and the date of signature.
- F. The Program Manager's Signature line in the bottom left hand corner of the page is for payment authorization by ADHS
- G. OCSHCN and NICP charges are separated to facilitate allocation to the appropriate funding source.
- H. Documentation for billable trainings (agenda, registration confirmation forms, etc.) must be submitted for each attendee with monthly invoices.

- I. The original, signed invoice and required documentation should be submitted to:

Arizona Department of Health Services
Bureau of Women's & Children's Health
ATTN: Community Nursing Services
150 North 18th Avenue, Suite 320
Phoenix, AZ 85007

10.3 Billing Definitions

Contractors are reimbursed for managing the care of each infant referred for services per the conditions of the contract. Home visitors are required to provide services according to the needs of the infant/toddler and family based on risk assessment. Unit billing rates are reflected in the Provider contract price sheet and are defined as follows:

10.3.1 Location

- **Local** – Total miles from one point to another that do not exceed 30 miles. I.e.): from office to home visit, or from CHN home to first visit, or from visit one to visit two.
- **Out-of-town** – Total miles between two points that exceed 30 miles but remain within the county.
- **Out-of-County** – Outside of the contracting county
Home visitors must write in mileage on the visit form for any visit that is considered out of town (over 30 miles one way), or Out of County.

10.3.2 Type of Visit

- **Interim** – Usually shorter in duration. An interim visit does not require a full assessment of child.
 - Examples of an Interim visit: Weight check, follow-up on feeding issues, environmental assessment, referral to community resources
- **Regular** – Complete a physical, developmental, psychosocial and environmental assessment of infants, provide family support and early intervention along with referral services to community resources as needed and provide interconception support and education to the mother.
- **Staffing** - Family-centered Multidisciplinary visit (participation in IFSP, joint visit with another discipline, Foster Care Review Board, CPS staffing, a nurse making a home visit with a health professional when the nurse IS NOT doing a full assessment of the child, etc.). The family is usually present.
- **Bereavement** – Counseling and referral to appropriate community

resources (can occur in the hospital or in the home). There are not to be more than two bereavement visits per family.

- **Pre-Discharge** - Visit with the infant/family in the hospital for the purpose of orientation to the program, discharge planning, explaining the home visit process, and for making that initial connection. This visit is charged at the “local” “regular” rate. Parent/guardian must be present for visit to occur. Child must be enrolled in the NICP before visit can occur.
- **Shadowing/training visit**-ADHS recognizes that one of the best ways to learn a new skill is through hands on training. Therefore ADHS is willing to reimburse the contractor, for each newly hired CHN, Social Worker, or EI to shadow visit an existing program nurse. The contractor shall be reimbursed 50% of the visit rate charged by the CHN (not the mileage rate for the person shadowing), and SHALL NOT EXCEED 5 shadow visits per new hire.
- **Family Visit**-Often times a CHN or social worker is making a visit that addresses social or emotional concerns of the family. This visit does not include a full assessment of the infant or infants. The visit form should indicate that this is a family visit. This would be billed as a single visit regardless of the number of children in the family.

10.4 Approval Process

- A. Reimbursement for training other than required business meetings requires prior approval by the Community Nursing Program Manager.
- B. All information contained on the following invoice sample must be included.

10.5 Invoice – See Appendix

CHAPTER 11 QUALITY MANAGEMENT AND IMPROVEMENT

11.1 Introduction

The ADHS Bureau of Women's and Children's Health recognizes the need to support the development of effective quality assessment and improvement initiatives into its programs. Contractors must develop a systematic process for continuous monitoring of the quality of patient/client services. This document provides guidelines for the development and/or ongoing implementation of a continuous quality management and improvement program.

Quality management and improvement is an ongoing process to monitor and improve health services. The process is summarized in the JCAHO Ten Step Model (adaptation):

- A. Assign responsibility for activities.
- B. Delineate scope of care.
- C. Identify criteria and indicators for review.
- D. Establish thresholds for evaluation and implement.
- E. Data collection.
- F. Review actions with analysis of data and reports.
- G. Evaluate care and assess prior interventions.
- H. Cooperative planning and implementation of change (a new plan) as necessary.
- I. Assess effectiveness and document improvement.
- J. Communication-establish a feedback system for communication about trend, interventions and evaluations.

11.2 The Annual Plan

The ongoing quality management and improvement process is documented in the contractor's quality management plan. An annual quality management plan must be developed which includes three indicators of quality service delivery, two selected by Program and one selected by Contractor. The plan must be completed on contractor's letterhead, submitted annually by 7/31 and available for review at the formal site visit. Please see format example at the end of this chapter. The annual plan includes:

11.2.1 The Selected Indicator

The indicator is what is looked at to determine how well the organization is doing on an aspect of care. It is a measurable variable that relates to the quality of services. Each indicator has its own performance or

effectiveness goal and has the potential to impact the health of the patient. In recognition of the fact that both state-wide trends and local concerns must be addressed by the ongoing quality improvement process, the Bureau of Women's and Children's Health will identify **two indicators** per contract year that must be included in program quality management and improvement activities. Other indicators will be selected by the contractor conducting the quality improvement activities and will reflect local concerns.

11.2.2 The Goal

Performance or effectiveness goals may be selected. Performance goals identify the organization's target for the result of a process or system. Performance goals measure the compliance of the organization or its providers in relation to its processes or systems. Effectiveness goals, on the other hand, measure a change in health, patient/client performance, or patient/client satisfaction as a result of the performance of the organization or its providers. Performance goals may be drawn from a variety of sources including various regulations and standards governing health care practice, organizational policy and procedures or contractual requirements.

11.2.3 Quality Improvement Plan (QIP) Level

The threshold or acceptable performance or outcome level

11.2.1 Data Source

The identified source for data is specific to the indicator. Common data sources would be patient/client charts, patient/client satisfaction surveys or routine database reports. In most cases, fairly simple methods can be devised in order to collect the data needed. The attachments below provide an example of a simple data collection form. Cost effectiveness (cost of collecting the data a certain way versus the value to your quality assessment and improvement program) and validity of data collected are important considerations. Consider data sources you may already have in place, developing new ones only where needed. Collecting data is the most expensive part of quality assessment; therefore, careful consideration must be given to two points: a) sample size and b) who collects the data. It is not necessary to collect a statistically valid sample, however, a sample size must be developed that can be reasonably used to monitor trends. If the base population from which the sample is taken is reasonably large, a 1% sample is usually adequate. Careful consideration should be given to who collects the data. In general,

clerical staff can collect information from medical records more cost effectively than professional staff.

Reports from information already entered into the computer can significantly reduce data collection costs.

11.2.1 Responsibility

The person identified to be in charge of documenting the plan, collecting the data, reporting results, developing and documenting strategies and results. Results of each contractor's performance related to quality improvement indicators are to be reported on the quarterly reports and available for scheduled formal site visits.

(The Report must be submitted on contractor's letterhead)

Annual Plan

Continuous Quality Improvement

Contractor:
Fiscal Year 2014

Mission: (describe the mission of your specific program as it relates to Community Nursing Services)

Goals: (What are your goals for improving the quality of your services during the contract year?)

Review/Planning/Implementation: (Who will participate in the review, analysis, planning and implementation of quality improvement activities at your site?)

Assessment of Effectiveness: (How will you assess your effectiveness and who will participate?)

Feedback System: (What mechanism will you use to provide feedback to your team?)

Quality Improvement Indicators:

1. Contact families within one week of hospital discharge (Required)
2. Home visit within two weeks of hospital discharge (Required)
3. Contractor selected indicator

Responsibility: (Identify the individuals that will have responsibility for developing the Annual plan, collecting data, reviewing and analyzing results, developing and implementing strategies for improvement and assessing effectiveness)

(The Report must be submitted on contractor's letterhead)

Quarterly Summary
Continuous Quality improvement

Contractor:
Quarter reporting on:

Accomplishments:

Issues/Concerns/Barriers and Possible Solutions:

Goals for the next quarter:

Current program staff: Name & Title

Date:

Program Coordinator:

Quality Improvement Indicator #1 (2013-2014)

Name of Organization:

Date:

Program: Community Nursing

Responsible Person: Individual
Contractors

Description: The time period immediately following discharge from a Newborn Intensive Care Unit is extremely stressful for families. Timely follow up by a Community Health Nurse is an important factor to ensure that families receive the support they need to become competent full time caregivers for their children.

Goal: Families will be contacted within one week of receipt of discharge papers

Indicator: % of patients contacted within one week of receipt of discharge papers

QIP Level: 85%

Indicator Score:

Data Source: Contractor records
and ADHS reports

Total Referred _____

Total Contacted _____

% Contacted in one week _____

Plan for Improvement:

Target date for Resolution:

Signature:

Resolution

Review Date:

Indicator Score:

Signature:

Quality Improvement Indicator #2

Name of Organization:

Date:

Program: Community Nursing

Responsible Person:

Description: The time period immediately following discharge from a Newborn Intensive Care Unit is extremely stressful for families. Timely follow up by a Community Health Nurse is an important factor to ensure that families receive the support they need to become competent full time caregivers for their children.

Goal: Families will be visited within two weeks of receipt of discharge papers

Indicator: % of patients contacted within two weeks of receipt of discharge papers

QIP Level: 85%

Indicator Score:

Data Source: Contractor records and ADHS reports

Total Referred _____

Total Visited in 2 weeks _____

% Visited in 2 weeks _____

Plan for Improvement:

Target date for Resolution:

Signature:

Resolution

Review Date:

Indicator Score:

Signature:

Quality Improvement Indicator #3 (Contractor Selected)

Name of Organization:

Date:

Program: Community Nursing

Responsible Person:

Description:

Goal:

Indicator:

QIP Level: 95%

Indicator Score:

Data Source:

Recommendations for QIP Resolution:

Target date for Resolution

Signature:

Resolution

Review Date:

Indicator Score:

Signature

CHAPTER 12 SITE REVIEW

12.1 Process Overview

The purpose of the Site Review process is to establish a mechanism for the evaluation and monitoring of contracts executed by the Arizona Department of Health Services (ADHS) to ensure services were delivered pursuant to the terms and conditions of the contract, statutes, rules and other policies applicable or made a part of the contract. During the site review monitoring process, ADHS shall provide training and technical assistance to the contracted provider and service area, provide a demographic profile of the area, engage in dialog to identify public health concerns, and provide a general overview of ADHS services.

The Community Health Nursing (CHN) Guidelines for Evaluation provides a structured framework for reviewing and assessing the Community Health Nursing Contractor's progress, program strengths and compliance with CHN Standards.

12.2 ADHS Program Responsibilities

- A. Schedule the on-site review with the Contractor a minimum of five (5) days in advance of the review.
- B. Prepare and provide the Contractor with a comprehensive Site Review Monitoring Guide.
- C. Provide the Contractor with a draft agenda, a list of the review team members, a copy of the site review monitoring guide, and list of patient charts that should be available for review.
- D. Conduct the on-site review utilizing a team comprised of staff with the expertise in the specific area(s) being reviewed.
- E. Conduct interviews with administrators, staff, clients, family members and others as appropriate.
- F. Provide feedback on performance to the Contractor during the on-site review exit conference.

- G. Provide the opportunity for the Contractor to discuss program strengths and identify issues and concerns.
- H. Provide the Contractor with desired training or technical assistance.
- I. Provide the Contractor with a Site Review Summary which covers: Areas of Excellence, Recommendations for Improvement, and Required Corrections.
- J. Provide the Contractor with the opportunity to review and respond to the Site Review Summary. The Contractor will be given seven (7) days to inform ADHS if there are any corrections that should be made to the content.
- K. ADHS will revise monitoring report within 30 days of receipt of the contractor's comments. A copy of the report shall be provided to the Contractor and a copy will be maintained in the Contractor's program files.
- L. Review and accept or revise (in collaboration with the Contractor) the written plan of correction.
- M. Monitor the Contractor's progress and provide technical assistance in support of the plan.

12.3 Contractor Responsibilities

- A. Cooperate with the Program in the monitoring process by making information and records available and by allowing interviews and inspections of the facilities.
- B. Notify the ADHS Site Review Team leader regarding any desired training or technical assistance that will be required during the on-site visit.
- C. Request the attendance of staff directly responsible for the contract.
- D. Make space available for the meeting and review of patient records.
- E. Have the following materials available for review at the site: Personnel Educational logs, CQI records
- F. Identify Contractor strengths, concerns and education/technical assistance needs during the site visit.

- G. Inform ADHS of changes to be made to the Site Review Summary Report within seven (7) days of receipt.
- H. Prepare and submit to the Program a written plan of corrective action, if required, within fourteen (14) days of receipt.

12.4 Site Review Monitoring Guide

The Review Guide is divided into five sections. Each section represents a major category of the ADHS/CHN standards. These sections are:

- A. Program Administration and Documentation
- B. Staff Recruitment and Training
- C. Home Visiting and Direct Caregiving
- D. Family Involvement
- E. Quality Management and Improvement

Each section of the Guide identifies the performance standard for the Contractor. These performance standards have been stated in the "Scope of Work" sections of the contract or in the ADHS/CNS Policy and Procedure Manual. The NICP/OCSHCN review team gathers data, reviews documents and conducts interviews and inquiry of the CNS Contractor to assess whether the performance standard has been met. Prior to the start of the reviews, the NICP/OCSHCN review team will notify the contractor of the requested review, and state the materials requested for the review. (H-Have R-Request from the contractor O-Observed).

It is possible to use several different resources, documents or methods to gather information about the CHN Contractor's program. These sources allow for a variety of means for reviewers to gather evidence to support findings and conclusions.

The topic in each section will cue and guide the reviewers about what types of questions to ask the Contractor and what things to look for in reviewing documents or other types of descriptive data and information that supports a standard. Reviewers will document areas for follow-up with the Contractor during the site visit.

SCORING: C=Compliant P=Partially Compliant N=Noncompliant

The contractor is given one score for each standard, based on the findings and

conclusions of the review team. Areas above standards can be highlighted as strengths and areas of noncompliance can be documented so that the CHN Contractors can prepare action plans for resolving problem areas.

Collection of data and descriptions of processes will support the findings and conclusions and will provide the site review team with information to identify program strengths and opportunities for improvement.

Site review documents listed in Appendix

CHAPTER 13 PROCEDURAL SAFEGUARDS

13.1 Introduction

This chapter provides the process for ensuring the implementation of the safeguards to which each child eligible for services and his/her family is entitled.

13.2 Consent

Consent in this context means permission from the family. It ensures that:

- The family has been fully informed of all information relevant to the activity for which consent is sought, in the family's native language or mode of communication.
- The family understands and agrees in writing to the activity for which consent is sought. The written, signed agreement describes the activity and a list of records (if any) to be released and to whom.
- The family understands that consent is voluntary and they may revoke it at any time.
- The family has the right to determine whether the infant/toddler or any other family member will accept or decline referrals to other providers or an early intervention service without jeopardizing other early intervention services under IDEA, Part C

13.2.1 Parental Consent

Parental Consent shall be obtained in writing before:

- Conducting physical, developmental, psychosocial and environmental assessment of infant
- Initiating the provision of referral to other providers or early intervention services
- Initiating the provision of interconception support and education to the mother

13.2.1 Parental Consent Not given

If parental consent is not given, reasonable effort shall be made to ensure that the family:

- Is fully aware of the nature of the CHN visit and assessment or service that would be available
- Understands that the child will not be able to receive the CHN visit, assessment or services unless consent is given.

13.3 Review and Inspection of Records

Parents shall be permitted to examine, inspect and review (without unnecessary delay) any records relating to their child's evaluations, assessments, HRPP/NICP Plan, and eligibility determination. Every parent of a child enrolled in the program has the right to examine, inspect and review the records of their child and family related to:

- CHN visit
- Assessments and evaluations
- Eligibility determinations
- Individual complaints dealing with the child

13.3.1 Requests for Review of Records

Each provider shall comply with a parent's request to examine, inspect, and review the records of his/her child and family:

- Without unnecessary delay
- Before any assessment
- Before any referrals to other providers or early intervention service
- Within no more than 45 days of the request

13.3.1 Procedures for Record Review

When a parent makes a request to examine, inspect, and review the records of his/her child and family the following steps will be taken:

- The contractor shall provide the parent with written instructions on his/ her rights and how to access the records, and ensure that the parent understands these instructions.
- A date and time, that is convenient to the parent, will be set up to

explain the purpose for which the information in the records shall be used and to provide explanations and interpretations of the records. This may be done:

- I. At the same time the parent is inspecting and reviewing the records
- II. Immediately following the parent's inspection and review of the records, or at a later date and time.

13.4 Corrections to Records

A parent may request to make corrections to information in his/her child's records which they believe is inaccurate, misleading, or violates the privacy or other rights of the child or family. Each provider shall decide whether to make the requested corrections to the information in the child's records within a reasonable amount of time, but no later than 45 days.

13.5 Confidentiality

The confidentiality of personally identifiable information at collection, storage, disclosure, and destruction stages shall be protected. Each participating agency shall maintain, for public inspection, a current listing of the names and positions of those employees who may have access to personally identifiable information and those other parties who obtained access to the records.

13.6 Record Retention

The Bureau of Women's & Children's Health and Office for Children with Special Health Care Needs program administration and ADHS Office of Auditing shall have access to client records in order to conduct necessary evaluations or programmatic review.

A. Administrative Records

Under A.R.S. §§35-214 AND 35-215, the contractor shall retain and shall contractually require each subcontractor to retain all data and other records ("records") relating to the acquisition and performance of the contract for a period of three years after the completion of the contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the contractor shall produce a legible copy of any or all such records.

B. Patient Records

ADHS requires the Contractor to store and maintain all client records in a safe secure location for 5 years after the last date of service. Records may

be retained longer as required by the existing legal requirements of the contracting entity. Clients will have signed an informed consent statement on admission of their infant to the program indicating, in part, that a record will be maintained and to whom those records may be released.

C. Termination of Contract

Upon termination of the contract, all administrative documents, data and reports prepared by the Contractor under the Contract shall be maintained for a period of three years beyond termination. Patient records shall be maintained as outlined in B above.

13.7 Complaint Process (system complaint)

All children/families served through ADHS programs have the right to file a complaint. The following steps will be taken when a complaint is filed:

- The family of a child served by CHN services may file a complaint with the program coordinator at the facility where the child is being served. The Program Coordinator is required to respond in writing within 15 working days.
- A copy of the complaint and the response shall be forwarded to the appropriate ADHS Program Manager.
- If the complaint is not resolved by the contract provider, the family may contact the ADHS program managers:

150 North 18th Avenue, Suite 320
Phoenix, AZ 85007-3242

- Complaints that cannot be resolved by the ADHS Program Managers will be presented for a higher-level review.

APPENDIX

1.0 Program Documents

- Request for Participation Page 1
- Request for Participation Page 2
- Financial Worksheet & Questionnaire
- Hospital Discharge Summary
- Community Nursing Form Page 1
- Community Nursing Form Page 2
- HRPP/NICP Family Plan
- OCSHCN Request for Participation Enrollment Form
- Change enrollment Form
- Community Nursing Neonatal and Pediatric Assessment Form
- Medical Risk Criteria Form
- CHN Visit Reference Tables
- CHN Invoice
- Site Review – CHN Site Visit Guide
- Site Review – Chart Review Audit

ARIZONA DEPARTMENT OF HEALTH SERVICES
High-Risk Perinatal Program/Newborn Intensive Care Program
Request for Participation Page 1 of 2

Place required label here

PLEASE PRINT ALL INFORMATION

| INFANT'S INFORMATION | | | | | | | |
|---|--|--|---|--|---------|---|--------------------|
| 1. Infant's Last Name | | 2. Suffix | 3. First Name | | 4. MI | 5. DOB | 6. Gender M F U |
| 7. Alias: Last Name | | 8. Alias: First Name | | 9. Race <input type="checkbox"/> American Indian / Alaskan Native, <input type="checkbox"/> Asian, <input type="checkbox"/> Black / African American, <input type="checkbox"/> White, <input type="checkbox"/> Native Hawaiian / Pacific Islander, <input type="checkbox"/> Bi-Racial / Multi-Racial <input type="checkbox"/> Unknown | | 10. Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino | |
| 11. Street Address (No. P.O. Box) | | | 12. City | 13. State | 14. Zip | 15. County | |
| 16. Tribe (select one) <input type="checkbox"/> Apache <input type="checkbox"/> Pueblo <input type="checkbox"/> Other (specify) <input type="checkbox"/> Chemehuevi <input type="checkbox"/> Quecham <input type="checkbox"/> Cherokee <input type="checkbox"/> Seminole <input type="checkbox"/> Choctaw <input type="checkbox"/> Seneca <input type="checkbox"/> Cocopah <input type="checkbox"/> Shoshone <input type="checkbox"/> Unknown <input type="checkbox"/> Creek <input type="checkbox"/> Sioux <input type="checkbox"/> Havasupai <input type="checkbox"/> Tohono O Odham <input type="checkbox"/> Hopi <input type="checkbox"/> Ute <input type="checkbox"/> Hualapai <input type="checkbox"/> Washoe <input type="checkbox"/> Not Applicable <input type="checkbox"/> Maricopa <input type="checkbox"/> Yavapai <input type="checkbox"/> Mohave <input type="checkbox"/> Yuma <input type="checkbox"/> Navajo <input type="checkbox"/> Zuni <input type="checkbox"/> Paiute (Kaibab) <input type="checkbox"/> Pasqua Yaqui | | | 17. Reservation (select one) <input type="checkbox"/> Ak Chin <input type="checkbox"/> Camp Verde (Yavapai - Apache) <input type="checkbox"/> Cocopah <input type="checkbox"/> Colorado River(Mohave-Chemehuevi) <input type="checkbox"/> Fort Apache <input type="checkbox"/> Fort McDowell (Yavapai-Apache) <input type="checkbox"/> Fort Mohave <input type="checkbox"/> Fort Yuma (Quechan) <input type="checkbox"/> Gila Bend <input type="checkbox"/> Gila River (Pima-Maricopa) <input type="checkbox"/> Havasupai <input type="checkbox"/> Hopi <input type="checkbox"/> Hualapai <input type="checkbox"/> Kaibab-Paiute (Paiute) <input type="checkbox"/> Maricopa Ak Chin <input type="checkbox"/> Navajo Nation <input type="checkbox"/> Pasqua-Yaqui <input type="checkbox"/> Payson-Yavapai <input type="checkbox"/> Salt River (Pima-Maricopa) <input type="checkbox"/> San Carlos (Apache) <input type="checkbox"/> San Juan Southern Paiute <input type="checkbox"/> San Xavier <input type="checkbox"/> Tohono O Odham (Formerly Papago) <input type="checkbox"/> Yavapai-Prescott (Yavapai) <input type="checkbox"/> White Mountain Apache <input type="checkbox"/> Zuni Pueblo <input type="checkbox"/> Other (specify): _____ | | | | |
| 18. Birth Hospital | | 19. Current Hospital (if not birth hospital) | | 20. Infant's Insurance | | | |

| FAMILY INFORMATION | | | | | | |
|--|--|-------------------------|--------------------------------------|--|---|---------|
| 21. Mother's Last Name | | 22. Mother's First Name | | 23. MI | 24. DOB | |
| 25. Alias: Last Name / Maiden Name | | 26. Alias: First Name | | 27. Phone # () | | |
| 28. Marital Status: <input type="checkbox"/> Divorced, <input type="checkbox"/> Living Together, <input type="checkbox"/> Married, <input type="checkbox"/> Never Married, <input type="checkbox"/> Separated, <input type="checkbox"/> Widowed, <input type="checkbox"/> Unknown | | | | | | |
| 29. Race: <input type="checkbox"/> American Indian / Alaskan Native, <input type="checkbox"/> Asian, <input type="checkbox"/> Black / African American, <input type="checkbox"/> White, <input type="checkbox"/> Native Hawaiian / Pacific Islander, <input type="checkbox"/> Bi-Racial / Multi-Racial <input type="checkbox"/> Unknown | | | | 30. Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino | | |
| 31. Mother's Highest Grade Completed: <input type="checkbox"/> ≤8 th , <input type="checkbox"/> 9-11 th , <input type="checkbox"/> High School Grad/GED, College: <input type="checkbox"/> < 2 yr, <input type="checkbox"/> 2 yr, <input type="checkbox"/> 4 yr, <input type="checkbox"/> 6 yr+ | | | 32. Primary Language Spoken at Home: | | 33. Second Phone # <input type="checkbox"/> None () | |
| 34. Father's Last Name | | 35. Suffix | 36. Father's First Name | | 37. MI | 38. DOB |

| PRIMARY CAREGIVER (if not Mother and/or Father) | | | | | | | |
|---|--|----------------|----------|------------------|-----------|--------------------|--|
| 39. Caregiver's Last Name | | 40. First Name | | 41. Relationship | | 42. Phone # () | |
| 43. Street Address | | | 44. City | | 45. State | 46. Zip | |

| CONTACT INFORMATION (someone who will always know how to reach family) | | | | | | | |
|--|--|----------------|--|------------------|--|--------------------|--|
| 47. Contact: Last Name <input type="checkbox"/> None | | 48. First Name | | 49. Relationship | | 50. Phone # () | |

Distribution by Enrolling Contractor: Original to ADHS Yellow to CHN Pink to Family Copy for Development Follow-up if High Risk FOR ALL TRANSPORTS AFTER INITIAL HOSPITAL ENROLLMENT: Sending hospital -Copy p1 & p2 of this form to accompany baby to receiving Level II, II EQ or III hospital. Transport carriers do not receive copies of this form.

ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program/Newborn Intensive Care Program
Request for Participation, Page 2 of 2

Place required label here

PLEASE PRINT

FAMILY INFORMATION

| | | | | | | |
|-----------------------|--------------------|------------------------|---------------|--------|----------------------|--------|
| 1. Infant's Last Name | 2. Alias Last Name | 3. Suffix | 4. First Name | 5. MI | 6. Gender M F U | 7. DOB |
| 8. Mother's Last Name | | 9. Mother's First Name | | 10. MI | 11. Current Hospital | |

The State of Arizona has established a High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) to provide a system of *Transportation, Hospital, Medical, and Follow-up* for critically ill newborns whose parents reside in Arizona. This program also assists families when needed to cope with catastrophic costs related to newborn intensive care.

I REQUEST THE FOLLOWING LEVEL OF PARTICIPATION:

- FULL (Includes financial assistance)** - I request participation in the High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) which may include transport, inpatient hospital care, and community home nursing. I am requesting financial assistance, if needed, and I understand that HRPP/NICP is the payor of last resort. I agree to submit all necessary documents on behalf of my child for purposes of collection from third party payors and shall retain no insurance proceeds from claims intended as payment for services provided. **I agree to enroll my infant on my third party and/or AHCCCS plan, if eligible, within 30 days from infant's date of birth, and understand that failure to do so will result in HRPP/NICP financial assistance being denied. I agree to complete the HRPP/NICP *Financial Worksheet* and *Financial Questionnaire* forms and to fulfill any HRPP/NICP family liability.**
- PARTIAL (No financial assistance)** - I request participation in the High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) which may include transport, inpatient hospital care, and community home nursing but *do not* wish to apply for or receive financial assistance. *I shall be liable for all transport, hospital and medical charges incurred. I understand that I may request a change in my level of participation during the first sixty (60) days after the birth of my child.*
- PARTIAL / LATE ENROLLMENT (No financial assistance)** - I request participation in the follow-up provided by the High Risk Perinatal Program/Newborn Intensive Care Program (community home nursing). I reside in the State of Arizona and my child meets HRPP/NICP eligibility criteria.

- Reason:** Parent originally declined participation Enrollment Hospital never offered program
 Sibling of eligible infant Out of state NICU

I authorize the release of any necessary medical, social and financial information held by any institution or individual that provided newborn services to my child to the Arizona Department of Health Services (ADHS) and to their contracted providers for provider quality management purposes.

I agree to submit my child's NICP Enrollment forms, Request for Participation and Financial Worksheet & Questionnaire (if applicable), to the Hospital NICP Liaison within thirty (30) days from the date my child is eligible for the NICP program. Failure to do so may result in loss of eligibility for financial assistance.

 Signature of Parent/Guardian/Responsible Party Requesting Full or Partial Participation Date

I CERTIFY THAT THIS CHILD MEETS THE ENROLLMENT CRITERIA OF THE NICP

 Signature of Authorized Hospital/Follow-up Representative Date

**ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program / Newborn Intensive Care Program
Financial Worksheet & Questionnaire**

Place Required Label Here
(If label will not fit, place
on the back of the form)

| | | | | |
|---|------------|---|--------|---------|
| 1. Infant's Last Name | 2. Suffix | 3. First Name | 4. MI | 5. DOB |
| 6. Last Name (Responsible Person) | 7. Suffix | 8. First Name | 9. MI | 10. DOB |
| 11. Insured Last Name | 12. Suffix | 13. First Name | 14. MI | |
| 15. Infant's Insurance Coverage Type <input type="checkbox"/> 3 rd Party Private <input type="checkbox"/> AHCCCS <input type="checkbox"/> KidsCare <input type="checkbox"/> IHS non-AHCCCS <input type="checkbox"/> None | | 16. Infant's AHCCCS Status <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> Pending <input type="checkbox"/> Refused | | |
| 17. Infant's AHCCCS # | | 18. Infant's AHCCCS Eligibility Date | | |

Do include current income of both parents prior to any tax or other deductions. Include mother's income if she will be returning to work after maternity leave. Include ALL sources of parental income.*

DETERMINATION OF FAMILY LIABILITY

A. Household Size
Include newborn(s), parent(s), siblings & any dependent(s) claimed on latest tax forms.

GROSS ANNUAL HOUSEHOLD INCOME

Father's _____
Mother's _____
Other _____
B. Total **Gross** Household Income*
\$ _____

*Include income of both parents, if working. Do not include income of other family members such as grandparents, unless they are assuming financial responsibility for the baby.

Medical expenses are defined as medical, vision and dental expenses, including insurance premiums, incurred from the infant's date of birth and 12 months prior. Do not include expenses paid or expected to be paid by any third party insurance payer. Do not include current charges for infant's stay in the intensive care unit. **DO** include mother's prenatal care, **mother's hospital charges** and baby's hospital charges before transported (if not enrolled in NICP at that hospital).

| | |
|--|-------|
| Medical, Dentist, and Vision insurance premiums (Deducted from paycheck or direct pay) | _____ |
| Doctor, Dentist, and Vision co-pays, deductibles and charges | _____ |
| Prescriptions | _____ |
| Lab and other medical testing charges | _____ |
| Vision Care (glasses/contact lenses) | _____ |
| Medical Supplies | _____ |
| Surgery Charges | _____ |
| Other medical expenses | _____ |
| Total Medical Expenses | _____ |
| B. Total Gross Household Income \$ | _____ |
| C. Less Total Medical Expenses \$ | _____ |
| D. Adjusted Gross Income (B minus C) \$ | _____ |
| E. NICP Family Liability taken from the ADHS Family Liability Table (Use A and D above) \$ | _____ |

I hereby request financial assistance for payment of expenses for transport and/or care in the hospital intensive or intermediate care centers in accordance with the policies of the Arizona Department of Health Services (ADHS). I agree to enroll my infant on my third party and/or AHCCCS plan, if eligible, within thirty (30) days from infant's date of birth, and understand that failure to do so will result in denial of NICP financial assistance. I shall assist all providers to obtain 3rd party payments. I have completed the NICP Financial Worksheet & Questionnaire, and will receive a copy from the hospital representative after signing below. I understand that financial assistance is not available for out-of-state hospital, out-of-state physician care, or care through non-contracted hospitals. **I understand that if my Household Income changes during the first 60 days from my infant's date of birth, I may contact the hospital interviewer to complete a revised financial questionnaire. Any revisions must be received by ADHS within 90 days from infant's date of birth.**

Signature of Parent / Guardian / Responsible Person

Relationship to Patient

Date

Signature of Hospital Interviewer

Printed Name of Interviewer

Date

Interviewer Comments _____

ARIZONA DEPARTMENT OF HEALTH SERVICES
High-Risk Perinatal Program/Newborn Intensive Care Program
Hospital Discharge Summary

Place required label here

Current Hospital:

Enrollment Forward Transport Back Transport

| | | | | | |
|--|--------|--|-------------------------------------|----------------------|----------------|
| Infant's Last Name | | First Name | | MI | DOB: |
| Alias Last, First | Phone: | Birth weight: lbs oz | Birth Length: | | Birth OFC (HC) |
| Gestational Age by Exam: _____ weeks | | Fetal Growth: <input type="checkbox"/> AGA <input type="checkbox"/> SGA <input type="checkbox"/> LGA | APGAR @ 1" _____ 5" _____ 10" _____ | | |
| Discharge Date: | | Disch. Wt. lbs oz gms | Disch. OFC (HC) _____ cm | | |
| English Proficiency: Proficient Good Some None | | Discharged/Transferred to: | | DIED: Date of Death: | |

Respiratory Diagnosis/Complication

- 486 Pneumonia
- 512.8 Air Leak Syndrome
- 747.89 PPHN (pulmonary hypertension)
- 748.3 Subglottic Stenosis/Tracheomalacia
- 769 Respiratory Distress
- 770.1 Meconium RDS
- 770.6 TTN
- 770.7 BPD (or Chronic Lung Disease)
- 770.8 Apnea
- Other _____

Respiratory Treatment (RT)

- Hood O2 Only
- CPAP Only
- IPPV>7 days
- IPPV<7 days
- Jet Ventilation
- ECMO
- Tracheostomy
- Surfactant
- Oscillator
- Other _____

Cardiovascular Diagnosis/Complication

- 785.5 Shock Hypotension with Pressor Support
- 746.9 Congenital Heart Disease
- 401 Systemic Hypertension
- 427.8 Cardiac Dysrhythmias
- 747.9 Cardiac Anomaly
- Other _____

Cardiovascular Treatment

- 747 PDA-Indomethacin
- 747 PDA-Surgical
- Other _____

Gastrointestinal/Genitourinary

- 779.3 GE Reflux
- 777.5 Proven NEC
- 584 Renal Failure
- 751.9 GI Anomaly
- 522.9 GU Anomaly
- Other _____

Neurological Diagnosis

- 768.9 Hypoxic Encephalopathy
- 767.0 Intraventricular Hemorrhage GR I/II
- 772.1 IVH-Grade III / IV
- 742.4 PVL
- 320.9 Meningitis
- 742.3 Congenital Hydrocephalus
- 331.4 Acquired Hydrocephalus
 - Shunted V45.2
- 742.1 Microcephaly
- 794 Abnormal Neurologic Exam _____
- 779 Seizures
- Other _____

Dysmorphology

- 758 Chromosomal Anomaly
- 759 Congenital Anomaly (unspecified)
- 759.9 Dysmorphic Infant
- Type of Syndrome _____
- Anomaly Requiring Surgery _____
- Other _____

Hematological

- 776.4 Polycythemia
- 776.1 Thrombocytopenia
- 774.6 Hyperbilirubinemia Requiring Exchange Transfusion or a Total of 25 or Indirect above 1
- 774.2 Highest Bilirubin Total _____ Indirect _____
- 762.3 Twin to Twin Transfusion Syndrome
- Other _____

Other Diagnoses

- 775. Symptomatic Hypoglycemia (BG<40)
- 647.8 Suspected/Proven Sepsis
- 771 Congenital Viral Infections (CMV, Herpes, HIV)
- 764.9 SGA-Symmetrical
- 362.2 ROP
- 779.5 Newborn Drug Withdrawal Syndrome
- 760.70 Positive Drug Screen for _____
- 651 Multiple Birth
- 764.9 IUGR
- Other _____

Developmental

- NIDCAP # of times _____
- Other Developmental Assessment
- Kangaroo Care Co-bedding
- OT Evaluation PT Evaluation
- Speech Evaluation
- Psychosocial Assessment
- ROP/Vision Screen:
 - Pass/WNL Refer / Abnormal
- Copy of Developmental Care Plan given to:
 - Family CHN
- Other _____

Comments: _____

Completed by _____
 Hospital Representative

Primary Care Physician:

Discharge Information / Adaptations

- Apnea Monitor Oxygen
- Medication Special Therapy
- Special Feeding CPR
- Car Seat

Newborn Screening

- Hearing Screen: Pass Refer
- Bloodspot Screen: 1st 2nd 3rd

Immunizations

- HepB Synagis
- DTaP Pneumococcal
- Polio
- Hib

Discharge Risk: High Risk At Risk
Criteria: _____

Referral to:

- NICP Community Home Nursing
- ASDB CRS SSI
- CPS DDD WIC
- Healthy Families Health Start
- Social Worker
- Home Health Agency _____
- Other _____

Social Concerns:

- Infant Placed in Foster Care
- History of Parental Substance Abuse
- Parent has Chronic Illness
- Problems Buying Food & Other Necessities
- Family Conflict/Anger
- No Transportation
- Parental Unemployment
- Single Parent
- Teen Parent
- Parent has Mental Illness
- Father of Baby Not Involved
- Housing Inadequate or Homeless
- Domestic Violence/Child Abuse History
- Parent has Developmental Disability
- Siblings have Chronic Illness or Developmental Disability
- No Family/Community Support System
- Language Barrier: _____
- Parent has Cognitive Limitation
- Adoption (CHN information only)

Directions to home:



PLEASE PRINT

El: Specify _____

PROGRAM: NICP OCSHCN NBS

CHILD'S INFORMATION

| | | | | | | | |
|----------------------|-----------------|---|----------------------|---|-----------|-----------------|--------------------------|
| 1. Child's Last Name | | 2. Suffix | 3. First Name | | 4. MI | 5. DOB / / | |
| 6. Alias: Last Name | | | 7. Alias: First Name | | 8. Gender | | 9. Primary Care Provider |
| 10. Street Address | | | 11. City | | 12. State | 13. Zip Code | 14. County |
| 15. Race | | 16. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | | 17. Tribe | | 18. Reservation | |
| 19. GA at Birth | 20. Birthweight | 21. Place / Hospital of Birth | | 22. Insurance Coverage Type: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Kidscare <input type="checkbox"/> AHCCCS <input type="checkbox"/> IHS-Non AHCCCS | | | |

FAMILY INFORMATION

| | | | | | | | |
|---|--|---|-----------------------|-------------------------|-----------------|-----------------|--------------------|
| 23. Mother's Last Name | | 24. Mother's First Name | | 25. MI | 26. DOB / / | | 27. Marital Status |
| 28. Alias: Last Name | | | 29. Alias: First Name | | 30. Maiden Name | | |
| 31. Race | | 32. Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | | 33. Tribe | | 34. Phone # () | |
| 35. Father's Last Name | | | 36. Suffix | 37. Father's First Name | | 38. MI | 39. DOB / / |
| 40. Primary Language Spoken in the Home | | | | | 41. Phone # () | | |

PRIMARY CAREGIVER (IF DIFFERENT FROM MOTHER AND/OR FATHER)

| | | | | | | | |
|---------------------------|--|----------------|--|------------------|--|-----------------|--------------|
| 42. Caregiver's Last Name | | 43. First Name | | 44. Relationship | | 45. Phone # () | |
| 46. Street Address | | | | 47. City | | 48. State | 49. Zip Code |

VISIT INFORMATION

| | | | | | | | | | |
|--|--|---------------------------------|--|---|--|--|--|--|--|
| 50. Visit Date / / | | 51. Service Setting | | 52. Contractor | | 53. Provider | | 54. Source of Referral | |
| 55. Date of Discharge / / | | 55A. First contact date / / | | 56. CA at this visit | | 57. Adjusted Age | | 58. Breastfed: <input type="checkbox"/> Never <input type="checkbox"/> Not Now <input type="checkbox"/> Currently <input type="checkbox"/> Unknown | |
| 59. General Health Status Good ___ Fair ___ Poor ___ | | 60. Medical Home Y ___ N ___ | | 61. Immunizations Current? Y ___ N ___ Unknown ___ | | 62. Uses Car Seat: Y ___ N ___ <input type="checkbox"/> Information Given | | | |
| 63. Service: (check both) <input type="checkbox"/> Local <input type="checkbox"/> Out-of-Town (Mileage _____) <input type="checkbox"/> Out-of-County | | | | | | | | | |
| 63A. <input type="checkbox"/> Interim <input type="checkbox"/> Regular <input type="checkbox"/> Staffing <input type="checkbox"/> Bereavement <input type="checkbox"/> Pre-Discharge <input type="checkbox"/> Shadow <input type="checkbox"/> Family Visit | | | | | | | | | |
| 64. Periodicity : (Visit Type) <input type="checkbox"/> 0 to < 4mos <input type="checkbox"/> 4 to < 6mos <input type="checkbox"/> 6 to < 8mos <input type="checkbox"/> 8 to < 12mos <input type="checkbox"/> 12 to < 18mos <input type="checkbox"/> 18 to < 24mos <input type="checkbox"/> 24 to < 36mos <input type="checkbox"/> 36 to < 48 mos <input type="checkbox"/> +48mos | | | | | | | | | |
| 65. Growth: Physical assessment (Adjusted to age two) Height: _____ cm _____ in Weight: _____ lb _____ oz OFC: _____ cm _____ in WT/HT Ratio: _____ % | | | | | | | | | |

Community Nursing Services

| | | | | | |
|---|---|---|---|---------------------------------|--------------------|
| Last Name: | | First Name: | | MI: | DOB: / / |
| Family Service Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Ages & Stages: <input type="checkbox"/> Age Appropriate <input type="checkbox"/> Suspicious <input type="checkbox"/> N/A | | |
| | | | DENVER II: <input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Untestable <input type="checkbox"/> Not attempted | | |
| Purpose of CNS Visit: | | | | | |
| NURSING INTERVENTIONS | | | | | |
| <input type="checkbox"/> V70.0 Infant Assessment | <input type="checkbox"/> V62.82 Bereavement Coun. | <input type="checkbox"/> V25.09 Family Planning | <input type="checkbox"/> V65.3 Nutrition/Feeding | | |
| <input type="checkbox"/> V77.7 Newborn Screen | <input type="checkbox"/> V65.49 Child Health/Dev | <input type="checkbox"/> V26.3 Genetics | <input type="checkbox"/> Other code: | | |
| <input type="checkbox"/> V79.3 Developmental Screen | <input type="checkbox"/> V60.2 Community Resource | <input type="checkbox"/> V65.43 Injury Prevention | <input type="checkbox"/> | | |
| <input type="checkbox"/> V65.5 Anticipatory guidance | <input type="checkbox"/> V65.42 Substance Abuse | <input type="checkbox"/> V65.4 Immunizations | <input type="checkbox"/> | | |
| SOCIAL RISK FACTORS - environmental assessment | | | | | |
| <input type="checkbox"/> Domestic Violence/Abuse History | <input type="checkbox"/> Language Barrier | | <input type="checkbox"/> Parental Developmental Disability | | |
| <input type="checkbox"/> Family Conflict/Anger | <input type="checkbox"/> No Support System | | <input type="checkbox"/> Parental Substance Abuse | | |
| <input type="checkbox"/> Father Uninvolved | <input type="checkbox"/> No Transportation | | <input type="checkbox"/> Sibling/Chronic Illness/Disability | | |
| <input type="checkbox"/> Food/Other Necessities | <input type="checkbox"/> Parent/Chronic Illness | | <input type="checkbox"/> Single Parent | <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Parent/Cognitive Limitations | | <input type="checkbox"/> Teen Parent | | |
| <input type="checkbox"/> Housing/Homeless | <input type="checkbox"/> Parent/Mental Illness | | <input type="checkbox"/> Unemployment | | |
| Chronic Medical Conditions/Post Discharge (ICD-9 Codes): | | | | | |
| Hospital (Medical Care): <input type="checkbox"/> None <input type="checkbox"/> Inpatient <input type="checkbox"/> E.R. <input type="checkbox"/> Urgent Care Date: / / | | | | | |
| Reason for Hospitalization: | | | | | |
| REFERRALS TO OTHER PROVIDERS | | | CLOSED/REASONS | | |
| Agency | Status | Barriers | <input type="checkbox"/> Goals Met/Service Complete | | |
| AHCCCS | | | <input type="checkbox"/> Moved Out of State | | |
| AzEIP | | | <input type="checkbox"/> Lost to Follow-up | | |
| CPS | | | <input type="checkbox"/> Declined Nursing Follow-up (Initial Contact) | | |
| CRS | | | <input type="checkbox"/> Closed/Discharged (Receiving Other Services) | | |
| DDD | | | <input type="checkbox"/> AzEIP <input type="checkbox"/> DDD <input type="checkbox"/> Health Start | | |
| Early Head Start | | | <input type="checkbox"/> Early Head Start <input type="checkbox"/> Healthy Families | | |
| Health Start | | | <input type="checkbox"/> Voluntary Withdrawal (<i>Parent Declines Further Services</i>) | | |
| Healthy Families | | | <input type="checkbox"/> NICP Closed (<i>Low Risk</i>) | | |
| WIC | | | <input type="checkbox"/> Death Date: / / | | |
| Other: | | | | | |
| Date of Last Visit to PCP: / / | | | Date of Next CHN Visit: | | |
| CHN Signature | | | Date: / / | | |

Child's Name: _____

♥ Family Resources, Priorities and Concerns ♥

| Date discussed | Existing | Requested | May include existing or requested information, family, social, financial, professional & community services & support, such as WIC, SSI, Food Stamps | Outcomes |
|----------------|----------|-----------|--|----------|
| | | | | |

**Request for Participation
CHILDREN WITH SPECIAL HEALTH CARE NEEDS
COMMUNITY HEALTH NURSING SERVICES**

| | | | |
|-------------------------------------|----------------------------------|---------------------|-------------------------|
| Child's Last Name: | First Name: | MI: | Date of Birth: |
| Gender: | Gestational Age at Birth: | Birthplace: | Weight at Birth: |
| Address: | | City: | Zip: |
| Preferred Method of Contact: | | | |
| Telephone | Text | Email | |
| Home Phone: () | Msg Phone: () | Text: () | |
| Email Address: | | @ | |
| Mother's Name: | | | |
| Father's Name: | | | |
| Other Caregiver: | | | |
| Medical Home Provider: | | | |

The Office for Children with Special Health Care Needs (OCSHCN) in collaboration with the Office of Women's and Children's Health, High Risk Perinatal Programs, Community Health Nursing within the Arizona Department of Health Services (ADHS) supports eligible infants and children with special health care needs through referrals and linking families to services for which the infant or child may be eligible.

I request participation in the ADHS OCSHCN Community Health Nursing Program and authorize the one-time release of any necessary medical, social or other relevant information held by any institution or individual that provided services to my child to the Arizona Department of Health Services (ADHS) and to their contracted providers for provider quality management purposes. This release effective 1 year from the date of signature.

Date: _____ Parent/Guardian Signature _____

Date: _____ CHN or Hospital Representative _____

Reason for referral: _____

REQUEST: Approved Denied

Date: _____ OCSHCN Manager _____

ADHS/NICP ENROLLMENT STATUS CHANGE FORM

NICP

OCSHCN

| | | | |
|------------------------|------------|---------|-----|
| Child's Last Name | First Name | MI | DOB |
| Mother's Name | | | |
| Current Street Address | | | |
| City | State | Zipcode | |

- Address Change** (See above)
- Change in Primary Caregiver – Relationship:** _____
(insert change in address above)

Closed/Discharged

() **Death Date:** _____

() **Goals Met/Service Complete**

() **Moved (out-of-state)**
Address:

() **Lost to Follow up**

() **Declined Nursing Follow up** (initial contact)

() **Closed/Discharged** (receiving other services)

- AzEIP
- DDD
- Health Start
- Early Head Start
- Healthy Families
- Other: _____

() **Voluntary Withdrawal** (parent declines further services)

() **NICP Closed** (low risk)

() **Case transfer From:** _____ **To:** _____

Parental/guardian signature to release case file to new contractor:

Date: _____ **Contractor:** _____ **Signature:** _____

The Enrollment Status Change form is to be used to change enrollment status, to report a change of address (in-state or out-of-state) that was not reported on the visit form, report a change of primary caregiver (foster parent, adoption, etc.), and to transfer a case from one ADHS/NICP contractor to another ADHS/NICP Contractor.

Community Nursing Neonatal and Pediatric Assessment Form

Child's Name _____

Date of Birth _____

CATEGORY: PHYSICAL (Check and detail all abnormal findings)

| | Normal | Concerns | | Normal | Concerns |
|--------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| General Appearance | <input type="checkbox"/> | <input type="checkbox"/> | Skeletal | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | Extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| Head | <input type="checkbox"/> | <input type="checkbox"/> | CNS | <input type="checkbox"/> | <input type="checkbox"/> |
| ENT | <input type="checkbox"/> | <input type="checkbox"/> | GU | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | <input type="checkbox"/> | <input type="checkbox"/> | Nutrition/Feedings | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Tone | <input type="checkbox"/> | <input type="checkbox"/> |
| GI | <input type="checkbox"/> | <input type="checkbox"/> | Elimination | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Pattern | <input type="checkbox"/> | <input type="checkbox"/> |

Describe:

CATEGORY: DEVELOPMENTAL (Check and detail all concerns)

| | Age Appropriate | Concerns | | Age Appropriate | Concerns |
|--------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Gross Motor | <input type="checkbox"/> | <input type="checkbox"/> | Personal-social | <input type="checkbox"/> | <input type="checkbox"/> |
| Fine Motor | <input type="checkbox"/> | <input type="checkbox"/> | Behavior/Attachment | <input type="checkbox"/> | <input type="checkbox"/> |
| Language | <input type="checkbox"/> | <input type="checkbox"/> | Vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Adaptive/Self-Help | <input type="checkbox"/> | <input type="checkbox"/> | Hearing | <input type="checkbox"/> | <input type="checkbox"/> |

Describe:

THERAPIES:

CATEGORY : ENVIRONMENT (Check and describe)

| | Appropriate | Concerns | | Appropriate | Concerns |
|----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|
| Housing | <input type="checkbox"/> | <input type="checkbox"/> | External home safety | <input type="checkbox"/> | <input type="checkbox"/> |
| Utilities | <input type="checkbox"/> | <input type="checkbox"/> | Neighborhood safety | <input type="checkbox"/> | <input type="checkbox"/> |
| Transportation | <input type="checkbox"/> | <input type="checkbox"/> | Parental employment | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal home safety | <input type="checkbox"/> | <input type="checkbox"/> | Food/necessities | <input type="checkbox"/> | <input type="checkbox"/> |

Describe:

| | |
|--------------|-------------|
| Name: | DOB: |
|--------------|-------------|

CATEGORY : RELATIONSHIP/FAMILY (Check all that apply and describe)

| | Appropriate | Concerns | | Appropriate | Concerns |
|-------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| 2 Parent Family | <input type="checkbox"/> | <input type="checkbox"/> | Extended family | | |
| Single Parent | <input type="checkbox"/> | <input type="checkbox"/> | Other household members | <input type="checkbox"/> | <input type="checkbox"/> |
| Planned pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Daycare/childcare | <input type="checkbox"/> | <input type="checkbox"/> |
| Siblings | <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Primary caregiver | <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence | <input type="checkbox"/> | <input type="checkbox"/> |
| Teen Parent | <input type="checkbox"/> | <input type="checkbox"/> | Parent cognitive/mental illness | <input type="checkbox"/> | <input type="checkbox"/> |
| Foster care | <input type="checkbox"/> | <input type="checkbox"/> | Other: | | |

Describe:

IMPRESSION (Indicate risk status and if change in status occurred since last visit)

High
 Intermediate
 Low
 Change in risk status

Plan:

Signature _____

Date _____

Newborn Intensive Care Program

MEDICAL RISK CRITERIA FORM

MAJOR RISK FACTORS:

the presence of ONE risk factor qualifies the infant as “high risk”

<1250 grams at birth

<28 weeks gestation

Extracorporeal membrane oxygenation (ECMO)

High frequency ventilation

Nitric Oxide

Discharge home with oxygen

Abnormal neurological assessment

Seizures for other than metabolic reasons

Small for gestational age-symmetrical

Dysmorphic infant

Syndromes with known developmental delay/or unknown neurological outcomes

Congenital viral infections (CMV, Herpes, HIV)

Intra-ventricular hemorrhage (IVH) all grades

Periventricular leukomalacia (PVL)

Hydrocephalus

Meningitis

Microcephaly

Twin-to-twin transfusion syndrome

Substance abuse in utero (cocaine, Heroin, multiple drugs)

MINOR RISK FACTORS:

Two or More minor risk factors qualify infants as “high risk”

One minor risk factor qualifies infants for “At risk”

28-32 week gestation

Retinopathy of prematurity (ROP) grades III&IV

Confirmed hearing impairment

APGAR <4 at 5 minutes

Meconium respiratory distress syndrome

PPHN (Severe pulmonary hypertension)

Symptomatic hypoglycemia (BG<40)

Hypotension with pressor support

Hyperbilirubinemia: with exchange transfusion or a total of 25, or free above 1

Multiple birth

**Community Nursing Services
Reporting Form Instructions
REFERENCE TABLES**

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|------------------|-------------------------------|---------------|---------|--------------|------------------------------------|----------------|-------------|----------------------------|--------------------------------|---------------------|--------------|--------------------------|---------------------|------------|-----------|--|----------------------------|----------------------------|-----------|-----------------------|------|--------------------|----------|---------|------------------------|-----------------|---|----------|----------|--|
| 1. RACE (SELECT ONE) American Indian or Alaskan Native Black or African American Asian Native Hawaiian or other Pacific Islander White Other/Unknown | | 2. TRIBE (SELECT ONE) <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Apache</td> <td style="width: 33%;">Mohave</td> <td style="width: 33%;">Sioux</td> </tr> <tr> <td>Chemehuevi</td> <td>Navajo</td> <td>Tohono O'odham</td> </tr> <tr> <td>Cherokee</td> <td>Paiute (Kaibab)</td> <td>Ute</td> </tr> <tr> <td>Choctaw</td> <td>Pasqua Yaqui</td> <td>Washoe</td> </tr> <tr> <td>Cocopah</td> <td>Pima</td> <td>Yavapai</td> </tr> <tr> <td>Creek</td> <td>Pueblo</td> <td>Yuma</td> </tr> <tr> <td>Havasupai</td> <td>Quecham</td> <td>Zuni</td> </tr> <tr> <td>Hopi</td> <td>Seminole</td> <td>Unknown</td> </tr> <tr> <td>Hualapai</td> <td>Seneca</td> <td>Other (specify)</td> </tr> <tr> <td>Maricopa</td> <td>Shoshone</td> <td></td> </tr> </table> | | Apache | Mohave | Sioux | Chemehuevi | Navajo | Tohono O'odham | Cherokee | Paiute (Kaibab) | Ute | Choctaw | Pasqua Yaqui | Washoe | Cocopah | Pima | Yavapai | Creek | Pueblo | Yuma | Havasupai | Quecham | Zuni | Hopi | Seminole | Unknown | Hualapai | Seneca | Other (specify) | Maricopa | Shoshone | |
| Apache | Mohave | Sioux | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chemehuevi | Navajo | Tohono O'odham | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cherokee | Paiute (Kaibab) | Ute | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Choctaw | Pasqua Yaqui | Washoe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cocopah | Pima | Yavapai | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Creek | Pueblo | Yuma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Havasupai | Quecham | Zuni | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hopi | Seminole | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hualapai | Seneca | Other (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maricopa | Shoshone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. RESERVATION (SELECT ONE) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Ak-chin</td> <td style="width: 50%;">Maricopa AK Chin</td> </tr> <tr> <td>Camp Verde (Yavapai - Apache)</td> <td>Navajo Nation</td> </tr> <tr> <td>Cocopah</td> <td>Pasqua-Yaqui</td> </tr> <tr> <td>Colorado River (Mohave-Chemehuevi)</td> <td>Payson/Yavapai</td> </tr> <tr> <td>Fort Apache</td> <td>Salt River (Pima-Maricopa)</td> </tr> <tr> <td>Fort McDowell (Yavapai-Apache)</td> <td>San Carlos (Apache)</td> </tr> <tr> <td>Fort Mohave</td> <td>San Juan Southern Paiute</td> </tr> <tr> <td>Fort Yuma (Quechan)</td> <td>San Xavier</td> </tr> <tr> <td>Gila Bend</td> <td>Tohono O'odham (Formerly Papago)</td> </tr> <tr> <td>Gila River (Pima-Maricopa)</td> <td>Yavapai-Prescott (Yavapai)</td> </tr> <tr> <td>Havasupai</td> <td>White Mountain Apache</td> </tr> <tr> <td>Hopi</td> <td>Zuni Pueblo</td> </tr> <tr> <td>Hualapai</td> <td>Unknown</td> </tr> <tr> <td>Kaibab-Paiute (Paiute)</td> <td>Other (specify)</td> </tr> </table> | | Ak-chin | Maricopa AK Chin | Camp Verde (Yavapai - Apache) | Navajo Nation | Cocopah | Pasqua-Yaqui | Colorado River (Mohave-Chemehuevi) | Payson/Yavapai | Fort Apache | Salt River (Pima-Maricopa) | Fort McDowell (Yavapai-Apache) | San Carlos (Apache) | Fort Mohave | San Juan Southern Paiute | Fort Yuma (Quechan) | San Xavier | Gila Bend | Tohono O'odham (Formerly Papago) | Gila River (Pima-Maricopa) | Yavapai-Prescott (Yavapai) | Havasupai | White Mountain Apache | Hopi | Zuni Pueblo | Hualapai | Unknown | Kaibab-Paiute (Paiute) | Other (specify) | 4. SERVICE SETTING (SELECT ONE) Child Care Center/Nursery School Clinic/Outpatient Service Facility Community Setting Early Intervention Classroom/Center Extended Day Care Facility Family Day Care (baby sitter) Hospital Home Residential Facility Other (specify) | | | |
| Ak-chin | Maricopa AK Chin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Camp Verde (Yavapai - Apache) | Navajo Nation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cocopah | Pasqua-Yaqui | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Colorado River (Mohave-Chemehuevi) | Payson/Yavapai | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fort Apache | Salt River (Pima-Maricopa) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fort McDowell (Yavapai-Apache) | San Carlos (Apache) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fort Mohave | San Juan Southern Paiute | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fort Yuma (Quechan) | San Xavier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gila Bend | Tohono O'odham (Formerly Papago) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gila River (Pima-Maricopa) | Yavapai-Prescott (Yavapai) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Havasupai | White Mountain Apache | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hopi | Zuni Pueblo | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hualapai | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kaibab-Paiute (Paiute) | Other (specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. CHRONIC MEDICAL CONDITIONS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 285.9 Anemia 767 Birth Trauma 425 Cardiomyopathy 749 Cleft Lip/Palate 315.3 Delayed Language 277 Cystic Fibrosis 437.50 Gastrostomy 783.4 Failure to Thrive 741.9 Myelomeningocele 530.11 Esophageal Reflux 742.1 Microcephaly 780.3 Seizures V55.0 Tracheostomy | | 770.8 Apnea 369.0 Blindness 343.9 Cerebral Palsy 771.2 Cytomegalovirus 743.3 Cataract 759.9 Congenital Anomaly 760.71 Fetal Alcohol Syndrome 767.6 Erb's Palsy 227.9 Metabolic Disorder 756.79 Gastroschisis 753.29 Hydronephrosis 493.9 Asthma 748.3 Tracheomalacia 741.0 VP Shunt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 770.7 Bronchopulmonary Dysplasia (BPD) 427.9 Cardiac Dysrhythmia 758.9 Chromosome Abnormality 443.20 Colostomy 428.0 Congestive Heart Failure 779.5 Drug Withdrawal 315.9 Delayed Development 042 HIV/AIDS 783.3 Feeding Difficulties 382.9 Chronic Otitis Media 331.4 Hydrocephalus (Acquired) 268.0 Rickets 362.21 Retinopathy of Prematurity (ROP) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. REFERRAL STATUS (use letter code) A. Is receiving service(s) B. Not receiving service(s) C. Referral Made D. Service(s) completed E. Service(s) declined | | 7. BARRIERS (use letter code) A. Child Care not available B. Eligibility determination not completed C. Illness D. Ineligible E. Language Barrier F. Limited hours of service G. Service(s) not available in community H. Transportation not available I. Inadequate finances | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**INVOICE
ADHS COMMUNITY HEALTH NURSING**

Payable to:

Contract Number:

P. O. Number:

Billing Period: From:

To:

| Service | Unit Rate | NICP | | MCHBG | | OCSHCN-1 | | NBS | | Addl \$ | |
|------------------------------------|-----------|------|-------|-------|-------|----------|-------|-----|-------|---------|-------|
| | | # | Total | # | Total | # | Total | # | Total | # | Total |
| Interim Local | | | | | | | | | | | |
| | | | | | | | | | | | |
| Reg Local | | | | | | | | | | | |
| | | | | | | | | | | | |
| Out-of-town | | | | | | | | | | | |
| | | | | | | | | | | | |
| Out-of-county | | | | | | | | | | | |
| | | | | | | | | | | | |
| Shadowing local | | | | | | | | | | | |
| | | | | | | | | | | | |
| Shadowing nonlocal | | | | | | | | | | | |
| | | | | | | | | | | | |
| Family Visit Local | | | | | | | | | | | |
| | | | | | | | | | | | |
| Multi-Disciplinary/ staffing Local | | | | | | | | | | | |
| | | | | | | | | | | | |
| Low risk letter | | | | | | | | | | | |
| | | | | | | | | | | | |
| Training/Local * | | | | | | | | | | | |
| | | | | | | | | | | | |
| Training/ Non-Local * | | | | | | | | | | | |
| | | | | | | | | | | | |
| NBS Follow Up | | | | | | | | | | | |
| | | | | | | | | | | | |
| TOTALS | | | | | | | | | | | |

* Attach Title of Training and list of attendees

| | |
|-----------------------------|--------------|
| Contractor Signature | Date: |
| ADHS Approval | Date: |

| For ADHS Use Only | | | | | | |
|-------------------|--------------|---------------|------------------|-------------|------------------|-------|
| PROGRAM | Line 1 -NICP | Line 2 - MCHB | Line 3 - OCSHCN1 | Line 4 -NBS | Line 5 - Addl \$ | TOTAL |
| INDEX: | 43010 | 99201 | 99209 | 45001 | | |
| PCA: | 43440 | 43400 | 43440 | 67400 | | |
| TOTALS | | | | | | |

**ARIZONA DEPARTMENT OF HEALTH SERVICES
COMMUNITY NURSING SERVICES
SITE REVIEW GUIDE**

| | |
|-------------|----------------|
| Contractor: | Date: |
| Attendees: | ADHS Reviewer: |

H=Have R=Requested O=Observation

C=Compliant P=Partially Compliant N=Non-Compliant

| STANDARD | | Source | COMMENTS |
|---|--------|----------------------|----------|
| PROGRAM ADMINISTRATION | | | |
| 1. The Contractor has at least one individual dedicated to the administration and oversight of the program (program coordinator). (Contract/Scope of Work) | O | Site Visit Interview | |
| 2. The Contractor has sufficient and adequate staff (registered nurses, social workers and/or early interventionists) to support the contractual requirements of the Community Nursing Services program. (Contract Scope of Work) | O | Site Visit Interview | |
| 3. CHN Contract providers shall participate in the discharge planning process as outlined. (P&P Chapter 3) | O | Site Visit Interview | |
| 4. CHN Providers shall collaborate with other community partners and participate in multidisciplinary staffing meetings as appropriate. (P&P Chapter 3) | O | Site Visit Interview | |
| 5. The Contractor shall submit written educational or marketing materials prepared by the Contractor for review & approval by the CNS Program Manager. (P&P Chapter 3) | O H | Site Visit Review | |

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|--|--------|---|--|
| 6. The Contractor stores and maintains all Administrative records for five years beyond the end date of the contract. (P&P Chapter 13) | O H | Site Visit Interview, Contractor records | |
| 7. The Contractor stores and maintains all Client Records in a safe, secure location for a minimum of five years beyond the last date of service. (P&P Chapter 13) | O H | Site Visit Interview, Client files, Contractor policy | |
| 8. The Contractor has established a network of resources available to which participants could be referred for services they may need. In circumstances where resources do not exist within the community served, Contractor documents the gap in services and attempts to refer the family to equivalent services in another community. (Contract, Scope of Work) | O R | Site Visit Interview, Quarterly Report, Contractor record | |
| 9. Within 30 days after the end of the service month, the Contractor submits the billing invoice, and a log of all clients seen during the service month. (Contract, Deliverables) | H | Billing Invoices and logs | |
| 9. Contractor shall notify the ADHS Community Nursing Program Manager of any new professional staff and changes to existing staff within 30 days of the change (P&P Chapter 7) | | | |
| | | | |
| STAFF RECRUITMENT/CREDENTIALING | | | |
| 1. Contractor assures that providers review the Policies and Procedures on an annual basis. (P&P Chapter 7) | R | Site Visit Interview | |

| | | | |
|---|--------|--|--|
| 2. Contractors provide the ADHS Program Manager with a list of providers who are working within the Program. Changes in staffing must be reported to the Program Manager within 30 days of the change. (P&P Chapter 7) | H | Site Visit Interview, Quarterly Report | |
| 3. Contract providers shall meet the educational and experience requirements as noted in the Policy and Procedure Manual. (P&P Chapter 7) | R O | Personnel Records | |
| 4. Contractor shall establish a mechanism for ongoing review of staff's level of professional competence including coping, communication, and assessment skills. (P&P Chapter 7) | R O | Provider files | |
| 5. Contractor shall maintain a team of providers that have experience in working with infants/children and families and meet the educational requirements as outlined in the Policy Manual. Requests for exception are communicated in writing to the Program Manager for Community Nursing Services. (P&P Chapter 7) | R O | Provider files | |
| STAFF EDUCATION | | | |
| 1. Basic orientation must be completed by the contract provider before unsupervised client home visits may be initiated. The balance of the orientation process must be completed within six months of hire date. (P&P Chapter 7) | R O | Orientation and Training Log | |
| 2. A continuing education plan is developed annually for all providers that includes the training needs of the individual. (P&P Chapter 7) | R O | Personnel Records | |
| 4. Contract providers are strongly encouraged to attend NICIP/OCSHCN supported meetings, conferences and workshops. (P&P Chapter 7) | O | Training logs | |

| DOCUMENTATION | | | |
|--|--------|---------------------------------------|--|
| <p>1. Contractor shall maintain documentation of the following provider credentials: (P&P 6.1)</p> <ul style="list-style-type: none"> • Staff orientation/training • Current Arizona Nursing Licensure • Certification/licensure for EI or Social Work staff • Continuing Education for previous year • Annual Review of Standards of Care | R O | Provider File Review | |
| <p>2. The Home Visitor documents all pertinent information about client interactions in a confidential client case file. The Home Visitor maintains entries in the file that reflect professional, nonjudgmental statements of fact.</p> | R O | Client File Review | |
| <p>3. The Client file shall contain at a minimum: Request for Participation (NICP or CSHCN), Discharge Summary, Physical Assessments including Growth Charts, Developmental Screenings, Family Service Plan, Data Collection forms corresponding to each visit, and nursing notes.</p> | | Client Files | |
| HOME VISITING/ASSESSMENT | | | |
| <p>1. Initial contact with the family shall occur within one week of discharge from the Hospital or the date the referral is received. Exceptions shall be documented in client file. (P&P Chapter 4,5,6)</p> | R O | QA Report Client File Review | |
| <p>2. The initial visit is provided within two weeks after referral; Exceptions are documented in client file. The first home visit shall be provided by a CHN. (P&P Chapter 4,5,6)</p> | R O | Client File Review | |
| <p>3. Children who have ongoing medical problems shall be visited on a regular basis by the RN. (Contract Requirements/Scope of Work)</p> | O | Client File Review | |
| <p>4. Based on discussions with the family, the home visitor will develop a HRPP/NICP Plan as outlined in Policies. (P&P Chapter 8)</p> | O | Site Visit Interview, Client files | |
| <p>5. Periodic developmental assessments are provided using the Ages & Stages Questionnaire, Denver II or other appropriate screening tool. (P&P Chapter 8)</p> | R O | Client File Review | |

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| 6. Referrals are made to appropriate community resources with documentation of “status” and “barriers” as indicated. (P&P, Chapter 6) | R O | Client File Review | |
| 7. Client files include documentation of periodic physical, developmental, and environmental assessment based on the needs of the child and family. (P&P Chapter 8) | O | Client File Review | |
| QUALITY IMPROVEMENT PROCESS | | | |
| 1. Contractor has developed an Annual Quality Management Plan, which includes at a minimum, two indicators of quality service delivery. (P&P Chapter 11) | O R | Quarterly Reports Contractor files | |
| 2. Quarterly Reports include progress on all indicators and a Summary of Accomplishments, Issues/Barriers, and Goals for the next quarter. Quarterly reports are submitted in October, January, April, and July. (Contract Deliverables) | O H | Site Visit Interview, Quarterly Report | |
| 3. The Contractor has developed and implemented a process for addressing and resolving Client Complaints , issues, and concerns in a timely manner. (P&P Chapter 13) | O | Site Visit Interview, Contractor policy | |
| 4. Contractor participates in Client Satisfaction Surveys as part of the Continuous Quality Improvement Process. (P&P Chapter 13) | O H | Site Visit Interview, Quarterly Report | |

PROGRAM STRENGTHS/ACHIEVEMENTS:

FUTURE PLANS

COMMENTS BY THE EVALUATOR:

ADHS COMMUNITY NURSING PROGRAM

CHART REVIEW AUDIT

Contractor:

Contract #:

County:

Chart Auditor:

Date of Audit:

| INDICATOR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | RESULT | COMPLIANCE |
|--|---|---|---|---|---|---|---|---|---|----|--------|------------|
| CONSENT FORM (RFP or OCSHCN FORM) | | | | | | | | | | | | |
| DISCHARGE SUMMARY | | | | | | | | | | | | |
| DEMOGRAPHICS CHARTED | | | | | | | | | | | | |
| ADJUSTED AGE DOCUMENTED | | | | | | | | | | | | |
| TYPE OF VISIT DOCUMENTED | | | | | | | | | | | | |
| DEVELOPMENTAL RESULTS DOCUMENTED (CHN FORM & TOOL) | | | | | | | | | | | | |
| IMMUNIZATION ASSESSMENT DOCUMENTED ON CHN FORM | | | | | | | | | | | | |
| CAR SEAT USAGE DOCUMENTED ON CHN FORM | | | | | | | | | | | | |
| PHYSICAL ASSESSMENT DOCUMENTED (Including growth measurements) ON CHN FORM | | | | | | | | | | | | |

| INDICATOR | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | RESULT | COMPLIANCE |
|---|---|---|---|---|---|---|---|---|---|----|--------|------------|
| CODES DOCUMENTED NURSING INTERVENTIONS CHRONIC MEDICAL CONDITIONS SOCIAL ISSUES/FAMILY INTERACTION | | | | | | | | | | | | |
| HOSPITALIZATION/MEDICAL CARE DOCUMENTED | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| REFERRALS DOCUMENTED REFERRAL MADE (Initial or Follow Up) REFERRAL STATUS BARRIERS TO SERVICE | | | | | | | | | | | | |
| PRIMARY CARE PHYSICIAN DOCUMENTED | | | | | | | | | | | | |
| NURSE=S SIGNATURE (or SOCIAL WORKER) | | | | | | | | | | | | |
| FAMILY SERVICE PLAN COMPLETED | | | | | | | | | | | | |