ARIZONA
HEALTH START
PROGRAM

POLICY & PROCEDURE MANUAL

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

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Leadership for a Healthy Arizona

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11. QUALITY MANAGEMENT AND IMPROVEMENT

12. PROGRAM MONITORING AND EVALUATION

CHAPTER 1
INTRODUCTION

1.1 Health Start Program Background and Description

In 1982, Arizona began experiencing a steady increase in the rate of women receiving inadequate or no prenatal care, and in 1984 the Rural Health Office of the University of Arizona College of Medicine in the Department of Family and Community Medicine developed community health worker programs to address gaps in the health care infrastructure in Arizona. One of the earliest programs, “Un Comienzo Sano/A Health Beginning” was established to deliver prenatal and perinatal care particularly among rural and minority populations. By 1990, the state was ranked 45th in the nation for the number of women receiving adequate prenatal care. Many Arizona women experience barriers that kept them from seeking prenatal care. These barriers encompass a number of social and cultural factors, as well as geographical accessibility. African American, Hispanic, and Native American women are four times more likely than Anglos (non-Hispanic Whites) to receive no prenatal care. These same groups have the highest infant mortality rates in Arizona, and the low birth weight rate among African Americans is twice that of any other group.

Teens comprise a growing number of pregnant women. They are three times more likely to receive inadequate or no prenatal care than are older women, and are therefore at special risk for poor pregnancy outcomes. The cultural, emotional and financial problems encountered by teens add to their risk for complications during pregnancy. Barriers to adequate prenatal care, both real and perceived, also contribute to poor pregnancy outcomes for this group.

Since 1985, Arizona has experienced persistent outbreaks of vaccine-preventable diseases among its children. This is due in large part to the state's low immunization rates, particularly among its disadvantaged children. Although efforts to improve immunization rates have increased in recent years, success rates for children younger than 4 have lagged behind. Statistics indicated that statewide only 48% of two-year-olds have completed the basic series of immunizations. In rural Arizona, the rate drops to 40%, putting Arizona third which is 13% below the national average. Current local research confirms that minority children account for the majority of the under-immunized group and comprise the fastest growing segment of the population.

In 1992, the Health Start Program was established in Arizona, administered by the Arizona Department of Health Services' (ADHS) Office of Women's and Children's Health. Health Start is a neighborhood outreach program that helps high-risk pregnant women obtain early and consistent prenatal care

and, for their children, timely immunizations. Early and continuous prenatal care is one core determinant that is associated with the prevention of low birth weight and birth defects. It also ensures adequate immunizations that are provided protect women and children from preventable diseases.

From July 1993 through June 1994, there were over 1,000 pregnant women served in seven (7) neighborhood/community locations throughout Arizona. During this time period, follow up for infants to age two and their siblings was initiated through funding provided by a three year grant from the National Association for the Education of Young Children.

In 1994, the passage of the Arizona Children and Families Stability Act formalized and expanded several early intervention programs for Arizona's high-risk children and families, including the Health Start Program. The legislation established overall goals and structure for the program, and extended the family follow-up period from two years to four years.

In March of 1998, the Health Start program was notified that the Legislature funding for the Health Start Program would cease (FY1998). In July 1998, the Prenatal Outreach Program was established with Federal and donated funds. Prenatal Outreach with seven sites followed the same guidelines as Health Start except that the children were only followed until the age of two, group classes were added to the curriculum, and all the recommended changes from the Auditor Generals Report were added. In May 1999, the FY 2000 Health Start Program was funded by the State Legislature – general funds until June 2004, and was expanded to cover postpartum women. In August 1999 (FY 2000), eight Health Start sites were implemented which served 1312 prenatal women, 9 postpartum women, 202 non pregnant women (Family Planning only), and 599 children. Health Start increased to fifteen sites in July 2000 (FY2001), and served 3057 pregnant women, 68 postpartum women, 367 non-pregnant women (Family Planning only), and 1147 children. In FY 2005, the program issued another Request for Proposal (RFP) and funded 16 programs for 5 years until June 2010. Two of the projects terminated their contracts with ADHS. Funding for the program during the last 5 years, was provided through a mix of state general funds and state lottery funds until state funds were cut. Currently, the program is funded solely by Arizona State Lottery funds at approximately 1.6 million dollars. In 2009, there were 2,319 unduplicated clients served and 13,922 visits provided.

Using community health workers who reflect the ethnic, cultural and socioeconomic makeup of the neighborhoods they serve, the Health Start Program connects pregnant/ postpartum women with community resources that provide prenatal and related infant/ child services. The families are followed for two years after the birth of the child to assist with identification of a "medical home" for each family member and to encourage immunizations

for all children in the family. The community health workers also provide education on normal child development and parenting skills, and may serve as a referral source in the identification of children with special needs.

Health Start recruits community health workers from within the targeted communities because it is felt that they are most knowledgeable of the local customs, problems, cultures and service system. By utilizing neighborhood or community health workers, the program works to assure that the program respects the differences in culture, family structure, personal and family resources which are found in the different communities throughout the state, while addressing the needs of women, children and their families based on the unique characteristics of the community in which they live. By making the program sensitive and responsive to local concerns, Health Start attempts to promote collaborative efforts within the community to improve the health of women, children and their families.

1.2 Mission Statement

The mission of the Health Start Program is to educate, support, and advocate for families at risk by promoting optimal use of community based family health and education services through the use of community health workers, who live in, and reflect the ethnic, cultural and socioeconomic characteristics of the community they serve.

1.3 Program Goals and Objectives

The overall goals of the Health Start Program, as determined by Arizona State Statue 36-697 are:

1. Increase prenatal care services to pregnant women.
2. Reduce the incidence of infants who at birth weigh less than one thousand five hundred grams (1,500 grams, 3 lbs 4 oz) and who require more than seventy-two hours of neonatal intensive care.
3. Reduce the incidence of children affected by childhood diseases.
4. Increase the number of children receiving age appropriate immunizations by two years of age.
5. Increase awareness by educating families:
    - On the importance of good nutritional habits to improve the overall health of their children.
    - On the need for developmental assessments to promote the early identification of learning disabilities, physical handicaps or behavioral health needs.
    - Of the benefits of preventative health care and the need for screening examinations such as hearing and vision.

1.4 Services To Be Provided

The core service(s) in the Health Start Program is the family-centered continuum of basic prenatal and family health education, referral, and advocacy services. The services are delivered through prenatal and family follow-up visits to enrolled clients and families, and prescheduled classes. Services are most commonly provided at a prescheduled home visit, in the client's primary residence, but can be provided in the child's natural environment. The service may also be provided at other community/ neighborhood locations, based on client need and preference. Client visits may also be provided upon approval by ADHS in temporary alternative living situations including but not limited to rehabilitation centers, jails, inpatient treatment centers or homeless shelters on a case by case basis.

Per ARS 36-697, the Health Start Program, through its community health workers, shall:

1. Identify pregnant women and postpartum mothers in the community health worker's neighborhood or community, and enroll them in the program.

2. Inform clients of how to receive prenatal care services.

3. Assist clients to access appropriate prenatal care.

4. Educate clients on appropriate prenatal and neonatal care, preventative health care and child wellness, including appropriate nutritional habits to improve the overall health of their children.

5. Assist and encourage clients to provide age appropriate immunizations so that their children are fully immunized by two years of age.

6. Assist and encourage clients and their families to access comprehensive public and private preschool and other school readiness programs.

7. Assist clients to apply for private and public financial assistance.

8. Assist clients and their families to access other applicable community and public services, including employment services.

9. Provide clients with a list of local private, both non-profit and for profit, and public educational institutions and governmental agencies that provide program and referral services (Arizona Family Resource Guide).

10. Assist clients to access adult services including, continuing education, employment & other community involvement, such as religious or social services, as appropriate.

1.5 Overview of ADHS and Contractor Roles

The formalization of the Health Start Program into Arizona law (ARS 36-697) has increased the scope and funding for Health Start services. The Arizona Department of Health Services (ADHS) is designated as the state agency responsible and accountable for program goals and expenditures. With the expansion of the program, and a subsequent increase in program documentation requirements, there is a commensurate need for ADHS to establish a high-level structure and framework for attaining program goals and objectives.

ADHS provides the criteria, policies, and requirements for developing and implementing the Health Start Program in a neighborhood or community. These requirements include community health worker training guidelines and employment guidelines that include background checks for all program personnel who have direct contact with pregnant and postpartum women and their families or who will have access to program participant records. These guiding principles reflect the core requirements of the legislation (ARS 36-697), while also attempting to promote the community/client-centered approach that is the cornerstone of the program.

ADHS contracts with local public and private agencies (Contractors), who recruit, train, and manage a unique group of service providers, called community health workers. Community health workers reach out to eligible women in their communities to enroll them in the program. They provide basic prenatal and family health education, referral, and advocacy services. Health Start is a link for clients to programs that reduce illiteracy, encourage employment, self-sufficiency and community involvement. Contractors develop and oversee a network of resources and referral sources that the community health workers utilize to serve the Health Start clients. Contractors, utilizing methods that are appropriate for the demographics and particular characteristics of their community, determine how to achieve program standards and desired outcomes. Within the framework of the Health Start Program is the flexibility for Contractors to implement the program in a manner that "fits" their neighborhood or community.

ADHS and its Contractors share a dynamic role in the continued expansion and evolution of Arizona's Health Start Program to include preconception and interconception care education, screenings, and limited services by community health nurses. ADHS performs a variety of roles in the oversight of the Health Start Program: monitor; regulator; partner; facilitator; technical advisor; educator, and payer. In addition to working with the Contractors to distribute the Arizona Family Resource Guide compiled under section 36-698 to Health Start clients, ADHS also distributes the resource guides to hospitals, physician health clinics, and other home visiting programs.

Within the structure and framework of the Health Start Program, ADHS has delegated responsibility to Contractors to develop, implement, and manage all aspects of the program at the contracted site. Management responsibilities include, but are not limited to: administrative and support staff; program site organization and operations; community health worker recruitment, training, and monitoring; referral and information networks; service delivery systems; program documentation; quality management activities; and, site-specific program evaluation activities. Additional information about the roles and responsibilities of ADHS and Health Start Contractors is contained in various sections throughout this policy manual.

1.6 Services to be Referred

The "agents" for delivering Health Start Program services are community health workers. These community health workers provide basic health education, referral, and advocacy services for at risk pregnant women and postpartum mothers in their communities. Community health workers can be thought of as a **catalyst** in helping pregnant women/mothers and their families to access prenatal care, and preventive medical care and services.

Community health workers **must refer** any potential or identified need for medical diagnosis or treatment, preventive health care services, behavioral health services, or social services to a qualified health care or social services professional or provider. The family must be followed until the advanced services are obtained. Contractors are responsible for monitoring the appropriateness of these service referrals. Community health workers coordinate their clients care with hospitals, physicians, and other community agencies.

1.7 Year 2010 Overview

Building on the health objectives established during Healthy People 2010 and Healthy Arizona 2010 new plans and objectives to be achieved by the year 2020 are being reviewed at the national level and developed in Arizona. The Health Start Program addressed a variety of the Arizona Healthy People 2010 objectives in the areas of Nutrition, Immunization and Infectious Diseases, Access to Care, Injury and Violence Prevention and Maternal and Child Health.

1.8 How To Use This Manual

The purpose of this manual is to document the Health Start Program's policies for development, implementation, and management of the program. The manual is to be used as a reference and information resource for Health Start Program Contractors, ADHS Administration, and other interested parties.

This manual will be reviewed and revised as changes occur in the program. Suggestions for changes to the manual to clarify a policy or to update a procedure may be sent in writing or by fax to the Health Start Program Manager at the address below. These suggestions will be considered during the review process.

Revisions to the manual will be available to all Contractors and other entities through the ADHS website. Revisions will be released 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 question or concern, if you have suggestions for additional information that can be included in the policy manual, or if you wish to be placed on the distribution list for the manual, please contact the Health Start Program Manager at the following address:

Health Start Program Manager
Arizona Department of Health Services
Bureau of Women's and Children's Health
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007

CHAPTER 2
GLOSSARY

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, including the Health Start Program.

AHCCCS

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

ATTEMPTED VISIT

An attempted visit is when the community health worker goes to the client's home or designated meeting place and does not have a face-to-face contact with the client.

AzEIP

Arizona Early Intervention Program (AzEIP). OCSHCN provides services to children with special care needs, and has service providers located in the counties throughout the state. If a child tests suspicious after a repeat Ages & Stages Developmental Assessment, they would be referred to this agency. This program has many services for children with special needs, and works closely with NICP & Health Start.

BACKGROUND CHECK

A review of relevant personal background and references. A background check is required for each potential community health worker and also any Contractor personnel who will have direct contact with Health Start clients or access to program participant's records. Minimum requirements for a background check include at least two non-family references and an affidavit that the person has not committed a felony or a misdemeanor involving moral turpitude. A Department of Public Safety Fingerprint Card is highly recommended.

CASE FILE RECORD

A confidential written record of services and client contacts that is maintained for each enrolled Health Start client.

CASELOAD

Refers to the number of clients, both prenatal and family follow-up, being served by an individual community health worker or community health nurse. Contractors are expected to monitor the caseloads of the community health workers and community health nurses to ensure that the services provided are appropriate for client's needs, and properly documented.

CASE MANAGEMENT

Refers to a method of service delivery that consists of community health workers, nurses, social workers, counselors and any other person deemed necessary to provide services to the clients. Some counties have as many as four teams, while other counties function as one large team. The team comes together at regular intervals for case conferencing of their clients. This method provides for better coordination between the Health Start members, and better coordination of client care.

CLIENT

An enrolled pregnant woman or mother who receives Health Start services.

COMMUNITY HEALTH NURSE (CHN)

A community health nurse is a registered Professional Nurse (R.N.) who provides high risk nursing home visit services to infants who have been in the Neonatal Intensive Care Unit (NICU) for five days or longer and are enrolled in Health Start and are not followed by High Risk Perinatal Program (HRPP).

COMMUNITY HEALTH WORKER (CHW)

A community health worker is an individual who has been specially trained to reach out into the community to identify pregnant/postpartum women, to provide information and education about specific topics, and to provide support and advocacy to help them access resources which they may need. Community health workers reflect the ethnic, cultural and socio-economic makeup of the neighborhoods they serve.

COMPLETED FAMILY FOLLOW-UP

The term used when the client has completed the family follow-up period (the index child who precipitated enrollment in the Health Start program has attained his/her second (2) birthday), thereby completing the Health Start Program.

CONTRACTOR

A public or private organization that has a contract with the Arizona Department of Health Services to develop, manage, and provide Health Start services in a designated Program Site.

CORE CURRICULUM

A basic set of minimum information that is provided to community health workers to assist them in providing services to Health Start clients.

DES

Department of Economic Security (DES). DES is an Arizona State agency that is responsible for determining eligibility for Federal assistance for low-income persons (Medicaid). DES also administers Arizona's Child Welfare Program, which includes Child Protective Services (CPS).

DISENROLLMENT

When a client is no longer participating in the Health Start Program. This can result from the following situations: Completed Family Follow-up; Withdrew From the Program; Lost To Follow-up/Moved; Refused Family Follow-up; Referred To A Specialized Program; or a Pregnancy Loss.

DISTRICT

The six major designated service areas in Arizona as designated by DES.

ELIGIBILITY

Pertains to meeting the requirements for enrollment in the Health Start Program. Please refer to Chapter 6 for more information on eligibility for Health Start services.

ENROLLED CLIENT

Enrolled clients are pregnant or post partum women living in a targeted neighborhood/community who have: met eligibility criteria, received information about the Health Start Program, signed the Intent to Participate form for services, and enrolled in the program.

ENROLLMENT

A process of voluntary request to receive Health Start services, occurring after verification of pregnancy and medical/social risk factors or post partum medical/social risk factors.

FAMILY

For purposes of the Health Start Program, a family unit is defined as a pregnant woman/mother and any persons residing in the same household, whom the pregnant/mother woman considers a part of her nuclear family.

FAMILY PLANNING

Family planning refers to the concept of persons making and implementing personal decisions regarding reproduction, including measures to prevent unintended pregnancies to ensure birth spacing. Family planning education and referral services are provided by community health workers to enrolled clients in the Health Start Program and to non-enrolled women who are provided negative pregnancy test services. Family planning education helps clients make informed decisions about various family planning methods available.

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical mental, behavioral, and/or learning disabilities with possible lifelong implications.

FETAL ALCOHOL SPECTRUM DISORDER (FASD) SCREENING AND BRIEF INTERVENTION EDUCATION

Fetal Alcohol Spectrum Disorders (FASD) Screening and Brief Intervention refers to the required screening of all enrolled pregnant Health Start women using the Screening Tool Form and the prevention education provided to eligible clients.

FAMILY FOLLOW-UP CLIENT

A family follow-up client is a woman who was enrolled while pregnant or enrolled after delivering the index child (postpartum enrollment) and is now receiving family follow-up services through the Health Start Program. Family follow-up services include: postpartum education, child development education, referral services, immunization follow-up and referral, health maintenance education, assistance in identification of early childhood education programs, assistance in identification of a medical home, assistance in accessing medical or financial assistance programs, and community, social, or faith-based services.

GROUP CLASSES

Group prenatal, postpartum, and childhood care classes that are held by the contractor. Each class must consist of four or more enrolled Health Start clients.

HEALTH START TEAM

A group of ADHS and other individuals who guide and shape the development and implementation of the Health Start Program**.**

HIGH RISK PERINATAL PROGRAM/NEWBORN INTENSIVE CARE PROGRAM (HRPP/NICP)

The High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/NICP) is a comprehensive, statewide system of services dedicated to reducing maternal and infant mortality (deaths) and morbidity (abnormalities that may impact a child's growth and development). The program provides a safety net for Arizona families, to ensure the most appropriate level of care surrounding birth as well as early identification and support for the child's developmental needs.

HOME VISIT

A one-on-one, face-to-face contact between the community health worker or community health nurse and the Health Start client that occurs in a place of residence.

IDENTIFIED/TARGETED NEIGHBORHOOD

Refers to a neighborhood or community that has been chosen through a needs assessment by a contractor as having distinctive needs or the type of profile that would qualify community residents to receive Health Start services.

INDEX CHILD

Is the child born to the enrolled client that will be followed in family Follow-up until two years of age.

INTENT TO PARTICIPATE

Intent to Participate refers to the obtaining of knowledge or information about the Health Start Program, including benefits, risks, terms of participation, and client rights and responsibilities prior to enrollment in the program. A signature on the Intent to Participate form indicates the potential client's desire to receive services, their understanding of the level of services chosen, the terms of participation in the program, that they voluntarily want to participate and their agreement that data gathered will be shared with the Arizona Department of Health Services.

INTERCONCEPTION / PRECONCEPTION

Interconception health is a woman's health between pregnancies. Preconception health is a women's health before she becomes pregnant. Preconception care promotes the health of women of reproductive age before conception and thereby improving pregnancy related outcomes.

LOST TO FOLLOW-UP/MOVED

Is the term used when the community health worker made at least three unsuccessful attempts to personally visit the client with no response from and/or contact from the client. The community health worker can terminate the client's enrollment in the program.

MEDICAL HOME

An established source for receiving routine medical care that is recognized by the client.

MULTIPLE-CHILD VISIT

A Family Follow-Up Visit for a woman where there is more than one index child (multiple birth or previous index child whose birth was recorded with the program), contractor must submit a separate Family Follow-Up Visit form for the subsequent child. A prenatal visit for a woman where there is a child under the age of two (2) enrolled in Health Start, that is also being visited on the same day, Contractor must submit a separate family follow-up form for that child.

NEEDS ASSESSMENT

A needs assessment is a specific study or analysis that is conducted by a public or private organization to determine potential communities or neighborhoods that may meet the desired criteria of need for Health Start funding. These criteria include: incidence of inadequate prenatal care and infant health care, low birth weight babies, or inadequate childhood immunizations.

NEGATIVE PREGNANCY TEST SERVICES

Services provided to a woman including a pregnancy test (with negative results) and interconception/preconception education by a community health worker lasting a minimum of 30 minutes.

NEIGHBORHOOD/ TARGET COMMUNITY

A group of individuals who are distinguished by particular demographic characteristics, which may include, but are not limited to: geographic location, age, ethnic, cultural, or religious preferences.

NETWORK

For purposes of this policy manual, a network is a collection of service resources or information pathways that have been developed by the Health Start Program Contractor. This network allows the community health workers to assist clients in accessing appropriate information, education, medical, social, and financial services.

NICP

The Newborn Intensive Care Program (ADHS) provides nursing and developmental care to babies who spend five days or longer in the Newborn Intensive Care Unit after birth.

OUTREACH

Methods used to locate and identify prospective Health Start clients in the neighborhood or community being served.

OUTREACH PLAN

A comprehensive plan prepared by the Health Start Contractor that outlines strategies, objectives, and action steps for addressing the needs of the target population.

POSTPARTUM CLIENT

A postpartum woman who has given birth, meets the postpartum medical and social risk assessment criteria and elects to enroll into the program.

PREGNANCY LOSS-DISENROLLMENT FROM THE PROGRAM

If the pregnancy results in the loss of the baby, the family will be provided up to two bereavement visitations. At the end of the visits the client is closed from the program.

PRENATAL CLIENT

A pregnant woman who is enrolled in the Health Start Program and is receiving prenatal education, appropriate referrals and advocacy services from a community health worker.

PROFESSIONAL SUPPORT

Professional support, in the context of this manual, refers to the availability of a Registered Nurse and a Certified Independent Social Worker (CISW) or Licensed Professional Counselor (LPC). The Contractor must have both professional support persons available for consultation with community health workers, to advise the Contractor or community health workers of needs for client referrals to emergency or urgent care medical or social services. (Also see Case Management definition).

PROGRAM COORDINATOR

An individual hired by the Health Start Program Contractor who is responsible for administration and oversight of the Health Start Program at the Program Site.

PROGRAM MANAGER

The Program Manager is an ADHS employee who is responsible for the agency's implementation and oversight of the Health Start Program. The Program Manager coordinates activities among Contractors and among Health Start Team members, receives and reconciles invoices, handles budget issues, and provides technical assistance. The Program Manager is also responsible for negotiating contracts, requesting contract amendments to be processed by the Procurement Office, conducting site visits, sponsoring appropriate Community Health Worker training, and monitoring Contractor compliance with the provisions of the contract.

PROGRAM SITE

The Contractor's designated targeted community or neighborhood for providing Health Start services. This may also refer to the Contractor's place of business.

QUALITY MANAGEMENT

A combination of activities traditionally referred to as quality assurance, utilization review, and risk management. Also included in quality management are concepts such as continuous quality assessment and continuous quality improvement. Contractors must incorporate quality management activities into the management of their Program Site.

REFERRAL

Refers to the concept of linking persons in need of particular services or service alternatives, to services appropriate for their needs, and assisting individuals to access these services when necessary. Community health workers provide information, education and referral services to potential, and enrolled Health Start clients.

REFERRAL TO SPECIALIZED PROGRAM.

Depending on the needs of the family, other programs may be more appropriate. In such circumstances, service coordination for the family may shift to another agency or program. The community health worker and/or Program Coordinator will work with a representative of the other program to transition the client into the other program.

RE-ENROLLMENT

Any previous Health Start client may be re-enrolled into the program if they meet the enrollment criteria. An enrollment form and the eligibility risk assessment criteria will need to be completed.

REFUSED FAMILY FOLLOW-UP

The term used when the client completes the prenatal portion of the Health Start Program, but does not want to participate in family follow-up portion of the program. The client's enrollment in the program ends at this time.

SITE

Location of the neighborhood or community served by the Contractor.

SITE-SPECIFIC CURRICULUM

An educational or training curriculum for community health workers that gives specific information about the particular community that the community health workers serve.

SITE VISIT

A visit to the Contractor's business location by ADHS Health Start Program staff or designees.

VISIT

A visit is a one-on-one, face-to face contact between the community health worker or community health nurse and the enrolled Health Start client, for the purpose of providing and receiving appropriate education, referral, and advocacy services. Visits may take place in a variety of locations. Home visits occur at a place of residence. Clinic or office visits occur at a medical clinic, health department or public office location designated as a meeting place for Health Start clients. Visits may also take place at community centers, places of worship, or other community locations, if appropriate to the client's situation and circumstances. Visits must be at least 30 minutes in length and may not occur over the phone.

WITHDRAWAL FROM THE PROGRAM

Since participation in the Health Start Program is entirely voluntary, a client may withdraw from the Program at any time. Withdrawal connotes that termination of participation in the Program is the client's choice.

CHAPTER 3
PROGRAM PLANNING REQUIREMENTS

3.1 Role of the Contractor in Program Supervision

The Contractor must develop administrative, management, and organizational systems that meet all Health Start Program requirements. The Contractor must also have sufficient and adequate staff and support services to implement the program at each site.

At a minimum, the following personnel are required:

Program Coordinator

The Program Coordinator is responsible for administering and overseeing the Health Start Program at each contracted site. At a minimum, the Program Coordinator will be a .25 FTE.

Professional Support

The Contractor must have professional support persons, Registered Professional Nurse (R.N.) and a Certified Independent Social Worker (CISW) or a Licensed Certified or Masters Social Worker, or a Licensed Professional Counselor (LPC) available for a minimum of four (4) hours per R.N. per month and/or four (4) hours per Social Worker or LPC per month for consultation. If professional support is not available, the contractor will need to consult with ADHS Health Start Program Staff as to an alternative plan. The consultation can be to advise the Contractor or community health workers regarding health and behavioral health education, or for other complex referral issues. They may also provide Orientation, Core or in-service training, and participate in case review conferencing and staffings. The Contractor can fulfill the consultation requirement in the following ways:

a. Utilization of outside Registered Nurse and Certified Independent Social Worker/Licensed Certified or Masters Social Worker or Licensed professional Counselor (LPC) consultants who are not Health Start Program staff.
b. If the Health Start Program Coordinator is a registered nurse, he/she can provide the nursing consultation, thereby, meeting the R.N. requirement.
c. If the Health Start Program Coordinator is one of the other professional support persons then, he/she can provide the social worker or licensed professional counselor consultation, thereby, meeting the Social Worker counselor/requirement.
d. If the Health Start Program Coordinator happens to be both an R.N. and a Social Worker or Counselor, then he/she can choose which of the consultations they will provide. The contractor will have available the remaining consultant.

One required method of service delivery is the Case Management Module in which the Health Start personnel work together as a team or teams, and case conferencing is provided. ADHS Health Start Program is requiring monthly case conferencing to occur, where the CHW would present client cases with the Registered Professional Nurse (R.N.) and the Social Worker/Counselor providing consultation**.**

Community Health Nurse Component

The Health Start Program will integrate a community health nursing component, providing home visits to high risk infants who have been in the neonatal intensive care unit for five (5) days or longer and are enrolled in Health Start. The Community Health Nurse (CHN) will provide support to families during the transition of the infant to home; conduct developmental, physical and environmental assessments and make referrals to specific community services as needed. Services may be provided if needed, until a child's first birthday. This additional component may be more time intensive and may require longer than 30 minute visits by the CHN, who will only serve the high risk clients in need which may impact the total number of clients served.

The Contractor will employ or subcontract with a Registered Professional Nurse (R.N.) to provide home visits to high risk infants who have been in the neonatal intensive care unit for five (5) days or longer and enrolled in Health Start who are not being followed by the High Risk Perinatal Program (HRPP). The Community Health Nurse will screen and enroll clients, provide a maximum of three (3) visits for a minimum of 30 minutes each per year until a child's first birthday.

3.2 Development of Written Materials for Distribution

Program materials written for community health workers, eligible and potentially eligible clients and families must meet certain requirements.

The materials must be printed in a size and type style that is easy to read. Materials should be prepared at an appropriate reading level (suggested 4th-6th grade reading level).

ADHS and Contractors may apply an independent standard or reference to determine whether this requirement is met (SMOG Index, Fry Readability Index, etc.).

The written materials must be prepared in two languages, if appropriate, English and the predominant other language (spoken or written) of the neighborhood being served by the Contractor.

All written materials prepared by the Health Start Contractor for community health workers, Health Start clients, or the public pertaining to the Health Start Program must display the Bureau of Women's and Children's Health (BWCH) logo, the Health Start name and acknowledgement that the Health Start Program funded in part by the BWCH as made available through the Arizona Department of Health Services (ADHS). Any outreach, educational, training or informational materials prepared by the Contractor must be submitted to the ADHS Health Start Program Manager for approval. ADHS must approve these materials prior to the Contractor's dissemination of the materials to community health workers, clients or the public.

3.3 Storage and Retention of Client Records

The Contractor is expected to store and maintain all client records in a safe, secure location, whether they are in the possession of the community health worker(s) or in a personal/program office. Client files must be kept in a locked location and kept in a locked file during transport at all times. The ADHS Health Start Program expects the Contractor to take all reasonable measures to protect the confidentiality and privacy of their Health Start clients. Except for non-identifiable demographic characteristics, records shall be destroyed five (5) years after the client's last participation in the Health Start Program. For more information on access to client records, refer to Section 9.4 of this manual.

3.4 Arizona Family Resource Guide

ADHS developed the Arizona Family Resource Guide, through funding provided by the Arizona Children and Families Stability Act, as a directory of resources that families can use to obtain information on and assistance with services they may need. This guide, available in English or Spanish, provides a list of organizations and their phone numbers through which families can be connected with private and public organizations and providers that specialize in early childhood development and other early intervention, preventive and community services, and services dealing with special needs and is updated annually. The purpose of the directory is to enable parents to obtain information that is critical to the development of their young children without reliance on public programs.

ADHS distributes this directory to:

- ☐ Hospitals in Arizona, for general distribution to families of all newborn children.
- ☐ Clinics and private physicians.
- ☐ The Arizona Department of Economic Security (Healthy Families), AzEIP, County and Community Agencies, Military Personnel.

☐ Other interested parties.

Health Start Contractors shall receive a supply of the resource guides for distribution to community health workers. Contractors shall develop a protocol for distribution of the resource guide by community health workers to ensure that each client is offered a copy of the resource guide.

CHAPTER 4

COMMUNITY HEALTH WORKER RECRUITMENT, TRAINING, SUPERVISION AND MANAGEMENT

4.1 Role of the Contractor and Overview the Community Health Worker Role

It is the Contractor's responsibility to recruit, hire, train and supervise the community health workers to fulfill the requirements of the program. The contractor should create a standard job description for the Community Health Worker that is specific to their geographic area and based on the following Community Health Worker responsibilities.

Community health workers visit pregnant women during the prenatal period, and teach them about their pregnancy and the importance of getting prenatal care from a medical provider. They teach what to expect in pregnancy, labor and delivery, and follow the pregnant women through the pregnancy and labor and delivery process. The community health worker also routinely visits the new mother and her family to promote positive parenting skills, provide basic developmental education and support, and assist parents in obtaining necessary immunizations and preventive health care for their children. The community health worker conducts prescheduled classes on topics, which are beneficial to the new mother and her family in a social setting. The community health worker helps link the family to early education programs or other necessary financial or social support services.

One of the most critical roles of the community health worker is that of a client advocate. Because community health workers are positive role models for pregnant women and mothers in the community, they can use their knowledge and experience to help mothers learn how to become independent, and learn to care for themselves and their children. They can help their clients learn about the system of resources in the community, and how to effectively access these services. The community health worker may also help their clients develop parenting, stress reduction, or problem-solving skills. The support that the community health worker provides is always based on the particular needs of the pregnant woman, mother, or family.

4.2 Minimum Qualifications for Community Health Workers (CHW)

The Contractor must recruit sufficient numbers of community health workers who are from the communities the Health Start Program Site will serve. The community health workers will reflect the ethnic, cultural, and socioeconomic characteristics of the neighborhoods/ communities they serve. Each .50 community health worker shall maintain a minimum caseload of thirty five (35) clients, with the majority being prenatal.

Community health workers must be able to read and write in English. They should also be bilingual in the non-English language of prevalence for the community they serve. It is also preferable that they be able to read and write in the non-English language of prevalence for the community. A high school diploma or graduate equivalency degree (GED) is required. Post high school education in early childhood development education, family studies, social work, nursing or closely related field is desirable.

4.3 Background Checks

A "background check" is a review of the relevant personal background and references of a potential community health worker. Background checks are required for all Contractor personnel who will have direct contact with Health Start clients, or potential clients, including pregnant women or families, or those who will have access to program participants' records.

Contractors must establish requirements and protocols for conducting these background checks. The protocols must include: who will do the background checks, when they will be done, exactly what the Contractor's background check is comprised of, and where documentation of the checks will be kept. Passing a background check is a condition of employment for the community health worker and other persons in direct contact with clients or client records. Minimum requirements for the background check include at least two non-family references, and a Criminal History affidavit by the applicant that the person has not committed a felony or a misdemeanor involving moral turpitude. A copy of the background check documentation shall be in the personnel file and shall be kept in a separate file available during site reviews.

4.4 Community Health Worker Identification to ADHS

Each Contractor is required to provide the ADHS Health Start Program Manager with a list of the community health workers that are serving the Program Site. The list must include: 1) the name and date of hire of the community health worker, 2) the community or location they are serving, 3) the number of hours per week that each community health worker is employed, and 4) other important information about the community health workers, such as current caseload. The Contractors will send the community health worker list to ADHS at the beginning of the contract service date, and when changes occur.

4.5 Recruitment and Training of Community Health Workers

General Requirements

The Contractor is responsible for developing and implementing methods to recruit; hire and train community health workers from the community. Once

the community health workers have met the Contractor's basic conditions of employment, within 90 days of the community health worker's employment date, the Contractor shall have provided training in all of the subjects included in the ADHS Health Start Orientation and Core Curriculum or other recommended curriculum. **This shall include at least eight hours of training in the subjects included in the ADHS Health Start Orientation Training Curriculum and at least eight hours of supervised home visiting for each community health worker before the community health worker is allowed to assume independent client contact responsibilities.** A Home Visiting Checklist must be completed for each visit observed and a copy kept in the personnel file and a separate file during site reviews. Because the training and preparation of the community health worker is such an integral component of the Health Start Program, Chapter 5 is devoted to the Community health Worker Orientation and Core Training requirements and topics. The Orientation and Core Training that a community health worker is expected to have is based on the requirements of the ADHS Policy and Procedure Manual in effect at the date of hire or date of contract, whichever is later.

4.6 Documentation and Evaluation of Community Health Worker Training

The Contractor shall designate a person responsible for the coordination and documentation of community health worker training. In most cases, this person will be the Program Coordinator.

Community health workers are required to take a pre-test and/or post-test for each training component. These tests are prepared by ADHS for all Contractors to utilize in assessing community health workers' knowledge of the subject matter contained within the ADHS Health Start Orientation and Core Training Curriculum. The Contractor's designated training coordinator shall administer the appropriate tests before and after each training session. Copies of the tests, master score sheets, and the home visiting checklist must be kept in each community health worker's personnel file for review.

If a community health worker scores 90% or higher on a pre-test for a particular component, they may be exempted from the training and post-test of that component, at the discretion of the Program Coordinator. In such a case, the pre-test will be considered to be the post-test in satisfying the testing requirement. Additional training, such as cardiopulmonary resuscitation (CPR) and first aid, is recommended.

4.7 Continuing Education Requirements

The Contractor, with the community health worker, shall develop an annual continuing education plan that outlines individual training needs. It may be

convenient for the Contractor to develop the plan during the time frame of the community health worker's employee appraisal.
The Contractor shall provide or make available a minimum of six (6) hours of continuing education each year. This requirement may be fulfilled by attendance at community, state, national and/or contractor workshops, college course work, or any other documented training/education which meets the needs identified in the individual community health workers continuing education plan. Any trainings submitted for reimbursement must have prior approval by the ADHS Health Start Program Manager. Documentation of attendance and completion must be submitted with the monthly billing for each training for each CHW.

4.8 Contractor Management of Community Health Worker Performance.

Contractors must review the role of the community health worker (section 5.1 of the Health Start Policy and Procedure Manual, and the ADHS Orientation Training curriculum) with community health workers. Contractors must also develop and implement an employee appraisal system for community health workers. The Contractor's employee appraisal system must incorporate mechanisms to consider Orientation and Core Training test scores and Home Visiting Checklist results during the community health workers' probationary employment period. The Contractor is responsible for developing with each community health worker a continuing education plan and including this plan in the community health worker's personnel file. A copy of the continuing education plan for each community health worker shall be available in a separate file curing site reviews. The Contractor must document all training of the community health worker (including post-tests, home visiting checklist, continuing education, college certification, and copies of all certificates), and include this documentation in the community health worker's personnel file. The community health worker's file should also contain important information about problems or positive achievements, annual supervised home visit checklist, as well as results of client satisfaction surveys regarding the community health worker's performance. All documentation shall be copied and shall be available in a separate file during site reviews.

An important responsibility of the Program Coordinator is to monitor the "caseload", or the number and types of clients being served by each community health worker. This management activity is important to ensure that the services provided meet the client and family needs, and are of high quality. Some examples of factors to consider in community health worker monitoring include, but are not limited to:

- Number of active, enrolled clients the community health worker is serving.
- .50 Community Health Worker maintains caseload of thirty five (35) clients of which more than half are prenatal

- Number of services/visits/classes per client for each community health worker.
- Client visits are conducted predominately at the client's home or contractor's office or other location for a minimum of 30 minutes.
- Prenatal client visits are provided a minimum of once per month but not more than four (4) visits per month.
- Family follow-up visits are provided at a minimum of once per month but not more than four (4) per month; one month the visit will be with the child; next month the visit will be with the client discussing interconception care. *More than four (4) visits per month requires prior approval.*
- Size of the client's family unit.
- Severity or complexity of the client/family situation, a higher acuity or complexity of needs will require more intervention by the community health worker.
- Existence of medical high risk factors that require urgent referrals, intensive monitoring and follow-up. Such factors may include: pre term labor, gestational diabetes, pre-eclampsia, substance abuse, etc.
- Duration of the client contact (30 minute minimum). Is the duration reasonable, and sufficient to meet client's need?
- Travel time for client visits.
- Timing of the initial contact, early versus late in the pregnancy. (Early contacts are preferred)
- Quality of contact. Were actions, information, and interventions appropriate to the client need?
- Comparison of hours worked to number of encounters submitted by the community health worker.
- Results of Client Satisfaction Surveys.

Contractors are expected to develop criteria and systems for regular review of client case files, to assess the quality and appropriateness of services provided by the community health worker. Results of these reviews should be used to assist in: community health worker performance appraisals; periodic review of the Contractor's program plan; determining if and when it might be necessary to hire a new community health worker or adjust the hours of an incumbent community health worker; and management decision-making for improving the Contractor's Health Start Program Site operations. Refer to Chapter 11 for additional information on quality management and improvement activities.

CHAPTER 5
HEALTH START COMMUNITY HEALTH WORKER TRAINING

*** This chapter is in the process of being revised by ADHS and will be made available at a later date.**

5.1 Overview of Community Health Worker Training

The role of the community health worker is to provide outreach, education, referral, and advocacy services within his/her own community. In order for community health workers to perform these responsibilities safely and competently, they must receive sufficient orientation, training and information about the program content.

Information that all Health Start community health workers must receive is divided into two major areas: Orientation Training and Core Training. The initial orientation and core training must cover the topics described in the Training Guide and meet the learning and performance objectives that all community health workers must be offered. Community health workers must complete orientation before they may initiate unsupervised client outreach or home visits. Core training includes relevant subject matter and information that must be offered to each community health worker within the first ninety (90) days after employment by the Contractor. In addition to the Orientation and Core Training, "site-specific" training is developed, coordinated, and presented by the Contractor at each Program Site as appropriate. Site-specific training is geared to the special needs of the community health workers, Contractor, and the Health Start neighborhood or community. The training, which a community health worker is to have, is based on the requirements of the ADHS Policy and Procedure Manual in effect at the date of hire or date of contract, which ever is later.

The rationale for Contractors providing Orientation and Core training to their community health workers, rather than having a single trainer provide it, is to accommodate the cultural, educational, linguistic, and experiential differences among community health workers. A training style appropriate to one population may not be appropriate for another. In addition, it allows Contractors to have local professionals give the training to facilitate the development of local resources upon which community health workers may draw in serving their clients. It also provides Contractors with the flexibility to provide the training whenever it becomes necessary, due to staff turnover, and to structure the timing and location of the training to accommodate community health workers' work schedules, case loads and outreach activities.

5.2 Orientation Training and Supervised Home Visits

The Orientation Training includes components of the Core Training and is intended to give community health workers an overview of their role and job responsibilities. The orientation program provides basic information on

several critical areas of the Health Start Program. Through this initial orientation process, community health workers can demonstrate that they possess sufficient knowledge about the program. They must also demonstrate that they have mastered the necessary skills to begin conducting client contact activities safely and competently.

The Orientation Training for community health workers shall include a total of **at least eight** (8) hours of training in the following content areas **and at least eight (8) hours of supervised home visiting** for each community health worker before the community health worker is allowed to assume independent client contact responsibilities.

- Role of the Community Health Worker
- Pregnancy
- Child Growth and Development
- Communication Skills
- Identifying and Accessing Community Resources
- Documentation and Confidentiality
- Supervised Home Visit

The information in these areas must, at minimum, address the Orientation learning objectives from the Training Guide and conform to ADHS Health Start policies wherever applicable. Training must also include relevant information from the Contractor's specific community to allow community health workers to successfully work within that community.

All newly hired community health workers for the Health Start Program must take the orientation test. A community health worker must receive a score of at least 90% for the entire Orientation Test, a total of 21 objectives, and the home visiting checklist before assuming home visiting responsibilities. The test for – Orientation Training (green) must be included in the community health worker's personnel file and in a separate file for site reviews.

5.3 Core Training

Core Training is intended to be the foundation of knowledge, skills, and information that community health workers should have within the first 90 days (3 months) after employment. The Core Training must also include any relevant "site-specific" instruction for community health workers. The "site-

specific core" is needed to educate community health workers in how to effectively provide Health Start services within their own community.

The following outline lists the Core Training topics that must be provided to each community health worker within 90 days (e months) after employment:

A. Program Overview
   1. History, Goals and Objectives of the Health Start Program
   2. Community Outreach
   3. Communication Skills
   4. Documentation
   5. Confidentiality
   6. Role of the Community health Worker

B. Emotional Support
   1. Problem Solving
   2. Self-Esteem
   3. Special Population Issues
   4. Community Resources

C. Pregnancy and Prenatal Care
   1. Fetal Development
   2. Components of Prenatal Care
   3. Maternal Changes
   4. Discomforts of Pregnancy
   5. Warning Signs in Pregnancy
   6. Medical/Nursing Resources and Referrals

D. Nutrition
   1. Prenatal and Postnatal Nutrition
   2. Infant Feeding
   3. Child Nutrition
   4. Family Nutrition
   5. Nutritional Resources and Referral

E. Labor and Delivery
   1. Getting Ready
   2. Process of Labor and Delivery
   3. Cesarean Birth
   4. Leaving the Hospital

F. New Mother
   1. Concerns of the New Mother
   2. Postpartum/6 week checkup
   3. Physical/emotional/family changes/reactions to the new baby

4. Bonding/Attachment
5. Caring for the Infant

G. Well-Woman Care
1. Family Planning
2. STD/HIV
3. Recommended Preventive Health Services
4. Referrals

H. Infant and Child Development
1. Growth and Development
2. Parenting Skills
3. Child Safety
4. Well-Child Care
5. Immunizations
6. Oral Health
7. Early Childhood Care and Education Programs
8. Ages and Stages Questionnaires

I. Families with Special Needs
1. Cultural/ethnic Diversity
2. Developmental Disabilities/Chronic Illness
3. Domestic Violence
4. Child Abuse and Neglect
5. Crime Victims Assistance
6. Substance Abuse

J. Elements of Case Management
1. Building a Helping Relationship
2. Identifying Client Needs and Strengths
3. Developing and Revising a Home Visiting Plan
4. Finding and Using Resources/Support Materials
5. Coordination
6. Ongoing Assessment
7. Ending the Helping Relationship

K. Safety
1. Household Safety for Children
2. Mandatory Seat Belt Law
3. Lead Safety
4. Bike and Traffic Safety
5. Client Home Safety
6. Community Health Worker Safety on Home Visits

A community health worker must receive a score of at least 90% for the Core

tests, a total of 60 objectives, before Core Training can be considered complete. The tests and the Core Training Master Scoring Sheet must be included in the community health worker's personnel file. Contractors should use the results of the Core Training tests to identify continuing and/or additional training needs for each community health worker on an education plan.

5.4 Certificate of Completion

An ADHS Certificate of Completion for Core Training is available for community health workers. Completion of training shall be defined as the community health worker obtaining a 90% or above total score for Core Training. Certificates may be requested from the ADHS Program Manager by the Contractor's submission of the names of the community health workers who have completed Core Training and a copy of their Core Training Master Scoring Sheets.

5.5 Continuing Education

Continuing education should be designed to strengthen the skills, provide updated information, and support the activities of the community health worker. A continuing education plan should be developed annually for each community health worker. This plan should include the training needs identified through the Orientation and Core training post testing, the Home Visiting Checklist results and/or observed need. Community health workers should have a role in the development of the plan. A copy of the continuing education plans for each community health worker shall be available in a separate file during site reviews.

The Contractor shall provide or make available a minimum of six (6) hours of continuing education for each community health worker on an annual basis after completion of the Core Training. This education/training requirement may be fulfilled by community, state, national, or Contractor workshops, college course work, or any other documented training/education. The continuing education plan and documentation of training must be included in the community health worker's personnel file. Any trainings submitted for reimbursement must have prior approval by the ADHS Health Start Program Manager. A copy of the community health worker's certificate of attendance or course completion record shall be sent to ADHS with monthly billing.

Annual training opportunities will be provided by ADHS. The ADHS Health Start Program Manager will obtain input from Health Start Coordinators and community health workers on topics of interest and need.

5.6 Site-Specific Training

This training is individualized to meet the specific demands of community health workers in a particular community. Contractors are responsible for developing and implementing appropriate site-specific training for community health workers. This site specific training is not billable training. At a minimum, site-specific training should:

- Support the Core Training
- Consider the special health education or social needs of 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 health workers for developing and accessing referral networks and community resources within that community.

Site specific training is appropriate any time the Contractor, community health worker, 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 client case management (build upon concepts presented during the Core Training, see 5.3 J), and help community health workers learn how to apply what they have learned to their own neighborhoods and communities. Suggested topics for this training include any information that is specific to the targeted neighborhood/community:

- Special Characteristics of the Community
- What are the Community Resources, and How to Access Them
- How to Build a Community Network
- 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 (such as Gestational Diabetes, Fetal Alcohol Spectrum Disorders, Drugs and Drug-addicted Babies, etc.) especially leading to Community Health Worker Certification.

CHAPTER 6
HEALTH START ELIGIBILITY AND ENROLLMENT

6.1 Overview of Eligibility and Enrollment

Health Start, a voluntary program, is designed to serve pregnant women at risk for poor birth outcomes, and to serve postpartum women who meet eligibility criteria. The process is intended to facilitate the timely identification of eligible persons, and help them start receiving services as quickly as possible, if they are eligible and choose to enroll. It is expected that the Contractor will design and implement a mechanism to conduct continuous outreach and recruitment of at risk pregnant women and post partum women residing in their targeted service area.

A general description of the process is as follows: At risk women who reside in the Health Start targeted service area program sites, and who may be pregnant, or just had a baby, have an initial contact with a community health worker. Community health workers through a variety of sources identify these women. A potential client learns about the program from the community health worker, or through other sources. The community health worker verbally explains the program and determines if the potential clients: 1) resides in the targeted service area; 2) is pregnant; 3) is postpartum with a child under age two; 4) has one or more medical and social prenatal/postpartum risk factors. Community health worker offers enrollment to the woman if criteria is met. If enrollment is accepted, the woman fills out the Intent to Participate form, signs the form and the community health worker completes the Health Start Enrollment form.

Checking just one medical risk factor and one social risk factor automatically makes the woman eligible, however, all relevant risk factors should be identified and checked (see section 8, page 8-11 Enrollment Form for complete list of prenatal and postpartum risks factors). The Intent to Participate form signed by the client indicates that she understands the services that she will receive, and her rights and responsibilities as an enrolled client. All participation in the Health Start Program is on a strictly voluntary basis. A woman under age 18 will need to have a parent or legal guardian sign the Intent form if visits are going to be conducted at the client's primary residence.

Women who test negative on a pregnancy test, as well as those who decline enrollment or are not offered enrollment receive preconception or interconception care education, including family planning and folate education and referral services. A Negative Pregnancy Test Visit form is completed by the community health worker only for those women who had a negative pregnancy test.

6.2 Eligibility Criteria for Health Start Program

The at-risk women who are eligible for participation in the Health Start Program must have their primary residence located within the Contractor's Program Site targeted

service area. At risk women from these targeted communities who are pregnant or who are postpartum may choose to be enrolled in the Health Start program. If pregnancy testing reveals that the woman is not pregnant, that woman is eligible to receive Negative Pregnancy Test Visit Services, including preconception and interconception care education, family planning education, folate education, limited emotional support (to determine if the woman is reconciled to the fact that she is not pregnant and to help her establish a Family Planning Goal), help developing a Reproductive Life Plan and referral services. A Health Risk Assessment tool will be used to assess the women's needs. Only Negative Pregnancy Test Visits to non-enrolled Health Start clients are billable. No more than two (2) pregnancy tests per woman per year are to be provided.

If the pregnancy test reveals that the woman is pregnant, she is asked if she has one or more medical/social prenatal risks on the Client Enrollment form to determine eligibility for enrollment into the program. Based on the results of this assessment, she may be offered enrollment in the Health Start Program. Pregnant women who choose enrollment in the program and sign the Intent to Participate form, will receive the full spectrum of prenatal, advocacy and family education services. Enrollment forms are only completely filled out for women who agree to enroll in the program.

Pregnant women who decline to sign the Intent to Participate form, decline enrollment for another reason, or are not offered enrollment on the basis of the results of the risk assessment are eligible to receive preconception and interconception care education, family planning education and folate education, limited emotional support and referral services. These services are not billable to the program.

Postpartum women who have given birth, have one or more medical/social risk factors and elect to enroll into the program and sign the Intent to Participate form will receive the full spectrum of advocacy and family education services. This is considered a Postpartum Enrollment.

Enrolled postpartum women and at risk pregnant women who have given birth (the index child) will receive follow-up from the community health worker. The community health worker shall follow the enrolled client and her family until the child's second birthday, unless the family is lost to follow-up by moving, transfers to another site or voluntarily withdraws from the program. If an enrolled client loses the index child, she may choose to remain enrolled in the program until the community health worker and the woman have finished appropriate bereavement and discharge planning, whereupon the case would be closed. A maximum of two bereavement family follow-up visits is allowable.

Enrolled postpartum women who have given birth to an infant that has been in the neonatal intensive care unit for five (5) days or longer who are not being followed by the ADHS HRPP program will be followed by a Community Health Nurse (CHN). The CHN will schedule and conduct a minimum of one (1) but no more than three (3) per year family follow-up home visits up to infant's first birthday.

6.3 Identification of Potential Enrolled Clients

The Contractor must arrange for the administration of a pregnancy test to all women who have not yet had an appropriate test and who desire to participate in the Health Start Program. The pregnancy test must be acceptable to the Department of Economic Security (DES) for use in AHCCCS eligibility determination for Federal Medicaid assistance for pregnant women (SOBRA Program). If the potential client is already enrolled in an AHCCCS health plan, the AHCCCS provider may do the pregnancy test, or another referral source may be utilized for pregnancy verification.

6.4 Initial Contact

The Contractor is expected to develop strategies to assist community health workers to identify and recruit at risk women into the program early in their pregnancies in the first trimester. Community health workers may contact potential clients in a variety of ways, either at the potential client's home, or at community or group settings. The initial contact may be in person and at any convenient location, except that if the initial contact occurs at the primary residence of the potential client, the community health worker shall not enter the residence during the initial contact without the permission of the potential client.

The Contractor is expected to develop strategies to assist community health nurses to identify and recruit post partum women who have had infants who have been in the neonatal intensive care unit for five (5) days or longer who are not being followed by the ADHS HRPP program. During the initial contact, the community health nurse shall provide a verbal explanation of the program explain the rights and responsibilities of the potential client and the community health nurse.

During the initial contact, the community health worker shall provide the potential client with a description of the types of Health Start services that are available. At a minimum, the community health worker shall provide a verbal explanation of the program, and explain the rights and responsibilities of both the potential client and the community health worker.

6.5 Intent to Participate

A written Intent to Participate form must be received from all women who are determined eligible to enroll and agree to enrollment prior to enrolling for the Health Start Program, whether they are pregnant or not. The Intent to Participate form must be signed by the client, <u>before</u> the community health worker can record any demographic or health information from the client. This form must be signed in order for the client to receive any visiting services. If the client declines to sign the Intent to Participate form, then the community health worker <u>cannot</u> proceed with of the Health Start Enrollment procedures.

If the potential client is a minor living with the minor's parent or legal guardian, home visits shall not be provided unless the minor's parent or legal guardian also signs the

Intent to Participate for the client's enrollment into the program and to receive home visits.

The Intent to Participate Form will be provided to Contractors by ADHS in English and Spanish. Copies of these forms are located in Section 8.

6.6 Enrollment

After the potential client has received a description of the program and its services, and has received information about her rights and responsibilities and has been determined eligible, she may elect to enroll in the program. At the time of enrollment, the community health worker collects appropriate data on the Client Enrollment form. Chapter 8.5 contains a detailed explanation of this form. The Client Enrollment form requires documentation of demographic data, insurance, the referral source, and pertinent information about the woman's pregnancy status.

If the at risk woman is pregnant and a pregnancy test is not needed, and the woman is determined eligible is using the medical and social prenatal risk assessment on the Client Enrollment form to determine if she meets the criteria for enrollment into the program. This assessment may serve as a mechanism to triage potential clients, considering their level of need, the caseloads of available community health workers, and other factors that may be appropriate. Based on the results of the assessment, she may be offered enrollment in the Health Start Program. Additional supplemental forms developed by the Contractor may also be used.

If an acceptable pregnancy test has not yet been done, the community health worker arranges for (coordinates referral to lab or medical provider), or performs a pregnancy test as a part of the initial contact process (refer to Section 6.3 for pregnancy test requirements). If the community health worker is coordinating the referral of the pregnancy test, another attempt will be made to contact the potential client to obtain the results of the pregnancy test, to determine if the woman is reconciled to the fact that she is or is not pregnant, to help her establish a Family Planning Goal (if appropriate), and complete the enrollment process. If the pregnancy test reveals that the woman is pregnant, she is asked if she has one or more of the medical and social prenatal risks on the Client Enrollment form to determine eligibility for enrollment into the program.

If the pregnancy test reveals that the woman is not pregnant, the community health worker provides negative pregnancy test visits services including preconception interconception care education family planning education and support and makes appropriate referrals. This is documented on the Negative Pregnancy Test Services form.

If the potential client is a postpartum woman, the community health worker will determine eligibility using the postpartum risk assessment criteria on the Client Enrollment form to determine if she meets the criteria for enrollment into the program.

Any enrollment is not effective unless and until the Intent to Participate documentation is signed by the client. Program status on the Enrollment form designates that a client is enrolled based on the assessment, and is either pregnant, post partum, transferred or both pregnant and post partum. The Contractor is required to send a copy of all Client Enrollment forms to ADHS monthly (see Section 8.10). The original completed Client Enrollment form is placed in the client's file.

After meeting the eligibility criteria and signing the required Health Start written Intent to Participate form, and obtaining any other appropriate consent, the pregnant or postpartum woman is considered enrolled in the program. The community health worker may then begin to provide Health Start services.

Enrolled postpartum women and at risk pregnant women who have given birth will receive follow-up from the community health worker. The community health worker shall follow the enrolled client and her family until the child's (index child) second birthday, unless the family is lost to follow-up by moving, transfers to another site or voluntarily withdrawing from the program.

Enrolled post partum women who have given birth to a high risk infant that has been in the neonatal intensive care unit (NICU) for five (5) days or longer and is not being followed by a ADHS HRPP program will be followed by a community health nurse up to the infants first birthday.

6.7 Enrollment Notification to ADHS

As summarized on the Health Start Form Schedule (Section 8.3), copies of the Client Enrollment form for all newly enrolled clients are sent to ADHS monthly. The original copy is placed in the client's file.

6.8 Disenrollment Process

There are several ways that a client may be disenrolled from the Health Start Program:

- The client completes the prenatal portion of the Program, but does not want to participate in family follow-up. This is termed "Refused Family Follow-up" on the Status Closed Record form.

- The client has completed the family follow-up period (the index child who precipitated enrollment in the Health Start program has attained his/her second (2) birthday or the high risk infant has attained his/her first (1) birthday). This is termed "Completed Family Follow-up" on the Status Closed Record form.

- The client is lost to follow-up. The community health worker must have made at least three unsuccessful attempts to personally visit the client

with no response; this is termed “Loss to Follow-up/Moved” on the Status Closed Record form.

- The client has participated in the program more than eight (8) years.
- The client moves from the Contractor’s service area and is not known to be transferring to another Health Start site. This is termed “Withdrew from Program” on the Status Closed Record form.
- The client is known to be transferring to another Health Start site. This is termed “Transferred Sites” on the Status Closed Record form.
- The client voluntarily disenrolls from the Program. This is termed “Withdrew from Program” as a status on the Status Closed Record form.
- The mother and index child are no longer living together on a permanent basis. This may occur in any number of ways, including if either the mother or child dies while in the Program, the child is adopted or removed from the family, or the child is sent to live with relatives out of the service area and the mother is not expected to participate in parenting the child. In this circumstance, the case may remain open if the foster or adopted parent wishes to continue the services. If the foster or adopted parent does not wish to continue the services, then you would mark “Withdrew from Program” as a status on the Status Closed Record form.
- Service coordination for the family has changed to another agency or program. Depending on the needs of the family, other home visiting programs such as Healthy Families may be more appropriate for the family. In such a circumstance, the community health worker and/or Program Coordinator will work with a representative of the other program to transition the client into the other program. Once the transition has been accomplished, the client is disenrolled from the Health Start Program. This is termed “Referred to Specialized Program” on the Status Closed Record form. If the specialized service notifies the community health worker that the child has completed the services, and the child is under the age of two, the community health worker may continue to see the child. Every effort needs to be made to ensure that the programs are not duplicating services.
- If the pregnancy results in the loss of the baby, the family will be provided two (2) bereavement visits, and then closed as “Pregnancy Loss” and noted on the Status Closed Record form.

6.9 Re-enrollment

Any previous Health Start client can be re-enrolled into the program if she meets the enrollment criteria. This would include such circumstance as a second pregnancy or

a pregnancy that resulted in a miscarriage or stillbirth and the woman is pregnant again. A new Client Enrollment form will need to be completed. If a current enrolled post partum client becomes pregnant, a new enrollment form is completed. The maximum number of years a client can participate in the Health Start Program is eight (8) years.

6.10 Transfer of Clients between Contractors

General Information

With the increase in the number of sites offering Health Start services and in the length of time that a client and her family may be followed in the program, the possibility that a client may move from a neighborhood served by one Contractor (termed the "Losing Contractor") to a neighborhood served by another Contractor (termed the "Gaining Contractor") may increase.

Both the Losing Contractor and Gaining Contractor may be able to bill for the client, based on the number of visits made to the client while she lives in the Contractor's targeted neighborhood. She should be closed by the Losing Contractor (Transferred Sites), and re-enrolled in the program by the Gaining Contractor. A copy of the records from the Losing Contractor may be transferred to the Gaining Contractor with the permission of the mother.

Procedure to Affect Transfer of a Client Between Contractors

The need to transfer a client may be discovered in several ways, which will determine the procedures to be used in communicating this information. These procedures described below are vague to offer the Contractors the greatest flexibility in determining the status and meeting the needs of the client.

- If the Losing Contractor first learns that a client is moving and wishes to continue Health Start services, the community health worker or Program Coordinator may contact the Program Coordinator for the Gaining Contractor and relay the information. If the Gaining Contractor first learns that a client was enrolled in Health Start at another location, the community health worker or Program Coordinator should contact the Program Coordinator for the Losing Contractor and relay the information. Together they will work out the details of transferring the client. They should also discuss how copies of pertinent parts of the client's record may be given to the Gaining Contractor. Signed permission by the client for the Losing Contractor to release the client's records should be obtained.

  The Losing Contractor will complete a Status Closed Record form and submit a copy to ADHS and list the Program Status as "Transferred Sites" and annotate the name of the Gaining Contractor. The original form would be placed in the client's file. The Losing Contractor would bill for the client

based on the number of home visits made during the month while the client lived in its targeted neighborhood.

The Gaining Contractor would submit a new Client Enrollment form, indicating that the client has been “Transferred from Another Site”. This Contractor could also bill for the client based on the services provided by that program site.

In the event, ADHS first learns that a client may have been enrolled in Health Start at two locations for the same pregnancy, a member of the Health Start program staff would contact the Program Coordinator for the Gaining Contractor and relay the information. The Gaining Contractor should verify with the client if she had previously been enrolled at another site. If so, the above procedure for completing a Status Closed Record form will take place.

CHAPTER 7
CLIENT VISITS AND PRESCHEDULED CLASSES

7.1 General Standards for Conducting Client Visits and Classes

Community health worker or community health nurse visits with clients are prescheduled, and are recommended to occur predominately at the client's primary residence. However, there may be instances when a client visit may be done at any location that is reasonable and convenient to the client such as the contractor's office. Client visits must occur in person with the client lasting a minimum of 30 minutes. Visits to clients temporarily residing in alternative living situations, including but not limited to rehabilitation centers, jails, inpatient treatment centers or homeless shelters and when the primary care giver of the child or children is out of the home for extended periods of time (over one month), shall be approved on a case by case basis by ADHS. Contractor will provide information to ADHS for approval prior to providing visits. The client may also participate in prescheduled classes on pertinent prenatal, postpartum, childcare, and child development topics. For a contractor to be reimbursed for a class there must be at least four (4) Health Start clients enrolled per class and the class must be a minimum of sixty minutes long.

Contractors are responsible for incorporating specific standards for conduct during client visits into the community health worker's job descriptions and performance appraisal system.

The community health worker or community health nurse will have each client sign and date in blue ink each visit form. See Chapter 8, Data Collection and Reporting Requirements, for information about documentation of client visits in the client's file.

The community health worker or community health nurse will maintain a confidential relationship with clients. The Contractor and staff supervisor will have appropriate access to client records and information, in order to assist community health workers or community health nurse with day-to-day client issues, and oversee their performance. Community health workers or community health nurse may discuss issues or concerns regarding the client or the family with the supervisor or consultants.

The Contractor is required by Arizona law to report a suspected non-accidental injury or neglect of a child to Child Protective Services as per ARS 13-3620. Community health workers or community health nurse will also report any case of suspected non-accidental injury or neglect of a child to their supervisors immediately.

7.2 Prenatal Visits and Classes

<u>General information</u>

It is essential that pregnant women be identified as early in their pregnancies as possible, ideally in the first trimester. Once the client is enrolled in the Contractor's Health Start program, the client will receive at least one monthly prenatal visit from a community health worker throughout the remainder of her pregnancy. The purpose of the prenatal visits and classes is to assist clients in accessing appropriate prenatal care services, and to provide prenatal education, information and referral services, and advocacy.

Community health workers will make at least one visit per month during the prenatal period of enrollment. Visits must not exceed four (4) per month. If a client requires more visits or receives fewer visits, the community health worker will note the reason for variation in the client's record. Contractor must request approval from ADHS to provide more than four (4) prenatal visits in one month.

The number of prenatal visits and classes that an enrolled client receives may be impacted by a variety of factors, including whether her enrollment in the program occurred early or late in the pregnancy. The most important factor influencing the number of prenatal visits and classes is the client's need. Because the Health Start Program is a client and family centered program, the timing and content of prenatal home visits and classes will be variable, depending on client and family need. Some clients will need more intensive assistance and intervention than others. The frequency, intensity, and duration of each client interaction will be individualized to accommodate the client's needs and the family's individual circumstances. Contractors will provide adequate supervision of community health workers to ensure that client needs are being met, and that client visit standards are maintained.

Although prenatal home visits and classes may require intensive advocacy, problem solving, and referral services, community health workers are still expected to cover educational topics directed to address program goals at some time during the client's participation. Discussion of these educational topics may stimulate discussion about family needs in other areas.

Prenatal Visit and Class Services

Services that may be provided during prenatal visits include, but are not limited to:

1. Assistance to access prenatal care from a medical provider.

2. Assistance to access financial assistance, if appropriate.

3. Referrals and follow-up to other appropriate community resources that the client or family members may need.

4. Prenatal, perinatal, and postpartum education, including but not limited to education about the importance of early and continuous prenatal care, nutrition, breast feeding, labor and delivery, healthy behaviors during pregnancy, warning signs in pregnancy, and other related topics based on client need.

5. Screenings for alcohol use, tobacco/drug use and signs of perinatal depression and other related behaviors as needed.

6. Immunization education and promotion of complete and timely immunizations for the entire family.

7. Personal and family support, including listening, assistance in job referral, assistance in development of coping and problem solving skills, etc.

8. Assistance in overcoming barriers to care, especially transportation.

Family - Centered Services

Although the focus during the prenatal period is on assisting the pregnant client to have a healthy baby, the needs of other family members may be addressed as well, since they have an impact on the overall well being of the pregnant client. Discussion of immunization, well-baby check-ups, family planning, etc. should not be confined to the family follow up period. Services should be guided by the needs of the family. Services are primarily focused on the needs of the index child and mother. As time allows, the same Health Start program services may be extended to other children and family members

7.3 Family Follow-Up Visits and Prescheduled Classes

Once the client has completed the prenatal visits, and delivered the infant (index child), she and her family will receive postpartum and family follow-up visits and classes from the community health worker until the index child's second birthday, unless the family voluntarily withdraws from the Program, is lost to follow-up by moving, or transfers into another program. Family follow-up visits focus on promoting preventive health care, good nutritional habits, immunizations, maternal issues, breast feeding, safety education/assessment, child development education/assessment, and assisting with necessary referrals to community resources, including early childhood education programs. As with prenatal visits, community health workers will gear the content, timing, and structure of family follow-up visits to the specific needs of clients and their families. Family follow-up visits must be a minimum of thirty (30) minutes in length and must not exceed four (4) per month.

Unless family considerations require more frequent follow-up visits, the

minimum number of family follow-up visits and classes provided by a community health worker will be based on the following periodic schedule:

- One visit (or attempted visits) in the first two weeks after the birth of the index child. This is the first Family Follow Up visit and the birth outcome is documented on the Health Start Family Follow Up form at this visit.

- One visit and/or prescheduled class during the month that the index child reaches 2, 4, 8, 12, 18, and 24 months of age. These visits are Family Follow Up visits and will be focused on the child. Visits occurring on alternating months will be focused on the needs of the mother providing interconception care education and other post partum education as needed.

The rationale for the frequency and timing of the family follow-up visits coincides with the children's expected immunization schedule and the Ages & Stages Developmental Assessment at 4, 8, 12, 18 and 24 months and Social Emotional Assessment at 12 and 18 months. As much as possible, the community health worker will schedule family follow-up visits to coincide with when children should have completed each scheduled immunization.

Because the maximum length of time the family is followed is until the second birthday of the index child (see Chapter 6, Eligibility and Enrollment for other exception criteria), the scheduled family follow-up visit at 24 months must occur before the child's second birthday. Contractors will ensure that there is a mechanism in place at the program site to provide for transition to termination of participation for families completing the Health Start Program.

The community health nurse will schedule and provide family follow-up visits for a minimum of 30 minutes to enrolled postpartum women who had an infant that has been in the neonatal intensive care unit five (5) days or longer who are not being followed by the ADHS HRPP program. The community health nurse will provide a minimum of one (1) but no more than three (3) visits per year up to the infants first (1) birthday.

Services that may be provided during family follow-up visits and/or class shall include, but are not limited to:

1. Assistance in identifying and accessing a medical home for all family members.

2. Assistance in accessing financial assistance, if appropriate.

3. Referrals and follow-up to other appropriate community resources that the client or other family members may need.

4. Basic child development education and Ages & Stages Developmental Assessment, Social and Emotional Assessment, parenting skills, and child and family safety.

5. Immunization education and promotion of complete and timely immunizations for the entire family.

6. Nutrition education and promotion of good nutritional habits for the entire family.

7. Assistance in identifying early childhood education programs, such as Head Start.

8. Review of postpartum and interconception care education topics, if indicated. This may include review of changes after pregnancy, maternal high risk conditions, maternal/infant diet, breast feeding, emotions/feelings, exercise, parenting, safety, SID's, social issues, and other related topics, based on client and family need.

9. Personal support, including listening, assistance in job referral, assistance in development of coping and problem solving skills, etc.

10. Assistance in overcoming barriers to care, especially transportation.

7.4 Making Referrals to Other Services

The referral network for each Health Start Program site is individualized. The referral and communication pathways that link community health workers or community health nurses and clients to services will depend on the types of services that are available in the neighborhood or community, and methods that each Contractor has developed for accessing these services.

Contractors will establish a comprehensive network of referral resources and instruct community health workers in how to access services. These include, but are not limited to:

- Financial assistance
- Medical services
- Behavioral health and counseling services
- Social services
- Educational services
- Nutritional services
- Early childhood education programs
- Low cost or no cost services

When a Community Health Worker or Community Health Services identifies an appropriate referral, they may give the client the referral, help the client to make an appointment and/or arrange transportation to the appointment. On subsequent visits, the community health worker or community health nurse will follow-up with the client on the outcome of the referral. Both the referral (R) and the outcome of the referral (V) must be indicated on the family follow-up forms, and filed in the client's chart. A copy of the contractor developed referral form documenting that the referral was made and that follow up on the referral was verified, must be in the client chart.

Services shall be available and accessible to Health Start clients, to the extent that these services exist in the community. In circumstances where resources or necessary services do not exist within the neighborhood or community served by the Health Start program, Contractors will document the gap in services and attempt to establish methods to make alternative services available, or to obtain equivalent services in another community. If Contractors are unable to access or establish a relationship with an existing community resource, or if an existing relationship undergoes a significant change, the Contractor will notify the Health Start Program Manager of the network gap. Contractors and Program Manager will work cooperatively to minimize gaps in service availability and accessibility for Health Start clients.

7.5 Coordination with Other Home Visiting Programs

In communities served by both Health Start, Healthy Families, Healthy Start or other Home Visiting programs, the community health worker may assess the needs of the client to determine the appropriate program and make referrals as needed and assist in the possible transition of the client to another program. A joint visit may be made with the Healthy Families or other Home Visiting representative to assess eligibility. The Healthy Families Program is a CPS program for families with complex social issues that compromise the health of children. Families referred may not have any previous CPS referrals.

If the Health Start Program Coordinator suspects a child has developmental delays or physical disabilities, or the child has suspicious results on the Ages & Stages screening despite repeat testing, the Contractor will contact Arizona Early Intervention Program (AzEIP) for possible referral or evaluation.

Whether it is feasible to transition the client to another program or not, the community health worker will document contact with the other program(s) and all follow up. All parties, including the client, will be included in the discussion of a transition to another program. The contractor will ensure that enrolled Health Start clients are not receiving duplicate services by other Home Visiting programs at the same time while receiving services under the Health Start Program.

CHAPTER 8
DATA COLLECTION AND REPORTING REQUIREMENTS

8.1 Overview of Requirements

The forms used by the Health Start program to collect data and information each have a special purpose. Data contained on these forms provides the Health Start Program and its Contractors with information on the performance of the individual program sites, and on the Health Start program as a whole. Contractors will have procedures in place to review the completeness, accuracy, and integrity of the information submitted on the forms. Information on the data that is required to be completed on each form as documentation of a billable: Negative Pregnancy Test visits, Client Enrollments, High Risk Nurse Home visits, Client Prenatal visits, Family Follow-up and Multiple Child visits, Prescheduled Classes, Enhanced Alcohol Screening visits, Enhanced Brief Intervention visits, Nurse Consultation, Social Work/CPC Consultation, Approved Community Health Worker Training.

In this chapter, each form will be briefly outlined, including a description of the purpose of the form, whether it is mandatory or optional, due dates if any, and where the form should be sent or filed. A summary of this information is included on the Health Start Forms Schedule (Section 8.3). Instructions on completing each form are included with a sample of the actual form. Refer to the glossary for definition of terms used on forms.

8.2 Client Files

Community health workers and community health nurses will document all pertinent information about client interactions in a confidential client file and provide client visit notes written in English. All documentation will reflect professional, nonjudgmental statements of fact. Contractors may specify documentation procedures to be followed by community health workers in preparation and organization of the client file; however, at a minimum, a record of all client contacts and supporting documentation forms will be maintained in client/family files.

8.3 Health Start Forms Schedule

Sequence	*Frequency*	*EVENT*	*HEALTH START FORM*	*PROCESSING OF FORM*
1.	One time only	Initial Contact with a potential client who may be pregnant but isn't sure and requests a pregnancy test. Contractor explains Health Start Program to potential client and has client sign Intent to Participate Form. Contractor arranges for the administration of a pregnancy test. If test is negative, Contractor provides preconception/interconception care education to woman. If test is positive, potential client is offered enrollment if client meets other eligibility criteria for Program.	Intent to Participate Form Negative Pregnancy Test Visit	1 copy in Client File 1 copy to Client 1 copy in Client File 1 copy to Health Start Program
2.	One time only	Initial Contact with a potential client who is pregnant and/or postpartum and meets eligibility criteria. Potential client is offered enrollment in Health Start Program and agrees to participate. Client signs the Intent to Participate form and Community Health Worker/Community Health Nurse fills out the information on the Client Enrollment Form. A Child Information Form is filled out for all children up to age two for postpartum enrollment.	Intent to Participate Form Client Enrollment Form Child Information Form	1 copy in Client File 1 copy to Client 1 copy in Client File 1 copy to Health Start Program 1 copy in Client File 1 copy to Health Start Program
3.	High Risk Nurse Home Visits (1 – 3 times per year/client up to age 1)	Community Health Nurse conducts a home visit with a post-partum client and her high risk infant. The Community Health Nurse visit box is checked on form.	Family Follow-up Form	1 copy in Client File 1 copy to Health Start Program
4.	Prenatal Visits (1-4 visits per month/per client)	Community Health Worker conducts a prenatal visit with client. Any prenatal visit that includes a family follow-up visit with Health Start enrolled child on the same day, will be a multiple child visit.	Prenatal Visit Form	1 copy in Client file 1 copy to Health Start Program

5.	Family Follow-up Visits (1-4 visits per month/client up to age two)	Community Health Worker visits client after delivery within the first two weeks after the birth. A second Family Follow-Up Form is filled out if there is more than one child visited at the same time on the same day. This is considered a Multiple Child Visit and the Multiple Child box is checked on the form. A Family Follow-Up Form is filled out for each additional child visited at the same time on the same day, up to the age of two.	Family Follow-Up Visit Form	1 copy in client file 1 copy to Health Start Program
6.	Class Attendance Record (each class completed with a minimum of 4 clients lasting a minimum of one hour)	Community Health Worker conducts a class for Health Start Clients. Contractor may conduct planned classes on educational topics related to maternal and child health throughout the contract year. A minimum of four clients are required to attend the class.	Class Attendance Record	1 copy in Client file 1 copy to Health Start Program
7.	Enhanced Alcohol Screening Visit	Community Health Worker conducts alcohol screening of prenatal client at first or next visit after enrollment.	Form C – Screening Questions with TWEAK	1 copy in Client file 1 copy to Health Start Program
8.	Enhanced Brief Intervention Visit	Community Health Worker conducts brief intervention education with prenatal clients who have scored 2 or higher once and again at 36 weeks.	Form E – Process Information Form	1 copy in Client file 1 copy to Health Start Program
9.	Consultation Services	Health Start Program Contractor consultants: nurse, social worker, or licensed professional counselor, provide services. Contractor provides documentation of services including type and description of services, number of hours and $ amount billed, and signature of consultant	Contractor consultant form	1 copy in Consultant file 1 copy to Health Start Program
10	Approved Community Health Worker Training	Contractor obtains prior approval from Health Start Program to attend training. Contractor provides documentation of attendance/completion of training.	Certificates of Attendance/ Completion of Training Forms	1 copy in Staff Personnel file 1 copy to Health Start Program

11	Never Shake A Baby	Community Health Worker provides Never Shake A Baby (NSB) education to clients after delivery. Commitment forms are signed by client.	Commitment Forms	1 copy in Client file 1 copy to Health Start Program
12	Edinburgh Postnatal Depression Screening	Community Health Worker provides Edinburgh Postnatal Depression Screening	Edinburgh Postnatal Depression Scale	1 copy in Client file

8.4 Intent to Participate Explanation

The Intent to Participate form is a very important document that must be signed by the client <u>before</u> the community health worker can <u>record</u> any demographic or medical information from the client. If the client declines to sign the Intent to Participate, then the community health worker <u>cannot</u> proceed with any of the Health Start Enrollment procedures. This document must be signed in order for the potential client to receive any services (pregnancy testing, referrals, enrollment). Health Start benefits, including home visits from the community health worker cannot occur until this form is signed. The Intent to Participate form indicates the client's desire to receive services, their understanding of the level of services chosen and their agreement that data gathered will be shared with Arizona Department of Health Services. If the client is a minor living with the minor's parent or guardian, home visits shall not be provided unless the minor's parent or guardian also signs the Intent to Participate for the client's enrollment into the program and to receive home visits. The original signed Intent to Participate Form will be placed in the client record with a copy given to the client.

The Intent to Participate form is available in English and Spanish (See pages 8-8 and 8-9 at the end of this chapter). Additional information about the Intent to Participate agreement process is found in Chapter 6.

8.5 Client Enrollment

The Client Enrollment form is intended to document basic demographic information about the Health Start client. Community health workers are required to complete this form for all persons who enroll with the program if they meet eligibility criteria and elect to participate. (See page 8-10 located at the end of this chapter). If the community health worker is following a client postpartum and the client has had twins, triplets, etc. the community health worker only needs to fill out one Client Enrollment Form. Client enrollment is limited to a maximum of three enrollments per client. Additional enrollments by one client must be approved by ADHS.

8.6 Prenatal Visit

Community health workers complete a Prenatal Visit Form for each prenatal visit. Important components of the form include documentation about educational topics discussed with the client, referrals made during the visit and pregnancy warning signs. If any pregnancy warning signs are present, the community health worker will advise the client (and assist if needed) to contact the client's health care provider for the pregnancy urgently. This referral will be noted in the referral portion of the Prenatal Visit form. (See page 8-11 located at the end of this chapter). Prenatal visits are limited to four (4) visits per month and must be a minimum of 30 minutes per visit.

8.7 Family Follow-Up Visit

Community health workers or community health nurses complete Family Follow Up forms for each family follow-up visit beginning with the first visit after delivery. Important components of the form include documentation about birth outcome, education provided, child's immunization status, review of "developmental milestones" and referrals made during the visit. If there is more than one index child (multiple birth or previous index child less than two years old from program participation), a second Family Follow Up Visit form will be completed for second child's information and visit date only and will be checked as a multiple child visit. Family follow-up visits are limited to four (4) per client per month for a minimum of 30 minutes per visit for community health workers and three (3) per year up to age one (1) for community health nurses. (See page 8-12 located at the end of this chapter).

8.8 Class Attendance Record

The community health worker completes a Class Attendance Record for each class they provide for Health Start clients. There must be at **least four (4)** Health Start clients in attendance for the class to be submitted for reimbursement. The community health worker should check all applicable topics being discussed during the class. If less than four Health Start clients attend one class, the community health worker may combine two different Class Attendance Records on different dates, as long as the class topic is exactly the same for each class, and the total attendance is as least four Health Start clients and the classes were held in the same contract year. (See page 8-16 located at the end of this chapter).

8.9 Status Closed Record

The community health worker will complete a Status Closed Record whenever a client ends their participation in the Health Start Program. There are seven (7) identified reasons why a client would no longer be participating in the Health Start Program: they have Completed Family Follow-up; they were Referred to a Specialized Program; they Withdrew From the Program; the community health worker made at least three attempted visits (dates recorded on the form) with no

contact made with or contact received from the client; this is referred to as Lost To Follow-up/Moved and the community health worker can terminate the client's enrollment in the program; the client Refused Family Follow-up after completing the prenatal portion of the program; there was a Pregnancy Loss; or the client transferred to another Health Start site. (See page 8-14 located at the end of this chapter).

8.10 Procedures for Sending Forms to Health Start Program Manager

All Negative Pregnancy Test Visit forms, Enrollment forms, Prenatal Visit forms, Alcohol Screening and Brief Intervention forms, Family Follow Up Visit forms, Class Attendance Record forms, consultation documentation, training documentation and Status Closed Record forms will be sent to Health Start Program Manager with each monthly invoice and client log. Forms will be sent by certified mail and addressed to Health Start Program Manager. Health Start Program staff will enter data from these forms into the Health Start database and store client forms in a secure and confidential manner. Illegible or incomplete forms may be returned to the Contractor for clarification or completion. The Contractor's Health Start Program Coordinator will employ quality review and control procedures to ensure that the data on the forms is accurate and complete. If there are many incomplete/missing forms, the Data Preparation Unit may be deducted from monthly billing. Submission of billing invoices is described separately in Chapter 10.

8.11 Procedures for Requesting Reports on Site Data and Aggregate Program Data

Much of the data and information needed by Contractors to monitor program quality may be provided periodically to the Contractors by Health Start Program Manager. Refer to Section 11.4 for a description of the current data indicators being collected. Contractors may request additional management reports on site-specific data and aggregate program data from the Health Start Program Manager.

8.12 Ages and Stages Developmental Assessment

The Ages and Stages Developmental Assessment will be administered to all index children at the ages of four (4) months, eight (8) months, twelve (12) months, eighteen (18) months and twenty-four (24) months (if needed). The community health worker can decide whether the assessment should be done at additional ages. The Ages and Stages Developmental Assessment is a screening tool that is designed for either the parent(s) or a healthcare provider to complete. The community health worker can assist with the assessment if the parent(s) are having difficulty with the questions and/or if the community health worker feels that for some reason the parent(s) is not able to appropriately assess their child. Assessment records are maintained in client files at the contractor site. Forms are available in English and Spanish. The Social Emotional Assessment may be provided at 12 months and 18 months to all children to identify future difficulties.

For the best results, the community health worker and parent(s) will sit down and discuss each item as they evaluate the infant/child. The Ages and Stages Developmental Assessment does not have a pass/fail result. Scores in five areas are either “doing well” or a recommendation is made to “talk to a professional for possible further evaluation”. Children who have developmental results recommending “talk to a professional for possible further evaluation” will be referred to Arizona Early Intervention Program.

8.13 SafeHome/ SafeChild Safety Assessment

The Arizona SafeHome/SafeChild system is the outcome of a project begun in 1995 as a community-based collaboration led by Pima County Health Department’s Division of Public Health Nursing. Arizona Department of Health Services’ Office of Women’s and Children’s Health Early Childhood Education, Arizona Department of Health Services Office of Prevention, and Office of Injury Prevention. Community health workers and Health Start Coordinators are trained in this safety assessment system. SafeHome/SafeChild assesses home, water, environmental, and automobile potential hazards. Community health workers also provide in-home demonstrations on safety devices.

The Arizona SafeHome/SafeChild assessment is voluntary; the law that governs Health Start does not mandate it. Therefore, though it is recommended that the community health worker do an Arizona SafeHome/SafeChild assessment in the home, a client can refuse. If the client does not want the assessment done in their home by the community health worker, the community health worker needs to document this in the client file. The community health worker will then provide the Arizona SafeHome/SafeChild assessment information as an educational topic and explain to the client the importance of the assessment and instruct the client on how to do a self-administered assessment. The community health worker will document in the client file that they have done this. Either the community health worker or the client should conduct the initial assessment **when the child is four or five months of age**. The assessment may be updated at any time. Arizona SafeHome/SafeChild safety assessment results are maintained in the client’s file at the contractor site. The community health worker can use their discretion whether they feel the assessment should be done prenatal as well. A copy of the Arizona SafeHome/SafeChild Checklist (English and Spanish) is at the end of the chapter.

Intent to Participate in the Health Start Program

My name is _____

Client initials in boxes for desired type of participation

I am requesting a pregnancy test because I think I may be pregnant and may qualify for the Health Start Program and would like the Community Health Worker to meet with me and give me more information. I understand that the information recorded about me on the Health Start Enrollment form will be kept confidential by the Community Health Worker but will be shared with Arizona Department of Health Services for the purpose of understanding more about the health care needs of my community.

I am pregnant and would like Community Health Worker visits. My Community Health Worker will meet with me at least once a month, while I am pregnant, and then she will visit regularly until my child is 2 years old. She will keep a record of our visits. I have the right to look at my record and correct any information I think is inaccurate. The forms will be shared with the Arizona Department of Health Services for statistical purposes. If I am involved in court proceedings in the future, a review of this record may be required.
During these visits, my Community Health Worker will:

- Help me get into prenatal care and help me to understand my caregiver's instructions.
- Show me how to sign up for AHCCCS, WIC and other assistance services, if I need them.
- Give me emotional support while I am pregnant and after I have the baby.
- Teach me about pregnancy and having a healthy baby, and ways to keep my family, my baby and myself healthy.
- Teach me how my children should grow and develop and refer me to early childhood education and other programs my children may need.

I have had a baby within the past two years and would like Community Health Worker visits. My Community Health Worker will meet with me regularly until my child is 2 years old. She will keep a record of our visits. I have the right to look at my record and correct any information I think is inaccurate. The forms will be shared with the Arizona Department of Health Services for statistical purposes. If I am involved in court proceedings in the future, a review of this record may be required.
During these visits, my Community Health Worker will:

- Help me understand any information from my baby's health care provider.
- Show me how to sign up for AHCCCS, WIC and other assistance services, if I need them.
- Give me emotional support.
- Teach me about having a healthy baby, and ways to keep my family, my baby and myself healthy.
- Teach me how my children should grow and develop and refer me to early childhood education and other programs my children may need.

I have recently had a baby within the last month that was in the Newborn Intensive Care Unit five (5) days or longer and is not being followed by the ADHS HRPP Program and would like Community Health Nurse visits.

I read the information and my Community Health Worker/Community Health Nurse answered my questions. I have initialed the type of services I would like to have in the Health Start Program.
I know that my Community Health Worker/Community Health Nurse has been trained to help me. The CHW is not a licensed medical person, but can call my care giver or other people who may be able to answer my questions.
I know that I do not have to pay any money for this service and that I can stop being in the program at any time. The information I give the Community Health Worker/Community Health Nurse will not be shared with neighbors in my community without my permission, but may be shared with mine or my child's health care providers.
I will try to keep all my appointments with my health care provider and Community Health Worker/Community Health Nurse. I will also try to make and keep appointments for my children to get their shots (Immunizations) and keep them healthy.

_____ _____
Signature Date

_____ is a minor and living with me in my home. I give permission for her to enroll in Health Start and for the Community Health Worker/Community Health Nurse to visit her in my home.

_____ _____ _____
Signature of Parent or Legal Guardian Date Witness Date

Forma Para Participar en el Programa de Comienzo Sano

Mi nombre es: _____

Iniciales de los clientes en los cuadros para determinar el tipo de participación.

☐ Yo estoy solicitando una prueba de embarazo porque pienso que estoy embarazada y puedo calificar para el Programa de Comienzo Sano y me gustaría que la promotora se entrevistara conmigo y me proporcionara información. Yo entiendo que la información que se registra en la forma del Registro del Programa será confidencial pero será compartida con el Departamento de Servicios de Salud de Arizona con el propósito de entender más acerca de las necesidades de servicios de salud en mi comunidad.

☐ Yo me encuentro embarazada y me gustaría que me visitara la Promotora por lo menos una vez al mes, mientras me encuentre embarazada, y después me visitara regularmente hasta que mi hijo cumpla dos (2) años. Ella mantendrá un archivo de nuestros encuentros. Yo tengo todo el derecho de ver mi archivo y corregir información cuando yo lo juzgue necesario. Las formas serán compartidas con el Departamento de Servicios de Salud de Arizona con el propósito de establecer estadísticas. Si en el futuro yo estoy involucrada en un proceso legal, este archivo pudiera ser citado para revisión.

Durante estas visitas, mi Promotora:

- me ayudará a obtener cuidado prenatal y a entender las indicaciones y la información que me han proporcionado mis proveedores médicos
- me ayudará a aplicar para AHCCCS, WIC, y otros servicios de ayuda, si los necesito
- me apoyará emocionalmente mientras estoy embarazada y después del nacimiento de mi bebé
- me enseñará acerca de lo que puedo esperar en el embarazo y de tener un bebé saludable, y como conservar mi salud, la de mi bebe y la de mi familia.
- me enseñará cómo mis niños deben crecer y desarrollarse, y me recomendará programas de educación en la infancia y otros que mis hijos pueden necesitar.

☐ Yo tuve a mi hijo dentro de los últimos dos (2) años y me gustaría que me visitara la Promotora. La Promotora me visitara periódicamente hasta que mi hijo cumpla dos (2) años. Ella mantendrá un archivo acerca de la visitas. Yo tengo el derecho de ver mi archivo y corregir cualquier error. Las formas serán compartidas con el Departamento de Servicios de Salud de Arizona con el propósito de establecer estadísticas. Si en el futuro yo estoy involucrada en un proceso legal, este archivo pudiera ser citado para revisión.

Durante estas visitas, mi Promotora:

- me ayudará a entender la información médica proporcionada por los proveedores médicos de mi hijo
- me ayudará a aplicar para AHCCCS, WIC, y otros servicios de ayuda, si los necesito
- me brindará apoyo emocional
- me enseñará acerca de lo que es tener un bebé saludable, y como conservar mi salud, la de mi bebe y la de mi familia.
- me enseñará cómo mis niños deben crecer y desarrollarse y me recomendará programas de educación en la infancia y otros que mis hijos pueden necesitar.

☐ Yo tuve a mi bebe dentro del último mes que estuvo cinco (5) días o más en la Unidad de Terapia Intensiva de Recién Nacidos y no se le está haciendo seguimiento por el programa de HRPP (Programa Perinatal de Alto Riesgo) de ADHS (Servicios de Salud del Departamento de Arizona) y me gustaría que la Enfermera Comunitaria le hiciera visitas.

Leí la información y la Promotora/Enfermera Comunitaria respondieron mis preguntas. Yo puse mis iniciales en el tipo de servicios que quiero obtener en el Programa de el Comienzo Sano. Entiendo que mi Promotora está entrenada para ayudarme. Ella no tiene licencia médica, pero puede llamar al médico o a otras personas que pueden contestar mis dudas o preguntas. Entiendo que este servicio es gratuito y que yo puedo salirme de este programa a mi conveniencia. La información que yo proporcione a mi Promotora/Enfermera Comunitaria no será compartida con otros en mi comunidad sin mi autorización o consentimiento, pero podrá ser compartida con mis proveedores médicos o los de mi hijo.
Trataré de cumplir con mis citas con el médico y con mi Promotora/Enfermera Comunitaria. También, trataré de hacer citas y cumplir con ellas para llevar mis niños a vacunarse para que se mantengan saludables.

_____ _____
Firma Fecha

_____es menor de edad y vive conmigo en mi casa. Doy mi permiso para que se inscriba en el Programa de Comienzo Sano, y que la visiten en mi casa la Promotora/Enfermera Comunitaria.

_____ _____ _____
Firma del Padre o Tutor Legal Fecha Testigo Fecha

Arizona Department of Health Services

HEALTH START PROGRAM CLIENT ENROLLMENT FORM

Prenatal ☐ **Postpartum** ☐ **NICU** ☐

Contractor ID/Site Code: _____ **Mother's DOB:** _____

CHW/CHN Name: _____ **Enrollment Date/Type:** _____

Client ID (ADHS Only): _____ **Current/Prev enrolled in Health Start?** ☐ **Yes** ☐ **No** ☐ **Not Sure**

Enrollment ID (ADHS Only):_____

Mother's Last Name | **Mother's First Name** | **MI** | **Alias / Maiden/Married**

Residential Address | **City**

ZIP Code | **County** | **Telephone Number**

Mailing Address (if different from above)

Directions to Home

SOCIAL RISK ASSESSMENT:

MARITAL STATUS:
- ☐ Married
- ☐ Unmarried lvg w/partner
- ☐ Divorced/separated
- ☐ Never Married

LIVING SITUATION:
- ☐ With Father of Child
- ☐ With Parents
- ☐ With Grandparents
- ☐ With Extended Family
- ☐ Other:
- ☐ Living alone

RACE/ETHNICITY:
- ☐ African American
- ☐ Asian/Pacific Islander
- ☐ Hispanic or Latino
- ☐ Native American
- ☐ White Non Hispanic
- ☐ Other:

EDUCATION LEVEL:
- ☐ College Graduate
- ☐ Some College
- ☐ Tech/Trade School
- ☐ HS Graduate
- ☐ Attending HS
- ☐ Less than HS

HOUSEHOLD INCOME:
- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $29,999
- ☐ $30,000 to $39,999
- ☐ $40,000 or more
- ☐ Don't Know/Refuse

INCOME SOURCE(S):
- ☐ Own full time job
- ☐ Own part time job
- ☐ Partner, full time job
- ☐ Partner, part time job
- ☐ AFDC/TANF
- ☐ Social Security
- ☐ Child Support
- ☐ Disability
- ☐ Other
- ☐ None
- ☐ Parent Support

HOUSEHOLD SIZE:
How many people live in your household?

REFERRAL TO HEALTH START:
- ☐ CHC/CHD
- ☐ CPS
- ☐ DES
- ☐ Friend/Family
- ☐ Healthy Families
- ☐ Hospital
- ☐ Community Based Agency _____
- ☐ IHS
- ☐ Medical Provider
- ☐ School
- ☐ Tribal
- ☐ WIC

INSURANCE TYPE:
- ☐ AHCCCS
- ☐ IHS-Non AHCCCS
- ☐ Kids Care
- ☐ Private
- ☐ None

AHCCCS STATUS:
- ☐ Enrolled
- ☐ Applied Waiting
- ☐ Denied
- ☐ Refuses to Apply

MEDICAL PRENATAL/POST PARTUM RISK ASSESSMENT: (Check all that apply)

Risk Factors
- ☐ Preterm birth/labor
- ☐ Low birth weight (< 5lbs, 8oz.)
- ☐ High birth weight (> 10lbs)
- ☐ Birth defects
- ☐ Miscarriage
- ☐ Previous birth complications
- ☐ Previous termination
- ☐ Kidney disease
- ☐ Anemia
- ☐ Diabetes (GDM, Type 1 -2)
- ☐ Weight (< 100lbs or obese)
- ☐ Height (< 5' 0")
- ☐ High Blood Pressure
- ☐ HIV/AIDS or STDs
- ☐ Prev/Current Multiple Births
- ☐ Birth spacing < 2 years
- ☐ Age (≤ 18 or ≥ 35)
- ☐ Alcohol use
- ☐ Tobacco Use
- ☐ Cocaine/other illicit drug use
- ☐ Bacterial Vaginosis
- ☐ Urinary tract infections
- ☐ Vaginal hemorrhaging
- ☐ Lack of dental care

Social Risk Factors
- ☐ Prenatal/Postpartum depression
- ☐ Domestic Violence
- ☐ Lack of Social /Family Support
- ☐ Lack of basic needs -food, shelter, transportation, unsafe neighborhood
- ☐ No OB/GYN or PC Providers in area
- ☐ Unemployed/lack of job opportunities
- ☐ Less than high school education

PROGRAM STATUS:

Eligible:
- ☐ Pregnant
- ☐ Pregnant and Post Partum
- ☐ Post Partum
- ☐ Transferred

PREGNANCY STATUS:

Pregnancy Test (CHW):
- ☐ Positive

Date administered:_____

Trimester of Pregnancy
- ☐ 1st ☐ 2nd ☐ 3rd ☐ Post Partum

Currently receiving prenatal care?
- ☐ Yes ☐ No Name of Provider:_____

Expected Delivery Date: _____ ☐ Not Sure

How many weeks Pregnant is the client: _____

Arizona Resource Guide given:
- ☐ Yes ☐ No

Father of Child: _____

SCREENING CHECKLIST:

☐ Alcohol Screening _____# ☐ Depression Screening _____#

Arizona Department of Health Services

PRENATAL VISIT FORM
HEALTH START PROGRAM

Contractor ID# _____

Place of Meeting _____

Length of Visit (Min.30mts)
Start Time: _____ **End Time:** _____

Visit Date _____ **Community Health Worker/CHN** _____

Mother's Last Name _____ **First Name** _____ **MI** _____

Alias/Maiden/Married _____ **DOB** _____ **Client ID/Enrollment ID (ADHS)** _____

INSURANCE STATUS:
- ☐ AHCCCS
- ☐ IHS – Non AHCCCS
- ☐ Kids Care
- ☐ Private
- ☐ None

Since the first visit when we talked about drinking, have you had an alcoholic drink?
☐ Yes ☐ No

INCOME: SOURCES:
(Check all that apply)
- ☐ Own full time job
- ☐ Own part time job
- ☐ Partner, full time job
- ☐ Partner, part time job
- ☐ AFDC/TANF
- ☐ Social Security
- ☐ Child Support
- ☐ Disability
- ☐ Other
- ☐ None
- ☐ Parent Support

MARITAL STATUS:
- ☐ Married
- ☐ Unmarried living w/partner
- ☐ Divorced/separated
- ☐ Never Married

AHCCCS STATUS:
- ☐ Enrolled
- ☐ Applied Waiting
- ☐ Denied
- ☐ Refuses to Apply

EDUCATIONAL TOPICS DISCUSSED:
- ☐ Abuse/Domestic Violence
- ☐ Alcohol Use
- ☐ Bereavement
- ☐ Breastfeeding
- ☐ Changes After Pregnancy
- ☐ Changes During Pregnancy
- ☐ Chronic Disease
- ☐ Community Resources
- ☐ Dental Health
- ☐ Diabetes
- ☐ Emotions/Feelings
- ☐ Environmental Hazards
- ☐ Exercise/Physical Activity
- ☐ Family Planning/Birth Spacing
- ☐ Fetal Growth & Development
- ☐ Fetal High Risk Condition
- ☐ Fetal/Infant Nutrition/Diet
- ☐ Finances
- ☐ Gestational Diabetes
- ☐ Health Insurance
- ☐ Health Start Program
- ☐ Healthy Weight
- ☐ Immunizations – Client
- ☐ Infant/Newborn Care
- ☐ Labor & Delivery
- ☐ Maternal Diet
- ☐ Maternal High Risk Conditions
- ☐ Medications/Vitamins/Folate
- ☐ Newborn Screening
- ☐ Parenting
- ☐ Prenatal Care
- ☐ Prenatal/Postpartum Depression
- ☐ Safety (Car Seats)
- ☐ Safety (Home)
- ☐ SIDS
- ☐ STDS
- ☐ Tobacco/Drug Use
- ☐ Stress Reduction
- ☐ Women's Health
- ☐ Other _____

Since the last visit have any risk factors changed?
☐ Yes ☐ No If Yes, explain_____

DANGER SIGNS: Does your client have any of the following **DANGER SIGNS?** * (Update only if danger signs are new or have changed)

Yes	No		Yes	No		Yes	No	
☐	☐	Back Pain	☐	☐	Contractions	☐	☐	Swelling (Face, hands, Feet)
☐	☐	Bleeding	☐	☐	Cramping	☐	☐	Vaginal Discharge
☐	☐	Blurred Vision	☐	☐	Fever	☐	☐	Other
☐	☐	Burning (Urination)	☐	☐	Headaches			

REFERRAL TO COMMUNITY RESOURCES:
(R: Client was Referred; V: Verified that client went to referral; D: Denied – Client denied referral or was denied or did not qualify for services)

R	V	D		R	V	D		R	V	D		R	V	D		R	V	D	
☐	☐	☐	Adult Education	☐	☐	☐	Child Care	☐	☐	☐	Food Stamps	☐	☐	☐	Nursing Care	☐	☐	☐	SSA
☐	☐	☐	AFDC/TANF	☐	☐	☐	Dental Care	☐	☐	☐	Genetics Services	☐	☐	☐	Parenting Classes	☐	☐	☐	Substance Abuse
☐	☐	☐	AHCCCS	☐	☐	☐	Employment	☐	☐	☐	Health Families/CPS	☐	☐	☐	Prenatal Care	☐	☐	☐	Transportation
☐	☐	☐	Bereavement	☐	☐	☐	Faith-Based	☐	☐	☐	Immunizations	☐	☐	☐	Primary Care	☐	☐	☐	Unemployment
☐	☐	☐	Breastfeeding	☐	☐	☐	Family Planning	☐	☐	☐	Kids Care	☐	☐	☐	Social Services/	☐	☐	☐	WIC
☐	☐	☐	Childbirth Classes	☐	☐	☐	Food Bank	☐	☐	☐	Mental Health				Counseling	☐	☐	☐	FASD Referral

Agency: _____

Does Your Client Plan to Breastfeed Her Baby? ☐ Yes ☐ No
Has a Family Planning Goal Been Identified? ☐ Yes ☐ No
Date of Next CHW Visit: _____
Date of Last Medical Prenatal Visit: _____
Date of Next Medical Prenatal Visit: _____
Name of Provider: _____ Expected Delivery Date (EDD): _____

Client Signature: _____ ***Date:*** _____

Arizona Department of Health Services

FAMILY FOLLOW-UP FORM
HEALTH START PROGRAM

_____
Contractor ID#

_____
Place of Meeting

_____
Length of Visit (Min.30mts)

Start Time: _____End Time:_____

_____ Multiple Child Visit ☐ yes ☐ no CHN Visit ☐ _____
Visit Date **Community Health Worker/CHN**

_____ _____ _____
Mother's Last Name **First Name** **MI**

_____ _____ _____
Alias/Maiden/Married **DOB** **Client ID/Enrollment ID (ADHS)**

_____
If Applicable, New Address **New Phone Number**

Update Only if Status Has Changed

MARITAL STATUS:
- ☐ Married
- ☐ Unmarried living w/partner
- ☐ Divorced/Separated
- ☐ Never Married

INSURANCE STATUS:
- ☐ AHCCCS
- ☐ IHS – Non AHCCCS
- ☐ Kids Care
- ☐ Private
- ☐ None

AHCCCS STATUS:
- ☐ Enrolled
- ☐ Applied Waiting
- ☐ Denied
- ☐ Refuses to Apply

SOURCES OF INCOME:
- ☐ Own full time job
- ☐ Own part time job
- ☐ Partner, full time job
- ☐ Partner, part time job
- ☐ AFDC/TANF
- ☐ Social Security
- ☐ Child Support
- ☐ Disability
- ☐ Parent Support
- ☐ Other ☐ None

QUESTIONS:
Did mother have a medical post-partum visit? ☐ Yes ☐ No
Has a family planning goal been identified? ☐ Yes ☐ No

EDUCATIONAL TOPICS DISCUSSED:
- ☐ Abuse/Domestic Violence
- ☐ Never Shake A Baby
- ☐ Bereavement
- ☐ Breastfeeding
- ☐ Changes After Pregnancy
- ☐ Chronic Disease
- ☐ Community Resources
- ☐ Dental Health – Child
- ☐ Diabetes
- ☐ Early Childhood Education
- ☐ Emotions/Feelings
- ☐ Finances
- ☐ Health Insurance
- ☐ Health Start Program
- ☐ Hearing/Vision Testing
- ☐ Immunizations – Child
- ☐ Infant/Child Health & Development
- ☐ Infant/Child High Risk Conditions
- ☐ Infant/Child Nutrition/ Diet
- ☐ Infant/Newborn Care
- ☐ Inter-conception Care
  - ❍ Family Planning/Birth Spacing
  - ❍ Tobacco/Drug Use
  - ❍ Alcohol Use
  - ❍ Maternal Diet
  - ❍ Healthy Weight
  - ❍ Dental Health – Client
  - ❍ Exercise/Physical Activity
  - ❍ Stress Reduction
  - Reproduction Life Plan
  - Mental Health
- ☐ Medications/Vitamins/Folate
- ☐ Maternal High Risk Conditions
- ☐ Newborn Screening
- ☐ Prenatal/Post Partum Depression
- ☐ Parenting
- ☐ Paternity Establishment
- ☐ Safety – Car Seats
- ☐ Safety – Home
- ☐ SIDS
- ☐ STDs
- ☐ Transportation
- ☐ Women's Health
- ☐ Other _____

REFERRAL TO COMMUNITY RESOURCES:
(R: Client was Referred; V: Verified that client went to referral; D: Denied – Client denied referral or was denied or did not qualify for services)

R V D		R V D		R V D		R V D		R V D	
☐☐☐	Adult Education	☐☐☐	Dental	☐☐☐	Food Stamps	☐☐☐	Nursing Care	☐☐☐	SSA
☐☐☐	AFDC/TANF	☐☐☐	Early Childhood Educ	☐☐☐	Genetics Services	☐☐☐	Parenting Classes	☐☐☐	Substance Abuse
☐☐☐	AHCCCS	☐☐☐	Employment	☐☐☐	Healthy Families/CPS	☐☐☐	Prenatal Care	☐☐☐	Transportation
☐☐☐	AZEIP	☐☐☐	Faith-Based	☐☐☐	Immunizations	☐☐☐	Primary Care	☐☐☐	Unemployment
☐☐☐	Bereavement	☐☐☐	Family Planning	☐☐☐	Kids Care	☐☐☐	Social Services/ Counseling	☐☐☐	WIC
☐☐☐	Child Care	☐☐☐	Food Bank	☐☐☐	Mental Health				

Safe Home/Safe Child Assessment: ☐ Assessment completed (4-6 months) ☐ Assessment Updated: ☐ No Update

PREGNANCY OUTCOME: ☐ Live Birth ☐ Still Born ☐ Miscarriage **Problems in Delivery:** _____
Child ID/Enrollment ID (ADHS Only): _____
BABY'S NAME_____ **BABY'S DOB:** _____ **SEX:** ☐ M ☐ F

BIRTH HOSPITAL: _____ **BIRTH WEIGHT: (lbs., oz.):** _____

CHILD'S BIRTH CERTIFICATE #: _____ **Client Satisfaction Survey after delivery:** ☐ Yes ☐ No

QUESTIONS:
Is the Mother breastfeeding? ☐ Yes ☐ No
Is this the 2-year visit? ☐ Yes ☐ No
Has the baby been hospitalized since the last visit? ☐ Yes ☐ No
Has the child had well child checks? ☐ Yes ☐ No
Are immunizations up to date? ☐ Yes ☐ No ☐ unknown

Ages & Stages Assessment
Child's Age (months) ☐ 4 M ☐ 8 M ☐ 12 M ☐ 18 M ☐ 24M
Other _____
☐ Normal ☐ Suspicious ☐ Referred

Date of next well child check up: _____

Client Satisfaction Survey Provided (after baby is born/after closing): ☐ Yes ☐ No
INSURANCE TYPE (BABY): ☐ AHCCCS ☐ IHS – Non AHCCCS ☐ Kids Care ☐ Private ☐ None

CHILD'S DATE OF DEATH: _____ MOTHER'S DATE OF DEATH: _____

Client Signature: _____ ***Date:*** _____

Arizona Department of Health Services

HEALTH START PROGRAM
NEGATIVE PREGNANCY TEST VISIT FORM*

Contractor ID/Site Code: _____ **Place of Visit:** _____

Length of Visit: _____ **Start Time:** _____ **End Time:** _____ **Visit Date:** _____

Community Health Worker: _____ **Previously enrolled in Health Start** ☐ **Yes** ☐ **No** ☐ **Not Sure**

_____ _____ _____ _____
Woman's Last Name **First Name** **MI** **Alias**

_____ _____
DOB **AGE**

Ethnicity:
- ☐ **African American**
- ☐ **Asian/ Pacific**
- ☐ **Hispanic or Latino**
- ☐ **Native American**
- ☐ **White Non Hispanic**
- ☐ **Other**

Results of Pregnancy Test: _____ _____

☐ **Positive (if Positive, offer Enrollment in Health Start)**

☐ **Negative* (if Negative, provide education and referrals)**
- **Only Negative Pregnancy Test Visits to non-enrolled Health Start Clients are billable; no more than two pregnancy tests per woman per contract year**

Preconception / Interconception Topics Discussed:

☐ **Preconception / Interconception Care Topics**
- o Family Planning/ Birth Spacing
- o Tobacco/ Drug Use
- o Alcohol Use
- o Maternal Diet
- o Healthy Weight
- o Dental Health – Client
- o Exercise/Physical Activity
- o Stress Reduction

Reproduction Life Plan
Mental Health
- o Other Women's Health

Referrals Made To:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

STATUS CLOSED RECORD
HEALTH START PROGRAM

Contractor Name and ID Number: _____

Community Health Worker/
Community Health Nurse: _____

_____ _____ _____
Mother's Last Name **Mother's First Name** **MI**

_____ _____
Alias **DOB**

_____ _____
Name of Child* **DOB**

Reason Closed:

☐ Completed Family Follow-Up

☐ Lost To Follow-up/Moved
Attempted Visit Date (3)
_____
_____
_____

☐ Pregnancy Loss
☐ Still Born
☐ Other Loss

☐ Referred To Specialized Program
☐ Withdrew from Program
☐ Adoption
☐ Child Removed from Home

☐ Refused Family Follow-Up
☐ Death of Child
☐ Mother Removed/Left Home

☐ Transferred Sites
☐ Death of Mother

Client Satisfaction Survey Provided:

☐ Yes _____ (date / sent)

☐ No (please explain) _____

Effective Date: _____

** Only list child being closed.*

Exit Interview Satisfaction Questions: On Next Page

Health Start Site: _____

Health Start Client Satisfaction Survey (example)

PLEASE MARK YOUR ANSWERS BY FILLING IN THE BUBBLES COMPLETELY **In order to further improve Health Start Program, we need to know what you think about the services you received.**	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**
1. I like the services that I received as a part of the Health Start Program.	○	○	○	○	○	○
2. If I had other choices, I would still get services from this agency.	○	○	○	○	○	○
3. I would recommend the Health Start Program to a friend or a family member.	○	○	○	○	○	○
4. The Staff was willing to see me as often as I felt it was necessary.	○	○	○	○	○	○
5. Services were available at times that were good for me.	○	○	○	○	○	○
6. I was able to get all the services I thought I needed.	○	○	○	○	○	○
7. I was able to see a doctor when I wanted to.	○	○	○	○	○	○
8. I felt comfortable asking questions about my health and my child's health	○	○	○	○	○	○
9. I felt free to complain.	○	○	○	○	○	○
10. I was given information about my rights.	○	○	○	○	○	○
11. Staff respected my wishes about who is and who is not to be given information about my treatment.	○	○	○	○	○	○
12. Staff members were sensitive to my cultural background (race, religion, language, etc.)	○	○	○	○	○	○
13. I received assistance to access prenatal or postpartum services.	○	○	○	○	○	○
14. I was provided with prenatal/postpartum education and information.	○	○	○	○	○	○
15. I was assisted by the Staff to access financial help.	○	○	○	○	○	○
16. Staff provided referrals and follow-up to other community services.	○	○	○	○	○	○
17. Staff provided prenatal/postpartum education about the importance of early and continuous prenatal care.	○	○	○	○	○	○
18. Staff educated me about the importance of nutrition, breast feeding, labor and delivery, family planning and health screenings	○	○	○	○	○	○
Now thinking about your pregnancy, tell us if....	○	○	○	○	○	○
19. The health worker contacted you during first three months of the pregnancy.	○	○	○	○	○	○
20. The health worker visited you at least once a month (prenatal) and once a month (postpartum).	○	○	○	○	○	○
21. You received appropriate information on prenatal or postpartum care from the health worker.	○	○	○	○	○	○
22. Did you deliver the baby since you enrolled in the Health Start Program?	Yes		○	No		○
23. I have received information about immunizations since my delivery.	Yes		○	No		○
24. I have received information about good nutrition since my delivery.	Yes		○	No		○
25. I have received assistance for transportation since my delivery.	Yes		○	No		○
26. Thinking about the program... rate how useful and/or not useful are/were some of the services that are/were provided by Health Start Program...	**Not at all Useful**	**Somewhat Useful**	**Neutral**	**Useful**	**Very Useful**	**Not Applicable**
A. Monthly prenatal visits or postpartum visits	○	○	○	○	○	○
B. Prenatal/Postpartum education and information	○	○	○	○	○	○
C. Referrals to other community services	○	○	○	○	○	○
D. Immunizations	○	○	○	○	○	○

Any other comments _____

Arizona Department of Health Services

CLASS ATTENDANCE RECORD
HEALTH START PROGRAM

Contractor ID Number: _____ Class Date: _____

Length of Class :_____(Minimum of 1 hour) Start Time: _____ End Time: _____

Community Health Worker: _____

Guest Speaker: _____

EDUCATIONAL TOPICS DISCUSSED:

- ☐ Abuse/Domestic Violence
- ☐ Alcohol Use
- ☐ Behavioral Health
- ☐ Birth Spacing
- ☐ Breastfeeding
- ☐ Bereavement
- ☐ Changes During Pregnancy
- ☐ Changes After Pregnancy
- ☐ Chronic Disease Management
- ☐ Community Resources
- ☐ Dental Health – Client
- ☐ Diabetes
- ☐ Early Childhood Education
- ☐ Exercise/Physical Activity
- ☐ Emotions/Feelings
- ☐ Family Planning
- ☐ Fetal Growth & Development
- ☐ Fetal High Risk Condition
- ☐ Fetal/Infant Nutrition/Diet
- ☐ Finances
- ☐ Health Insurance
- ☐ Health Start Program Overview
- ☐ Healthy Weight
- ☐ Hearing/Vision Testing
- ☐ Infant/Child Health & Development
- ☐ Infant/Child Nutrition/Diet
- ☐ Immunizations
- ☐ Infant/Child High Risk Conditions
- ☐ Labor & Delivery
- ☐ Maternal Diet/Nutrition
- ☐ Maternal High Risk Conditions
- ☐ Medications/Vitamins/Folate
- ☐ Never Shake a Baby
- ☐ Parenting
- ☐ Paternity Establishment
- ☐ Pre/Post Partum Depression
- ☐ Safety (Car Seats)
- ☐ Safety (Home)
- ☐ SIDS
- ☐ Stress Reduction
- ☐ Tobacco/Drug Use
- ☐ Transportation
- ☐ Women's Health
- ☐ Other _____

Class Attendees: Health Start Clients Only*(Minimum of 4 Enrolled HSP Clients)

First Name	Last Name	DOB

Arizona Department of Health Services

HEALTH START PROGRAM
CHILD INFORMATION FORM

Contractor ID/Site Code: _____ **Mother's DOB:** _____

CHW/CHN: _____ **Enrollment Date:** _____

NICU Infant*: ☐ Yes ☐ No

Client ID (ADHS Only): _____

Enrollment ID (ADHS Only): _____

Child's Last Name	**Child's First Name**	**MI**	**Alias**
_____	_____	_____	_____

Child's DOB*	**Age****
_____	_____

Birth Hospital	**Birth Weight**	**Birth Certificate #**
_____	_____	_____

***Infants up to age one ** Children up to age two can participate in Health Start Program**

Immunization Current:

☐ Yes ☐ No

Child's Primary Care Provider: _____

INSURANCE TYPE:

☐ AHCCCS
☐ HIS – Non AHCCCS
☐ Kids Care
☐ Private
☐ None

AHCCCS STATUS:

☐ Applied Waiting
☐ Denied
☐ Refuses to Apply
☐ Enrolled

Arizona Department of Health Services
Health Start Program
Never Shake a Baby Arizona – Commitment Form

You are your child's best advocate. We need you to prevent the shaking of your baby.

Commitment Statement:
I have learned that crying is normal for babies, and shaking baby can cause brain damage or death. I will make sure that anyone who watches my child knows about the dangers of shaking.

Please sign for yourself below:

_____ _____
Mother's Signature Date

_____ _____
Father's Signature Date

_____ _____
Witness's Signature Date

Health Start Contractor: _____
(1st Post-Partum Visit: Original to ADHS; 1 copy in file, tear off bottom portion for client)

My Plan in case my baby cries a lot:

What I can do if my baby continues to cry and I feel upset:

- ❑ take my baby for a walk or a ride in the car
- ❑ put my baby in a safe place and let him/her cry
- ❑ relax myself by doing _____
- ❑ other _____

Who I can call for help:

Name of doctor
Telephone Number

Name of family member
Telephone Number

Name of friend
Telephone Number

NOTE: This statement is not part of the medical record.
If found, please return to NSBAZ, c/o Prevent Child Abuse Arizona, PO Box 432, Prescott, AZ 86302

Arizona Department of Health Services
Health Start Program
Nunca Sacuda Un Bebé Arizona . Forma de Compromiso

Ud. es el major apoyo para su niño.
Necesitamos que Ud. prevenga el sacudimiento de su niño.

Forma de compromiso:
Aprendí que llorando es normal para los bebes, y sacudiendo un bebé puede causar daño cerebral o muerte. Me aseguraré que todos los que estén encargados de cuidar a mi hijo/a entiendan los peligros de sacudir a los bebes.

Favor de firmar abajo :

Firma de madre fecha

Firma de padre fecha

Firma de testigo fecha

Health Start Contractor:_____
(*1st Postpartum Visit; Original to ADHS;1 copy in file; tear off bottom portion for client)*

- -

Lo que yo puedo hacer si mi bebé continua llorando y yo estoy enojada(o).

- ❑ dar un paseo con bebé (de pie o en vehículo)
- ❑ pongo al bebe en una parte securo (como su camita) para llorar un poco solito
- ❑ haga lo que relajarme, _____
- ❑ otra cosa? _____

El/Ella quién puedo llamar para ayuda o apoyo:
Nombre del médico
Teléfono

Nombre de familia
Teléfono

Nombre de amigo
Teléfono

Note: This statement is not part of the medical record. If found, please return to NSBAz, c/o Prevent Child Abuse Arizona . PO Box 432 . Prescott, AZ 86302Rev. 3/2007

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have copied quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Escala de Edinburgo (EPDS)

Nombre _____ Fecha de nacimiento del bebé _____

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor, subraye la respuesta que más se acerca a como se ha sentido **EN LOS ÚLTIMOS 7 DÍAS**.

Éste es un ejemplo ya completo:

Me he sentido contenta
- ☐ Sí, siempre
- ☒ Sí, casi siempre
- ☐ No muy a menudo
- ☐ No, nunca

Esto quiere decir: "La mayor parte del tiempo, me he sentido contenta" durante la semana pasada. Por favor, conteste las siguientes preguntas en la misma manera.

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas
   - ☐ Tanto como siempre
   - ☐ No tanto ahora
   - ☐ Mucho menos
   - ☐ No, no he podido

2. He mirado al futuro con placer
   - ☐ Tanto como siempre
   - ☐ Algo menos de lo que solía hacer
   - ☐ Definitivamente menos
   - ☐ No, nada

*3. Me he culpado sin necesidad cuando las cosas marchaban mal
   - ☐ Sí, casi siempre
   - ☐ Sí, algunas veces
   - ☐ No muy a menudo
   - ☐ No, nunca

4. He estado ansiosa y preocupada sin motivo
   - ☐ No, nada
   - ☐ Casi nada
   - ☐ Sí, a veces
   - ☐ Sí, a menudo

*5. He sentido miedo o pánico sin motivo alguno
   - ☐ Sí, bastante
   - ☐ Sí, a veces
   - ☐ No, no mucho
   - ☐ No, nada

*6. Las cosas me oprimen o agobian
   - ☐ Sí, casi siempre
   - ☐ Sí, a veces
   - ☐ No, casi nunca
   - ☐ No, nada

*7. Me he sentido tan infeliz, que he tenido dificultad para dormir
   - ☐ Sí, casi siempre
   - ☐ Sí, a menudo
   - ☐ No muy a menudo
   - ☐ No, nada

*8. Me he sentido triste y desgraciada
   - ☐ Sí, casi siempre
   - ☐ Sí, bastante a menudo
   - ☐ No muy a menudo
   - ☐ No, nada

*9. He estado tan infeliz que he estado llorando
   - ☐ Sí, casi siempre
   - ☐ Sí, bastante a menudo
   - ☐ Sólo ocasionalmente
   - ☐ No, nunca

*10. He pensado en hacerme daño a mí misma
   - ☐ Sí, bastante a menudo
   - ☐ Sí, a menudo
   - ☐ Casi nunca
   - ☐ No, nunca

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786

Arizona SafeHome/SafeChild Checklist

Client Name **Address** **City/State/Zip** **Census Tract *or* ZIP** ☐☐ ☐☐☐ 0 O O O O O 1 O O O O O 2 O O O O O 3 O O O O O 4 O O O O O 5 O O O O O 6 O O O O O 7 O O O O O 8 O O O O O 9 O O O O O	**Structure** O Single Home O Apartment O Trailer **Multi-story** O Yes O No **Age (years)** O 0-10 O 10-20 O 21-30 O 31+ **Status** O Own O Rent/Lease O Other Total # Rooms __	**Client Education** O No high school diploma O High school diploma O Some college/vocational O College graduate **Yearly Income** O Less than $10,000 O $10,000 - 20,000 O $20,001 - 30,000 O $30,001+ **Client Age (years)** O Less than 20 O 20-30 O 31-40 O 40+	**Date of Survey** **Time Required** O ↓ than 60 min O 60-90 min O 91-120 min O 121+ min **Surveyor ID** ☐☐ ☐☐☐ 0 O O O O O 1 O O O O O 2 O O O O O 3 O O O O O 4 O O O O O 5 O O O O O 6 O O O O O 7 O O O O O 8 O O O O O 9 O O O O O
Children ages 0-5 living in the home O 0 O 1 O 2 O 3 O 4 or more	**Other children ages 0-5 cared for in the home** O 0 O 1 O 2 O 3 O 4 or more	**Children ages 6-18 living/cared for in the home** O 0 O 1 O 2 O 3 O 4 or more	

	Yes	No	NA	Nob	Comment
Kitchen:					
1. Cleaning supplies are out of the child's reach even while in use?	O	O	O	O	
2. Cleaning supplies are stored separately from food?	O	O	O	O	
3. Cupboards over the stove are free of food treats, cereals and snack items?	O	O	O	O	
4. Knives and sharp objects are kept out of the child's reach, even while in use?	O	O	O	O	
5. Small appliances are unplugged and away from the counter's edge?	O	O	O	O	
6. Appliances are free of small magnets?	O	O	O	O	
7. Pothandles are turned in, and out of the child's reach?	O	O	O	O	
8. Latches are installed on cabinets containing dangerous items?	O	O	O	O	
Bathroom:	O	O	O	O	
9. The bathroom door is kept closed when not in use?	O	O	O	O	
10. Hot water is 120ºF or less? Temp _____ºF	O	O	O	O	
11. Non-skid material is on the tub/shower floor and the bathtub spout is covered?	O	O	O	O	
12. There is a fastener installed on each toilet seat? (Ages 3 years and under)	O	O	O	O	
13. Rubber sink/tub stoppers less than 1 ½" in diameter are secured by a chain?	O	O	O	O	
14. Medicines/vitamins are locked or stored beyond the child's reach?	O	O	O	O	
15. Soaps, shampoos, mouthwashes, cosmetics, after shave, perfumes and razors, etc., stored out of the child's reach?	O	O	O	O	
16. Cleaners, drain openers, etc., are stored in a locked cabinet?	O	O	O	O.	
17. Electrical appliances are unplugged and put away when not in use?	O	O	O	O	

Pima County Health Department 1/31/07

Child Area:	Yes	No	NA	Nob	Comment
18. Crib mattress fits snugly in the bed frame, slats are no more than 2 3/8" apart, and posts extend no more than 1/16" beyond the top of the end panels?	O	O	O	O	
19. The crib is away from windows?	O	O	O	O	
2O. Pictures/wall hangings are away from the crib and out of the child's reach?	O	O	O	O	
21. Crib gyms which attach to both crib rails are absent and mobiles are removed if the child can reach them? (About age 5 months)	O	O	O	O	
22. Cribs are free from attachments/toys which can be used to climb out?	O	O	O	O	
23. Cribs are free from loose bedding and soft, fluffy objects?	O	O	O	O	
24. Mobile baby walkers are absent?	O	O	O	O	
25. Drapery or mini-blind cords are out of the child's reach?	O	O	O	O	
26. Toy chests have lid-supports that hold open at any position?	O	O	O	O	
27. Bunk beds have no more than 3 ½" between the lower edge of the guard rail and upper edge of the bed frame, and posts extend no more than 1/16" beyond the top of the end panels?	O	O	O	O	
General Safety:					
28. Choking-size objects are out of the child's reach? (Ages 3 years and under)	O	O	O	O	
29. Emergency medical service/poison control phone number stickers and the location address are on all household/message phones?	O	O	O	O	
3O. The home has a properly installed functioning battery-powered smoke detector?	O	O	O	O	
31. All unused electrical outlets are equipped with safety devices?	O	O	O	O	
32. The home has 2 unobstructed exits?	O	O	O	O	
33. Electrical cords are in good condition, and used appropriately?	O	O	O	O	
34. Space heaters/fans are in safe condition and out of the child's reach?	O	O	O	O	
35. Woodburning stoves and fireplaces are blocked off from the child and are vented to the outside?	O	O	O	O	
36. Potential lead sources are identified?	O	O	O	O	
37. Plastic bags are kept out of the child's reach?	O	O	O	O	
38. Trash containers are tightly covered and out of the child's reach?	O	O	O	O	
39. Candles are out of the child's reach, and away from flammable materials?	O	O	O	O	
4O. Tall lamps and tall furniture are blocked off or secured?	O	O	O	O	
41. Lighters, matches, and ash trays are kept out of the child's reach?	O	O	O	O	
42. Unattended tubs, buckets, wading pools, pet bowls and other containers of liquid are absent?	O	O	O	O	
43. If firearms and ammunition are on the premises, they are stored separately from one another and are locked?	O	O	O	O	
44. Purses/briefcases/adult backpacks are inaccessible to the child?	O	O	O	O	
45. Glass panels in coffee tables have been removed or replaced with acrylic, wood, or tempered glass?	O	O	O	O	
46. Poisonous plants in the home are removed and those in the yard have been identified?	O	O	O	O	
47. The dwelling address is clearly visible from the street?	O	O	O	O	
48. Stairs, protective walls, railings, gates are sturdy and in good condition?	O	O	O	O	
49. The pool isolation fence is in good condition and gates are securely locked or are self-latching and closed?	O	O	O	O	
5O. Pesticides, fertilizers, paints, hand tools and power tools are stored out of the reach of the child?	O	O	O	O	
Devices/literature given:					
Referrals made to:					

Lista de Casa Segura/Niños Seguros de Arizona

Nombre del Cliente **Dirección Completa**	**Estructura** O casa O Apartamento O Remolque habitale	**I De Varios Pisos** O Sí O No # Total de Cuartos	**Fecha del Informe** **Tiempo Requerido** O 60 min o menos O 6O-90 min O 91-12O min O 121+ min
Cuantos Niños 0 a 5 Años Viven En Su Casa O 0 O 1 O 2 O 3 O Mas de 4	**Cuantos Niños De 0 a 5 Años Se Cuidan En Su Casa** O 0 O 1 O 2 O 3 O Mas de 4	**Cuantos Niños de 6 a 18 Años Viven O Se Cuidan En Su Casa** O 0 O 1 O 2 O 3 O Mas de 4	

Cocina:	**Si**	**No**	**NA**	**Nob**	**Commentarios**
1.¿ Están los artículos de limpieza fuera del alcance de los niños aún cuando están en uso?	O	O	O	O	
2.¿Están guardados los artículos de limpieza lejos de los alimentos?	O	O	O	O	
3.¿Se ecuentran guardados los dulces, cereales y bocadillos sobre la estufa?	O	O	O	O	
4.¿Están los cuchillos y objetos afilados fuera del alcance de los niños aún cuando están en uso?	O	O	O	O	
5.¿Están los aparatos eléctricos desconectados y alejados de las orillas?	O	O	O	O	
6.¿Se ecuentran imanes decorativos en aparatos de cocina?	O	O	O	O	
7.¿Están las asas del sartén hacia atrás y alejadas del alcance de los niños?	O	O	O	O	
8.¿Hay pasadores instalados en gabinetes que contienen artículos peligrosos?	O	O	O	O	
Baño:	**Si**	**No**	**NA**	**Nob**	**Commentarios**
9.¿Está la puerta del baño cerrada cuando el baño no está en uso?	O	O	O	O	
10.¿Está el agua caliente a menos de 120E F? Temperatura_____EF.	O	O	O	O	
11.¿Hay material atiderrapante en el piso de la tina/regadera?	O	O	O	O	
12.¿Hay un mecanismo de cierre en el asiento del inodoro? (3 años de edad o menos)	O	O	O	O	
13.¿Están los tapones de hule mas chicos de 1 ½" sujetados a una cadena?	O	O	O	O	
14.¿Están los medicamentos/vitaminas guardados o almacenados fuera del alcance de niños?	O	O	O	O	
15.¿Están los jabones, champú, enjuague de la boca, cosméticos, loción para después del afeitado, perfumes y navajas para afeitar, etc., fuera del alcance de los niños?	O	O	O	O	
16. ¿Están los limpiadores, destapa-caños, etc., guardados en un gabinete cerrado con llave?	O	O	O	O	
17.¿Están los aparatos eléctricos desconectados y guardados cuando no están en uso?	O	O	O	O	

Area Infantil:	**Si**	**No**	**NA**	**Nob**	**Commentarios**
18. ¿Cabe el colchón de la cuna firmemente en el marco de la cama, la distancia entre tablillas no es mayor de 2 3/8", y los postes no se extienden mas de 1/16" más altos de la parte superior del panel al final?	O	O	O	O	
19. ¿Se encuentra la cuna debajo o cerca de una ventana?	O	O	O	O	
20. ¿Hay fotos y cuadros arriba de la cuna o al alcance del bebé?	O	O	O	O	
21. ¿Les han quitado los gimnasios a la cuna que se sujetan a ambos barrotes o los móbiles a los bebés mayores de 5 meses?	O	O	O	O	
22. ¿Se encuentran los accesorios de cuna o juguetes en donde el bebé los puede usar para salirse de la cuna?	O	O	O	O	
23. ¿ Se encuentran objetos suaves o esponja dentro de la cuna?	O	O	O	O	
24. ¿Se usan las andaderas para bebé?	O	O	O	O	
25. ¿Está el cordón de las cortinas o persianas al alcance del bebé?	O	O	O	O	
26. ¿Tienen los jugueteros algún tipo de soporte en la tapa que los mantiene abiertos o no están presentes?	O	O	O	O	
27. ¿No están las literas a mas de 3 ½" entre el borde inferior del barandal protector del borde superior del marco de la cama, y los postes no se extienden más de 1/16" desde la parte superior de los paneles al final?	O	O	O	O	
Seguridad en General	**Si**	**No**	**NA**	**Nob**	**Commentarios**
28. ¿Están los objetos pequeños que pudieran asfixiar a un niño fuera del alcance de ellos?	O	O	O	O	
29. ¿Están los números de teléfono de los servicios de emergencias médicas y del centro de control de substancias tóxicas en calcomanías pegadas en todos los teléfonos de la casa?	O	O	O	O	
30. ¿Tiene la casa un detector de humo funcionando correctamente?	O	O	O	O	
31. ¿Tienen todos los contactos eléctricos dispositivos de seguridad?	O	O	O	O	
32. ¿Tiene la casa 2 salidas sin obstrucción?	O	O	O	O	
33. ¿Se ecuentran los cables eléctricos en buenas condiciones y son usados correctamente?	O	O	O	O	
34. ¿Están los calentones y abanicos en buenas condiciones y alejados del alcance de los niños?	O	O	O	O	
35. ¿Están las estufas de leña y chimeneas inaccesibles a los niños y ventiladas hacia el exterior?	O	O	O	O	
36. ¿Han sido identificadas las posibles fuentes de plomo?	O	O	O	O	
37. ¿Están las bolsas de plástico fuera del alcance de los niños?	O	O	O	O	
38. ¿Están firmemente tapados los botes de basura y fuera del alcance de los niños?	O	O	O	O	
39. ¿Están las velas fuera del alcance de los niños y lejos de materiales flamables?	O	O	O	O	
40. ¿Están lámparas grandes y muebles altos fijos o asegurados?	O	O	O	O	
41. ¿Están encendedores, cerillos y ceniceros fuera del alcance de los niños?	O	O	O	O	
42. ¿Son vaciadas inmediatamente después de cada uso las tinas, cubetas, piscinas para niños u otros recipientes con agua?	O	O	O	O	
43. ¿Si hay armas y municiones presentes, están guardadas con llave en un lugar aparte?	O	O	O	O	

44. ¿Están las bolsas de mano, maletines y mochilas inaccesibles a los niños?	O	O	O	O	
45. ¿Se ha quitado removido o reemplazado el vidrio de las mesas o se ha reemplazado con acrílico, madera o vidrio templado?	O	O	O	O	
46. ¿Han sido identificadas las plantas venenosas en la casa y en el jardín?	O	O	O	O	
47. ¿Son claramente visibles el número y dirección de la casa desde la calle?	O	O	O	O	
48. ¿Están las escaleras, paredes protectoras, barandales y portón fuertes y en buenas condiciones?	O	O	O	O	
49. ¿Está la cerca alrededor de la alberca en buenas condiciones y las puertas cerradas?	O	O	O	O	
50. ¿Están las pesticidas, fertilizantes, pinturas, herramienta de mano y eléctrica guardadas fuera del alcance de los niños?	O	O	O	O	

¿Tiene la familia un asiento pasajero apropiado para cada niño de edad 5 años o menos que vive en este domicilio?	Si O	No O
Enumere los dispostivos de seguridad o literatura porporcianados al cliente:		
Referido a:		

SAMHSA FASD Center for Excellence
Form C
Alcohol Brief Intervention First Visit Screening Questions with TWEAK

The purpose of this form is to determine your eligibility to participate in the SAMHSA FASD Center for Excellence Screening and Brief Intervention. To protect your privacy, your name and any other individually identifying information will not be reported to SAMHSA. It is important to us to obtain this information to maintain and improve the quality of our services; however, your participation is voluntary.

Client ID_____

Agency Name_____

Date of Visit: __ __/__ __/__ __ __ __
Mo Day Year

1. How many weeks pregnant are you today? _____weeks

Use the standard drink chart (last page) to answer Questions 2–6. (One standard drink is equal to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces [one shot] of 80-proof spirits or liquor.)

2. During the time you were pregnant but didn't know you were pregnant, how many alcoholic drinks did you usually have at one time? Circle your answer.

10 or more 9 8 7 6 5 4 3 2 1 0

3. During the time you were pregnant but didn't know you were pregnant, how often did you drink beer, wine, or other alcoholic beverage? Check a box for your answer.

- ☐ Every day
- ☐ Almost every day
- ☐ 3-4 days a week
- ☐ 1-2 days a week
- ☐ 2-3 days a month
- ☐ Once a month
- ☐ Less than once a month
- ☐ Never

4. How often did you have 4 or more drinks in 1 day in the past 30 days? Circle your answer.

10 or more 9 8 7 6 5 4 3 2 1 0

5. How many drinks did you have on a typical day when you were drinking alcohol in the past 30 days? Circle your answer.

10 or more 9 8 7 6 5 4 3 2 1 0

6. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?

Write <u>one</u> number between 0 and 30 days as your answer: _____ days

This may help you estimate the number of days you drank:
Drinking every day would be 30 days.
Almost every day would be a number between 17 to 29 days.
3–4 days a week would be a number between 12 to 16 days.
1–2 days a week would be a number between 4 to 8 days.
2–3 days a month would be either 2 or 3 days.
Once a month would be 1 day.
Never would be 0 days.

Circle your answers to the questions below.

7. How many drinks does it take until you feel the effects of alcohol?
10 or more 9 8 7 6 5 4 3 2 1 0 ☐

8. Do close friends or relatives worry or complain about your drinking? No Yes ☐

9. Do you sometimes take a drink in the morning when you first get up? No Yes ☐

10. Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? No Yes ☐

11. Do you sometimes feel the need to cut down on your drinking? No Yes ☐

_____

TWEAK Score ☐
[add Q7 –Q11]

Scoring the TWEAK

Question 7	2 or more drinks = 2 points
	0-1 drinks = 0 points
Question 8	"Yes" = 2 points
	"No" = 0 points
Question 9-11	"Yes" = 1 point
	"No" = 0 points

12. What is your date of birth? __ __/__ __/__ __ __ __
Mo Day Year

13. Are you Hispanic or Latino? Circle your answer Yes No

14. What is your race? (Select one or more)
☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or other Pacific Islander ☐ White

15. What is the highest level of education you have finished, whether or not you received a degree?
Check one box below.

- ☐ Never attended school
- ☐ 6th grade or less
- ☐ 7th-8th grade
- ☐ 9th-11th grade
- ☐ 12th grade/or GED
- ☐ Equivalent of 1-2 years full-time college
- ☐ Equivalent of more than 2 years but less than 4 years full-time college
- ☐ Equivalent of 4 or more year's full-time college

16. What is your marital status? Check one box below.

☐ Married ☐ Unmarried, living with partner ☐ Widowed
☐ Divorced or separated ☐ Never married

Final Eligibility Check

A1. Did client qualify for Alcohol Brief Intervention based on drinking?

(If answer to Question #6 is 1 or more days (>0), client qualifies for brief intervention)

Yes No

A2. Did client qualify for Alcohol Brief Intervention based on TWEAK score?

(If TWEAK score is 2 or more, client qualifies for brief intervention)

Yes No

A3. Would you like to participate in the Screening and Brief Intervention project?

Yes No

Screening Results

INTERVIEWER: Check the relevant boxes below when you have completed the screening interview.

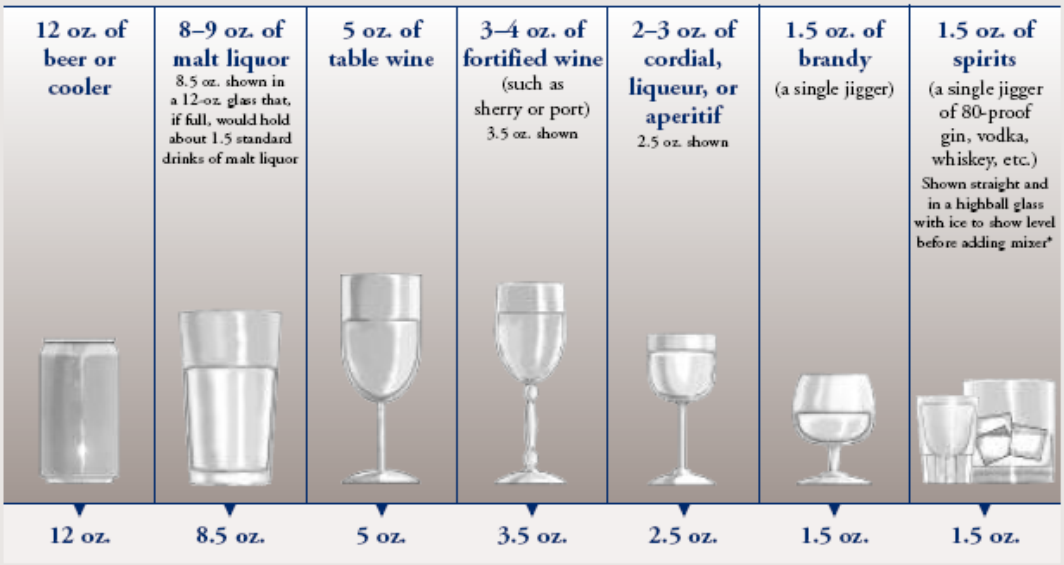
☐ Client did not qualify for Alcohol Brief Intervention (A1 and A2 = "No")

☐ Client qualified for Alcohol Brief Intervention and agreed to participate (A1 or A2 = "Yes" and A3 ="Yes")

☐ Client qualified for Alcohol Brief Intervention and refused to participate (A1 or A2 = "Yes" and A3 = "No")

What Is a Standard Drink?

A standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are standard drink equivalents. These are approximate, as different brands and types of beverages vary in their actual alcohol content.



Many people do not know what counts as a standard drink, and thus are unaware of how many standard drinks are held in the containers in which these drinks are often sold. Some examples:

- For **beer**, the approximate number of standard drinks in
  - 12 oz. = 1
  - 16 oz. = 1.3
  - 22 oz. = 2
  - 40 oz. = 3.3
- For **malt liquor**, the approximate number of standard drinks in
  - 12 oz. = 1.5
  - 16 oz. = 2
  - 22 oz. = 2.5
  - 40 oz. = 4.5
- For **table wine**, the approximate number of standard drinks in
  - a standard 750 mL (25 oz.) bottle = 5
- For **80-proof spirits**, or "hard liquor," the approximate number of standard drinks in
  - a mixed drink = 1 or more*
  - a pint (16 oz.) = 11
  - a fifth (25 oz.) = 17
  - 1.75 L (59 oz.) = 39

**Note:* It can be difficult to estimate the number of standard drinks served in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

SAMHSA FASD Center for Excellence

Form E

Process Information About Visits for Women that Screened Positive

First and Subsequent Visits (Completed by Staff)

This is a form to collect information related to your participation in the SAMHSA FASD Center for Excellence Screening and Brief Intervention. To protect your privacy, your name and any other individually identifying information will not be reported to SAMHSA. It is important to us to obtain this information to maintain and improve the quality of our services; however, your participation is voluntary.

Client ID _____ Staff Name_____ Agency Name: _____

Date of visit: _ _ /_ _ /_ _ _ _
Mo Day Year

1. **What drinking goal did the client set for the next month?** (From page 9 of *Health and Behavior* Booklet)
   ☐ Stop drinking ☐ Cut down on drinking ☐ Goal was not set

2. **What did the client say will be the maximum number of drinks she will consume per week in the next month?** (From page 9 of *Health and Behavior* Booklet)

   _____ Maximum drinks per week in next month

3. **How many minutes did it take to give the alcohol intervention? _____**Minutes

4. **Was the client asked to sign a HIPAA consent form that allows her record to be shared with the child's pediatrician or physician?**
   ☐ Yes ☐ No

5. **Did the client agree to allow her record to be shared with the child's pediatrician or physician?**
   ☐ Yes ☐ No

6. **Did the client meet criteria for referral for assistance to stop drinking alcohol?**
   ☐ Yes ☐ No If answer is "no," skip remaining questions.

7. **Was the client given an appointment for assistance to stop drinking alcohol?**
   ☐ Yes ☐ No

   If "yes," what type of assistance?
   ☐ Outpatient counseling ☐ Intensive outpatient program (IOP)
   ☐ Partial hospitalization ☐ Residential ☐ Medical detox

8. **What is the date and time of the appointment for the assistance to stop drinking alcohol?**
   _ _ /_ _ /_ _ _ _ Time: _____p.m. or a.m.
   Mo Day Year

9. **Did client agree to attend first appointment?** ☐ Yes ☐ No

Additional Comments: _____

Staple

Arizona Department of Health Services

Programa de Comienzo Sano Cuestionario TWEAK de detección e intervención breve en el consumo de alcohol, realizado en la primera visita

Client ID _____
Client Name _____ **Client DOB** _____
Staff/Agency Name_____

Fecha de la Visita: __ __/__ __/__ __ __ __
Mes Día Año

---

1. ¿Cuántas semanas de embarazo tiene? _____semanas

Utilize la gráfica sobre bebida estándar para responder las preguntas 2–6. (Una bebida estándar es igual a 12 onzas de cerveza, 5 onzas de vino, o 1.5 onzas [un trago] de una bebida alcohólica de 80-Proof o licor.)

2. Antes de saber que estaba embarazada, ¿cuántas bebidas alcohólicas usualmente consumía en un momento dado? Circule su respuesta.

10 o más 9 8 7 6 5 4 3 2 1 0

3. Antes de saber que estaba embarazada, ¿cuántas veces tomó cerveza, vino, u otra bebida alcohólica? Marque el cuadro que indique su respuesta.

- ☐ Todos los días
- ☐ Casi todos los días
- ☐ 3-4 días a la semana
- ☐ 1-2 días a la semana
- ☐ 2-3 días al mes
- ☐ Una vez al mes
- ☐ Menos de una vez al mes
- ☐ Nunca

4. Durante los últimos 30 días, ¿cuántas veces consumió 4 bebidas o más en un día? Circule su respuesta.

10 ó más 9 8 7 6 5 4 3 2 1 0

5. Durante los últimos 30 días, ¿cuántas bebidas tomó en un día de consumo normal? Circule su respuesta.

10 o más 9 8 7 6 5 4 3 2 1 0

6. Durante los últimos 30 días, ¿cuántos días consumió una o más bebidas alcohólicas?
Escriba un número entre 0 y 30 como respuesta : _____ día(s)

Esta tabla le puede ayudar a calcular el número de días que usted bebió:
Tomar todos los días serían 30 días.
Casi todos los días sería un número entre 17 y 29 días.
3–4 días a la semana sería un número entre 12 y 16 días.
1–2 días a la semana sería un número entre 4 y 8 días.
2–3 días al mes seria un número entre 2 o 3 días.
Una vez al mes sería 1 día.
Nunca sería 0 días.

6-OWCH-029 (6/09)

Circule sus respuestas para las siguientes preguntas.

7. ¿Cuántas bebidas necesita para sentir los efectos del alcohol?
10 ó más 9 8 7 6 5 4 3 2 1

8. ¿Se preocupan o se quejan sus familiares o amigos cercanos por su forma de beber? No Sí

9. En algunas ocasiones, ¿toma usted temprano en la mañana seguido se levanta? No Sí

10. ¿Le ha comentado algun amigo(a) o familar las cosas que dijo o hizo cuando estaba tomada que usted no recuerda? No Sí

11. ¿Ha sentido alguna vez la necesidad de disminuir el consumo de alcohol? No Sí

---

12. ¿Cuál es su fecha de nacimiento? __ __/__ __/__ __ __ __
Mes Día Año

13. ¿Es usted hispana ó latina? Circule su respuesta No Sí

14. ¿Cuál es su raza? Marque una ó más opciones.
☐ Blanca ☐ Negra o Afroamericana ☐ India Americana ☐ Asiática
☐ Nativa de Alaska ☐ Nativa de Hawaii o de las Islas del Pacífico

15. ¿Cuál es el nivel de educación más alto que ha completado, con o sin título? Marque una de las siguientes opciones.
☐ Nunca he asistido a la escuela
☐ 6to grado o menos
☐ 7mo -8vo grado
☐ 9no-11vo grado
☐ 12vo grado/o GED
☐ Equivalente a 1-2 años de tiempo completo universitario
☐ Equivalente a más de 2 años pero menos de 4 años de tiempo completo universitario
☐ Equivalente a 4 años o más de tiempo completo universitario

16. ¿Cuál es su estado civil? Marque una de las siguientes opciones.
☐ Casada ☐ Soltera, viviendo con una pareja ☐ Viuda
☐ Divorciada o separada ☐ Soltera

6-OWCH-029 (6/09)

Immunizations for Babies

A Guide for Parents

These are the vaccinations your baby needs!

At birth	**HepB**
2 months	**HepB** 1–2 mos[1] + **DTaP** + **PCV** + **Hib** + **Polio** + **RV**
4 months	**HepB**[2] + **DTaP** + **PCV** + **Hib** + **Polio** + **RV**
6 months	**HepB** 6–18 mos[1] + **DTaP** + **PCV** + **Hib**[3] + **Polio** 6–18 mos[1] + **RV**[4] + **Influenza**[5]
12 months or older	**MMR** 12–15 mos[1] + **DTaP** 15–18 mos[1] + **PCV** 12–15 mos[1] + **Hib** 12–15 mos[1] + **Chickenpox** 12–15 mos[1] + **HepA**[6] 12–23 mos[1] + **Influenza**[5]

Check with your doctor or nurse to make sure your baby is receiving all vaccinations on schedule. Many times vaccines are combined to reduce the number of injections. Be sure you ask for a record card with the dates of your baby's vaccinations; bring this with you to every visit.

Here's a list of the diseases your baby will be protected against:

HepB: hepatitis B, a serious liver disease

DTaP: diphtheria, tetanus (lockjaw), and pertussis (whooping cough)

PCV: pneumococcal conjugate vaccine protects against a serious blood, lung, and brain infection

Hib: *Haemophilus influenzae* type b, a serious brain, throat, and blood infection

Polio: polio, a serious paralyzing disease

RV: rotavirus infection, a serious diarrheal disease

Influenza: a serious lung infection

MMR: measles, mumps, and rubella

HepA: hepatitis A, a serious liver disease

Chickenpox: also called varicella

Footnotes to above chart:

1. This is the age range in which this vaccine should be given.
2. Your baby may not need a dose of Hep B vaccine at age 4 months, depending on the vaccine used. Check with your doctor or nurse.
3. Your baby may not need a dose of Hib vaccine at age 6 months, depending on the vaccine used. Check with your doctor or nurse.
4. Your baby may not need a dose of RV vaccine at age 6 months, depending on the vaccine used. Check with your doctor or nurse.
5. All children who are 6 months of age or older should be vaccinated against influenza in the fall or winter of each year.
6. Your child will need 2 doses of HepA vaccine, given at least 6 months apart.

Technical content reviewed by the Centers for Disease Control and Prevention, October 2008. www.immunize.org/catg.d/p4010.pdf • Item #P4010 (10/08)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.vaccineinformation.org • www.immunize.org

ASQ-3 Ages & Stages Questionnaires®

3 months 0 days through 4 months 30 days

4 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____ If baby was born 3 or more weeks prematurely, # of weeks premature: _____ Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

Street address: _____ Relationship to baby: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

City: _____ State/ Province: _____ ZIP/ Postal code: _____

Country: _____ Home telephone number: _____ Other telephone number: _____

E-mail address: _____

Names of people assisting in questionnaire completion: _____

Program Information

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101040100

ASQ-3

4 Month Questionnaire

3 months 0 days through 4 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby chuckle softly?	○	○	○	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	○	○	○	___
3. Does your baby stop crying when she hears a voice other than yours?	○	○	○	___
4. Does your baby make high-pitched squeals?	○	○	○	___
5. Does your baby laugh?	○	○	○	___
6. Does your baby make sounds when looking at toys or people?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	○	○	○	___
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	○	○	○	___
4. When your baby is on her tummy, does she hold her head straight up, looking around? *(She can rest on her arms while doing this.)* 	○	○	○	___

E101040200

ASQ-3 **4 Month Questionnaire** *page 3 of 5*

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
5. When you hold him in a sitting position, does your baby hold his head steady?	○	○	○	___
6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? 	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? 	○	○	○	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	○	○	○	___
3. Does your baby grab or scratch at his clothes?	○	○	○	___
4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?	○	○	○	___
5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?	○	○	○	___
6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes, sometimes turning his head?	○	○	○	___
2. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes?	○	○	○	___
3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	○	○	○	___
4. When you put a toy in her hand, does your baby look at it?	○	○	○	___
5. When you put a toy in his hand, does your baby put the toy in his mouth?	○	○	○	___

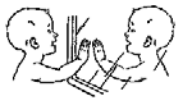
E101040300

ASQ-3 **4 Month Questionnaire** *page 4 of 5*

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy? 	○	○	○	___
PROBLEM SOLVING TOTAL				___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby watch his hands? 	○	○	○	___
2. When your baby has her hands together, does she play with her fingers?	○	○	○	___
3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?	○	○	○	___
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?	○	○	○	___
5. Before you smile or talk to your baby, does he smile when he sees you nearby?	○	○	○	___
6. When in front of a large mirror, does your baby smile or coo at herself? 	○	○	○	___
PERSONAL-SOCIAL TOTAL				___

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain: ○ YES ○ NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: ○ YES ○ NO

E101040400

ASQ-3 **4 Month Questionnaire** *page 5 of 5*

OVERALL *(continued)*

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: ○ YES ○ NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

5. Do you have concerns about your baby's vision? If yes, explain: ○ YES ○ NO

6. Has your baby had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

7. Do you have any concerns about your baby's behavior? If yes, explain: ○ YES ○ NO

8. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

E101040500

ASQ-3™ Ages & Stages Questionnaires®

3 meses 0 días a 4 meses 30 días

Cuestionario de 4 meses

Favor de proveer los siguientes datos. Al completar este formulario, use solamente una pluma de tinta negra o azul y escriba legiblemente con letra de molde.

Fecha en que se completó el cuestionario: _____

Información del bebé

Nombre del bebé: _____ Inicial de su segundo nombre: _____ Apellido(s) del bebé: _____

Fecha de nacimiento del bebé: _____

Para bebés prematuros, si el parto ocurrió 3 semanas o más antes de la fecha proyectada, # de semanas que se adelantó: _____

Sexo del bebé: ◯ Masculino ◯ Femenino

Información de la persona que está llenando este cuestionario

Nombre: _____ Inicial de su segundo nombre: _____ Apellido(s): _____

Dirección: _____

Parentesco con el bebé:
◯ Padre/madre ◯ Tutor ◯ Maestro/a ◯ Educador/a o asistente de preescolar
◯ Abuelo/a u otro pariente ◯ Madre/padre de acogida ◯ Otro/a: _____

Ciudad: _____ Estado/ Provincia: _____ Código postal: _____

País: _____ # de teléfono de casa: _____ Otro # de teléfono: _____

Su dirección electrónica: _____

Los nombres de las personas que le están ayudando a llenar este cuestionario: _____

Información del programa

de identificación del bebé: _____ Edad al realizar la evaluación ASQ, en meses y días: _____

de identificación del programa: _____ Si es bebé prematuro/a, edad ajustada, en meses y días: _____

Nombre del programa: _____

P102040100

ASQ-3™

Cuestionario de 4 meses

3 meses 0 días a 4 meses 30 días

En las siguientes páginas Ud. encontrará una serie de preguntas sobre diferentes actividades que generalmente hacen los bebés. Puede ser que su bebé ya pueda hacer algunas de estas actividades, y que todavía no haya realizado otras. Después de leer cada pregunta, por favor marque la respuesta que indique si su bebé hace la actividad regularmente, a veces, o todavía no.

Puntos que hay que recordar:

- ☑ Asegúrese de intentar cada actividad con su bebé antes de contestar las preguntas.
- ☑ Complete el cuestionario haciendo las actividades con su bebé como si fueran un juego divertido.
- ☑ Asegúrese de que su bebé haya descansado y comido.
- ☑ Por favor, devuelva este cuestionario antes de esta fecha: _____.

Notas:

_____

_____

_____

_____

_____

COMUNICACION

	SI	A VECES	TODAVIA NO	
1. ¿Su bebé se ríe haciendo sonidos, como produciendo una suave carcajada?	○	○	○	___
2. Cuando Ud. regresa después de haberse ausentado brevemente, ¿su bebé sonríe o muestra emoción al verlo/la?	○	○	○	___
3. ¿Deja de llorar su bebé cuando escucha la voz de una persona que no sea Ud.?	○	○	○	___
4. ¿Hace chillidos agudos su bebé?	○	○	○	___
5. ¿Se ríe su bebé?	○	○	○	___
6. ¿Hace sonidos su bebé al ver juguetes o al mirar a personas?	○	○	○	___

TOTAL EN COMUNICACION ___

MOTORA GRUESA

	SI	A VECES	TODAVIA NO	
1. Cuando su bebé está acostado boca arriba, ¿mueve la cabeza de un lado para otro?	○	○	○	___
2. Después de mantener la cabeza levantada al estar boca abajo, ¿su bebé la baja lentamente al suelo, en vez de dejarla caer hacia adelante?	○	○	○	___
3. Cuando su bebé está acostada boca abajo, ¿mantiene la cabeza levantada con la barbilla a una distancia de aproximadamente 3 pulgadas (8 centímetros) del suelo por al menos 15 segundos? 	○	○	○	___
4. Al estar boca abajo, ¿su bebé levanta la cabeza y mira a su alrededor? *(Puede apoyarse con los brazos al hacerlo.)* 	○	○	○	___

ASQ-3 **Cuestionario de 4 meses** *página 3 de 5*

MOTORA GRUESA *(continuación)*

	SI	A VECES	TODAVIA NO	
5. Al sentar a su bebé sujetándolo con las manos, ¿puede sostener la cabeza?	○	○	○	___
6. Cuando su bebé está boca arriba, ¿junta las manos sobre su pecho, tocándose los dedos? 	○	○	○	___

TOTAL EN MOTORA GRUESA ___

MOTORA FINA

	SI	A VECES	TODAVIA NO	
1. Cuando está despierta, ¿su bebé mantiene las manos abiertas, al menos parcialmente (en vez de tenerlas cerradas en puño, como cuando era recién nacida)? 	○	○	○	___
2. Cuando Ud. le pone un juguete en la mano, ¿su bebé lo mueve de un lado para otro, al menos por unos momentos?	○	○	○	___
3. ¿Su bebé intenta agarrar o jalar su propia ropa?	○	○	○	___
4. Al ponerle un juguete en la mano, ¿su bebé lo agarra por al menos un minuto, mientras lo mira, lo mueve de un lado para otro, o intenta morderlo?	○	○	○	___
5. ¿Su bebé intenta agarrar o arañar con las uñas una superficie que tenga enfrente, ya sea al estar sentado o cuando está boca arriba?	○	○	○	___
6. Cuando Ud. tiene a su bebé sentada en su regazo, ¿intenta agarrar un juguete que está en una mesa cercana, aunque no pueda alcanzarlo?	○	○	○	___

TOTAL EN MOTORA FINA ___

RESOLUCION DE PROBLEMAS

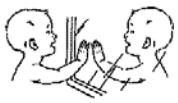
	SI	A VECES	TODAVIA NO	
1. Al mover lentamente un juguete pequeño de izquierda a derecha enfrente de la cara de su bebé (a unas 10 pulgadas, o 25 centímetros, de distancia), ¿lo sigue con los ojos o a veces gira la cabeza para seguirlo?	○	○	○	___
2. Al mover lentamente un juguete pequeño de arriba a abajo enfrente de la cara de su bebé (a unas 10 pulgadas, o 25 centímetros, de distancia), ¿lo sigue con los ojos?	○	○	○	___
3. Al sentar a su bebé en su regazo, ¿presta atención a un juguete (del tamaño de una taza o de una sonaja) colocado en una mesa o en el suelo enfrente de él?	○	○	○	___
4. Al ponerle un juguete en la mano, ¿su bebé lo mira?	○	○	○	___
5. Al ponerle un juguete en la mano, ¿su bebé se lo mete en la boca?	○	○	○	___
6. Cuando su bebé está acostada boca arriba y Ud. le enseña un juguete, haciéndolo oscilar, ¿alza los brazos y los mueve hacia el juguete? 	○	○	○	___

TOTAL EN RESOLUCION DE PROBLEMAS ___

E102040300

ASQ-3 **Cuestionario de 4 meses** *página 4 de 5*

SOCIO-INDIVIDUAL

	SI	A VECES	TODAVIA NO	
1. ¿Su bebé mira sus propias manos? 	○	○	○	___
2. Cuando tiene las manos juntas, ¿su bebé juega con los dedos?	○	○	○	___
3. Cuando su bebé ve el pecho o el biberón, ¿parece saber que le van a dar de comer?	○	○	○	___
4. Cuando Ud. le da de comer, ¿usa su bebé las dos manos para ayudarle a sostener el biberón?, o cuando lo/la amamanta, ¿le toca el seno con la mano que le queda libre?	○	○	○	___
5. Antes de que Ud. le sonría o le hable, ¿empieza su bebé a sonreírle al ver que Ud. está cerca?	○	○	○	___
6. Cuando está delante de un espejo grande, ¿empieza su bebé a sonreír o a hacer sonidos? 	○	○	○	___

TOTAL EN SOCIO-INDIVIDUAL ___

OBSERVACIONES GENERALES

Los padres y proveedores pueden utilizar el espacio después de cada pregunta para hacer comentarios adicionales.

1. ¿Usa su bebé ambas manos y ambas piernas igualmente bien? Si contesta "no", explique: ○ SI ○ NO

2. Al ponerlo/la de pie, ¿su bebé pone los pies completamente planos sobre el suelo la mayoría de la veces? Si contesta "no", explique: ○ SI ○ NO

E102040400

ASQ-3 **Cuestionario de 4 meses** *página 5 de 5*

OBSERVACIONES GENERALES *(continuación)*

3. ¿Le preocupa que su bebé sea muy callado/a o que no haga sonidos como otros bebés? Si contesta "sí", explique: ○ SI ○ NO

4. ¿Tiene algún familiar con historia de sordera o cualquier otro impedimento auditivo? Si contesta "sí", explique: ○ SI ○ NO

5. ¿Tiene Ud. alguna preocupación sobre la visión de su bebé? Si contesta "sí", explique: ○ SI ○ NO

6. ¿Ha tenido su bebé algún problema de salud en los últimos meses? Si contesta "sí", explique: ○ SI ○ NO

7. ¿Tiene alguna preocupación sobre el comportamiento de su bebé? Si contesta "sí", explique: ○ SI ○ NO

8. ¿Le preocupa algún aspecto del desarrollo de su bebé? Si contesta "sí", explique: ○ SI ○ NO

E102040500

EVERY WOMAN ARIZONA

ARIZONA DEPARTMENT OF HEALTH SERVICES
HEALTH RISK ASSESSMENT TOOL *(Draft)*

Agency: _____
Staff: _____

DATE: _____
NAME: _____ DOB: _____ AGE: _____

Are you planning to get pregnant in the next six months? Y___ N___

Would you like to complete a reproductive life plan? Y___ N___

If your answer to a question is Yes, put a Y mark on the line in front of the question, fill in the other information that applies to you.

HEALTH PROMOTION

__ Are you at a healthy weight ?
Weight: _____ Height :_____
__ Do you eat healthy balanced meals?
__ Do you follow a special diet (vegetarian, diabetic, other)?
__ Which do you drink (__coffee __tea __ cola __ milk __ water __soda/pop __ other)?
__ Do you eat raw or undercooked foods (meat, other)?
__ Do you take folic acid?
__ Do you take other vitamins daily (__multivitamin, __Vitamin A __ other)?
__ Do you take dietary supplements?
__black cohosh __ pennyroyal __ other
__ Do you have current/past problems with eating disorders?
__ Have you had a dental cleaning in the last year?
__ Do you exercise 3-5 times per week for 30 min?

WOMEN'S HEALTH AND TREATMENT

__ Do you have any problems with your menstrual cycle?
__ How many times have you been pregnant?
What was/were the outcome's?_____
__ Have you had a Preterm birth?
__ Have you had a low birth weight (less than 3lbs 4oz)?
__ Did you have difficulty getting pregnant before?
__ Have you had any other problems related to pregnancy or birth? _____
__ Are your Immunizations up-to-date?
__ Have you ever had unprotected sex with multiple partners?
__ Do you receive screenings for sexually transmitted infections (STDs)?
__ Have you ever been treated for a STD infection? (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)
List _____

HOME ENVIRONMENT

__ Do you feel emotionally supported at home?
__ Do you have help form relatives or friends if needed?
__ Do you feel you have serious money/financial worries?
__ Are you in a stable relationship?
__ Do you feel safe at home?
__ Does anyone threaten or physically hurt you?

__Is there anything else you'd like me to know?

LIFE STYLE CHANGES/ RISK FACTORS

__ Do you smoke cigarettes or use other tobacco products? How many cigarettes/packs a day? ____
__ Are you exposed to second-hand smoke?
__ Do you drink alcohol?
What kind? ____ How often?_____ How much?____
__ Do you use recreational drugs (cocaine, heroin, ecstasy, meth/ice, other? List_____
__ Are you taking any prescribed drugs
List_____
__ Are you taking non-prescribed drugs?
List _____
__ Are you using any birth control? Type_____
__ Do you use any herbal vitamins or remedies?
List_____
What kind of work do you do?_____
__ Do you work or live near possible hazards (x-rays, chemicals, lead, radiation, other? List_____
__ Do you use saunas or hot tubs?
__ In the last 2 weeks, have you felt sad, depressed, or hopeless?
__ In the last 2 weeks, have you felt anxious, worried, on edge about a lot of different things?

MEDICAL/FAMILY HISTORY

Do you have or have you ever had;

__ Epilepsy	__ Diabetes
__ Asthma	__ High Blood pressure
__ Heart Disease	__ Anemia
__ Thyroid disease	__ Hepatitis C
__ Hepatitis B	__ Lupus
__ Depression	__ HIV/AIDS
__ Other conditions	__ Any mental problems

Do your or your partner's family have a history of:

__ Hemophilia
__ Other bleeding disorders?
__ Tay-Sachs disease? _____
__ Blood disease (sickle cell, thalassemia, other)
__ Muscular dystrophy?
__ Down syndrome/mental retardation?
__ Cystic fibrosis?
__ Birth defects: spine/heart/kidney?
Your ethnic background is:_____
Your partner's ethnic background is:_____

__ Are there any questions you'd like to ask me?

CHAPTER 9

COORDINATION OF SERVICES

9.1 Establishing Referral and Communication Networks With Other Agencies and Services

Contractors will monitor their community networks to ensure availability, accessibility, and quality of services to pregnant women, mothers, and their families. Contractors will collaborate with other agencies and service providers to achieve a comprehensive network of available community resources and referrals. In circumstances where resources or necessary services do not exist within the neighborhood or community served by the Health Start program, Contractors will document the gap in services and attempt to establish methods to make alternative services available, or to obtain access to equivalent services in another community.

If Contractors are unable to access or establish a relationship with an existing community resource, or if an existing relationship undergoes a significant change, the Contractor should notify Health Start Program Manager of the network gap as soon as the gap is identified. Health Start Program Manager and Contractors will work cooperatively to minimize the effects of gaps in service availability and accessibility for Health Start clients.

9.2 Coordination with Other Home Visiting or Case Management Programs

Coordination and collaboration with programs such as Healthy Families or other home-visiting or case management programs is important, as there may be duplication in the services provided by these programs and those provided by Health Start. A goal of the Health Start Program is to avoid duplication of services, while providing the most appropriate services to the family.

The community health worker may request additional assistance in determining other referrals and education for clients from the Registered Nurse, Social Worker or Licensed Professional Counselor available through the Contractor.

When a referral to another program is made, Health Start will continue to see the infant/family until they begin services from the other home-visiting or case management program.

Referrals to AzEIP (Arizona Early Intervention Program)

The Ages and Stages Developmental Assessment does not have a pass/fail result. Scores in five areas are either “doing well” or a recommendation is made to “talk to a professional for possible further evaluation”. Children who have developmental results recommending, “talk to a professional for possible further

evaluation" will be referred to Arizona Early Intervention Program (AzEIP). If the outcome of the assessment is unclear, it may be repeated within a month. If still unclear or recommending "talk to a professional for possible further evaluation", the community health worker will refer to AzEIP. A joint visit of representatives from AzEIP and Health Start may help to establish if the infant/child is appropriate for an AzEIP referral, and to provide contiguity of care for the family.

9.3 Reporting of Immunizations

Community health workers will assess at each visit and record on the Family Follow Up Visit form if immunizations are appropriate for age for all children enrolled from birth through age 2. The community health worker will also educate clients on the importance of immunizations for the whole family. Contractors will direct community health workers to all available immunization resources, including AHCCCS health plans, county health departments, Arizona Department of Health Services, or community school districts. Whenever possible, community health workers will use immunization records provided by the client to establish evidence of immunization. A checklist for babies and pregnant women may be provided by ADHS for use by contractors. Client interview may serve as evidence of immunity only when written evidence cannot be obtained.

9.4 Access to Client Records and Information

Information contained in the client's file record is confidential. Clients may view their files at any time, and have the right to correct any information included in the records that they state is inaccurate. The Intent to Participate Form, signed by the client prior to enrollment in the program, indicates that a client file will be maintained by the contractor, information will be shared with Arizona Department of Health Services and the client file may be available for use in court proceedings (subject to subpoena).

The Contractor is responsible for storing client records in a safe, secure locked location at the contractor site, for maintaining the client's case file record in a confidential manner, and for ensuring that information contained in the records is released only to authorized parties. It is recommended that client records not be transported out of the contractor site. If transported, they must be kept in a locked file.

Representatives of the Health Start Program and Office of the Auditor General may have access to client records in order to conduct necessary evaluations or programmatic review. The client's file is available to other governmental agencies, including other programs within Arizona Department of Health Services only with specific permission by the client for the release of information in the client file.

CHAPTER 10
HEALTH START BILLING PROCESS

10.1 Contractor Billing Number

Each Contractor has a unique Contract Number. This Contract Number must be included in all Contractor invoices and correspondence to ADHS.

10.2 Invoice Format

Contractor invoices may be submitted on the Contractor's letterhead stationery, but must conform to the general specifications shown on the sample invoice located at the end of this chapter.

10.3 Invoice Submission Requirements

Within 15 days after the end of the service month, the Contractor shall submit a the billing invoice, a log of all clients who received billable services during the service month and the appropriate program forms to support each deliverable. The invoice must meet the specifications of the sample invoice at the end of this chapter. Any no charges (NC) must be marked on the client log before submitting to ADHS. The invoice must have an original signature of the contractor's signature authority.

Health Start Program Manager
Arizona Department of Health Services
Office of Women's and Children's Health
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007

The contractor shall submit a detailed log of client visits, classes, screening forms and staff certificates of attendance for non-Health Start sponsored trainings being billed. An example of a log is provided by ADHS at the end of this chapter.

10.4 Program Coordinator Role in Invoice Review

The Contractor's Program Coordinator is responsible for reviewing the accuracy and completeness of the monthly log of clients, the billing invoice submitted for payment, and the completeness and accuracy of the program forms accompanying the invoice and log. The Contractor should employ quality control and review procedures to ensure accuracy and integrity of all paperwork submitted to the Health Start Program Manager.

10.5 Units of Reimbursement

Health Start reimbursement provisions and methods are specified in each Contractor's written contract agreement with ADHS. Reimbursement for Health Start services and other program expenditures is made in accordance with these

contract specifications, and approved by the ADHS Health Start Program Manager. Face-to-face encounters are required for the service to be billed.

The Contractor has Several Service Units for Reimbursement:

Data Preparation

The Contractor will be paid a fixed monthly data preparation fee to compile, reconcile, review and correct the program forms that accompany the client log and invoice. The BWCH Assessment and Data Quality Assurance Coordinator will match each program form to the client log and will contact the Program Coordinator if the forms are missing any data. The data preparation fee may be deducted from the invoices by ADHS if contractor forms submitted are not complete and accurate.

Negative Pregnancy Test

The Contractor will be reimbursed for each initial contact with a potential enrollee who is provided a pregnancy test and that test is negative. Contractor will provide a minimum of 30 minutes of preconception/interconception health education. These encounter forms must accompany the client log and the billing invoice for the month of service. Only negative pregnancy test visits to non-enrolled Health Start clients are billable. No more than two (2) pregnancy tests per woman per contract year can be provided.

Client Enrollment

The Contractor will be reimbursed for each client enrolled with the Program. These enrollments are documented on the Client Enrollment form. The Contractor shall submit a client log, billing invoice and the HS enrollment form for each client billed to ADHS for the month of service. Enrollments should be submitted for those clients who have enrolled in the program.

High Risk Nurse Home Visit

The Contractor will be reimbursed for each face to face home visit between the Community Health Nurse and each enrolled postpartum client that has had an infant who has been in the neonatal intensive care unit (NICU) for five (5) days or longer and is not being followed by ADHS HRPP program. These visits involve an extensive exchange of information, assistance, education, advocacy and are documented on the Family Follow-up Form. These encounter forms must accompany the client log and billing invoice for the month of service.

Client Visit

The Contractor will be reimbursed for each face-to-face visit between the community health worker and each enrolled client during the Prenatal or Family

Follow-up periods. These visits involve an extensive exchange of information, assistance, education, advocacy, and are documented on the appropriate Health Start encounter forms. All client visit forms must be signed and dated by the client in blue ink at the bottom of the form. These encounter forms must accompany the client log and the billing invoice for the month of service.

Multiple-Child Visit

The Contractor will be reimbursed for each face-to-face visit between the community health worker and each enrolled client during the Family Follow-up period or during prenatal period if there is an enrolled Health Start child under age two (2). This visit is for a woman enrolled in the program where there is more than one index child (multiple birth or previous index child less than two years old from program participation). These visits involve an extensive exchange of information, assistance, education, advocacy, and documented on a Family Follow-up form. These encounter forms must accompany the client log and the billing invoice for the month of service.

Enhanced Alcohol Screening Visits

The Contractor will be reimbursed for each face to face enhanced alcohol screening of pregnant enrolled clients. The Alcohol Screening Form must be filled out and submitted for each client screened. These screening forms must accompany the client log and the billing invoice for the month of service.

Enhanced Brief Intervention Visits

The Contractor will be reimbursed for each face to face enhanced Brief Intervention visit provided to enrolled pregnant clients who have scored 2 or higher on the alcohol screening tool. The Process Information About Visits For Women That Screened Positive form must be filled out and submitted for each pregnant enrolled client provided the Brief Intervention education. These forms must accompany the client log and the billing invoice for the month of service.

Nurse Consultation

The Contractor will be reimbursed for a minimum of four (4) hours per month for consultation provided by a Registered Nurse (R.N.). Consultation can be advisement to contractor and/or Health Start Program staff regarding health education and other complex client referral issues. The nurse may provide contractor staff orientation, training, and may participate in case review conferencing and staffing. Documentation of services provided including number of hours, dates and cost per hour signed by consultant must be submitted with the billing invoice for the month of service.

Social Work/LPC Consultation

The Contractor will be reimbursed for a minimum of four (4) hours per month of consultation provided by a Social Worker (Certified Independent Social Worker,

Licensed Independent or Licensed Master Social Worker) or provided by a Licensed Professional Counselor (LPC). Consultation can be advisement to contractor and/or Health Start staff regarding health education or other complex client referral issues. The consultant may provide contractor staff orientation, training and may participate in case review conferencing and staffing. Documentation of services provided including number of hours, dates and cost per hour signed by consultant must be submitted with the billing invoice for the month of service.

Group Classes

The Contractor will be reimbursed for each class with four or more enrolled clients in the prenatal and family follow-up period. The Class Attendance Record containing the date of the class, the name of the guest speaker providing the education, the names of class attendees and the topics discussed during the class are submitted with the client log and invoice for the month of service. Classes must be one (1) hour in length and should cover one (1) or more related topics. It is recommended that clients sign the enrollment sheet and contractor provide a typed sheet of Health Start client names that attended.

Required Training

This is approved required training for the Health Start staff (e.g. community health workers, coordinators, RN's, social workers, and counselors). This training shall be pre-approved by the Health Start Program Manager, and will better enable them to do their jobs. This does not include contractor new employee orientation, Health Start required training of community health workers or community health nurses, or training provided onsite by subcontracted consultants. The reimbursement will be per day/per person and is expected to cover any registration costs and travel expenses. Certificates of attendance/ completion of training must be submitted with billing invoice.

10.6 Approval Process

Upon submission of the invoice, client listing of encounters, and the accompanying program forms, the information will be reviewed for correctness and completeness. If the client forms can be reconciled with the client log and invoice, the items are approved for payment. Should there be a discrepancy between the invoice, client log and/or the program forms submitted, the HS Program Manager and/or HS Data Quality Coordinator will contact the HS Program Coordinator to determine if any concerns can be rectified in a timely manner. In those cases where the concerns cannot be immediately addressed, the HS Program Manager will amend the invoice as needed and communicate any changes to the Contractor, if requested. Once the ADHS Program Manager has approved the invoices for payment, the invoice is processed per ADHS policy and procedures.

HEALTH START BILLING INVOICE

Health Start Program Manager
Arizona Department of Health Services
Bureau of Women's and Children's Health
150 N. 18th Ave., Suite 320
Phoenix, Arizona 85007-3242

Contractor Name: _____

Contract Number _____

Title of Program HEALTH START

Period Covered: **From:** _____ **To:** _____

Service	# Units Completed	Unit Price	Unit Description	Total
Data Preparation			Per Month	
Negative Pregnancy Test Visits			Per Person	
Client Enrollments			Per Person	
High Risk Nurse Home Visits			Per Child	
Client Visits Prenatal and Family Follow-up Visits			Per Person	
Multiple-Child Visits			Per Child	
Classes for Clients			Per Class	
Enhanced Alcohol Screening Visits			Per Person	
Enhanced Brief Intervention Visits			Per Person	
Nurse Consultation			Per Hour	
Social Work/LPC Consultation			Per Hour	
Approved Community Health Worker Training (provide name of worker and training)	# of people__ # of days __		Per Person/Per Day/Per the Arizona Department of Administration General Accounting Office guidelines www.gao.az.gov/travel/	
			TOTAL	

_____**Approved**

_____**Disapproved**

_____
Contractor Authorized Signature **Date**

_____
Program Manager's Signature **Date**

Health Start Visit Log

Contractor:

Month/Date:

Visit Date	Last Name	First Name	DOB	Negative Pregnancy Test	Enrollments	Prenatal	Family Follow Up	High Risk Nurse	Multiple Child	Closed	Health Worker	Nurse

Health Start Visit Log

Contractor:

Month/Date:

Visit Date	Last Name	First Name	DOB	Enhanced Alcohol Screenings	Score	Enhanced Brief Intervention	Monthly Follow Up	Health Worker

CHAPTER 11
QUALITY MANAGEMENT AND IMPROVEMENT

11.1 Overview of Quality Management and Quality Improvement Requirements

The ADHS Health Start Program recognizes the need to support the development of effective quality assessment and improvement initiatives into its program. Contractors must develop a systematic process for continuous monitoring of the quality and appropriateness of client services, as well as looking for ways to improve the development and ongoing implementation of the program.

This section describes requirements and general guidelines for Health Start Contractors to utilize in monitoring, evaluating, and improving the quality of services to pregnant women, infants, and children. Results of quality monitoring activities will be reported on the quarterly reports.

11.2 Resolving Client Problems

The Contractor is required to develop and implement a process for timely addressing and resolving client problems. Health Start clients may have concerns regarding a variety of issues. These issues may include, but are not limited to:

- ☐ A problem or conflict with their assigned community health worker or community health nurse.
- ☐ Concerns about the timing, frequency, or content of community health worker or community health nurse visits.
- ☐ Questions about the availability or accessibility of certain types of Health Start services.
- ☐ Disagreement with an administrative decision made about their enrollment in the Health Start Program.

Important information about ongoing client satisfaction can assist the Contractor with appropriately monitoring the community health worker's performance. Although the issues mentioned above are only examples, they highlight the types of input that can be valuable for the Contractor to have in order to improve the efficiency, effectiveness, and quality of its operations and services.

The Contractor should also develop a mechanism to track client problems and issues and to incorporate findings and feedback about client problems and issues into a plan for improving Contractor services. The Contractor shall cooperate with ADHS in the resolution of client problems brought to ADHS's attention.

11.3 Client Satisfaction Surveys

Client satisfaction surveys are an important tool in assessing the quality of services provided by community health workers. They are also an important evaluation tool for use by the Contractor in determining potential areas for improvement of program services. Contractors will design a client satisfaction survey for enrolled clients in their Program Site. ADHS staff is available to provide technical assistance with the development of potential questions for the client satisfaction surveys. An example of a survey is provided in Chapter 8.

At a minimum, client satisfaction surveys are provided to enrolled clients after the prenatal period, and after two years of family follow-up services.

The Contractor will develop written procedures to assess client satisfaction with Health Start Services that will include:

1. Design a client satisfaction survey for enrolled clients that is specific to Health Start.
2. The CHWs will provide the survey to prenatal clients at the next monthly visit after the birth of their child (the prenatal period) and after two years of family follow-up services.
3. There will be a signature blank for the client to sign and date the form. The client survey form needs to have an identifier that will link the form to the CHW.
4. The survey is filled out by the client at the visit and put in a sealed envelope by the client. The envelopes can be addressed, stamped, and be mailed to Health Start Coordinator by the client or the CHW will collect the envelopes from clients. The CHW will turn the surveys in to the Health Start Coordinator on a monthly basis to review and keep on file for each CHW to use for performance reviews and for Health Start site visits. This process may be changed in the future to have surveys mailed to ADHS for review and assessment.

11.4 Management Reports

The ADHS Health Start Program collects data from each Program Site. This data consists of information included on Client Enrollment forms, Prenatal Visit forms and Family Follow-up Visit forms and may include other forms. ADHS may provide management reports for use by each Program Site. Contractors may periodically receive these reports from the ADHS Health Start Program. These reports include site specific and summary information, and are intended to provide the Contractors and ADHS with pertinent information to manage and monitor the program's effectiveness. Contractors are required to continuously monitor the following indicators:

1. Trimester of entry into the program

2. Case load of each community health worker

3. Average number of home visits per client during the prenatal period

4. Outcomes of referrals

5. Number of clients lost to follow-up

6. Number of women declining enrollment into the program.

7. Training provided to community health workers

In addition, indicators which ADHS may monitor include, but are not limited to:

1. Trimester of entry into prenatal care

2. Case load of each Contractor (by community health worker)

3. Average number of visits (in each category) per client during the prenatal period

4. Outcomes of referrals (once standard outcome categories have been determined)

5. Number and percentage of clients delivering infants in standard weight ranges

6. Medical home status of children through age 2 in the client family

7. Immunization status of children through age 2 in the client family

8. Demographic characteristics of the client population

9. Educational topics discussed with clients

10. Services a client is receiving or to which she has been referred

11. Qualifying risk criteria for each client

ADHS will work with Contractors in developing any additional standard or special reports that may be helpful in assessing the quality and effectiveness of Health Start Services. It is expected that Contractors will utilize this information in their continuous monitoring and improvement processes.

11.5 Quality Management and Improvement

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 client services. This section provides guidelines for the development and/or ongoing implementation of a continuous quality management and improvement program. Described below are the components of the quality improvement process. (See pages 11-6 through 11-8 for the format of a three-part Quality Improvement Plan).

The Selected Indicator

The indicator is a measurable variable that is looked at to determine how well the organization is doing on an aspect of service provision. Each indicator has its own performance or effectiveness goal and has the potential to impact operational processes and the quality of service provision. In recognition of the fact that both state-wide trends and local concerns must be addressed by the ongoing quality improvement process, the BWCH will identify at least one indicator per contract year that must be included in program quality management and improvement activities. At least two (2) indicators will be selected by the contractor conducting the quality improvement activities and will reflect local concerns.

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 client performance or client satisfaction as a result of the performance of the organization or its employees. Performance goals may be drawn from a variety of sources including various regulations and standards governing organizational policy and procedures or contractual requirements.

ADHS Health Start performance measures are listed below.

- 95% of Health Start Program participants will receive prenatal care in their first trimester and at least five (5) doctor visits during their pregnancies.
- Refer 100% of women who enroll in Health Start while pregnant who are not already receiving prenatal care to a prenatal care provider within one (1) month of their first home visit.
- 90% of participating children up to age two (2) will be properly immunized.
- 85% of Health Start Program participants will receive individual or group classes discussing the importance of good nutritional habits.
- 85% of children whose mothers participate in Health Start will receive:
    - At least one (1) Ages and Stages developmental assessment by seven (7) months of age
    - At least two (2) Ages and Stages developmental assessments by twelve (12) months of age.

- 85% of Health Start Program participants will receive individual education or group classes on the importance of preventive health care.
- 85% of Health Start Program post partum enrolled participants will receive education on the importance of hearing and vision tests.

Quality Improvement Plan Level

The threshold or acceptable performance or outcome level.

Data Source

The identified source for data specific to the indicator. Common data sources would be client files, client satisfaction surveys or routine management reports. In most cases, fairly simple methods can be devised on order to collect the data needed. 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. 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. Care consideration should be given to who collects the data. In general, clerical staff can collect information from client files, more cost effectively than professional staff.

Responsibility

The person responsible to be in charge of documenting the plan, collecting the data, reporting results, developing 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.

11.6 Quarterly Report

The Quarterly Report serves as a means to document Contractor progress and concerns. The report identifies those areas requiring follow up by the ADHS Program Manager such as enrollment of low birth weight babies in the Newborn Intensive Care Program and is a formal communication process from the Contractor to the Program regarding improvements made in the social determinants of health, local barriers, successes and quality improvement activities. The Quarterly Report is due to the ADHS Program Manager 30 days after the end of each quarter. A sample Quarterly Report with all the required sections is at the end of the chapter (page 11-8/9).

11.7 Quarterly Client File Quality Assurance Form

The Quarterly Client File Quality Assurance form serves as a means to document that client files are being checked for completeness of file entries. Client File Quality Assurance is done when ten (10) charts are randomly chosen and reviewed each quarter to assure that all required Health Start forms (Intent to Participate and Enrollment) are in the client file, all client visit forms are accurately completed and referrals and follow-up are documented with a contractor referral form. A copy of the form is at the end of the chapter (page 11-9/10)

QUALITY IMPROVEMENT PLAN

Part I Quality Improvement Plan (2010-2011): Indicator Selected by BWCH

Name of Organization: ***Date: 07/01/10***

Program: Health Start Responsible Person: Individual Contractors

Description: It is critical that all Health Start forms are accurately and completely filled out prior to submission to ADHS.

Goal: All Health Start forms will be accurately completed prior to being submitted to ADHS for payment.

Indicator: The number of times ADHS contacts the contractor to obtain missing or incomplete information or submitted on forms.

QIP Level: 100% Indicator Score: Data Source: ADHS report

Recommendations for QIP resolution:

Target date for Resolution: Signature:

****

Resolution

DO YOU WANT TO UPDATE DATES SHOWN ABOVE AND BELOW??

Review Date: 6/30/11 Indicator Score: Signature:

Part II Quality Improvement Plan (2010-2011):
Indicator(s) Selected by Contractor (provide 2)

Name of Organization: Date:

Program: Health Start Responsible Person:

Description:

Goal:

QIP Level: Indicator Score: Data Source:

Recommendations for QIP resolution:

Target date for Resolution: Signature:

****

Resolution

Review Date: Indicator Score: Signature

Contractor: _____
Submitted by:_____
__September
__December
__March
__June
(Due within 30 days after Quarter)

HEALTH START QUARTERLY REPORT

1. **List all Babies born with weight under 3 pounds 5 ounces (LBW) and any babies born who spent 5 days or longer in the Neonatal Intensive Care Unit:**
   (Name of mother, Mother's DOB, Baby's name, Baby's DOB and CHW/CHN)

2. **Consultation services and hours provided each month for 3 months.**
   (Example: Mary Jones RN Case Management 6 hours May 2010
   Prenatal In-service 2 hours May 2010

   Social Worker/LPC services and hours provided each month for 3 months.

3. **List all training, in-services or certifications completed by staff.**
   (Example: Maria Lopez CHW – Breastfeeding Counselor Certification, 5/1/2010)

4. **Describe any improvements or changes made in social determinants of health in Contractor service area and among clients served:**
   Social Determinants:
   Access to Healthy Food: (example: List new Farmers Markets in area; list number of client referrals to WIC)
   Access to Primary Care/Obstetrical/Gynecological Services: (example: list any new primary care/ob/gyn providers in service area accepting clients; list the number of clients who did not have a primary care/ob/gyn provider at enrollment and were referred to a provider and now have a medical home)
   Access to Job Opportunities: (example: list any new employers in service area; list the number of clients that were provided assistance in seeking employment or referred to job services)
   Access to Safe Environment: (example: list any new safe areas to exercise or children's playgrounds in service area; list the number of Safe Home/Safe Child assessments provided by client/date; list any classes provided on injury prevention)

Access to Education: (List any new educational facilities/opportunities in the service area; list any activities with clients that promote literacy such as providing donated books to client's children to encourage reading)

5. **Barriers to providing service.**
   Describe in detail Contractor outreach activities during the 3 months.
   Describe any barriers to enrollment of new clients.
   Describe any barriers to providing screening and assessments to current clients.
   List the number of new prenatal clients and new post-partum clients enrolled during the 3 months.
   List the current client caseload by type of client for each Community Health Worker.
   List the current client caseload of postpartum high risk clients for each Community Health Nurse

6. **The Preconception/Interconception education provided.**
   List the number of Negative Pregnancy Test visits and the education topic(s) provided.
   List the interconception education provided to postpartum clients by topic and by number of times provided.

7. **Progress made in achieving quality improvement indicators.**
   Provide updates to the Quality Improvement Plan (QIP) and calculate the quarterly QIP for each indicator. (1 ADHS indicator, 2 Contractor Indicators)

8. **New funding awards received providing the same or similar services.**
   List any new funding received for the same or similar services; provide source and amount of award and executive summary.
   List any new subcontracts executed for any consultant services or other services under Health Start.

9. **List any Change in Personnel services.**
   List the names, positions and FTE level of any new staff and the date hired during the 3 months.
   List any change in % time that has occurred with existing staff under Health Start; provide revised itemized budget.
   List any new/revised subcontracts for consultant services or any other services under Health Start and provide a copy of subcontract.

- The fourth quarter report shall contain the above information as well as the following:
  - A description of the Contractor's prior year's summary of activities
  - Next year's projected number of prenatal and postpartum clients to be enrolled
  - Current and projected caseload of each CHW/CHN
  - Projected number and type of FTE's for program
  - Projected number of visits by type to be provided
  - Number of classes to be provided by topic
  - The plan to address any quality improvement indicators

QUARTERLY CLIENT FILE QUALITY ASSURANCE FORM

Client File Quality Assurance is done when ten (10) charts are randomly chosen and reviewed each quarter to assure that all required Health Start forms (Intent to Participate and Enrollment) are in the client file, that all client visit forms are accurately completed and referrals and follow-up are documented.

Visit Date	Type of Visit	Quarterly Check

CHAPTER 12
PROGRAM MONITORING AND EVALUATION

12.1 Overview of ADHS Monitoring and Evaluation Activities

This Chapter provides information about a variety of ADHS's program monitoring and evaluation activities. As mentioned in Section 1.5, ADHS and its Contractors will work together in partnership for many of the aspects of Health Start program development and implementation. Although ADHS acts as a partner, facilitator, educator, technical advisor, and payer, it also has a significant regulatory role, as it is the state agency accountable for all aspects of the administration and oversight of the program. ADHS will conduct an annual review of each Contractor (see Section 12.8).

12.2 ADHS Program Monitoring Personnel

The following ADHS personnel are responsible for various components of the Administration, evaluation, and oversight of the Health Start Program:

Program Manager

The Program Manager is responsible for the day-to-day operation of the program. The Program Manager coordinates activities among Contractors and among Team members, receives and reconciles invoices, handles budget issues and answers questions that arise. The Program Manager is also responsible for negotiating contracts, requesting contract amendments be processed by the ADHS Procurement Office, technical assistance, conducting site visits and monitoring Contractor compliance with the provisions of the contract.

Data Quality Assurance Coordinator

The Data Quality Assurance Coordinator provides the program with expertise in completeness and accuracy of data submitted. This individual is called with any problems for possible solution or referral, processes and enters all invoices received, mails out all program materials, and provides other support services for the Program Manager.

Other ADHS Staff

Other ADHS staff members may be involved in administering various contract or payment matters. These persons will generally include: an ADHS Contract Manager; accounting personnel who pay the Contractor invoices which have been approved by the Program Manager; budget personnel who monitor the funds from which Contractors are paid; and other administrative services personnel who monitor certain types of paperwork flow and contract documentation requirements.

12.3 ADHS/Contractor Meetings

The ADHS/Contractor meetings are designed to facilitate communication and collaboration among ADHS and its Health Start Contractors. Representatives from the ADHS Health Start Program will periodically meet with the group of Contractor's Program Coordinators. The purpose of these meetings, may include, but is not limited to:

- ☐ Development and implementation of program goals and objectives.
- ☐ Exchange of information, opinions and ideas.
- ☐ Discussion of program policy issues.
- ☐ Training needs or in service sessions.
- ☐ Networking opportunities.

12.4 Review of Contractor Documentation

The ADHS Health Start Program Manager and Data Quality Assurance Coordinator will review all routine and non-routine documentation, summaries, and reports submitted by the Contractor. The documentation will be reviewed against relevant Health Start program requirements and standards. The Program Manager may utilize this information in making assessments about Contractor's performance. Information reviewed shall include, but not be limited to:

1. Monthly invoices
2. Community health worker training materials
3. Any materials to be distributed to clients
4. Outreach materials for community health workers and clients
5. Changes or modifications to program plans, outreach plans, etc.
6. Responses to ADHS requests for information
7. Responses to ADHS request for investigation of a complaint
8. Written requests for technical assistance
9. Health Start chart review at the contractor site.
10. Quarterly reports.

12.5 Technical Assistance and Training

ADHS Health Start Program personnel recognize the need to work with Contractor staff to facilitate an effective Health Start operation, and promote timely problem resolution. Although the Contractor is ultimately responsible for the operation of its program site, ADHS will provide technical assistance to individual Contractors upon request, based on ADHS program staff availability. ADHS will also work with Contractors to identify ongoing needs for training and technical assistance.

12.6 Site Visits

A site visit is defined as any visit to the Contractor's business location by ADHS Health Start Program staff or designees. ADHS may visit the Contractor' place of business for a variety of reasons, including, but not limited to:

- ☐ Contract monitoring and evaluation activities.
- ☐ Investigation of problems.
- ☐ Technical assistance.
- ☐ Follow-up on a previous site visit.
- ☐ Contractor or community health worker training.

At a minimum, the ADHS Health Start Program will conduct an annual site visit of the Contractor's office location, to review and evaluate the Contractor's program. This annual site visit is called the annual review. The process and content of the annual review are described in more detail in Section 12.8.

Whenever possible, ADHS will work with Contractors to define goals and objectives for the site visit in advance of the visit. Contractors, in turn, are expected to cooperate fully with ADHS during the site visit.

12.7 Annual Review (Site Visit)

The ADHS Health Start Program will conduct an annual review of each Contractor. The annual review process includes a comprehensive review of the Contractor's Health Start operations and an assessment of compliance with Health Start Program policies. In addition, the annual review process will include a case file review of Health Start clients. The case file review component is intended to obtain information on the quality of services being provided, as well as the quality and completeness of documentation regarding the program.

These reviews are very important for both ADHS and the Contractors. Along with documenting contract compliance and assessing Health Start service quality, results from these reviews can be used to:

- ☐ Evaluate the effectiveness of the Contractor's program planning and outreach strategies.
- ☐ Identify opportunities to improve integration of Contractor services/operations and ADHS services.
- ☐ Enhance Health Start service accessibility, service delivery and case management systems.
- ☐ Improve organizational or operational efficiency of the Program.
- ☐ Identify ways to reduce excessive administrative costs or enhance revenues.
- ☐ Establish baselines for development of quality improvement strategies or corrective action plans with Contractors.
- ☐ Improve productivity and performance.
- ☐ Identify and recognize exemplary Contractor processes and outcomes.
- ☐ Identify potential causes for specific management, operational or financial problems.
- ☐ Document baselines for future development of performance standards.

In addition to the contract compliance and case file review, Contractors may have a comprehensive review of the implementation of the Health Start Program and site operations in the first year of the annual review. This "baseline" review documents the Contractor's organizational structure, administrative systems, and processes for planning, providing, and evaluating Health Start services.

ADHS Health Start Program representatives will discuss the annual review process with Contractors prior to the initiation of the reviews. Information Contractors receive about the annual review process may include, but is not necessarily limited to:

- ☐ Description of the ADHS Health Start Program Review Team
- ☐ Potential or expected dates and time frames for the review

- ☐ Materials required for review prior to the on-site visit

- ☐ Requests for Contractor assistance in scheduling entrance or exit conferences, or interviews with Contractor's Administrator and staff

- ☐ Requests for Contractor information, including but not limited to: internal policies and procedures, case files, training documents, management reports, job descriptions, etc.

- ☐ Description of methods that may be used to collect information during the review (e.g., interviews, group meetings, document review and analysis, data collection from case files)

- ☐ Description of the process that will be utilized to obtain Contractor input into the review findings (e.g., exit conference, review of the draft site visit report by the Contractor before it is finalized, etc.)

- ☐ Description of estimated procedures for finalizing the report

- ☐ Description of activities that might occur as a result of the site visit

The Contractor can expect that a review team representing the ADHS Health Start Program will visit the Program site during the annual review. ADHS will work with the Contractor, as much as possible, to assist in minimizing interruptions to the staff's normal workload during the course of the review. See copy of Site Review Evaluation at the end of the chapter, page 12-6 through 12-13 and the Chart Audit Review on page 12-14.

QUALITY PERFORMANCE GUIDELINES FOR SITE REVIEW EVALUATIONS

The Health Start Guidelines for Evaluation provides a structured framework for reviewing and assessing the Contractor's progress, program strengths and compliance with Health Start Standards. This Guideline is to ensure that Performance Assessment and Improvement are an integral, dynamic, on-going program function to define quality, establish means to measure and assess quality, and to take corrective action to maintain and improve quality.

RECOGNITION:

1. Performance improvement builds quality into the process rather than inspecting for it.
2. Performance improvement relies on teamwork rather than individual performance.
3. Performance improvement examines process as the source of problems rather than identifying the mistakes the caregivers make.
4. Performance Assessment and Improvement is an on-going process.

HEALTH START PROGRAM GOALS:

1. To reduce the incidence of very low birth weight babies.
2. To increase prenatal services to pregnant women.
3. To reduce the incidence of children affected by childhood diseases.
4. To increase the number of children receiving age appropriate immunizations by two years of age.
5. To increase awareness by educating families on the importance of good nutritional habits, developmental assessments, and preventive health care.

GENERAL INSTRUCTIONS:

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

1. Program Administration
2. Staff Recruitment /Credentialing
3. Staff Education
4. Documentation
5. Home Visiting/Class Services
6. Evaluation and Monitoring

Each section has an identified Performance Standard for the Health Start Contractor. These performance standards have been communicated to the Health Start Contractors in the "Scope of Work" sections of their contracts or in the ADHS/Health Start Policy Manual. The review team gathers data, reviews documents and conducts interviews and inquiry of the Health Start Contractor to assess whether the performance standards has been met. Prior to the start of the reviews, the 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 Health Start Contractor's program. These sources allow for a variety of means for reviewers to gather evidence to support findings and conclusions.

The question 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. Each section does not contain an exhaustive list of questions that will "prove" compliance; nor should the questions be the only ones reviewers consider asking when other areas of inquiry are appropriate. Reviewers are encouraged to document areas for follow-up with the Contractor during the site visit.

Reviewers are encouraged to make notations or references to data collection documents in the "Comments" section. This is the preferred area to summarize locations of information sources used, such as page numbers, document references, summaries and/or areas for follow-up at the site visit from the review.

CRITERIA SCORING
Evaluate the specific indicators as follows:

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. It is important to justify and support all scores. Areas above standard can be highlighted as strengths and areas of noncompliance can be documented so that the Health Start Contractors can prepare action plans for resolving problem areas. Collection of data information and descriptions of processes will help support the findings and conclusions and will provide ADHS/Health Start with information to identify program strengths and opportunities for improvement. The scores for the Health Start Contractor are summarized and used as a tool in identifying areas of strength and need for the Health Start Contractor. Health Start Contractor scores are examined together to identify areas of strength and need for all Health Start Contractors and the Health Start program as a whole. Results of reviews are used by Health Start Contractors and ADHS to develop action plans for improvement of the Health Start program. The review team members sign the front of each review to acknowledge that the scores for each area reflect their findings and conclusions.

ARIZONA DEPARTMENT OF HEALTH SERVICES
HEALTH START PROGRAM
SITE REVIEW EVALUATION

Location: Date:

Attendance:_____ ADHS Reviewer:

H = Have
R = Request
O = Observed

Source

C = Compliant
P = Partially Compliant
N= Non Compliant

PROGRAM ADMINISTRATION

1.	The Contractor has a minimum of 0.25 FTE dedicated to the administration and oversight of the program at the contracted site (Program Coordinator). P&P 3.1	O	Site Visit Interview	C P N
2.	The Contractor has sufficient and adequate staff that will support services to implement the Health Start program for all contracted areas of service. P&P 3.1	O	Site Visit Interview	C P N
3.	The Contractor has professional support persons (Registered Nurse and Certified Independent Social Worker or Licensed Professional Counselor), each available for a minimum of 4 hours of consultation services per month. P&P 3.1, Contract 4c	O H	Site Visit Interview, Quarterly Report	C P N .

Comments

4. The ADHS Health Start Program Manager has approved any educational, training or informational materials prepared by the Contractor that are distributed to Health Start clients. P&P 3.2, Contract 8a	O H	Site Visit Interview, Contractor records	C	P	N
5. The Contractor stores and maintains all client records, including files with the community health workers, in a safe, secure location, and destroys records (except for non-identifiable demographic characteristics) five (5) years after the client's last participation in the Health Start Program. P&P 3.3	O H	Site Visit Interview, Client files, Contractor policy	C	P	N
6. Strategies are in place to assist community health workers to identify and recruit at risk women into the program early in their pregnancies. P&P 6.4, Contract 4d	O	Site Visit Interview, Client File Review	C	P	N
7. The Contractor has established a network of resources available to which participants could be referred for services they may need and assist the community health worker with referrals as needed. In circumstances where resources do not exist within the community served, Contractor documents the gap in services and attempts to establish methods to make alternative services available or to obtain equivalent services in another community. P&P 7.4, Contract 4c	O R	Site Visit Interview, Quarterly Report, Contractor record	C	P	N
8. Within 15 days after the end of the service month, the Contractor submits copies of all visit forms, the billing invoice, and a log of all clients seen during the service month, and a class attendance record of clients for each group class billed. P&P 10.3, Contract 10	H	Billing Invoices and logs	C	P	N

9. Contractor's billing invoice for Health Start services and other program expenditures is made in accordance with contract specifications. Face-to-face encounters are required for the service to be billed. P&P 10.5	H	Billing Invoices and logs	C	P	N

STAFF RECRUITMENT/CREDENTIALING

1. Contractor utilizes a community health worker job description, and implements an employee appraisal system for community health workers. P&P 4.1 & 4.8	R	Site Visit Interview	C	P	N
2. Contractors provide the ADHS Health Start Program Manager with a list of community health workers who are serving the Program Site, and updates on a quarterly basis, if there have been changes. P&P 4.4	H	Site Visit Interview, Quarterly Report	C	P	N
3. Contractor hires community health workers from the communities served. Contractor conducts required background checks for all personnel who will have direct contact with Health Start clients, or potential clients, including pregnant women or families, or those who will have access to program participants' records. Minimum requirements for the background check are at least two non-family references, and a Criminal History affidavit by the applicant that the applicant has not committed a felony or a misdemeanor involving moral turpitude. P&P 4.1 & 4.3, Contract 4b	R O	Personnel Records	C	P	N

STAFF EDUCATION

1. Within 90 days of the community health worker's employment date, the Contractor provides training in all of the subjects included in the ADHS Health Start Core Curriculum. P&P 4.5 & 5.1, Contract 4b	R O	Personnel or Education Records	C	P	N

2. The Contractor provides or makes available a minimum of six (6) hours of continuing education each year for each community health worker. Any trainings or continued education submitted for reimbursement must have prior approval by the ADHS Health Start Program Manager P&P 5.5	R O	Personnel or Education Records	C	P	N
3. Contractor includes ADHS prepared pre-tests and post-tests, performance evaluations (e.g. supervised home visiting sessions), home visiting checklist, continuing education plan and documentation of training in the personnel file for each employee performing Health Start services. P&P 4.8, 5.5, Contract 4b	R O	Personnel Records	C	P	N

DOCUMENTATION

1. All files in client file review contain the minimum required documents to meet ADHS data collection and reporting requirements. At a minimum, a record of all client contacts and supporting documentation forms (consent, enrollment and encounter visit forms) must be maintained. P&P 8.2, 8.3	R O	Client File Review	C	P	N
2. Community health worker documents all pertinent information about client interactions in a confidential client case file record. Community health workers maintain entries in the file that reflect professional, nonjudgmental statements of fact in English. P&P 8.2, 8.3, Contract 4f	R O	Client File Review	C	P	N

HOME VISITING/CLASS SERVICES

1. Community health Workers initiate contact for a Home Visit promptly after receipt of the referrals, follow the periodicity schedule with home visits/classes and track the infants to the age of two years. P&P 7.2, 7.3	R O	Client File Review	C	P	N

2. Community health workers make at minimum: a. At least one prenatal visit per month during the prenatal period and/or classes for each enrolled client in their caseload b. One visit (or attempted visits) in the first two weeks after the birth of the index child. c. One visit and/or prescheduled class during the month that the index child reaches 2, 4, 8, 12, 18, and 24 months of age. P&P 7.1, 7.3, Contract 4e	R O	Client File Review	C P N
3. Community health workers ensure that each client is offered a copy of the resource Arizona Children and Families Resource Directory. P&P 3.4	O	Site Visit Interview, Contractor policy	C P N
4. The Ages and Stages Developmental Assessment and SafeHome/SafeChild Assessment results are in the individual client file at the contractor site. P&P 8.12, 8.13	R O	Client File Review	C P N
5. If a referral is made, both the referral (R) and the outcome of the referral (V) are indicated on the visit forms, and the contractor referral form is in the client's file. P&P 7.4	R O	Client File Review	C P N

EVALUATION AND MONITORING

1. The Contractor has developed a systematic process for continuous monitoring of the quality and appropriateness of client services, as well as looking for ways to improve the development and ongoing implementation of the program. P&P 11.1	O R	Site Visit Interview, Contractor documentation	C P N
2. The Contractor reviews ten client files per quarter, checking completeness of file entries (Intent to Participate and enrollment forms are present, visit forms accurately completed, referrals and follow-up are documented) P&P 11.7	O H	Site Visit Interview, Quarterly Report	C P N

3. The Contractor has developed and implemented a process for timely addressing and resolving client problems, issues, and concerns. P&P 11.2	O	Site Visit Interview, Contractor policy	C P N
4. Contractor has designed a client satisfaction survey for enrolled clients in their Program Site. At a minimum, client satisfaction surveys are provided to enrolled clients after the prenatal period, and after two years of family follow-up services. P&P 11.3	O H	Site Visit Interview, Quarterly Report	C P N

CHALLENGES AND BARRIERS:

ACHIEVEMENTS:

FUTURE PLANS

COMMENTS BY THE EVALUATOR:

HEALTH START PROGRAM
CHART REVIEW AUDIT

Contractor: **Contract #:** **County:** **+ PRESENT**
- MISSING

Chart Auditor: _____ Date of Audit: _____

INDICATOR	**1**	**2**	**3**
INTENT TO PARTICIPATE FORM COMPLETED ENROLLMENT FORM COMPLETED	a. b.	a. b.	a. b.
CLIENT FILE QUALITY ASSURANCE –DOCUMENTATION OF QA			
DEMOGRAPHICS CHARTED			
REFERRALS DOCUMENTED REFERRAL MADE (Initial or Follow Up) SERVICES RECEIVED APPROPRIATE REFERRALS DOCUMENTED			
TYPE OF VISIT DOCUMENTED 1. COMMUNITY HEALTH WORKERS MAKE AT MINIMUM: a. AT LEAST ONE PRENATAL VISIT PER MONTH DURING THE PRENATAL PERIOD AND/OR CLASSES FOR EACH ENROLLED CLIENT IN THEIR CASELOAD b. ONE VISIT (OR ATTEMPTED VISITS) IN THE FIRST TWO WEEKS AFTER THE BIRTH OF THE INDEX CHILD. c. ONE VISIT AND/OR PRESCHEDULED CLASS DURING THE MONTH THAT THE INDEX CHILD REACHES 2, 4, 8, 12, 18, AND 24 MONTHS OF AGE.	**Baby's D.O.B**	**Baby's D.O.B**	**Baby's D.O.B**
DEVELOPMENTAL RESULTS DOCUMENTED AGES&STAGES 4 MONTHS AGES& STAGES 8 MONTHS AGES & STAGES 12 MONTHS AGES & STAGES 18 MONTHS AGES & STAGES 24 MONTHS			
SAFEHOME/SAFECHILD INITIAL ASSESSMENT UPDATED ASSESSMENT			
CURRENT IMMUNIZATION DOCUMENTED			
CLASSES DOCUMENTED IN THE CHART (Including Topic)			

HEALTH START
HOME VISITING CHECKLIST

Community Health Worker _____

Supervisor/Observer Name _____

Date of Home Visit _____

HOME VISITING ACTIVITY	DATE/ INITITAL	COMMENTS
1. The Community Health Worker conducts pre-visit planning activities: ____ Plans travel route and transportation needs ____ Develops objectives for the home visit ____ Gathers/prepares handouts or materials in advance ____ Organizes materials for the visit ____ Obtains supply of Health Start Forms ____ Confirms appointment time and place ____ Leaves appointment schedule with Health Start office and/or supervisor		Score = _____ of 7
2. The Community Health Worker demonstrates how to develop a schedule of appointments with clients: ____ Plan the length of the visit ____ Plans travel time between visits ____ Involves client in scheduling the time for the visit and length of the visit ____ Plans for other staff duties or conflicts when preparing visit schedule ____ Maintains an appointment book or scheduling calendar with references and important phone numbers.		Score = _____ of 5
3. The Community Health Worker demonstrates the appropriate initiation of a home visit ____ Arrives on time to the scheduled visit ____ Greets client/family members appropriately ____ Identifies self to the client and/or family ____ States purpose and objectives of the visit		Score = _____ of 4

HOME VISITING ACTIVITY	DATE/ INITITAL	COMMENTS
4. The Community Health Worker uses appropriate communication skills in the home visit setting. ____ Exhibits positive, polite, respectful attitude ____ Clarifies client role as a partner ____ Uses praise and encouragement effectively ____ Practices good listening skills ____ Uses east to understand language ____ Uses reflection, clarification, paraphrases client's feelings and concerns ____ Gives appropriate nonverbal cues to the client ____ Does not interrupt the client ____ Avoids gossip or discussion of other clients' situations or information ____ Is sensitive to client's cultural and religious customs ____ Encourages client to verbalize questions or concerns ____ Encourages and praises healthy behaviors in the client ____ Discusses sensitive issues in a tactful manner ____ Is flexible in dealing with unexpected situations		Score = _____ of 14
5. The Community Health Worker identifies and uses appropriate resource and support materials for the client. ____ Makes sure client has a copy of the "Every Step Counts" Booklet. ____ Resource materials support the home visit objectives ____ Materials are explained and reviewed with the client ____ Client given instructions about what to do if they have additional questions.		Score = _____of 4
6. The Community Health Worker refers persons to appropriate resources or services. ____ Looks for referral opportunities with the client ____ Notifies client that community health workers are not medical professionals ____ Avoids giving medical or treatment advice to client ____ Gives accurate information to the client about referrals and community resources ____ Assists client in completing access to the referral, if necessary ____ Informs client when they will follow up with the client on the referral		Score = _____ of 6

HOME VISITING ACTIVITY	DATE/ INITITAL	COMMENTS
7. The Community Health Worker uses appropriate personal safety and security measures in conducting home visits. ____ Provides or advises as appropriate supervisor/office with home visit schedule ____ Secures personal valuables in a safe place or avoids bringing valuables on the visit ____ Attire is appropriate for home visiting ____ Has a plan for where to go or what to do in an emergency ____ If driving, checks care for gas and proper maintenance before leaving for the visit ____ Locks and secures vehicle ____ Scheduling visits after dark only when necessary ____ Avoids and/or recognizes potentially dangerous situations in a home visit setting and takes appropriate action ____ Practices techniques to minimize exposure to contagious diseases		Score = _____ of 9
8. The Community Health Worker sets goals with the client for the next home visit. ____ Reviews with the client what has been accomplished During the visit ____ Works with client to set goals/objectives for next visit ____ If possible, schedules next visit, time, location, duration, informs client when she will call client for confirmation		Score = _____ of 3
9. The Community Health Worker appropriately terminates the home visit. ____ Leaves care or phone number where the Community Health Worker can be reach for concerns or questions ____ Thanks client for meeting		Score = _____ of 2

HOME VISITING ACTIVITY	DATE/ INITITAL	COMMENTS
10. The Community Health Worker demonstrates proper completion of Health Start documentation forms. ____ Informed Consent Form ____ Negative Pregnancy Test Visit Form ____ Client Enrollment Form ____ Child Information Form ____ Prenatal Log Record ____ Prenatal Encounter Form ____ Prenatal Summary Form ____ Form C – Screening Questions with Tweak ____ Form E – Process Information Form ____ Educational Topics Form ____ Family Follow-up Encounter Form ____ Family Follow-up Log Record ____ Family Follow-up Summary Form ____ Edinburgh Post Natal Depression ____ Never Shake a Baby Commitment Form ____ Immunization Status Update Form (Optional) ____ Closed Form ____ Client Satisfaction Survey		‘ Score = _____ of 18
11. The Community Health Worker utilizes the Contractor's recordkeeping and document filing requirements. ____ Documentation about the home visit is promptly recorded ____ Forms are filed in the appropriate locations in the client Record ____ Copies of forms are appropriately distributed to other Locations when indicated		Score = _____ of 3

By signing below, the Community Health Worker agrees that they have reviewed the results of the supervised home visiting sessions, scoring, and comments of the Supervisor/Observer. The Supervisor acknowledges that they have reviewed the results of the home visiting sessions with the Community Health Worker, and that they have discussed additional training needs with the Community Health Worker, and documented these needs in an individualized training plan.

Signature of Community Health Worker _____ Date _____

Signature of Supervisor/Observer _____ Date _____