

## **Chapter 2: Outreach – Participant Identification, Provider Recruitment, and Community Education**

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### **Introduction**

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Each community will vary in its approach to Healthy Start outreach due to the unique nature of local communities. Outreach includes participant identification, public and private provider recruitment, and community education.

### **Definition of Service**

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Outreach has traditionally meant case finding and/or participant identification. Healthy Start outreach is **broadly** defined to include participant identification, public provider recruitment, private provider recruitment, and community education activities. Outreach should be a local, systematic, family centered, and community based approach to promote improved pregnancy and infant health outcomes.

### **Standards and Criteria**

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**Standard 2.1 The Healthy Start coalition will assure, through performance based contract or memorandum of agreement, that communities receive education and information about the Healthy Start program and services. This education must include how to access Healthy Start services and where services are available. Communities include, but are not limited to, potential participants, health care providers, social service agencies, and community based organizations.**

*Criteria:*

**2.1.a** All providers receive education and information on the Healthy Start initiative and Healthy Start programs and services annually.

**2.1.b** All educational and outreach information is developed and disseminated with consideration of the culture, language, education, and literacy of the participants, as well as their ability to access community resources.

**2.1.c** All SOBRA prenatal care providers receive education and information on the standards of care addressed in the Medicaid Waiver and/or established by the Statewide Medicaid Waiver Workgroup.

**Standard 2.2 The Healthy Start coalition’s service delivery plan update will include evaluation of the effectiveness of outreach activities.**

*Criterion:*

The effectiveness of participant identification, public and private provider recruitment, and community education activities is evaluated and documented in the service delivery plan update.

**Standard 2.3 The Healthy Start coalition will assure that there is a designated provider for screening, assessment, and determination of Presumptive Eligibility for Pregnant Women (PEPW).**

*Criteria:*

**2.3.a** Pregnant women with incomes equal to or less than 185 percent of poverty access PEPW within two weeks of first contact seeking prenatal care.

**2.3.b** All providers receive information and education regarding PEPW.

**Standard 2.4 The Healthy Start coalition will collaborate with the Department of Children and Families district offices in the development and maintenance of a local operating procedure for the Simplified Eligibility process.**

*Criteria:*

**2.4.a.** Pregnant women with incomes equal to or less than 185 percent of poverty complete Simplified Eligibility form at the verification of pregnancy.

**2.4.b.** All providers receive information and education regarding Simplified Eligibility.

**Standard 2.5 The Healthy Start coalition will assure there is a system in place for providing prenatal care outreach (MomCare) to SOBRA women and ensuring participant entry into prenatal care.**

*Criteria:*

**2.5.a.** Provider adherence to standards of care is monitored annually and documented as part of the QI process.

**2.5.b.** The effectiveness of prenatal care outreach is evaluated annually and reflected in QI documentation.

**2.5.c.** The effectiveness of partnering efforts with the community for prenatal care outreach is evaluated annually and reflected in Quality Improvement (QI) and Quality Assurance (QA) documentation.

## **Guidelines**

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Education through media and local public forums, presentations, health fairs, door-to-door family contacts, and individual follow-ups are all examples of outreach to families that can benefit from Healthy Start services. The local Healthy Start coalition should determine through performance based contract or memorandum of agreement who is responsible for performing participant identification, public provider recruitment and retention, private provider recruitment and retention, and community education activities.

Each community demands its own unique cultural sensitivity when developing outreach activities. Implementation of the following guidelines will enhance outreach services and improve provider relationships and community collaboration.

- Inclusion of family members and significant others.
- Provision of information on how to access Healthy Start services.

- Outreach activities based on the local Healthy Start coalition's service delivery plan.
- Involvement of consumers in the design of Healthy Start activities.

Successful participant identification is dependent upon outreach directed toward the recruitment of public and private providers, education of the general community, and case finding activities that target underserved areas.

**Participant identification** activities occur one-on-one with potential participants, their family members, or legal guardians anywhere in the community. Activities should be targeted to areas where underserved populations cluster (e.g., community health fairs, soup kitchens, migrant camps, migrant day care centers, homeless shelters, and neighborhood centers in low-income neighborhoods).

**Public and private provider recruitment and retention** activities may include provider education as well as recruitment, recruitment of community agencies that may assist in providing Healthy Start services, and ongoing communication with providers, as needed.

**Community education** activities may include presentations on Healthy Start services at health fairs, public forums, small business organizations, and places of worship.

Public and private provider recruitment and community education activities may be directed toward but are not limited to the following groups:

**Public and Private  
Provider Recruitment**

- Hospitals
- Clinics
- Birthing Centers
- Community Health Centers
- Midwives/Nurses
- Physicians
- Social Workers
- Mental Health Providers
- Schools
- Juvenile Justice
- Law Enforcement
- Children & Families

**Community Education  
Activities**

- Churches
- Civic Groups
- Volunteer Organizations
- Schools/School Boards
- Service Clubs
- Parks and Recreation
- Local Businesses
- Health Fairs
- Public Forums

**Participant Identification:** Program participants may be identified in numerous ways including through the Healthy Start screening process and community education activities. Participants are pregnant and interconceptional women who are at risk for poor pregnancy outcomes and infants/children (0 to age 3) at risk for poor health or developmental outcomes.

The Healthy Start screening process assists in the identification of at-risk individuals. A positive score on the Healthy Start prenatal or infant screening

## **Healthy Start Standards & Guidelines 2007**

instrument, referrals for factors other than score, community-based organization referrals and self-referral are all methods of entry to the Healthy Start system.

Participant identification can be performed on an individual basis or within a family setting. This may be done door-to-door or at specific sites such as community health fairs, soup kitchens, migrant camps, migrant day care centers, homeless shelters, and neighborhood centers in low-income neighborhoods). This process includes ongoing follow-up with individuals identified as potential participants in Healthy Start services.

Special consideration should be given to individuals in need of financial assistance for prenatal or child health care. Women who receive early and regular prenatal care are more likely to have healthy babies. All pregnant women should have access in their community to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum and interconceptional period. Early prenatal care and continuous health care are more likely if there is an assurance that fees for services will be paid. Trained staff should be located at authorized, convenient places and at convenient hours to determine if pregnant women are presumptively eligible for Medicaid and if young children need referrals for eligibility determination. For pregnant women, there are two options for determining financial aid eligibility: Presumptive Eligibility for Pregnant Women (PEPW) and Simplified Eligibility. Both processes should be initiated at verification of pregnancy.

PEPW assures providers and families that there is a third-party payment system in place for eligible persons when care begins. This Medicaid coverage is temporary, allowing participants to follow through with the full application for Medicaid. The presumptive period begins with the date the presumptive eligibility determination is completed by the provider, and extends through the month in which the final determination of regular Medicaid eligibility is made. If the pregnant woman fails to follow-through for ongoing Medicaid by the last day of the month, following the month of the PEPW determination, coverage is only authorized through the last day of the second month. Presumptive eligibility is limited to one eligibility period per pregnancy.

Simplified Eligibility ensures expedited Medicaid prenatal care coverage for eligible pregnant women. The one-page mail-in Simplified Eligibility form does not require a face-to-face interview with Medicaid. Proof of pregnancy is the only requirement that needs to be included with the Simplified Eligibility form. The processing of Medicaid eligibility for pregnant women has different verification requirements and can be completed in a shorter time.

Florida KidCare is an “umbrella” program, combining public and private insurance into one affordable and comprehensive insurance program for children. The following programs are involved in KidCare: Medicaid, Children’s Medical Services Network, MediKids, and Florida Healthy Kids.

**Public and Private Provider Recruitment and Retention:** The development of a strong community network of service providers requires partnership building with those individuals in the community interested in meeting the health care

needs of pregnant women and infants. Retention of these providers will help maintain a seamless system of care.

Outreach activities identifying public and private providers may be extended by recruiting other community groups to help identify participants for referral to the Healthy Start program. Women receiving Healthy Start care coordination may also play a role in assisting with the identification of at-risk pregnant women and infants. Consumer participation is a vital part of this process.

Retention activities include but are not limited to providing ongoing feedback to providers, timely response to provider inquiries, and technical assistance and training as needed.

**Community Education and Activities:** Ongoing communication with community service providers and community groups is critical to support the education outreach function. Community education activities are those that promote improved public awareness of risk behaviors associated with adverse health outcomes for mothers and children and facilitate access to services designed to address those risks. Community education includes the provision of information on Healthy Start screening, care coordination, and services. Activities may include presentations at local places of worship, small business organizations, civic groups, and other community locales.

## **Provider Qualifications**

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All individuals who hold in common Healthy Start goals and philosophy and provide Healthy Start services should be considered potential outreach providers. The Healthy Start service delivery system includes coalition members and staff, local health care providers, hospital staff, employees of qualified community based service agencies, and Healthy Start care coordinators and staff who provide direct services.

Paraprofessionals who work under locally approved protocols and procedures that standardize their training, qualifications, and the services they provide, as specified in rule 64F-3.006(1), F.A.C. are also a part of the Healthy Start service delivery system.

## **Documentation**

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Documentation of outreach to individuals who are or become Healthy Start participants must be documented in the record and includes use of the following forms as appropriate:

- Problem List
- Progress Notes
- Florida's Family Support Plan

## **Health Management System (HMS) Coding**

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Each outreach component should be coded in accordance with approved protocols and procedures. The following codes should be used when coding outreach activities:

### **1. Program Component**

Each service delivered to a Healthy Start participant is coded into the HMS with a program component code. The program component coded indicates the funding source. Providers receive funding either directly from the Healthy Start coalition or from an allocation by the Healthy Start coalition to the county health department. As a provider of Healthy Start services, a prerequisite to coding is determining the funding source for the services provided. Different encounter forms correspond to the different program components depending on who receives funding, as noted below.

### **HEALTHY START ENCOUNTER FORM (not for use by Department of Health entities)**

This encounter form is used with program components 22, 26, and 30 when the funding flows directly from the Healthy Start coalition to a non-county health department provider.

- ◆ Program component code 22 is the Healthy Start interconception program component code used for all Healthy Start care coordination and Healthy Start services provided to a woman between pregnancies (interconception) who is beyond the 8 week post-delivery period included in the prenatal program component or has entered Healthy Start after a pregnancy loss (described in detail below).

The Healthy Start Interconception woman is a non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death, or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post delivery.

- ◆ Program component code 26 is the Healthy Start prenatal program component code used with all non-clinical Healthy Start care coordination and Healthy Start services provided to or on the behalf of prenatal and interconceptional participants and their families.
- ◆ Program component code 30 is the Healthy Start infant/child program component code used with all non-clinical Healthy Start care coordination and Healthy Start services provided to or on the behalf of infant/child participants and their families.

**Note:** Healthy Start care coordination services may be provided in the clinical setting using one of the appropriate Healthy Start care coordination program codes 22, 26, or 30 with location code 98.

### **COUNTY HEALTH DEPARTMENT AND COUNTY HEALTH DEPARTMENT CONTRACT PROVIDER HEALTHY START ENCOUNTER FORM**

This encounter form is used with program components 27, 31, and 32 when the funding source is a coalition allocation to the county health department.

- ◆ Program component code 27 is the Healthy Start prenatal program component code used with all non-clinical Healthy Start care coordination and services provided to or on behalf of prenatal participants and their families.
- ◆ Program component code 31 is the Healthy Start infant/child program component code used with all non-clinical Healthy Start care coordination and services provided to or on the behalf of infant/child participants and their families.
- ◆ Program component code 32 is the Healthy Start interconception program component code used for all Healthy Start care coordination and Healthy Start services provided to a woman between pregnancies (interconception) who is beyond the 8 week post-delivery period included in the prenatal program component or has entered Healthy Start after a pregnancy loss (described in detail below).

The Healthy Start Interconception woman is a non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post delivery.

**Note:** Healthy Start care coordination services may be provided in the clinical setting using one of the appropriate Healthy Start care coordination program codes 27, 31, or 32 with location code 39.

## **2. Service Codes**

Service codes used for Healthy Start outreach include:



### **ADMINISTRATION/SPECIAL SERVICES: PARTICIPANT IDENTIFICATION 3950**

Participant identification activities are those that identify specific individuals and groups who are in need of comprehensive prenatal, interconceptional, or child health care; provide culturally sensitive, family-centered, educationally, and demographically appropriate information regarding prenatal, interconceptional, and child services available within the community and the importance of accessing services early; and facilitate access to needed services.

On the direct level of participant identification, service provision would include sharing family centered information regarding prenatal, interconceptional, or child services available within the community and stressing the importance of accessing services. Direct services include the facilitation of access to needed services. Identification may be done door-to-door or at specific sites such as community health fairs, soup kitchens, migrant camps, migrant day care centers, homeless shelters, and neighborhood centers in low-income neighborhoods). This process may include ongoing direct follow-up with individuals that have been identified as potential recipients of Healthy Start services.

**Note:** If the service is delivered to an identified Healthy Start participant, also code the participant's identification number. Code one service for every 15 minutes spent in this activity.



**PARTICIPANT RELATED ACTIVITIES:  
HEALTHY START CARE COORDINATION ADMINISTRATION  
3951**

Providing administrative activities related to screening and care coordination for Healthy Start participants.

Participant related activities are administrative functions that assure the Healthy Start process and include:

1. Receiving and reviewing screening reports.
2. Reconciling discrepancies in screening data.
3. Transferring screening forms to the county health department in the county of residence.
4. Performing other Healthy Start care coordination **administrative** functions that assure the Healthy Start process is organized and coordinated.
5. Performing other Healthy Start care coordination **administrative** functions that may be participant specific.
6. Performing Healthy Start Quality Management/Program Improvement (QM/PI) functions.

**Note:** If the service is delivered to an identified Healthy Start participant, code the participant's identification number. Code one service for every 15 minutes spent in this activity.



**COMMUNITY ACTIVITIES:  
HEALTHY START CARE COORDINATION ADMINISTRATION  
3952**

This service entails providing information to the community related to Healthy Start and collaboration with other community groups providing services to pregnant and interconceptional women, children, and families.

Healthy Start care coordination administrative community activities include information sharing with community agency representatives or presentations at local places of worship or to business organizations, other community groups, or public and private providers. The process of information sharing includes the provision of information on the Healthy Start initiative. This process may include facts on the need for linking services, drafting interagency agreements, and discussion of ways to identify participants who may need ongoing support to secure services. It may also assist providers in identifying individuals who are potential recipients of Healthy Start services.

**Note:** Code one service for every 15 minutes spent in this activity.

### 3. Service location coding

Service location coding (#17, Section B, Healthy Start Encounter Form) provides information on where the Healthy Start service was provided.

Providers determine the location codes for home visits or services delivered in varied sites by the location of the actual activity or attempt, and use one of the following codes on the encounter form depending on the location. A list of service codes can be found in the Personal Health Coding Pamphlet DHP 50-20. Service locations for delivering Healthy Start services are:

Service location	Code
CHD Office	31
CHD Clinic	39
Private premise	84
School	92
Other	98

### Quality Management/Program Improvement (QM/PI) Performance Measures

The outreach process can be evaluated through the HMS coding data reports. These include the *Healthy Start Care Coordination Prenatal Executive Summary Report* and *Healthy Start Care Coordination Infant Executive Summary Report*. Local coalitions and providers involved with QM/PI issues can develop evaluation protocols that address agency and provider referrals and service provision in the community. This process may also involve providers of care coordination and other Healthy Start service providers. The review should include an evaluation of factors that encourage engagement and participation in services.

**The following is a list of possible data indicators that may help you determine whether or not your outreach program is working.**

- The percentage of pregnant women and infants offered screening
- The percentage of pregnant women and infants screened
- The percentage of pregnant women and infants consenting to the program
- The number of women entering care during their first trimester
- The number of private providers participating in screening
- The percentage of infants receiving timely well-baby care
- Results of provider and participant surveys and focus groups
- Other local information that reflects outreach goals

**Other activities that may assist in evaluating your outreach program include (but are not limited to):**

- Peer record reviews to determine if follow-up is adequate
- Feedback from participants, such as customer satisfaction surveys
- Tracking the number of referral resources provided for Healthy Start participants
- Information from coalition members regarding the outcomes of their outreach efforts in their local communities

**Notes:**

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**Self Study Questions:** (Answers to these questions may be found in Appendix H)

1. How is outreach defined as it relates to Florida's Healthy Start program?
2. How does outreach enhance Healthy Start participant identification?
3. What key components should be in place to demonstrate that a coalition has cultivated a successful provider recruitment and retention program?
4. What is the purpose of community education as it relates to Florida's Healthy Start program?
5. What are the provider qualifications for Healthy Start outreach?
6. How is evaluation of the effectiveness of outreach activities assured?
7. What are some key data indicators that may demonstrate an effective Healthy Start outreach program?
8. What are some examples of other activities that may assist in evaluation of a Healthy Start outreach program?