HEALTHY START

PRENATAL RISK SCREENING

PROVIDER REFERENCE GUIDE

FLORIDA STATE STATUTE 383.14

MANDATES THAT **ALL** PRENATAL PROVIDERS COMPLETE A PRENATAL RISK SCREEN FOR **EVERY** PATIENT AT HER **FIRST** PRENATAL CARE VISIT

THE BASICS

WHO?

EVERY pregnant woman must be offered the Prenatal Risk Screen (PRS). ANY woman who is interested in learning about the resources available to her may be referred to Healthy Start.

WHAT?

Complete the PRS form in its entirety

WHEN?

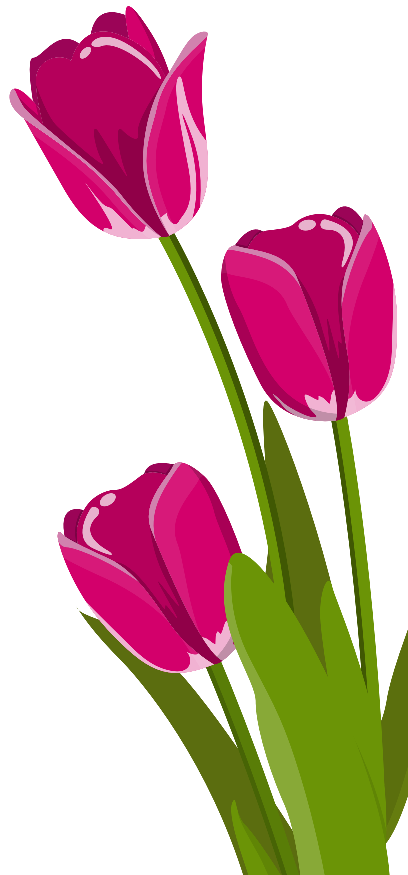
During her FIRST prenatal visit

WHERE?

At your [the OB provider's] site or office

WHY?

To assess pregnant women for risk factors contributing to fetal and infant mortality. *Healthy Start* is designed to provide targeted support services which promote optimal prenatal health and birth outcomes



***Please Remember: Any screens are to be mailed WEEKLY to the Health Department using postage paid envelopes provided by your liaison.**

HOW TO ENCOURAGE CONSENT

SERVICES AVAILABLE

- Prenatal education
- Childbirth education
- Breastfeeding support & education
- Nutrition education
- Parenting education
- Postpartum care education and support
- Interconception counseling
- Mental health services
- Specialized programs for pregnant teens
- Substance abuse education & smoking cessation support
- Home visiting

KEY TALKING POINTS FOR DELIVERY

- Screen is a simple wellness assessment
- The goal is healthy birth outcomes
- Personal information is protected under HIPPA
- Mommy will only be contacted if referred
- Info collected supports program funding for pregnant women & young children in Palm Beach County

FREQUENTLY ASKED QUESTIONS

1. What if the screen isn't relevant to my patient population?

The programs and services of Healthy Start are for all women in the state of Florida. Low birth weight babies and fetal and infant mortality affect families of all incomes. It costs an average of $6,000 per day to care for an infant in the NICU, and the prenatal risk screen is intended to promote healthy birth outcomes, thus saving the taxpayers money. Even a wealthy woman can be depressed, experiencing domestic violence, or be smoking.

2. Why do Black women automatically score 3 points?

Unfortunately Black babies die at a rate of 3 times that of White babies, and Black women, regardless of income or education are more likely to have poorer birth outcomes than White women. Environmental and life stressors, combined with other psychosocial factors all play roles in the increased rate of fetal and infant mortality among Black women.

3. Should I call HMHB in an emergency situation (e.g. homeless patient or maternal mental health crisis)?

Your liaison is here to assist you in utilizing resources available throughout the county, however, we are often only able to direct you to the correct community partners for referrals. In the event of an emergency mental health crisis where you believe the mother may be a danger to herself or others, you are required to call 911 immediately. 2-1-1 services are also available.

4. Shouldn't I be receiving compensation for doing this?

Although Medicaid no longer provides reimbursement for completing the Healthy Start PRS with a particular coding system, you are still receiving financial compensation for every screening form that is submitted during the first trimester. This fee is included in the billing for the first prenatal care visit.

SAMPLE SCREENING FORM

Patient Completes | Items to be scored | Provider completes | To check before mailing

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: ____________________

		YES	NO
1.	Have you graduated from high school or received a GED?	☐	✓
2.	Are you married now?	☐	✓
3.	Are there any children at home younger than 5 years old?	☐	☐
4.	Are there any children at home with medical or special needs?	☐	☐
5.	Is this a good time for you to be pregnant?	☐	☐
6.	In the last month, have you felt down, depressed or hopeless?	✓	☐
7.	In the last month, have you felt alone when facing problems?	☐	☐
8.	Have you ever received mental health services or counseling?	☐	☐
9.	In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10.	Do you have trouble paying your bills?	☐	☐

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

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

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

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

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

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

PATIENT INFORMATION

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

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

Patient Signature: ____________________ **Date:** ____________________

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

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

Signature: ____________________ *Date:* ____________________

PROVIDER ONLY

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

STAMP

DH 3134, 04/08, stock number 5744-100-3134-7

Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred
PINK—Retained in patient's record GREEN—Patient's Copy

NOTE: Items circled in pink are critical pieces of information from you. Please ensure that they are all completed before submitting the screen to prevent service coordination delays.

CONTACT INFORMATION

Your Community Liaison point of reference depends on where your site is located within Palm Beach County. We are here to assist with any of your needs pertaining to the Healthy Start program. When you are in need of more materials, please continue to get in touch with us.

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