

## **Critical Element #7**

### **Linkages to health and other services**

<b>HFNY POLICY AND PROCEDURE MANUAL</b>	
<b>Subject</b>	<b>Medical Homes, Immunizations, Well-Baby Visits and Lead Assessments</b>
<b>Policy</b>	Healthy Families New York programs link, at a minimum, the primary care taker and target child to medical homes, and are strongly encouraged to link all family members to a medical home. Target children receive immunizations, well-baby visits, and lead assessments and screenings following the NYS Health Department Recommended Schedules for each, as found on the MIS TC Medical Form.
<b>Site specific reference</b>	7-1.A, B, 7-2, 7-3
<b>Effective date</b>	July 2001
<b>Revised date(s)</b>	June 2006
<b>Appendices</b>	HFNY Target Child Identification and Birth Outcomes (MIS) HFNY Target Child Medical Form (MIS) HFNY Follow-Up Form (MIS) HFNY Service Referral Form (MIS)

**Rationale:**

To ensure optimal health and development, programs link participant families with a medical home to receive on-going preventive and other health care services. To ensure that families are provided with information, referrals and linkages to available health care resources. To ensure timely receipt of immunizations and well-baby check-ups, including lead and developmental screenings

**Procedures:**

**Medical Home**

A medical home is a partnership between a family and a primary health care professional. The health care professional may be an individual provider, medical group, public and/or private health agency, or a culturally recognized medical professional where participants can go to receive a full array of health and medical services. “Culturally recognized medical professionals” refers to practitioners of alternative therapies widely recognized within a cultural system, such as traditional Chinese medicine.

The emergency room may not be considered the family’s medical provider. An OB/GYN may not serve as the primary medical provider beyond six weeks postpartum, unless continuing to provide primary care to the participant.

Linkages to medical homes

1. Initially, the home visitor assists in linking the family with a physician, a prenatal care provider and/or pediatrician (depending on whether the family enrolls in services prenatally or postpartum) or other "medical home."
2. Part of the home visitor's role in connecting the family with a medical home is to facilitate clear communication between the child's medical provider and parents, and to assist parents in forming comfortable and informative relationships with medical providers.
3. Joint visits to medical providers soon after a family enrolls in the program and/or shortly after the baby is born may be a useful strategy for securing the medical home and helping to establish the relationship.
4. Joint visits are a useful way for the medical provider to learn about the HFNY program and the role of the home visitor. It is recommended that programs develop site specific memoranda of understanding with medical providers to facilitate these referrals and collaborative practice.
5. Home visitors document the target child's health care provider on the Target Child Identification and Birth Outcomes form in the MIS, and after that, on the Follow-Up form. Programs also document the current medical provider for the Primary Caretaker 1 and 2 on the Intake form and after that, on the Follow-Up form.

#### Information, referrals, and linkages to health care resources

1. When necessary, enrolled families are provided information, referrals and linkages to health care resources.
2. These activities are documented on the Service Referral Tracking Form (MIS).
3. Referrals to health care providers are also made when needed for families in the pre-intake stage or for those who were not offered the home visiting program.

#### Immunizations

1. Home visitors, parents, and medical providers collaborate to ensure that children receive regular, timely immunizations.
2. HFNY follows the NYS Health Department Recommended Childhood Vaccination Schedule as reflected on the Target Child Medical Form. Immunization dates may vary according to the preference and practice of the pediatrician or health care provider.
3. The home visitor verifies the target child's immunization status by either reviewing the health/immunization card from the medical provider or through written or verbal contact with the provider (with signed authorization of release). A description of the method of verifying immunizations is included in the programs' policies and procedures. Accepting a parent's report without written documentation from the provider is not recommended.
4. Documentation
  - a. Home visitors document the dates the child received the immunizations on the Target Child Medical Form (MIS).
  - b. HFNY sets a goal of having at least 90% of target children up-to-date with their immunizations as of their first and second birthdays. (See

performance targets HD1, HD2.) Where target children are not currently up-to-date, programs document the reasons why and attempts/steps that have been taken to obtain immunizations for these children. This may include instances where children were sick at the time the immunization was due, or that families are on Level X no information is currently available.

- c. The percentage of up-to-date immunizations includes children whose family beliefs preclude immunizations. Evidence of their beliefs is documented in the participant file.
- d. The original Target Child Medical Form record of immunizations is maintained in the participant file.

#### Well-Baby Visits, Lead Assessments, Developmental Screenings

1. Home visitors, parents, and medical providers collaborate to ensure that children receive regular, routine health care.
2. Home visitors help families to overcome barriers to accessing preventive health care. The home visitor may transport or provide program funds for mass or public transportation if these funds are included in the program's budget.
3. HFNY follows the well-baby visit intervals including lead screenings and developmental screenings as recommended by the NYS Health Department Recommended Schedule and as reflected on the Target Child Medical Form.
4. Well-baby visits may vary according to the preference and practice of the pediatrician or health care provider.
5. A well-baby visit includes height, weight, blood pressure, hearing, sight, developmental appraisal, dental care assessment and a nutritional assessment.
6. Acute care visits do not typically last long enough to include all of the required items to be counted as a well baby visit. If an acute visit is being counted as a well baby visit, it must contain all of the items specified in #5.
7. Home visitors conduct lead assessments with families at the intervals designated on the Target Child Medical Form. These do not replace lead screenings (blood work) done by the medical provider and tracked on the form.
8. Home visitors conduct developmental screenings on the target child using the ASQ. (See Developmental Screening.) These do not replace the medical provider administering a developmental screen as a routine component of the well-baby visit.
9. Documentation
  - a. The home visitor verifies the target child's well-baby visit by either reviewing the health/immunization card from the medical provider or through written or verbal contact with the provider (with signed authorization of release).
  - b. A description of the method for verifying immunizations is included in the programs' policies and procedures. A parent's report without written documentation from the provider is not recommended.

- c. Home visitors document the dates the child received the well-baby visit on the Target Child Medical Form (MIS).
- d. HFNY sets a goal of having all participating target children up-to-date with their well-baby visits at designated intervals. (See performance targets HD3, HD4, HD5, and HD6.) Where target children are not currently up-to-date, programs document the reasons why and attempts/steps that have been taken to obtain well baby visits for these children. This may include that families are on Level X and no information is currently available.
- e. Documentation of emergency room visits and overnight hospitalizations is completed on the Target Child Medical Form following each occurrence. The family's verbal account of the visit is sufficient for documentation; emergency or other hospital records are not required. Information from the form is added to the management information system, and the original maintained in the family's chart.
- f. It is recommended that supervisors review and sign off on the Target Child Medical Form on a monthly basis.

<b>HFNY POLICY AND PROCEDURE MANUAL</b>	
<b>Subject</b>	<b>Linkages to Other Programs and Services</b>
<b>Policy</b>	Healthy Families New York participants will receive referrals to available health care and community resources based on their need(s). Staff will follow-up with referral sources, service providers and/or participants to determine if needed services were received
<b>Site specific reference</b>	7-4.A-B
<b>Effective date</b>	July 2001
<b>Revised date(s)</b>	June 2007
<b>Appendices</b>	-Referral Tracking Form (MIS) -Kempe PC1 Issues Report (MIS)

**Rationale:**

To ensure that participants receive information and referrals to available resources based on their need(s). To ensure that programs follow-up with referral sources, service providers and/or participants to determine if needed services were received.

**Procedures:**

1. Staff makes referrals to health care and other community resources based on the information gathered in the assessment process, through the development of the IFSP and home visits.
2. A referral consists of either making arrangements for a participant to receive services or providing information about specific providers so that the participant can make arrangements him or herself.
3. Staff becomes familiar with the community agencies and the services they provide to be sure families are referred appropriately. Most referrals are discussed with the supervisor prior to providing information to the participant. During basic training, staff receive orientation to the program's relationship with other community resources (e.g. organizations in the community with which the program has working relationships. (See Required Training.)
4. Supervisors assist home visitors in identifying the need for referrals and staying informed about community resources and referral processes.
5. If domestic violence, substance abuse, or mental health is identified as a current issue on the Kempe Assessment of an enrolled participant, a referral is made within 6 months of enrollment. There is a Kempe PC1 Issues report in the MIS to help assure that these referrals have been made in a timely fashion. This report tracks only referrals made for Primary Caregiver 1 (PC1) however,

referrals are made for any family members, when appropriate. (see Performance Target MLC7)

6. To ensure families have access to available community resources, as well as to avoid duplication of services, program sites have established relationships (ideally described in a Memoranda of Agreement) with local social service districts including preventive services, local health departments, Infant Child Health Assessment, Early Intervention and Community Health Worker programs. Sites also have established relationships to ensure families access to community resources, with local Comprehensive Prenatal Perinatal Service Networks (CPPSN), family resource centers, adolescent pregnancy programs, Teenage Services Act program (TASA), employment programs, child development programs, food programs, WIC, Section 8 Housing, etc.
7. FSWs help families who are on public assistance to access the necessary supports (i.e. child care, transportation) to achieve their self-sufficiency goals, which may include obtaining a GED, employment, or entering an educational or vocational training program.
8. The FSW and supervisor also provide crisis intervention, assisting the family in managing crisis and linking them to appropriate community services to deal with and resolve the crisis. Over the course of working with the family, the FSW encourages the family to establish personal and community agency relationships to build ongoing support systems independent of the FSW and home visiting program.
9. All referrals are logged on the Service Referral Tracking form and all follow-up efforts are documented in the participant file.
10. On a quarterly basis, programs are required to report on Primary Care Taker 1 having a medical provider. (See performance target HD8.)
11. An important component of participant record review and of supervision includes attention to referrals and referral follow-up. This includes routinely checking the Service Referral Follow-Up tickler report to assure follow-up of referrals tracked in the MIS. After a referral has been made, FSWs seek information from the program participant (and the service provider, if the necessary consent forms have been signed) to determine if the service was obtained, if it was needed, and if the participant has found it helpful. The amount of time that it takes to make these determinations will need to be flexible based on the type of referrals. Procedures to follow up with agencies/programs to which referrals are made are developed by each site and may be included in the programs' Memoranda of Agreement.