

Chapter 4: Coordinated Intake and Referral (CI&R)

Introduction

CI&R services are the foundation for a system of care. It is through CI&R that participants are contacted, assessed, provided information, and referred to home visiting programs and other community services. Eligibility for CI&R begins when a pregnant woman, interconception woman, or an infant/child is referred to CI&R by a health care provider, a community service provider, or through self-referral.

The Healthy Start coalitions have been tasked with establishing and maintaining a CI&R system of care in every county of Florida. For anyone acting as a CI&R worker, it is important to think of CI&R as separate from the Healthy Start program. The CI&R worker does not represent Healthy Start, but instead represents all programs participating in CI&R. It is imperative that every home visiting program participating in CI&R is represented in a way that eliminates favoritism for or prejudice against any one program. This will strengthen trust with our community partners and enable stronger relationships to serve our communities.

Definition of Services

CI&R is a system that connects pregnant women, interconception women and families of children under the age of three to services to offset risk factors that may lead to poor pregnancy outcomes and/or poor developmental outcomes.

Provider Qualifications

CI&R workers are health care providers, health-related professionals, or qualified paraprofessionals working under the supervision of a professional, who function in partnership with the participant or family in providing linkage to programs and resources to address risk factors identified on the risk screen or referral.

CI&R workers should meet one or more of the following educational requirements and have received all required training:

1. Minimum of four-year college degree in one of the following areas:
 - a) Social sciences
 - b) A health-related field such as nursing, health education, health planning, or health care administration
 - c) Social work
2. Associate degree and licensure as a Registered Nurse with three years of public health/maternal-child health experience or licensure as a Licensed Practical Nurse with four years of public health/maternal child health experience

3. Two years of college with three years of public health/maternal-child health experience
4. Paraprofessional CI&R workers have a high school education or its equivalent and must meet additional requirements as follows:
 - a) Paraprofessionals providing CI&R services must receive ongoing supervision by a professional supervisor who meets the educational requirements specified in the qualifications in 1, 2, or 3 above.
 - b) Paraprofessionals providing CI&R services must meet the state job specifications for a family support worker or have equivalent experience.
 - c) Paraprofessionals work under locally approved written protocols.
 - d) All CI&R activities conducted by a paraprofessional must be reviewed every two weeks by a qualified professional supervisor as described above in section 4.a. A case summary review sheet signed by the paraprofessional and his or her supervisor may be used to document this process. Documentation of the supervisor's review will be kept in the participant's electronic record.
 - e) Paraprofessionals providing an initial intake must use a systematic process as outlined in this chapter and utilize thorough documentation. All the documentation must be reviewed and co-signed within two business days by the supervisor. If the participant or family has safety concerns or immediate needs that the paraprofessional has not been trained to handle, the paraprofessional should contact the supervisor immediately for guidance.
 - f) Paraprofessionals may not assume the role of lead CI&R coordinator.
 - g) Although paraprofessionals are important members of an interdisciplinary team, they may not function as interdisciplinary team leaders.

Competencies for CI&R Providers:

The CI&R worker is expected to demonstrate:

1. Cultural sensitivity to and competency in working with participants from a variety of cultural backgrounds;
2. Practice of family-centered communication skills;
3. Ability to advocate on the participants' behalf;
4. Ability to communicate verbally and in writing with health care providers and other community resource people;
5. Knowledge of:
 - a. Community resources for at-risk pregnant and interconception women, infants, young

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- children, and their families and procedures for accessing them;
 - b. Available maternal-child program services;
 - c. All components on the Department's Prenatal and Infant Risk Screen;
 - d. Evaluation of service needs and assessment;
 - e. Maternal and child health principles, including:
 - 1) Normal pregnancy anatomy, physiology, comfort measures, breastfeeding, danger signals, and what to do if danger signals occur;
 - 2) Normal infant and child growth and development and corresponding anticipatory guidance to promote optimal physical and emotional health, safety, and well-being for participant and family;
 - 3) Basic content of prenatal and well-child care;
 - 4) Importance of appropriate interpregnancy interval and basic knowledge of family planning methods;
 - 5) Child Health Check Up periodicity schedule and the components for each visit;
 - 6) Impact of and interventions related to the special needs of families with substance abuse issues and families with potential for or histories of domestic violence and/or child abuse;
 - 7) Recognition of stage of readiness to stop tobacco and other substance abuse and appropriate intervention; and
 - 8) Family dynamics including principles related to parents adjusting to role as care giver, appropriate discipline, parental/caregiver self-care, and managing stress.
 - f. Child abuse or neglect indicators and the responsibility to report to the Florida Abuse Hotline 1-800-962-2873;
 - g. Home environment and safety assessment;
 - h. Funding resources such as local funding options, eligibility and limits of Medicaid, and local workforce development resources;
 - i. CI&R coding procedures;
 - j. Situations in which it is necessary to contact a supervisor immediately regarding the participants' immediate needs and/or safety concerns; and
6. Knowledge and adherence to pregnancy and postpartum non-directive information and counseling for prenatal care and delivery, infant care, adoption and pregnancy termination options. (See Appendix I)

CI&R services must be provided in accordance with the constraints of the professional's practice act, established protocols and the individual's education, training, and experience.

Paraprofessionals must provide services under the supervision of a professional supervisor.

Standards and Criteria

Standard 4.1 Each Healthy Start Coalition will establish partnerships with all maternal-child evidence-based and research-informed home visitation providers in its service area, including programs funded by the Coalition as well as those supported by other funders, to participate as part of CI&R.

Criteria:

4.1.a Partnerships are formalized by comprehensive Memorandums of Agreement (MOAs) that are updated as needed.

4.1.b New evidence-based and research-informed home visitation providers in the service area will be contacted within 90 days of their establishment by the local Healthy Start coalition regarding the benefits and process of CI&R.

Standard 4.2 Each Healthy Start coalition will establish a Home Visitation Advisory Committee composed of representatives from every CI&R participating agency.

Criterion:

The Home Visitation Advisory Committee meets, at a minimum, quarterly to review CI&R activities, processes, enrollment data and referral data.

Standard 4.3 Each Healthy Start Coalition will create a Program Services Inventory that identifies all evidence-based/research-informed home visitation programs in their service area.

Criteria:

4.3.a The Program Services Inventory, at a minimum, will include provider name, program goals, key services, program frequency and duration, program restrictions, participant eligibility criteria, capacity, and key program contact.

4.3.b Each Program Services Inventory, at a minimum, will be reviewed quarterly and will be updated as needed.

Standard 4.4 Each Healthy Start Coalition will create a Decision Tree(s) that shows an ideal flow of home visitation referrals for prenatal women, interconception women, and children under the age of three to various service providers based on their program focus and criteria.

Criteria:

4.4.a Each Decision Tree will be updated as evidence-based/research-informed home visitation programs change (capacity, zip code focus, etc.), are added or are eliminated.

4.4.b Decision Trees are evaluated at each local Home Visitation Advisory Committee for effectiveness and revised as needed.

Standard 4.5 During screening activities or activities promoting CI&R, all CI&R participating programs must be promoted equally and without bias.

Criteria:

4.5.a Healthy Start program staff and Healthy Start coalition staff may not promote Healthy Start during screening activities (i.e. picking up risk screens, providing education on risk screens to health care providers/hospital staff, etc.) unless they are also promoting every participating CI&R program equally during the screening activity.

4.5.b Activities specific to the promotion of CI&R including presentations, training and informational materials must represent all CI&R participating programs equally.

Standard 4.6 All prenatal women, families with children under the age of three, women who have experienced a recent loss (miscarriage, stillbirth, infant death) and women who recently had an infant placed out of the home (adoption or removal by DCF) who are referred to CI&R will receive an initial intake through CI&R.

Criteria:

4.6.a The referred person/family will receive an initial intake or attempt at initial intake within five business days of the receipt of the screen, community referral or self-referral. If the initial attempt to contact is not successful, an additional attempt to contact will be made within ten business days of the first attempt. The third attempt to contact will be made within ten business days of the second attempt.

4.6.b At a minimum, the initial intake includes all initial intake service delivery activities specified in this chapter.

4.6.c Contact attempts will be varied as to time of day.

4.6.d Written notification of the status of the initial intake and plan for further services or closure are provided to the prenatal care provider or child's primary care provider within 30 calendar days of the first attempt to contact. If the child's primary care provider is not known, document in the case file why written notification is not possible.

4.6.e If a referral has been made to CI&R due to risk of child maltreatment, written notification of the status of the initial intake and plan for further services or closure are provided to the referral source within 30 calendar days of the first attempt to contact.

4.6.f CI&R services are provided in a manner that adheres to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care <https://www.thinkculturalhealth.hhs.gov/clas>.

Standard 4.7 CI&R staff will promote all home visitation services in a positive, supportive and engaging manner.

Criteria:

4.7.a When a client is eligible for multiple home visiting programs, each program should be neutrally presented for the person/family to choose.

4.7.b CI&R staff will receive ongoing training about all area program and referral options.

4.7.c CI&R staff will receive regular supervision to help ensure positive client engagement strategies.

Standard 4.8 CI&R workers will refer to community maternal-child home visiting programs with whom they have memoranda of agreements.

Criteria:

4.8.a CI&R staff will obtain and document verbal consent to share information with the participant's chosen home visiting program.

4.8.b Specific health information listed on the Prenatal Risk Screen and Infant Risk Screen including mental health, tuberculosis (TB), alcohol/drug abuse, sexually transmitted infections, and HIV/AIDS information may not be exchanged with any maternal-child home visiting programs (excluding Healthy Families Florida, the Healthy Start program and WIC) without written consent.

4.8.c CI&R participants who are high-risk and in need of ongoing services will be referred to a community home visiting program for which they are eligible.

Standard 4.9 The CI&R worker will follow-up with any participating CI&R program who has not completed referral disposition in the appropriate time frame.

Criterion:

Each participating home visiting program will document referral disposition in the approved data management system per their memorandum of agreement.

Standard 4.10 The CI&R worker will facilitate the participant's access to other health care funding options and resources through provision of appropriate referrals.

Criterion:

At a minimum, CI&R workers will evaluate the participant's ability to access and, if necessary, facilitate access to:

1. Medicaid and Title XXI eligibility determination
2. Prenatal and postpartum care

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3. Child primary health care
4. Immunization services
5. Family planning services
6. Adult primary care services including mental health and drug treatment
7. WIC
8. Housing
9. Transportation
10. Food
11. Child care

Standard 4.11 Services are based upon the participant's or family's risk and needs identified on the Prenatal/Infant Risk Screen, the community referral or the self-referral, maternal-child program eligibility criteria, and availability of area programs and local resources.

Criteria:

4.11.a Services are based on safety concerns and immediate needs identified in the Tier 1 Table (found in Guidelines section of this chapter), severity of risk and needs, and the participant's motivation to participate in a maternal-child program to address risk/needs.

4.11.b If a participant/family is deemed high-risk and in need of ongoing services and all area CI&R participating programs are at capacity or the participant/family does not meet eligibility requirements for any home visiting program, that participant/family will receive ongoing services from Healthy Start.

Standard 4.12 CI&R services will be provided by qualified and trained providers who meet education, training, and competency standards for their position.

Criteria:

4.12.a Qualifications and competencies are met as specified in this chapter.

4.12.b Paraprofessionals work under the direct supervision of a qualified professional supervisor and adhere to the additional requirements as specified in the provider qualifications section of this chapter.

4.12.c All CI&R workers receive pre-service training on the CI&R process, services and eligibility requirements of participating maternal-child health programs, area resources and demonstrate competencies as specified in this chapter.

4.12.d Each agency providing CI&R will have a written orientation plan with checklist sign off for their personnel file.

4.12.e All providers will be knowledgeable of Department of Health (DOH) Information Security Privacy Policies including confidentiality, managing the security and confidentiality of data, and other security requirements.

4.12.f All CI&R staff will receive ongoing training about all service options and regular supervision to help ensure positive client engagement and effective referral strategies.

4.12.g The CI&R worker is knowledgeable about eligibility requirements and fees for other services.

4.12.h The CI&R worker is knowledgeable about other funding sources, such as county service dollars, local agency services or funding, grant sources, private funds, and insurance services, such as Medicaid services.

4.12.i The CI&R worker is knowledgeable about Florida's Family Health Line, a statewide toll-free number (1-800-451-2229) for basic information and referrals for prenatal, infant and family health.

Standard 4.13 Participants may be closed to CI&R when it is determined services are not needed, services are not desired or the participant is receiving services from a home visiting program.

Criteria:

4.13.a At a minimum, three attempts to contact are made before closing as "Unable to Locate" any participant who has scored positive (6 or greater for prenatal; 4 or greater for infant) on the Risk Screen or who has been referred for safety concerns and immediate needs as defined by the Tier 1 Table located in the Guidelines section of this chapter. In addition, prior to closure as "Unable to Locate", the CI&R worker must check the following resources for updated information regarding phone number and address or follow-through with care:

- Participant's health care provider
- WIC staff and WIC Information Project (WIP) System
- Immunizations staff and Florida SHOTS database
- FLORIDA Medicaid database (FMMIS)

4.13.b At a minimum, three attempts to contact are made before closing as "Unable to Locate" any participant who does not score positive on the risk screen, but is identified as having a Tier 2 Concern or Need located in the Guidelines section.

4.13.c CI&R closure activities include:

1. Assessment of the need for referrals to community services, primary care, family planning, interconception counseling, and assisting in accessing these services;
2. Notification of the prenatal or primary care provider of closure and collaboration in the event the provider recommends additional services;
3. Notification of referral source and/or Department of Children and Families when referral

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reason was risk of child maltreatment;

4. When appropriate, transition to maternal-child home visiting program with release of information and record transfer; and
5. Providing the participant with information regarding the ability to return to CI&R if needed.

4.13.d All participants who are unable to be reached during the initial intake time frames, and who score a 3 or higher on the Prenatal Risk Screen, with proper consent, shall be referred to Healthy Families prior to CI&R closure.

Standard 4.14 Providers of CI&R services will document services in the approved data management system in a format determined by the local coalition and service provider within three business days of service completion.

Criteria:

4.14.a Services and attempts to provide services are documented in the approved data management system in the electronic record of the individual receiving the services.

4.14.b In the event that services are provided to another person on behalf of a CI&R participant (such as the parent of a referred infant), the services are only referenced in the participant's electronic record. The actual detailed documentation occurs in the record of the individual receiving the service.

4.14.c The following services and activities, when provided, are documented in the participant's electronic record:

1. The participant's risk screening form, or documentation of risks, if referred by a community provider or self-referred.
2. All attempts, successful and unsuccessful, to contact the potential program participant.
3. All interactions with the program participant, the family, or with others impacting their receipt of services.
4. Identified risks and needs and how these are addressed or rationale for not addressing the risks and needs.
5. All closure activities.
6. Follow-up with the participant's prenatal or primary health care provider.

Standard 4.15 Providers of CI&R will accurately code service information in the approved data management system within three business days of service completion.

Criterion:

Coding complies with the requirements of the Department of Health publication DHP 50-20 and as specified in Chapter 23, Healthy Start Coding, of these Healthy Start Standards and

Guidelines.

Standard 4.16 CI&R service providers will develop and implement an internal continuous quality improvement (CQI) process.

Criterion:

The CQI process, developed in collaboration with the local Healthy Start coalition and the Home Visiting Advisory Committee, includes an assessment of strengths, an assessment of areas needing improvement and a plan for assuring maintenance of program quality and improvement.

Guidelines

Initial intake after screening is the point-of-entry into various maternal-child home visiting programs. Women and families of children up to age three identified as at-risk for undesirable outcomes through screening or referral are required by legislation to receive notification of their risk status and the services available to them.

The county health department forwards all risk screens with proper consent to CI&R within five business days of receipt of the screen. The CI&R worker provides an initial intake, risks are addressed, and assets available to the participant to offset the risks are discussed.

Service Delivery Activities of Initial Intake:

1. Explain to the participant or family the meaning of a positive risk screen or why the referral to CI&R was made. It is important to stress to the participant or family that a positive risk screen means the woman or child MAY experience more problems during pregnancy or infancy.
2. Determine the participant's ability to access comprehensive prenatal and child health care services. Comprehensive prenatal and child health care includes those maternal and child health care services that are provided in the community to enable pregnant women to maintain good health and have positive birth outcomes and their children to experience optimal growth and development. Comprehensive prenatal and child health care should be available to all women and children through their routine prenatal or preventive child health care and includes:
 - Eligibility determination for financial assistance including Presumptive Eligibility for Pregnant Women (PEPW), Medicaid and Title XXI;
 - Prenatal, postpartum, and family planning care;
 - Periodic health and developmental screening, diagnosis, and treatment in accordance with professionally recognized periodicity schedule for the child;
 - Routine laboratory testing;

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- Appropriate immunizations;
- Basic nutrition services including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);
- Basic health promotion, counseling, and education;
- Acute care; and
- Referral to developmental, social, and economic services.

Note: If the participant is unable to access comprehensive prenatal and child health care services, further involvement with the family is warranted. Referral will be made for eligibility determination and/or the needed service and, at a minimum, one follow-up contact after referral is required to determine that the participant has been able to access the needed services.

3. Evaluate the participant's service needs by determining the participant's or family's assets, strengths, and resources to reduce risk status using risk appropriate care principles.
4. Provide information about how the risk factors can be addressed and what types of services may be available in the community to improve the chances of a healthy outcome.
5. Provide referrals to community resources. For many participants, adequate intervention is provided by giving information about community resources or making referrals to community services.
6. Provide a name and phone number of a contact person at the agency providing CI&R who can be contacted for assistance if the participant or family is unable to access needed prenatal, intrapartum, postpartum, family planning, pediatric or family support services.
7. Initiate the participant's electronic record.
8. Provide follow-up to the prenatal health care provider, the child's primary care provider, or the referral source within 30 calendar days of the first attempt to contact. This contact is to inform the provider of the results of the initial intake, the name and phone number of a contact at the agency providing the initial intake, and the name and phone number of a contact at the maternal-child home visiting program to which the participant/family was referred. In the event the screen was not provided by the prenatal care provider or the child's primary care provider, with appropriate release of information, a copy of the risk-screening instrument should also be forwarded to that provider.

Time Frames of Initial Intake:

First attempt to contact must be within five business days of the receipt of the screen or referral for all pregnant women, interconception women, and families of newborns/children who have been referred to CI&R and agree to program contact. A second attempt to contact must be

made within 10 business days of the first attempt and may be made by letter, by phone, or face-to-face. The third attempt to contact will be made no later than 10 business days of the second attempt.

Method of Contact:

Contact attempts may be by phone, face-to-face, or by mail. An initial intake may be completed by phone or face-to-face. All referred participants who have a positive risk screen or who are identified as having safety risks, as listed in Tier 1, must receive at least three documented attempts to contact. These attempts will be according to the following guidelines: Attempts may be by letter, telephone call, or attempted face-to-face visit. Only one of the three attempts may be by regular mail or by registered mail.

Best practice is to make more than three attempts to contact. These additional attempts may include an additional attempt by regular mail or registered mail.

Before closing a participant with a positive screen and/or Tier 1 safety concern, the CI&R worker must check the following resources for updated information regarding phone number and address or follow-through with care:

- Participant's health care provider
- WIC staff and WIC Information Project (WIP) System
- Immunizations staff and Florida SHOTS database
- FLORIDA Medicaid database (FMMIS)

Tier 1 Safety Concerns and Immediate Needs Requiring Priority Care Coordination Services (minimum 3 attempts to contact by phone, letter or face to face visit)
Knowledge of suspicion of current: <ul style="list-style-type: none">• Domestic violence• Sexual abuse• Child abuse or neglect• Substance abuse• Diagnosed mental illness (such as severe depression episodes, bipolar, personality disorder, schizophrenia, etc.)• HIV positive status• Hepatitis B positive status• Inadequate growth and development (i.e. small for gestational age)• Safety concerns noted by the health care provider on the prenatal/infant risk screen• Language barrier• Other, using professional judgement

All referred participants who are identified as having Tier 2 Concerns and Needs must have a minimum of at least three attempts to contact. The attempts to contact may be made by letter and/or phone. Phone attempts must be made on different times and days.

Tier 2 Concerns and Needs that Require a Minimum of 3 Attempts to Contact (phone and/or letter)
Knowledge of suspicion: <ul style="list-style-type: none">• Tobacco use• Known history of abuse (i.e. child, domestic, sexual) and/or neglect in family/household• Lack of basic needs such as housing and food• Lack of health care including prenatal care• If the participant's answer is yes to screening question for tobacco, alcohol/drug, depression and/or history of mental health counseling• Other, using professional judgement

Initial intake attempt by letter only. Participants referred to CI&R for factors other than score which do not include concerns and needs outlined as Tier 1 and Tier 2 in this chapter may be contacted by a letter for the initial intake attempt.

- The letter will 1) explain the CI&R process, 2) describe available CI&R services 3) explain how to obtain services through CI&R, and 4) provide the participant with a CI&R contact in the event assistance in obtaining services is desired.
- All participants that are unable to be reached during the initial intake time frames, and who score a 3 or higher on the Prenatal Risk Screen, with proper consent, shall be referred to Healthy Families prior to closure.
- Participants not referred to Healthy Families may be closed to CI&R 30 days after the letter is sent unless the potential participant notifies the CI&R worker, who will then make an evaluation of service needs. These participants may be reopened to CI&R as a self-referral in the event they notify the CI&R provider for services at a later date.

Unable to Locate

Before closing a participant with a positive screen and/or Tier 1 safety concern, the CI&R worker must check the following resources for updated information regarding phone number and address or follow-through with care:

- Participant's health care provider
- WIC staff and WIC Information Project (WIP) System
- Immunizations staff and Florida SHOTS database

- FLORIDA Medicaid database (FMMIS)

All participants that are unable to be reached during the initial intake time frames, and who score a 3 or higher on the Prenatal Risk Screen, with proper consent, shall be referred to Healthy Families prior to closure.

Plan of Action for Assuring Services:

After the initial intake, the CI&R provider will determine what additional resources the participant needs based upon professional judgment, family priorities, safety concerns, and immediate needs. Participants may:

- Receive only an initial intake and then be closed to CI&R with or without referral to other community-based services.
- Receive tracking to ensure the participant is able to make contact with the referred maternal-child home visiting program.

Documentation

CI&R services, or the provision of CI&R services, must be documented in the participant's electronic record in the approved data management system within three business days of service. CI&R documentation in the participant's electronic record must include:

- Prenatal Risk Screen, Infant Risk Screen or Referral
- Initial Intake documentation
- Authorization for release of information, signed by the participant, or on behalf of the participant, for any information that is to be shared among payers, providers, or others if the initial intake was completed face-to-face
- Documentation of obtained verbal consent to share information with the participant's chosen home visiting program if the initial intake is completed over the phone.

Coding

Services for CI&R should be coded in accordance with approved protocols and procedures for coding. CI&R services require specific codes for service delivery. 3100-series codes should be entered into the approved data management system, by participant name, within three business days of service completion. The provider of the service should code one unit for every 15 minutes of services provided to the appropriate program component.

No group coding is allowed. This is necessary to provide for tracking, analysis, and program evaluation of client specific data.

Refer to Chapter 23, Healthy Start Coding, in the Healthy Start Standards and Guidelines for more specific information on coding, including coding for referrals and follow-ups.

Continuous Quality Improvement (CQI)

Every woman, infant, or child who scores positive on the Prenatal Risk Screen or Infant Risk Screen, or is referred by a health care provider, a community service provider, or self-referred for services based on factors other than score, receives a timely initial intake and documented attempts to contact according to their risks, immediate needs, and safety concerns as outlined in Tier 1 and Tier 2. The CQI process should be designed to measure and help improve the extent to which women and families receive CI&R services, to eliminate barriers that prevent women from receiving services and to reduce risk factors identified through the screen, referral and initial intake.

The Healthy Start coalition should verify that the CI&R worker continues to meet provider qualifications and has continued their training in the home visiting programs and resources in the community.

Examples of targeted outcomes to be measured through the CQI process include:

1. Increase in the percentage of:
 - a. Women/families referred to CI&R who receive a completed initial intake.
 - b. Women/families who receive a completed initial intake within 30 calendar days of receipt of referral to CI&R.
 - c. Families who receive an initial intake and are referred to a home visiting program.
 - d. Families referred to a home visiting program who are enrolled in their program of choice.
 - e. Families referred to a home visiting program who are still participating in the program 90-day post-enrollment.
2. Increase in correct documentation in the approved data management system to show an initial intake was offered and/or provided to CI&R participants.
3. Increase in correct coding of 3100-series codes in the approved data management system to show CI&R services were provided to CI&R participants by qualified CI&R providers.
4. Adequate training opportunities for CI&R workers in their community's home visiting programs and resources.

Periodic participant satisfaction surveys can assist CI&R workers to identify areas in need of service expansion or improvement. Suggested questions to include on participant satisfaction surveys include:

- Was CI&R beneficial?

- Was staff courteous and helpful?
- Did the participant experience any barriers to services?
- Was the participant able to get the services to which they were referred?

Periodic satisfaction surveys of health care providers, community organizations and CI&R program representatives may also be beneficial by showing where improvements in outreach and working with community partners can improve.

Record reviews by CI&R supervisors are done at least quarterly to determine the effectiveness of CI&R. A randomly selected sample of records from all CI&R participants, ranging from those who have been closed to CI&R to those enrolled in a maternal-child home visiting program, will provide necessary information for determining the effectiveness of CI&R. Based on the information documented in the participant's record, including but not limited to the initial intake notes, consider the following key questions when conducting a record review:

- What are the basic identified risk factors of the participant selected for record review, including information from the risk screen and the initial intake?
- What are the critical risk factors documented in the record?
- What are the protective factors of the participant/family?
- What are the action steps (interventions) to address the risk factors/concerns of the participant?
- Was the intervention appropriate for the risk factors and needs of the participant?
- When needed, did the participant follow through with the referral to a maternal-child home visiting program?
- If the participant followed through with the referral to a maternal-child home visiting program, what critical factors contributed to the success?
- If the participant did not follow through with the referral to a maternal-child home visiting program, what critical factor(s) or barrier(s) contributed to the failure?
- If an initial intake was not completed, were the number of attempts and type of attempts to contact adequate based on risk factors and safety concerns?

Answers to these questions should be documented thoroughly. As the record reviews are conducted over time, the answers will begin to indicate the effectiveness of the CI&R system as well as patterns of action and behavior that may provide a great deal of information about which components or critical factors of CI&R have the greatest impact on outcomes.

See Chapter 30, Continuous Quality Improvement, for additional information.

Resources and References

Department of Children and Families

www.myflfamilies.com/service-programs/abuse-hotline/howtoreport

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Early Head Start	https://eclkc.ohs.acf.hhs.gov/programs/article/about-early-head-start-program
Early Steps	www.floridahealth.gov/programs-and-services/childrens-health/early-steps/index.html
Florida WIC	http://www.floridahealth.gov/programs-and-services/wic/
Florida's Head Start State Collaboration Office	http://floridaheadstart.org/
Healthy Families Florida	www.healthyfamiliesfla.org/
MIECHV	www.flmiechv.com/
Nurse-Family Partnership	www.nursefamilypartnership.org/
Parents as Teachers	https://parentsasteachers.org/
U.S. Department of Health & Human Services	https://homvee.acf.hhs.gov/Default.aspx
Zero to Three	https://www.zerotothree.org/resources/series/home-visiting-supporting-parents-and-child-development

Johnson, Kay. (2009.) *State-based home visiting: Strengthening programs through state leadership*. Retrieved from http://www.nccp.org/publications/pdf/text_862.pdf.

Notes
