Standard 7: Health Care and Community Resources

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**MEDICAL / HEALTH CARE PROVIDER** (EFFECTIVE 5/13/2025)

**HFA Best Practice Standard 7-1.A**

**POLICY: All target children will have a medical/ health care provider to ensure optimal health and development, and support is provided to assist parents in using health care appropriately for their children.**

HFNY Policy Guidelines

* Information regarding the medical/health care provider is collected and documented on the MIS Baseline Form.
* 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 Caregiver 1 on the Baseline Form and after that, on the Follow-Up form. There is no need to wait for a Follow-up form to be due when a family has a new doctor, the medical provider tab on the case home page can be updated at any time.
* Programs are required to report on Primary Caregiver 1 and Target Child having a medical provider, an HFNY Performance Target, on a quarterly basis.
* Home visitors assist the parent in securing preventive health care services, understanding the importance of a medical home, and reminding parents of upcoming immunizations, well-child and/or prenatal care visits.
* When necessary, Home visitors assist in coordinating health services through direct communication with the medical provider or physician office staff (with signed consent).
* When barriers to healthcare services are identified, the site develops strategies to address these and home visitors assist families in obtaining well-child care services, when possible.
* Strategies to address identified barriers to well-child care services are documented in the site’s Quarterly Report and Annual Service Review.
* Home visitors track and document the receipt of well-child care visits according to time frames indicated by the American Academy of Pediatrics schedule, and any other medical care, on the TC Medical Form in the MIS.
* It is strongly recommended that supervisors note any concerns related to linkages to a medical provider on a family’s Service Plan, with planned interventions/activities to address and track progress.

**Site will adhere to all HFNY Policy Guidelines specified above. Insert site-specific procedures that include:**

1. How sites will ensure that all target children have a medical/health care provider.
2. How Home Visitors will support parents in using health care appropriately for their children.
3. Specific data to be collected, time frames for collection, and where these are documented.
4. How the site will develop strategies to address the identified barriers impacting access to well-child care (7-1.C).

**IMMUNIZATIONS** (EFFECTIVE 5/13/2025)

**HFA Best Practice Standard 7-2.A**

**POLICY: Families receive education on the importance of immunizations, and children are up to date on their immunizations.**

HFNY Policy Guidelines

* Home Visitors provide information to parents regarding the importance of immunizations and encourage timely receipt of immunizations according to the immunization schedule recommended by the Center for Disease Control and Prevention/American Academy of Pediatrics.
* Home Visitors share an immunization schedule with parents for each child (using the child's date of birth). This schedule is then used to track the receipt of immunizations for that child. The site may gather this information either through a family report or medical provider report, however sites are not required to obtain medical provider confirmation of receipt of immunizations.
* The Home Visitor refers to the schedule and works with parents to ensure immunizations are scheduled and to assist with addressing any barriers to getting the immunizations (i.e., transportation, language barriers, etc.)
* Home Visitors document all scheduled immunizations and well-baby care visits on the TC Medical Form in the MIS.
* When immunizations are missed, Home Visitors record the explanation on the Home Visit Narrative and work with parents to reschedule and address any barriers to getting the immunizations.
* Should a child have a medical reason for not getting immunizations or the family is declining immunizations due to personal beliefs, this is documented in the family file and on the tracking form.

**Site will adhere to all HFNY Policy Guidelines specified above. Insert site-specific procedures that include:**

1. How parents are educated regarding the importance of immunizations
2. Describe how information related to receipt of immunizations is obtained (i.e. family report or medical provider)
3. How Home Visitors work with parents when immunization appointments are missed

**REFERRALS/ LINKAGES TO HEALTH CARE AND COMMUNITY RESOURCES**

(EFFECTIVE 5/13/2025)

**HFA Best Practice Standard 7-3.A**

**POLICY: Families receive information, referrals, and linkages to available health care resources and other community resources based on family need and interest, and follow-up to ensure that families receive the services to which they were referred.**

HFNY Policy Guidelines

* During initial assessments and ongoing contact with families, Home Visitors determine needs and provide information, referrals, and linkages to health care and other community resources as needs are identified.
* Home Visitors are knowledgeable and well connected to community services that might be beneficial for families.
* Depending on each family’s capacity and comfort level, Home Visitors are involved in varying ways and intensity levels when making referrals. Involvement can range from solely providing referral information to the parent, to making the initial contact with referral source (with signed consent), to accompanying the family to the initial appointment.
* When referrals are made, Home Visitors follow-up with the family and/or the referral source (with signed consent), as necessary, to support the connections and promote follow-through.
* All referrals, follow-up actions, and outcomes are recorded on the Home Visit Narrative and Service Referral Form.

**Site will adhere to all HFNY Policy Guidelines specified above. Insert site-specific procedures that include:**

1. The process for assessing need and interest, and providing information, referrals and linkages to available health care and community resources for all participating family members.
2. The follow-up mechanisms used to determine whether parents received the services they were referred to, and how well they have met the families’ needs.

**DEPRESSION SCREENING** (EFFECTIVE 5/13/2025)

**HFA Best Practice Standard 7-4.A**

**POLICY: The site conducts depression screening with the primary caregivers in each family using the PHQ-2 and the PHQ-9, standardized instruments.**

PHQ-9 scores are interpreted as follows:

|  |  |  |
| --- | --- | --- |
| **Total Score** | **Depression Severity** | **Action Steps** |
| 1-4 | None-Minimal | Watchful waiting |
| 5-9 | Mild | Watchful waiting, repeat PHQ-9 at follow up |
| 10-14 | Moderate | Referral for mental health counseling (MIS Referral Code 50) |
| 15-19 | Moderately severe | Referral for psychiatric or psychological treatment (MIS Referral Code 49) |
| 20-27 | Severe | If the participant scores 20 or above, the home visitor must consult immediately with the supervisor for emergency treatment referrals and move to the site-specific safety protocols. |

**IMPORTANT: Severe depression is life threatening and must be addressed by a licensed clinician.**

HFNY Policy Guidelines

* Staff must receive training to administer the PHQ-2 and PHQ-9 prior to use with families (see HFNY Policy 10-6).
* Home visitors conduct depression screening using the PHQ-2 and PHQ-9 Depression Screens with all primary caregivers to assess for risk of perinatal depression, in accordance with the tool developer guidelines.
* The PHQ-2 is administered during the assessment process and is incorporated into the FROG form. If the participant (s) score is a 3 or more, the PHQ-9 must also be given and documented at that same visit .
* The PHQ-9 is administered and documented in the MIS:
  + At least once within 30 days of the first prenatal home visit (if serving the family prenatally), and documented on the Baseline Form.
  + At least once within three months after birth, or within 3 months of enrollment if enrolled postnatally. This is documented on the Target Child Identification and Birth Outcomes form.
  + At least once within three months of all subsequent births, using the standalone PHQ-9 form.
* Families not screened within 3 months are screened at least once within 6 months postnatally or post-enrollment (unless a family declines the screen).
* **To achieve a 2 rating, you must achieve both:** 
  + **A minimum of 80% of all families must be screened within 3 months postnatally or post-enrollment.**
  + **All remaining families not screened within 3 months must be screened at least once by 6 months postnatally or post-enrollment, unless they decline the screening.**
* Depression screening will also be administered any time during home visiting services if a parent is displaying or reporting depressive behaviors or symptoms. This includes all other caregivers as determined necessary by the Home Visitor and supervisor. This should be documented in the Home Visit Log and a PHQ-9 Stand-Alone form should be completed in the MIS.
* If the participant scores positive on question 9 of the PHQ-9, move to the site-specific safety protocols. If a participant’s score on the PHQ-9 indicates depression, they are referred to mental health resources in the community (or provider of family’s choice) for a follow up mental health assessment. If a participant scores 20 or above, the home visitor must consult immediately with the supervisor for emergency treatment referrals.
* Families receive education on risks for, and signs and symptoms of perinatal depression during the course of home visits, and specifically when the PHQ-9 is administered.
* In rare instances where the depression screening is done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy to show that the screen was completed on time and to make and track any necessary follow-up referrals or interventions for the family.
* The home visitor and supervisor discuss the results of depression screens. When the screen is positive, the service plan is used to develop strategies for supporting the caregiver (e.g., addressing problem solving, building positive self-esteem, building family supports, referrals, etc.).
* Home visitors promote stress reduction and support parents to be responsive to their child’s physical and emotional needs.
* Staff members are not clinicians, and it is critical for home visitors to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options.
* When depression screens are positive, Home Visitors will provide appropriate referrals and explore with the family strategies and/or activities they may be interested in engaging in. These may include:
  + Providing linkages and referrals to appropriate resources
  + Providing referrals for mental health consultation (when available)
  + Using motivational interviewing (when trained) to assist parents in accepting resources, treatment
  + Utilizing supervision to assist staff in discussing depression with parents
  + Getting parents out in the sunshine (sun increases serotonin)
  + Encouraging parents to walk, exercise, or engage in other forms of physical movement
  + Encouraging parents to smile (even a “practice” smile increases serotonin)
  + Encouraging parents to keep hydrated (hydration increases brain functioning)
  + Encouraging self-care
  + Practicing gratitude
  + Using healthy strategies that have worked for the parent in the past
  + Utilizing Procedures for Working with Families in Acute Crisis
  + Encouraging parents to meet their baby’s physical and emotional needs
  + Using other strategies/activities identified locally

**Site will adhere to all HFNY Policy Guidelines specified above. Insert site-specific procedures that include:**

1. Describe how staff monitor and adhere to required timeframes for administering the PHQ-2 and PHQ-9 specified in policy guidelines.
2. Describe referral and follow-up expectations for positive screens.
3. Describe what activities home visitors do with families to address stress and depression.
4. Describe how any staff administering the tool are trained prior to administering it l, and who administers the training.
5. Describe the sites safety protocol for staff if the suicide screening question is positive.

**Reference Table**

**Best Practice Standard 7**

*This reference table contains a list of reports in the MIS that can be used to help programs monitor fidelity as well as helpful links and documents related to each policy*

|  |  |  |
| --- | --- | --- |
| **Policy** | **MIS Reports & Forms** | **Appendix & Links** |
| 7-1.A  Medical/ Health Care Provider | * TC Medical Form * Quarterly Performance Targets for 4 Quarters * 7-1.B Report | * NONE |
| 7-2.A  Immunizations | * Quarter Performance Targets * Quarterly Performance Targets for 4 Quarters * PC1/TC Medical Provider Listing * 7-2. B/C Target Child Immunization | * [Child and Adolescent Immunization Schedule by Age](https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html) |
| 7-3.A  Referrals/ Linkages to Health Care and Community Resources | * Case Filter/Site Options * Count of Service Referrals by Code * Quarterly Service Referrals * FROG PC1 Issues * Service Referrals Needing Follow-Up | * NONE |
| 7-4.A  Depression Screening | * Intake Form * TC ID * 7-4.B Prenatal Administration of the PHQ9 Screen * 7-4.C Postnatal Administration of the PHQ9 Screen * 7-4.D PHQ9 After Subsequent Birth * 7-4. E Referrals for Elevated Depression Screen - Details * 7-4. E Referrals for Elevated Depression Screen - Summary * New Risks Identified for Service Plan Report | * [Procedure for Working with Families in Acute Crisis](https://www.healthyfamiliesamerica.org/network-resources/protocols-working-with-families-experiencing-acute-crisis/)(HFA Login Required) * [Depression Management Action Plan](https://drive.google.com/file/d/1YlLNNL5WqbbC9-xc4nOipxbGmN15hXlU/view?usp=drive_link) * [Administering the Patient Health Questionnaires 2 and 9 in Integrated Care Setting](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-07-01_phq_2_and_9_clean.pdf)[[1]](#footnote-1) |

1. Please note, when administering the PHQ-2, HFNY staff should follow scoring guidance outlined in Policy 7-4.A. [↑](#footnote-ref-1)