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* **STRUCTURE** *
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Division of Nursing

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HACKETTSTOWN COMMUNITY HOSPITAL

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HEALTHSTART CLINIC
Scope

I. DESCRIPTION

The HealthStart Clinic is an outpatient pre- and postnatal OB clinic for low-income women in Hackettstown Community Hospital's service area.

II. PURPOSE/MISSION

A. Statement of Purpose: To provide pregnant women with a comprehensive package of care, which addresses all areas of their lives likely to affect their pregnancy outcomes and the health of their infants. Care is coordinated and continuous.

B. The key to the success of the program is case coordination of services, including vigorous follow-up, support, and advocacy. Twenty-four (24) hour access to emergency medical services and to the case coordinator is provided. Linkage to pediatric care, WIC for mother and baby, family planning and other needed services are provided.

C. Scope: Services are provided to pregnant women that are on Medicaid, Medicaid eligible, or a Medicaid HMO. Clients receive prenatal and postpartum services through the HealthStart Program as outpatients. Prenatal care is available from the point that the client has a positive pregnancy test until 60 days postpartum. The HealthStart Program encompasses case coordination and nursing process with medical care, and assessment of nutrition, psychosocial and educational status and needs.

III. GOALS

A. To provide the medical component of prenatal care for each eligible pregnant woman by assigning a provider based on clients choice and need.

B. To ensure that prenatal services are available, accessible, and that the client understands the need for early and continuous prenatal care.

C. To encourage the client to take an active role in her own health care. Rights and responsibilities are included in the initial visit, and efforts to help her improve her planning, communication, and problem-solving skills are ongoing.

D. To provide assessment to identify client's level of risk so that appropriate interventions may be utilized.

IV. ADMINISTRATION/ORGANIZATION OF UNIT

A. Organization Chart

1. The hospital organizational chart informs the staff of the departmental relationships and accountability of each department within the hospital system.

   a. See Nursing Department Standards Manual.

2. The Department of Nursing has an organizational chart, which informs the staff of the Nursing Department of relationships and accountabilities within the department.

   a. See Tab #1.

3. The HealthStart Clinic has an organizational chart that informs the staff of their relationships and accountabilities to other staff and department manager.

   a. This chart is written by the Administrative Director of Special Care Services and approved by the Administrative Council of Hackettstown Community Hospital.

   b. See Tab #2 for actual chart.

B. Narratives

1. The organizational chart of the Department of OB is defined in the narrative as to responsibility and accountability of staff and managers in terms of both direct and indirect communication.

2. The narrative is written by the Child Birth Family Center Manager and approved by the Administrative Director of Special Care Services.

3. See Tab #3 for actual narratives.

C. Policy Statements

1. Organization

a. The HealthStart Clinic is a specialty nursing unit, which is organized within the OB Department under the Department of Nursing. Overall management of the unit is the responsibility of the Child Birth Family Center Manager with direction and collaboration from the Administrative Director of Special Care Services. Collaboration with medical care providers and appropriate department managers takes place periodically through formal and informal meetings.

2. Nursing Administration

a. The Child Birth Family Center Manager is an RN with appropriate clinical and managerial experience and/or potential for the same. She has 24-hour responsibility for the effective functioning of the staff, including their development and evaluation, the efficient functioning of the clinic subsystem, and the quality of client care provided in the setting.

b. The case managers responsible for giving quality care in the HealthStart Clinic are assigned by the Child Birth Family Center Manager. They are responsible collaboratively with the Child Birth Family Center Manager for maintaining the budgeting and scheduling of the department.

c. Ongoing communication takes place between case managers and Child Birth Family Center Manager for resolving administrative problems.

3. Medical Administration

a. The responsibility of directing medical care is that of the provider and his/her/her associates. Delegation of that responsibility may be done as specified in the Medical Staff Bylaws via written order for transfer of services and/or by consultation. (See Addendum #1.)

b. Responsibilities of the attending medical care providers to the clinic are:

1) Examination of client at each prenatal visit.

2) Initial visit to include:

a) History - personal and family
b) Physical examination
c) Risk assessment
d) Current pregnancy status
e) Routine lab tests
f) Procedures (at initial visit or as indicated)

3) Subsequent visits to include:

a) Review of care plan
b) Interim history
c) Physical examination
d) Lab and screening tests, as medically indicated

4) Obstetrical delivery

5) Postpartum care, including:

a) History of labor and delivery experience and immediate postpartum period
b) Physical examination
c) Lab tests, as medically indicated
d) d) Parent/infant assessment
e) Referral/consultation as needed

6) Regular and systematic communication between medical care provider and case coordinator avoids any gaps in care. It is expected that the medical care provider will be available to nursing staff for educational support and client case conferencing.

7) See specific pre-printed orders (Addendum #9).

4. Departmental Relationship

a. HealthStart is an integral part of the hospital network. The relationship between HealthStart and other departments in the hospital is client focused and is facilitated through collaboration, verbal and written communication both formally and informally and by committee participation.

b. The HealthStart Clinic provides a special package of health care services provided by a network of health care professionals including registered nurses, social workers, registered dieticians, health educators, and providers. Funding for services is provided by New Jersey Care, a special Medicaid program allowing many low income pregnant women and children formerly ineligible for Medicaid benefits to receive them. The HealthStart Clinic is part of a statewide health program in New Jersey. Many standards of care followed in the clinic are set by state guidelines.

c. The HealthStart Clinic is part of the Gateway Northwest Maternal and Child Health Network. The case managers attend meetings at the Network, which provides an opportunity to share ideas, to troubleshoot and to receive inservice information pertinent to clinic management and client care.

V. HOURS OF OPERATION

Clients are seen by scheduled appointment. For medical emergencies, the client may contact the medical care provider through his/her office or answering service. The case coordinator can be reached through the HealthStart voicemail system or by contacting the Child Birth Family Center Unit directly with a non-medical emergency. This provides 24-hour access to the case manager for purposes of triage, telephone advice, and problem-solving. Messages will not be left on a client's answering machine unless instructed to do so by the client and noted in the chart.

VI. UTILIZATION OF THE UNIT

A. Admission to the HealthStart Clinic

1. HealthStart Clinic admissions are limited to the following:

   a. Clients already on Medicaid contact either the case coordinators or Child Birth Family Center Manager for provider assignment and an appointment. A confirmed pregnancy test is required and may be performed on site unless client has already been receiving prenatal care.

   b. Clients requesting enrollment in the clinic are referred to the financial counselor for presumptive eligibility. When an appointment is given the financial counselor will call the HealthStart clinic case manager who will contact the client and arrange an intake interview based on her provider preference.

   c. Clients who are PE (presumptive eligibility) screened must make an appointment with the County Welfare Board within 14 days for final determination. The PE period ends at the end of the month following initial eligibility or when a determination of eligibility or ineligibility is made by the CWA.

   d. Clients who are screened for Medicaid and are eligible may be seen in the HealthStart Clinic. Clients who are screened for Medicaid and denied but are eligible for “uncompensated care” will be seen in the clinic as well.

   e. Transfers of clients from other providers to the HealthStart Clinic will be accepted providing the client is Medicaid eligible. The client is informed of need to request all medical records of previous prenatal care

2. The client will receive an initial appointment within two (2) weeks of request. An exception may be made if client has already been receiving prenatal care elsewhere and visit would not normally occur within two weeks. If possible, the client will be seen when presumptive eligibility is initiated and provider appointment set up at that time.

3. All clients will be registered by admission clerks at first prenatal visit. Three OP charts and cards will be generated: one will be used for recurring visits, one will be used for Medicaid enrollment code and billing purposes, and the third card will be used for Radiology and Laboratory services. This card will be kept in the Diagnostic Center. A list will be given to the Diagnostic Center on a quarterly basis identifying those clients no

longer in the HealthStart Program. The client will sign the appropriate admission consents for treatments, tests and procedures done while she is in the HealthStart Clinic. Consent for HIV testing will be done per HCH policy located in the Nursing Standards Manual. A separate Medicaid consent will be signed by clients interested in postpartum bilateral tubal ligation per clinic policy 7070.039a, located in clinic policy manual.

B. Provider Assignment

1. Clients are assigned to providers according clients preference and medical needs.

2. HCH provides all of the support services.

C. Nursing Responsibilities for Admission and Duration of Care

1. Client is oriented to HealthStart program at first prenatal visit.

2. Informed consent applies to all procedures conducted at HCH. See Rights and Responsibilities in the Nursing Department Standards Manual.

3. All records are treated with confidentiality per HCH generic standards.

4. Client receives verbal and written information on who their case manager is, who their provider is, and how to reach them.

5. A nurse assists the Healthcare provider at each visit.

6. Documentation of all client contacts and visit content is recorded on POPRAS record.

7. Care plan will be completed within one (1) month of client entry to HealthStart. All members of the HealthStart team are expected to participate in writing the care plan. The nutrition or psychosocial specialist will document on the care plan. Consultations and recommendations, if any, will be documented in the POPRAS narrative. The provider will be responsible for the physical exam, documenting prenatal and postnatal visits and collaboration on the medical care plan.

8. For the client that is unable to arrange transportation for needed care, the case coordinator will assist in making transportation arrangements to the HealthStart site.

9. Pre-printed orders will be used.

D. Discharge/Transfer

1. If a client is denied Medicaid and does not meet financial criteria for uncompensated care, she will be referred to a provider for care.

2. She will be informed that if her circumstances change, she may reapply to Medicaid or do another PE determination.

3. Client receiving prenatal care may be transferred either to another clinic or provider at the client's request.

4. All client care is terminated 60 days postpartum.

5. If the client is transferred, the prenatal records will be sent to the client's new provider after a medical record release is obtained. It will be done by the Medical Records Department per HCH policy located in Nursing Department Standards Manual.

E. Outreach

1. Outreach activities, including home visits, phone follow-up, and referrals to local agencies/services, are conducted.

2. The HealthStart certificate is framed and in a public place.

F. Limitations of Area

1. Physical - The clinic includes a waiting area, four examining rooms, office space and a bathroom.

2. The clinic contains all the necessary equipment to provide ambulatory prenatal care including doppler, scale, disposable speculums, culturing media, BP equipment, measuring tape, otoscope, gestational wheels and educational materials.

3. High Acuity - Clients that are high-risk medically or require services not provided at HCH will be referred or transferred to a high-risk OB clinic.

VII. GOVERNING RULES

A. General Safety

1. All personnel will be familiar with the Environmental Safety Manual, which includes:

   a. General Safety
   b. Disaster Plan
   c. Fire Plan
   d. Infection Control Plan
   e. Department Specific Info.

2. No smoking is allowed.

3. Clients will be instructed verbally and by a posted sign not to leave children unattended in the waiting area.

B. Electrical Safety/Preventive Maintenance

1. Check all electrical equipment for damage to cords, plugs, etc. All appliances will have 3-pronged plugs and/or be checked by Maintenance for safety compliance.

2. Personnel must have knowledge of use of electrical equipment.

3. All electrical equipment will be periodically checked according to biomedical contract.

4. Broken equipment will be repaired by Maintenance or sent to Materials Management to send to respective companies for repair.

5. Extension cords will be avoided if at all possible.

6. Outlet covers will be placed on electrical outlets not in use.

C. Infection Control

1. Refer to Hackettstown Community Hospital Environment of Care and Child Birth Family Center Unit specific manual for generic standards.

2. A list of reportable diseases will be kept in the Infection Control/Isolation section of the Environmental of Care Manual. They will be reported to the Infection Control Nurse who will then report them to the State of NJ Department of Health.

3. Standard precautions will be practiced during each client's visit.

4. Contaminated equipment, if any, will be treated according to Hackettstown Community Hospital policies in Child Birth Family Center Unit Infection Control Manual.

5. Standards and procedures are reviewed yearly and updated with input from Infection Control Nurse.

6. Disposable-non reusable items contaminated with body fluids will be disposed of in a covered trash receptacle.

D. Valuables

1. Every effort should be made to safeguard personal belongings of a client treated within the department. All clients are advised to keep their valuables with them at all times.

2. Every client's privacy is respected both during examination and when counseling with nurse or provider.

E. Confidentiality/Safeguarding Records

1. Confidentiality - The clinic will adhere to HCH generic policy on privacy/confidentiality located in the Nursing Department Standards Manual.

2. All clients are given a copy of the pregnant client's Bill of Rights along with verbal explanation during their initial appointment.

3. The HealthStart client's chart will be kept in a chart rack in the Childbirth Family Center when not in use in the Prenatal Clinic.

4. The HealthStart Clinic will be locked when it is not in use.

5. When a HealthStart client presents to Child Birth Family Center for evaluation during clinic hours, the OP chart will be brought to Child Birth Family Center by a Hackettstown

Community Hospital staff member and be returned to the clinic chart rack following the client's discharge.

F. Supplies/Emergency Equipment

1. Nursing staff scheduled to work in the area will be responsible for ordering daily supplies. Major pieces of equipment will be ordered collaboratively with Manager.

2. Prescription pads are kept locked during non-clinic hours.

G. Client Support Services

1. HealthStart Clinic hours of operation are during the day. Personnel are available in the laboratory, radiology, Social Service and nutritional care.

2. HealthStart Clinic records (POPRAS) will be accessible to hospital staff at all times.

3. A copy of the POPRAS chart will be sent to Child Birth Family Center at 34 weeks gestation and stored in the “Prenatal Record” notebook.

4. Hospital discharge summary records will be transferred to the HealthStart record within two (2) weeks of delivery.

5. Language interpretation is available through the Language Line. See Procedure 8620.073a in Nursing Standards manuel.

6. Community resources utilized include WIC, County Health Department, Division of Youth and Family Services, Planned Parenthood, Pregnancy Center of Warren, Adoption Services, and First Call for Help or other agencies as indicated.

H. Adolescents

1. The RN/Case Manager is responsible for assessing the adolescent client's emotional, social, and physical needs during the prenatal and postpartum period, providing the appropriate nursing interventions, and referring the client to appropriate support services.

2. The nursing assessment includes a complete biophychosocial evaluation

3. A pregnant minor can give consent on her behalf for issues related to her pregnancy or her child (N.J.S.A. 9:17 A-1).

I. Genetic Counseling

1. Genetic counseling services are available upon the request of the client or the provider at our Regional Perinatal Center (Morristown Memorial Hospital) for clients enrolled on a medicaid Hmo, referral will be to provider within clients plan.

J. Rubella/Rhogam and Reubeola Screening

1. If a client is determined to be non-immune to Rubella and/or Rubeola during her prenatal care, the HealthStart chart will be flagged with a sticker to alert the postpartum staff. She will receive Rubella and/or Rubeolla vaccine while in the hospital and this will be verified at her postpartum visit.

2. All RH negative clients in care at 28 weeks will receive Rhogam per providers preprinted orders.

3. Rubella, Rubeola and RhoGam must have a provider's order before administration.

K. Sterilization

1. When a HealthStart client wishes sterilization, the RN/Case Manger will obtain the necessary consent on the Federal forms. The client cannot have the surgery unless these forms are on the HealthStart chart at time of delivery.

L. Adoption

1. The social service staff is available to act as liaison between the adoption agency and the relinquishing mother. Counseling is available to the client and to her family.

2. At no time is a hospital employee to participate in arranging a private adoption.

M. The Medical Records Department is responsible for the release of all records.

N. Management of Suspected Abuse or Neglect

1. Child victims of alleged or suspected abuse or neglect will be handled per policy NU03 in the Administrative Policies Manual. If a suspected victim presents to the clinic, she will be referred to the ER for further evaluation and medical treatment if indicated.

2. A referral to Adult Protective Services or appropriate agency will be made in cases of suspected elder abuse. (NU03 Administrative Manual)

3. In cases of suspected or reported domestic abuse, the client will be referred to DARC or other appropriate community resource. The client will be supported if they choose to file a police report.

4. A list is maintained private and public community agencies that provide or arrange for evaluation and treatment of victims of abuse and referrals will be made as appropriate.

5. Examination, treatment and referrals to other agencies and/or providers will be recorded on the POPRAS record.

6. Yearly inservices will include information designed to educate staff about the criteria for identifying and the procedures for handling possible victims of abuse.

O. Management of Alcohol and Substance Abuse

1. The assessment tool to be used on each prenatal client is the POPRAS III form. See page 1-b which identifies physical exam, nutrition and psychosocial concerns.

2. Clients who are identified as cigarette smokers will be offered a referral to "Quit Connection", which is run by the Gateway Northwest Consortia. The Case Manager will follow up on

referral and progress throughout her pregnancy.

3. Clients identified as having a history of alcohol or drug use will be referred to HCH MSW, who will make community referrals and follow up as needed.

4. Clients identified as current alcohol and/or substance abusers will be referred to a high risk clinic participating in their insurance plan, in addition to referral to HCH MSW.

VIII. STAFFING

A. Quantity

1. Each client will be assigned a case coordinator who is a registered nurse with concentrated maternal/child health background. (See Addendum #2.)

2. Other staff assigned to the area will be determined by the workload.

B. Levels

1. Registered nurses, graduate nurses, LPN's and attendants may be involved in client care.

2. The RN is responsible for carrying out the nursing process: directing, planning, supervising and evaluating the care given. For skills checklist, see Addendum #4.

C. Delivery of Care Methodology

1. The nursing care in the clinic is primary care. As such, the clinic nurse is expected to be accountable for knowledge and ability to implement all standards, policies, protocols, and procedures.

2. Issues that may raise questions of a controversial nature may be referred to the hospital Ethics Committee through the Child Birth Family Center Manager or the department chairman.

3. The HealthStart Clinic nurse is responsible for knowing both state and JCAH requirements for the clinic. She functions within the guidelines of pre-printed orders. She notifies the medical care provider of any significant deviation from normal.

4. All patients have the right to assessment and treatment of pain. Patients reporting pain will evaluate their pain level based on the Wong-Baker Pain Scale. Comfort measures will be reviewed with pharmacological intervention as deemed appropriate by provider. Findings will be documented on POPRAS record with follow up at subsequent visit.

5. Copies of all test results are sent to the clinic and to the provider's office. The HealthStart Clinic nurse will follow up abnormal test results by phoning the provider's office for further orders/instructions. The medical care provider will determine if they or the clinic nurse will contact the client. The client can be treated in the provider's office, ER or clinic for abnormalities.

6. Uniform risk assessment is assured through use of POPRAS form.

7. A case conference including at least the medical care provider and the case coordinator will occur whenever there is a change in the care plan or at least once per trimester.

8. Specific duties of RN/Case Manager are as follows:

    a. Orients new clients to the services available at the intake interview, performs admission assessment and initiates nursing care plan.

    b. Reviews charts prior to client's visit, to identify client teaching needs, changing lab values and to update care plan.

    c. During client's visit, the RN/Case Manager acts as a resource for other team members. Provides client teaching, assists medical care provider with procedures as necessary. Assesses any client that has had an acute change and notifies other members of the client care team.

    d. Following the visit, the RN/Case Manager updates care plan based on client's visit and documents all findings on the appropriate forms on the POPRAS chart.

    e. Refers clients to the appropriate in-house and community resources.

    f. Carries out provider's orders.

    g. Administers medication as ordered.

9. Nursing Process

    a. Assessment

        1) Assessment is done by the registered nurse at each visit and is documented on the POPRAS chart.

    b. Care plan

        1) The individualized care plan for each client is written within one month of the initial visit.

        2) The care plan is based on information gathered from the admission assessment and includes provider, social service, and dietary input.

        3) The RN/Case Manager collaborates with the client and significant other in developing the care plan unless the client requests that they not be involved.

        4) The plan is updated at each prenatal visit by the RN/Case Manager.

    c. Implementation

        1) Nursing standards of care are guidelines for specific nursing actions, and form the basis for nursing interventions.

        2) The process standards specific to Health Start are found in the HealthStart Standards Manual.

        3) Generic process standards are found in the Department of Nursing Standards

Manual.

d. Evaluation

1) The POPRAS chart, the care plan, and the client education flow sheet will reflect the effectiveness of the interventions identified on the nursing and medical care plan.

2) Each client is to have an entry made on their chart by the RN/Case Manager at each prenatal visit.

e. Nursing Documentation System

1) The POPRAS prenatal chart forms the basis of the documentation system for the HealthStart client. It includes psychosocial data, nutrition data, health education, medical History and assessment, and risk-assessment parameters. On the POPRAS chart, all the nursing care delivered and client response is charted by the RN/Case Manager.

2) The care plan and client education flow sheet are completed by the RN/Case Manager.

3) See Department of Nursing Standards Manual.

D. Preparation of Staff

1. Selection: Qualifications include:

a. Previous obstetric or prenatal clinic experience.

b. Ability to work independently with the nursing process.

c. Ability to teach on an informal and formal basis, and knowledge of principles of health teaching as they relate to the childbearing experience and newborn care.

d. Nurses are interviewed by the Child Birth Family Center Manager. They are hired with a three-month probationary period.

2. Orientation

a. See Obstetric Standard Manual for principles of orientation.

b. See Addendum #4 for skills check list for RN/Case Manager.

3. Continuing Education

a. Staff development on the unit is ongoing.

b. Staff meetings are arranged by the Child Birth Family Center Manager.

c. Staff members are expected to attend as many inservices as possible. Participation in the yearly in house educational review is mandatory. Inservices held by the Staff Development department are open to all staff members. OB staff meetings are to

be attended.

d. A sign-in sheet is used at each inservice, and a copy of this is sent to the Staff Development Office. Records of attendance at the OB staff meetings/inservices are also kept by the Child Birth Family Center Manager. Each nurse is expected to keep her record of outside inservices attended current in the Staff Development book on Child Birth Family Center.

4. Credentialing

a. Compliance to the job performance standards is evaluated by the Child Birth Family Center Manager. Anecdotal records are kept and used to prepare the yearly evaluation. Identified problems or deficient areas in job performance are dealt with as they are identified.

b. Nurses must sign off on new equipment or procedures to verify their understanding prior to use.

IX. NURSING RESPONSIBILITIES

A. Prenatal Activities

1. Client will be assigned an RN/Case Manager when registered. The RN/Case Manager will be responsible for tracking the client's appointments and facilitate entrance into the system.

2. Will orient client to available HealthStart services:

a. Specific services included in comprehensive package
b. Notification in writing, of assigned provider
c. Location of provider services
d. Scheduling of services
e. Emergency contact person - provider and case manager
f. Client will receive copy of client’s rights/responsibilities and these will be defined verbally.

3. Will develop and implement care plan within one (1) month of the initial visit.

4. Will maintain care plan through close communication with the client.

a. At each prenatal/postpartum visit, the case manager will reinforce instructions, provide follow-up appointments, referrals and review the care plan.

5. Monitor determination of HealthStart eligibility and services.

a. Financial counselor will perform presumptive eligibility services and communicate with RN/Case Manager.

b. Monitor final Medicaid eligibility, if applicable. Monitor enrollment into HMO and obtain pre-certification as indicated.

c. Assist the client in receiving ongoing care, utilizing community resources as needed.

d. Follow-up missed appointments, as needed. See procedure 7070.040a

6. Follow-up on referrals.

7. Reinforce health education.

8. Provide or arrange for home visits.

9. Responsible for completeness of client's record

a. Copy of antepartum record will be incorporated into inpatient record when admitted to the hospital.

b. Copy of discharge summary will be added to HealthStart record.

B. Postpartum Activities

1. Arrange one contact for each client during the time after hospital discharge and prior to the 4-week post partum medical visit.

2. Arrange or coordinate home visit for client identified at risk of needing additional support or referral

3. Arrange 4-6 week post-partum appointment.

4. Pediatric provider will receive a copy of the POPRAS prenatal record.

5. Each infant will have a pediatric care giver and follow-up will be done to assure that there is continuity of care.

6. If appointment missed, follow up is provided via certified letter and/or home visit.

7. Continue health education for client and her newborn.

8. Clients who have a spontaneous or therapeutic abortion are encouraged to return for post-op check-up and may be referred to grief support group.

X. HEALTH EDUCATOR

A. Qualifications - The health educator will be a registered nurse, a member of the OB staff with maternal/child health education experience, a childbirth instructor or the medical care provider delivering OB care. The case manager may also serve as the health educator.

B. Educator - All health education services will be coordinated by the case manager.

C. Responsibilities

1. Review History, physical assessment, nutrition and psychosocial assessment.

2. Complete POPRAS form, assess barriers to learning and determine health education plan.

D. Content of Health Education

1. Minimum health education requirements as listed in HealthStart guidelines, depending on when client begins prenatal care. (See Addendum #3)

2. Document teaching on Health Education sheet (see addendum #3a)

3. Childbirth classes offered at HCH available for all HealthStart clients at no cost to the client.

   a. Six-week basic prepared childbirth class
   b. Refresher classes
   c. C/S classes
   d. Sibling classes
   e. Breast feeding
   f. Baby care classes
   g. Early Pregnancy class

E. Guidance for Decision-Making

1. Individualized - based on client's needs.

2. Referrals to HCH programs (stress management, smoking cessation) and community programs, as appropriate.

F. Postpartum Health Education Assessment

1. Client record and care plan reviewed; HCH Clinical Guidelines reviewed.

2. Client's remaining needs identified and appropriate referrals made. Telephone resource number (908) 979-8899.

XI. NUTRITION SERVICES

A. Qualifications - Nutrition assessment, development of care plan and basic nutrition guidance will be provided by the case coordinator or her designee, a registered nurse with concentrated maternal/child background, specialized nutrition assessment and counseling will be provided by a registered dietician.

B. Responsibilities

1. Review POPRAS form, history, education, etc.

2. Take nutrition history, using POPRAS form and determine possible risk factors.

3. Evaluate current nutrition status with food frequency log.

4. Recommend referrals to WIC, food pantry, as needed.

5. Continued nutrition assessment to be included in each subsequent visit/contact.

5. Basic prenatal nutrition guidance ongoing throughout care. Case coordinator is responsible for completing WIC referral unless client is already WIC.

C. Specialized Nutrition Assessment and Counseling

1. Based on client's individual needs, nutrition services will be offered by the RD.
2. Criteria for specialized services include inadequate weight gain, inadequate food supply, excessive weight gain, diabetes, pre-eclampsia, pica, anemia, chronic eating disorders or diseases requiring a special diet, or serious dental disease interfering with adequate nutrition.

3. Services will be offered by HCH dietician upon request of the provider or by referral from the case coordinator.

D. Postpartum nutrition services include:

1. Maternal nutritional assessment

2. Infant nutritional assessment

3. Update care plan as appropriate

4. Basic postpartum guidance - review HCH postpartum/nursery teaching care plan. (See Addendum #6)

XII. SOCIAL/PSYCHOLOGICAL SERVICES

A. Qualifications - Development of the care plan and basic guidance will be offered by the case coordinator or designee. Specialized services will be provided by the Hackettstown Community Hospital Social Services Department.

B. Responsibilities

1. Assessment will be reviewed (POPRAS form).

2. Financial screening will have been done at presumptive eligibility determination. Copy to case coordinator.

3. Services client is receiving will be reviewed.

4. Social/psychological assessment to include review of living conditions, family support system, client's perception of problems/needs/concerns, and attitudes. For specific risk factors, see Addendum #7.

5. Client will receive initial orientation and information on community resources.

6. Client will receive referrals, follow-up and support for basic social services.

C. Specialized Social/Psychological Counseling

1. Hackettstown Community Hospital's Certified Social Worker will review client's initial assessment within one month of intake interview.

2. Based on risk assessment factors determined by the Licensed Certified Social Worker, the need for complex or intensive services will be determined and appropriate referrals made.

D. Postpartum Social/Psychological Assessment

1. Records of prenatal, hospitalization and POPRAS form will be reviewed.

2. Mother/baby interaction and bonding will be evaluated.

3. Family dynamics will be assessed.

4. Mother's goals will be reviewed.

5. Need for additional services will be identified and appropriate referrals made.

XIII. HOME VISITS

The purpose for visits includes assessment, education, support and advocacy. Clients will be identified as needing additional support based on noncompliance with the care plan risk factors developing during postpartum period, referral from HCH staff, clients of infants with health problems, parent suspected of parenting problems, and clients who have difficulty understanding and following instructions or linking with needed services. These criteria are subject to the clinical judgment of the case manager in conjunction with other team members.

A. Prenatal

1. For the client identified as needing additional support, during a prenatal assessment, at least one home visit will be made, with additional home visits as indicated.

2. Any client may receive a home visit if deemed appropriate.

3. Home visits will be made by referral to Warren County Public Health Department.

4. Clients will be identified as needing additional support based on noncompliance with the care plan.

B. Postpartum

1. For the client identified as needing additional support, at least one postpartum home visit will be made, with additional home visits as indicated.

2. Any client may receive a home visit if deemed appropriate.

5. Home visits will either be made by the case coordinator, her designee or by referral to the county VNA. Clients enrolled in Medicaid HMO's will have a skilled nursing home visit per HMO policy.

4. If the nutritional or social service specialist reviewing the assessment determines the client to be in need of additional support, they will document in the narrative section of the

POPRAS form. The medical care provider will be responsible for the physical exam, documenting prenatal and postnatal visits and will collaborate on the medical care plan.

C. Coordination of Visits

1. All visits are coordinated by the case manager, who:

   a. Identifies needs for visit based on the care plan.
   b. Makes the visit or writes a referral including time frame in which it is to be completed.
   c. Referral is given to Hackettstown Community Hospital's social worker who will contact VNA
   d. Plans specific goals and objectives of the visit.
   d. Writes or obtains a written summary on each visit including: date, agency, name of visitor, activities conducted and outcomes.

2. For ongoing home visiting, the case manager will confer with the provider at least monthly.

3. Visits for skilled nursing care will be arranged through local home health agencies by the social worker.