SUBPART H – Services to Enrolled Pregnant Women **5-22**

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Subpart H — Services to Enrolled Pregnant Women

§1302.80 Enrolled pregnant women.

Head Start Performance Standard Number	Who is Responsible	Who Implements	Timelines or Ongoing	Form Name
1302.80 (a) (b) (c)	Health Coor.	HB Teacher	Intake Visit & On-going	*Pre-natal Health Assessment, Referral Form, Prenatal Birth of Baby, Change of Status, Prenatal Social Service Release to Health Department*

(a) Within 30 days of enrollment, a program must determine whether each enrolled pregnant woman has an ongoing source of continuous, accessible health care – provided by a health care professional that maintains her ongoing health record and is not primarily a source of emergency or urgent care – and, as appropriate, health insurance coverage.
(b) If an enrolled pregnant woman does not have a source of ongoing care as described in paragraph (a) of this section and, as appropriate, health insurance coverage, a program must, as quickly as possible, facilitate her access to such a source of care that will meet her needs.
(c) A program must facilitate the ability of all enrolled pregnant women to access comprehensive services through referrals that, at a minimum, include nutritional counseling, food assistance, oral health care, mental health services, substance abuse prevention and treatment, and emergency shelter or transitional housing in cases of domestic violence.

<u>Expectant Mothers Enrolled in the Home Base Program</u>
The Home Based Teacher completes a *Prenatal Health Assessment* form during intake visit on all enrolled expectant mothers and fathers. This form assesses what providers (medical, dental, WIC, & health insurance) are being used. If they do not have the above, referrals are made on the intake visit (see referral process). The Home Based Teacher then assists the family as needed in following the scheduled care visits. Status and support of these scheduled visits (medical & dental) is documented on the *Prenatal Health Screening Progress Sheet*. (See Subpart E – Family Partnership Service and Home Visiting Training Guide) (See Subpart B – Health 1302.42 (a) (2) and 1302.46 (2) (i) for medical, dental, and health insurance referrals).

The *Prenatal Health Assessment* form also includes assessment of nutritional status, food assistance, oral health care, substance abuse prevention and treatment, emergency shelter or transitional housing in cases of domestic violence. Referrals for assistance are made as needed for each need. A risk assessment is also obtained so mental health interventions and follow-up treatment services can be arranged for as needed. If risks are identified, the mental health consultant may be contacted for advice and or intervention upon approval from Disabilities/Mental Health Coordinator.

While doing the *Prenatal Health Assessment* the Home Based Teacher will explain to the expectant mother that a health department nurse will be doing a home visit with her and the baby within two weeks of the baby being born. The HBT will have the expectant mother sign a *Prenatal Social Service Release to Health Department* form and email to the Health Coordinator. The Health Coordinator will

then contact the health department and inform them that we have an expectant mother enrolled and email/fax the release to them, so they have contact information and expected date of birth.

The last page of the *Prenatal Health Assessment* form has a place to document results of prenatal visits to the doctor and the dentist, along with education received on fetal development, good nutrition, infant care, safe sleeping, and benefits of breastfeeding. This information is provided through routine handouts and the PAT curriculum.

After the birth of the baby, the HBT will fill out the *Prenatal Birth of Baby* form during the Post-Partum Contact and email to the Health Coordinator. The PPC can take place over the phone or in person. A full 1 & 1/2 hour visit is not required at this time. The PPC is the mom's drop date and must be called in to Family & Community Services Coordinator or Health Coordinator right away. This will start the enrollment process for the baby.

When the Home Based Teacher sees mom in person, they will fill out the fillable *Change of Status* form seeing proof of birth and email to the Family & Community Services Coordinator. The HBT will communicate with the Family & Community Services Coordinator as to when the child will be accepted for the program and when an intake visit will be done.

The Home Based Teacher will remind parent of home visit from the local health department within two weeks of delivery. The Health Coordinator will notify the health department to inform them the baby has been born and a visit is needed. Once the visit is made, staff will fill out the top section of the Post-Partum Recovery form addressing the well-being of the mother and baby.

Head Start Performance Standard Number	Who is Responsible	Who Implements	Timelines or Ongoing	Form Name
1302.80 (d)	Health Coor.	HB Teacher,	Intake Visit & On-going	*Infant Follow Up Form*

(d) A program must provide a newborn visit with each mother and baby to offer support and identify family needs. A program must schedule the newborn visit within two weeks after the infant's birth.

Health Departments provide the service of visiting newborns and their mothers. These services are obtained through contracted services of health staff at the Health Departments.

The Health Coordinator emails the health department when the baby is born so they can contact the parent to set up the visit. The Home Based Teacher works with the family to assure this two week check is made. The health department will send results of this visit along with the invoice for payment. The result of the visit includes information on the well-being of both the mother and the baby.

§1302.81 Prenatal and postpartum information, education, and services.

Head Start Performance Standard Number	Who is Responsible	Who Implements	Timelines or Ongoing	Form Name
1302.81 (a) (b)	Health, HB ED, MH/Dis & SS Coor.	FA, & HB Teachers	Ongoing	*HVR, Prenatal Health Assessment, Edinburgh Postnatal Depression Scale*

a) A program must provide enrolled pregnant women, fathers, and partners or other relevant family members the prenatal and postpartum information, education and services that address, as appropriate, fetal development, the importance of nutrition, the risks of alcohol, drugs, and smoking, labor and delivery, postpartum recovery, parental depression, infant care and safe sleep practices, and the benefits of breastfeeding.
(b) A program must also address needs for appropriate supports for emotional well-being, nurturing and responsive caregiving, and father engagement during pregnancy and early childhood.

The Home Based Teacher provides and explains to the mother and father (caregivers) handouts and information on prenatal and postpartum information and education, fetal development, the importance of nutrition, the risks of alcohol, drugs, and smoking, labor and delivery, postpartum recovery, parental depression, infant care and safe sleep practices, father engagement, and the benefits of breastfeeding by using the PAT Curriculum, and handout list. Staff will document handouts given on the HVR and or Prenatal Health Assessment.

The HBT explains and has the mother complete the Edinburgh Postnatal Depression Scale when the baby is 6-8 weeks old. The Health Coordinator will send an email reminder when this is due. It is scored and referrals are made as indicated by the scale. The score and results of any referrals made are logged on the bottom section of the Post-Partum Recovery form and emailed to the Health Coordinator, along with page three of the Prenatal Health Assessment, and Prenatal Health Screenings Progress Sheet. The originals can then be shredded. Information on Post-Partum Depression is given to the parent through handouts and the PAT Curriculum as needed. Referrals to the Mental Health Consultant can also be made.

§1302.82 Family partnership services for enrolled pregnant women.

Head Start Performance Standard Number	Who is Responsible	Who Implements	Timelines or Ongoing	Form Name
1302.82 (a)	SS, Health, & HB ED Coors.	Home Based Teachers, Family Advocates	Ongoing	*Family Partnership Survey*

a) A program must engage enrolled pregnant women and other relevant family members, such as fathers, in the family partnership services as described in §1302.52 and include a specific focus on factors that influence prenatal and postpartum maternal and infant health.

Expectant parents have the opportunity to learn about prenatal and postpartum maternal and infant health while doing the Family Partnership Survey with their Home Based Teacher. (See subpart E –

Family Engagement - 1302.50 and Family Partnership Service - 1302.52) (Also see subpart D – Child Health Status and Care - 1302.45)

Head Start Performance Standard Number	Who is Responsible	Who Implements	Timelines or Ongoing	Form Name
1302.82 (b)	SS, Health, & HB ED Coors.	Home Based Teachers, Family Advocates	Ongoing	*Birth of Baby*

(b) A program must engage enrolled pregnant women and other relevant family members, such as fathers, in discussions about program options, plan for the infant's transition to program enrollment, and support the family during the transition process, where appropriate.

The HBT completes an Intake Visit with the parent/baby within two weeks of PPC. This visit enrolls the child in the mother's slot and services continue on a weekly basis. Program options and transition to other services needed is discussed during the Intake Visit with the family members, in the third trimester of the pregnancy, and after birth when completing the *Birth of Baby* form.