Babies First! and CaCoon

Manual 2024- Chapter 6

PUBLIC HEALTH DIVISION
Maternal and Child Health

CONTENTS

SERVICE PROGRAM AND ACTIVITIES

Visit Schedule

Babies First! and CaCoon services are crafted to be family-centered and flexible to meet the unique needs of the families and communities we serve. The Public Health Nurse (PHN) works in partnership with the client to co-create a plan of care to meet individual needs. The client's plan of care is informed by the nursing process with the frequency of routine visits tailored to the client's preferences, acuity and needs. The visiting schedule may also include a CHW if they provide case management according to the nursing plan of care. Regardless of the customized approach, all clients should receive:

- Initial Visit scheduled with the PHN
- Routine Visits scheduled with PHN, recommend a minimum of once a month (or every three months if a CHW is visiting monthly)
- Closing Visit scheduled with PHN

Model variation: CaCoon

The PHN may scale back contacts to as few as every three months if the family's situation or the child's condition has stabilized or requires only periodic monitoring.

Model variation: Community Health Worker (CHW)

A CHW can provide home visits in collaboration with a PHN by providing co-case management. A CHW may conduct client visits between nurse appointments to support the client based on the nursing care plan. This collaborative and flexible visitation model allows PHNs and CHWs to partner with families to determine the best visitation schedule. This ensures that the unique needs of each family are addressed, while aligning with the guidelines and standards set forth by both the Babies First! and CaCoon programs.

Initial Home Visit

For both Babies First! and CaCoon, the initial home visit should be offered within one month of receiving the referral and should only be completed by a PHN. The nurse should plan for the initial visit to be up to two hours long.

In the instance where there is a waitlist and the initial home visit cannot be completed within one month of a client accepting a visit, the client should, at a minimum, be connected to OHP and a primary care provider. Referrals to other home visiting providers or community services is also recommended when possible.

The initial home visit is an opportunity to slowly get to know the family and should be client centered and client led. The PHN uses open ended questions and a soft touch to complete an initial needs assessment and create a nursing plan of care.

The items that a PHN must complete if the client/family accept services during the initial visit include:

- Program and services overview
- Agreement for services:
  - **Informed consent** for program and data collection
  - **HIPAA, privacy, and communication agreements**
  - Any County/agency specific paperwork or policy
  - **TCM Assessment/Plan, including establishing client goals**

HOPEful moments:

Every encounter is an opportunity to spotlight strengths within the family.

- During the visit, celebrate moments of bonding and name PCEs you notice
- Create a safe space by reminding families that sharing information is optional. Acknowledge they are not obligated to go into detail.
- Close with positive and HOPEful messaging

Several assessments should be done within the first three visits to establish a relevant and applicable nursing plan of care. These are listed in Activities Table 1 under the Frequency Recommendation of “Initial Visit".

Note:

Each client accepting services needs to complete an initial visit, including individual care plans and enrollment paperwork. Example: A PHN is enrolling a parent and baby at an initial home visit. The nurse will provide one program and service overview but will need the parent to sign two sets of program consents, one for themselves, and one for the baby.

Minor Consent

Youth aged 15 years and older must consent to receive services. In Oregon, the legal age for giving consent to care is 15. There are no specific laws for CYSHCN nor for youth with physical or intellectual disabilities. This means that you would follow consent processes just as you would for any other youth. Youth enrolled in a program prior to their 15th birthday should sign consents by their 15th birthday to continue receiving services.

Though Oregon law does not give minors a "right" to confidentiality nor parents a "right" to disclosure**, it is recommended that youth 15 and older sign a release of information form permitting parents to discuss their youth's health needs with home visiting staf**f. More information regarding minor consent and confidentiality from the Oregon Health Authority can be found here. Frequently asked questions on working with clients in DHS custody can be found here.

CaCoon and Babies First! staff can encourage families to start a conversation with their youth regarding HIPAA laws and confidentiality. They can explore who will provide decision-making support if the youth needs or desires it. CaCoon staff can support the family in understanding the youth's ability to understand and provide informed consent. Evaluation of the youth's capacity to consent is an essential step in promoting their autonomy and involvement in their healthcare decision-making process. It is crucial to educate and support youth before signing consent and release of information documents so that they understand what consent and confidentiality mean. This practice aligns with Supported Decision Making practices and promotes informed healthcare decision-making for transition-aged youth.

Routine Visit Schedule:

The PHN and client/family decide the frequency of routine visits when they create the plan of care together. The routine visit schedule is centered on the client's preference but should also consider the PHN acuity assessment, nursing diagnoses, client needs, and best practice recommendations based on population. It is likely that frequency of visits will fluctuate during the client's enrollment and as the client begins to utilize needed services or develops additional needs.

In general, it is recommended that all clients/families be offered monthly visits. Evidence shows that frequency of visits has a positive effect on child development (11). Other evidenced based models have shown measurable outcomes using frameworks of frequent visiting.

Client factors that affect visit frequency include, but are not limited to family preference, client's medical home status, whether community support is established, and if the client will have an anticipated increase or decrease in needs based on family or client age/stage.

Best practice guidelines based on the client population also effects visit frequency. For instance, it is best practice to provide a home visit for a newborn baby within 2 weeks of birth; therefore, it would not be appropriate to visit this client every 2 months. On the other hand, a 2-to-3-month schedule may be appropriate with a CaCoon client who has established support from Early Intervention (EI) with an Individualized Family Service Plan (IFSP). For more on population-specific frequency, please review the applicable activity table, links to clinical guidelines, and review the THEO collection schedule.

Assessment and THEO Data Collection Schedule:

While the frequency of visits should be customized to align with the specific needs of each family, it's important to note that best practice guides timeliness of activities like developmental assessments, client screenings and education. The state data collection schedule is meant to align with typically expected case management activities based on the client's age or developmental stage. Every visit should be documented in THEO using the Every Visit Survey. The THEO data collection schedule below identifies additional data that should be entered. This data collection schedule should be considered when determining the timing of visits and completion of other data collection surveys.

THEO Data Schedule

Prenatal: 32-40 weeks
Postpartum: 1-8 weeks, 6 months, and 1 year
Infant and Young Child: Birth-2 months, 6, 8, 12, 18, 24, 30, 36, 42, 48, and 54 months
Child and Youth: Every 6 months
Parent/Caregiver: Every 6 months

Model variation: CHW

Either a CHW or a PHN may complete the data collection surveys; however, if a CHW has not been competency validated and assigned to conduct specific assessments (e.g., ASQ), they will not be able to complete the full Periodic Assessments (such as the Infant and Child Survey or Child/Youth Survey). In instances where these comprehensive surveys are due, we strongly recommend that the visit be scheduled with a PHN to ensure complete an accurate data collection.

Closing Visits:

When a family is prepared to transition out of the program, a final visit should be conducted by the PHN. Ideally, subsequent needs and referrals for transition out of the program would be addressed at previous visits and the last visit is a home visit used to celebrate or “graduate" out of the program. Give thought to other programs and community resources that can serve as supports for the client and family after they are ready to leave the program. Making those connections before discharge can smooth the transition and minimize risk of interrupting their momentum. This is sometimes called a “warm hand-off."

Outlined below are considerations to help home visitors in determining how ready a family is for closure. This is not meant to be a checklist and families don't need to meet all criteria.

Perinatal people enrolled during pregnancy

Consider graduation from the Babies First! Program if:

- A post-partum check-up has been completed
- A Reproductive Health Plan is in place
- There are no concerns about mental health, or mental health services are in place.
- There are no concerns about substance use, or support/treatment services are in place.
- A support system has been identified.
- Breastfeeding is going well, or other feeding plan is in place.
- A primary care provider/medical home has been established.
- A TCM Assessment shows that the client does not need services or declines assistance accessing and/or utilizing needed services.

Infants and children

Consider discharge from the Babies First! Program if:

- A primary care provider/medical home has been established.
- A support system has been identified.
- No concerns about growth and development.
- No concerns about child safety.
- No concerns about parent child interaction.
- A primary care provider/medical home has been established.
- A TCM Assessment (See Chapter 4) shows that the client does not need services or declines assistance accessing and/or utilizing needed services.

When continuing to maintain a client on the Babies First! Program beyond two years, seek the advice of your supervisor. Discuss transition plans with the family and review clear goals and timelines.

At times, closure of a case happens abruptly; for instance, if a family moves or does not make contact again (lost to follow up). There are many scenarios that make it difficult to “celebrate" the case closure or where a visit in the home is not possible. In these cases, it is still important to make

a good faith effort to have a final visit (e.g., via telephone) with clients to address any unmet needs and, if possible, refer for alternative support. If a final visit is not possible, **case closure must be documented in the client's medical chart and a Discharge Letter sent to the client**.

It is recommended to **discharge clients who have not been visited in three months (unless visits every 3-6 months is in the care plan).** If clients are willing to re-engage later, they may be re-enrolled in the program.

If a final visit is possible, below are some topic ideas for a strength-based closure visit:

- **List goals** that have been **completed**, no matter how "small" they may seem.
- **Name HOPEful moments** you have seen, like bonding/enjoying baby, being responsive to crying child during the visit, and family making it to these appointments.
- **Summarize some of the topics** you have explored together- especially those of interest to the family.
- **Summarize the next steps** for the family.
- If applicable, state they are always welcome to contact the agency to reestablish Nurse case management service.

Note: Example

"One goal was to make it to your postpartum appointment, and you did it! That is no small feat while recovering! I commend you for taking care of yourself in that way."

Note: Example next steps

"So, this is our last visit, can you tell me how you're feeling about this next stage? And let's review who you'll reach out to after today." Followed by, "So let me recap your plan. [Child] is enrolled in Head Start and you have great support from them and your pediatrician. Moving forward, if you have healthcare related questions, your plan is to contact you PCP or send a message through MyChart. And for other community support, your Family Support Specialist can help you at Head Start. Is that correct?" followed by "At any point if you find yourself needing more support for some reason, please contact us and we can explore if opening your case again would be helpful. Do you still have my contact information?"

Things to consider about case closure:

Have you explored long term planning with the caregiver/adult client about professional development and self-sufficiency?

- "Do you picture yourself back in the workforce at some point? If so, do you have an interest we could explore?"

- Have you considered work training/support or going back to school? You qualify for benefits being a parent. Do you know about Financial Aid?
- Have you thought about establishing Credit or exploring debt relief?
- Does the parent qualify or possibly qualify for DD services or TANF even if they are not accessing?

Do they anticipate, and are they planning for, the child's next development phase or life transition?

- Transfer to kindergarten or schools (ex: IFSP to IEP)
- Are they able to complete an ASQ and ASQ-SE independently and advocate for needed services?
- Can they verbalize the safety issues with the next age/stages?
  - » Example: learning to crawl/walk and needing to babyproof
  - » Transitioning to solids and learning about choking hazards and family style eating
  - » Preparing for the transition to preschool or kindergarten
- Do they have family rules and routines established?
- Have you explored discipline techniques and what to do when there is conflict?

Routine Visit Structure

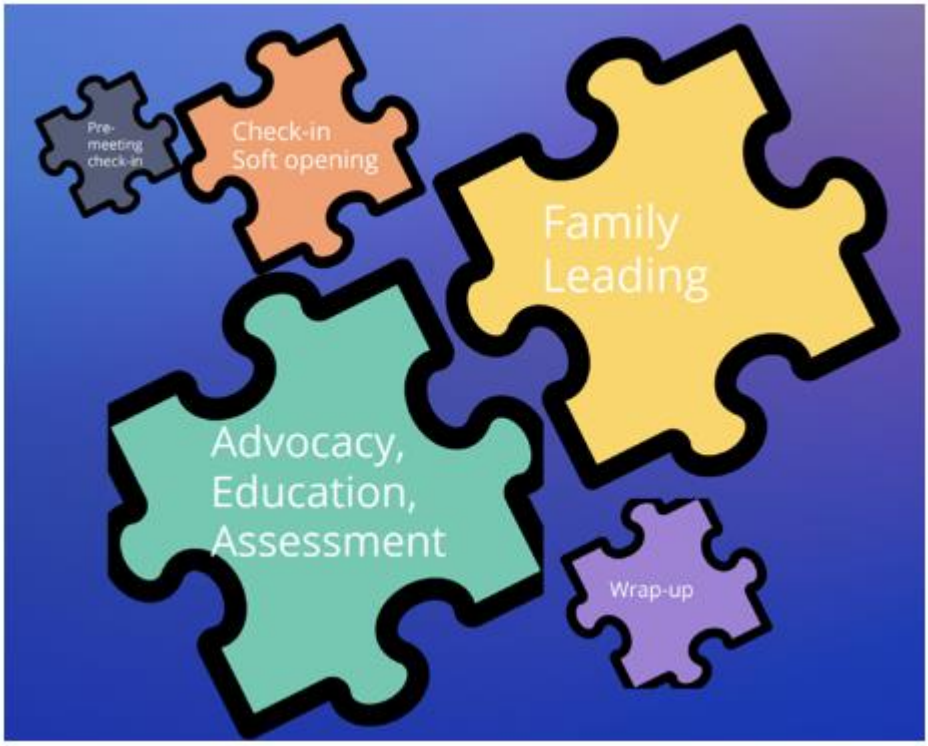
The Babies First! and CaCoon programs are crafted to be family centered programs with visit structure consisting of activities and topics informed by evidenced-based best practice and client interests. The 2023 Babies First! Program Evaluation highlights that while program implementation can look very different across Oregon's counties (staffing, population reach, etc.) there is a fundamental structure of a visit that consists of 5 main pieces.

Best Practice: Meeting Structure

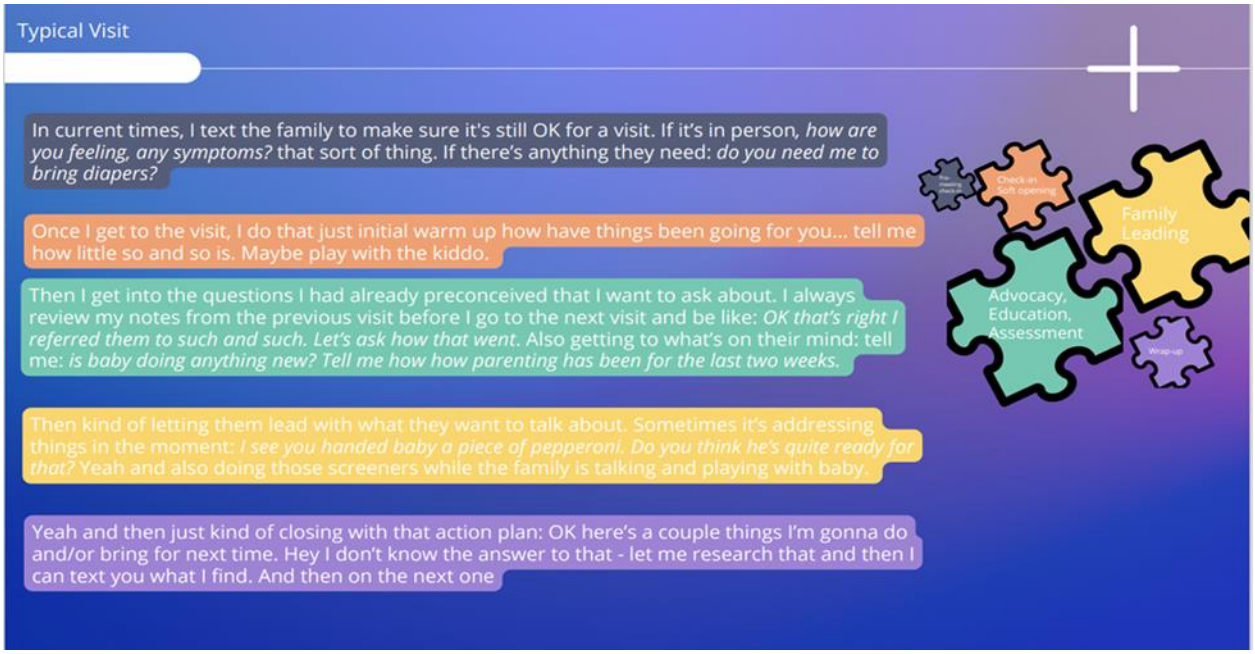
- Pre-meeting check-in
- Check-in soft opening
- Assessment, Education and Advocacy (also known as Care Coordination and Case Management)
- Family Leading
- Wrap-uprap-up

These 5 pieces can be thought of as puzzle pieces that are changing in size at each visit. Using the

pieces does not have an order (non-linear), and all the pieces may not be used together at every visit. These pieces are consistently implemented with family empowerment at the core.



Using the 5 pieces of a home visit: in the words of a Babes First! Nurse Home Visitor



Pre-Meeting Check-in

- Appointment reminder
- Home Visitor preparation:

    - Chart review
    - Gathering anticipated materials –educational handouts, referral forms, HV supplies
- Client screen for symptoms of illness (e.g., cough or sore throat), as indicated by local and state policy for infection control.

> Nurse bags should contain stethoscope, BP cuff, thermometer, eye pen light, basic first aid kit (such as available from a grocery store), weight machine, and length measure. Optionally, it may have cleanable toys.

Check-in Soft Opening

Entering a neighborhood and household is always a time to do a quick and friendly safety check. Usually, this starts by introducing yourself and asking permission to enter or proceed with visit (even if it's implied, and even if you have been there multiple times). When entering a household, it's always a good idea to greet everyone present. This helps you know who else is in the house, promote **community engagement**, and can **support the client with transitioning into the visit safely**.

Set the stage:

- Offer non-choking toys, or for older children, coloring or puzzle
- If a TV is on, ask permission to turn it off. Consider using this opportunity to engage in teachable moments, parallel play with the child, and promoting parent/child interaction and bonding.
- Ask permission and then set out prompts for the activity on the visit schedule, like a baby scale, blood pressure cuff, or educational material you are planning to share. This acts as a visual to identify the next task that is coming during the visit.
- Use the FAN approach
    - Start with routine opening questions that centers the client
    - Check in about “in the moment" needs.

Case Management/ Care Coordination:

After a soft check-in, home visitors may use a variety of technique to keep the visit client centered and conversational in format. This collaborative process of using the nursing process for assessments, planning and interventions is also known as case management, and often used interchangeably with the term care coordination.

Care coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective care (Agency for Healthcare Research and Quality). Care coordination is identified by the Institute of Medicine as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers. The Babies First! and CaCoon programs have utilized an approach that incorporates evidence informed Nurse home visiting activities with Targeted Case Management.

“Home visiting activities" is a family centered way we can define some of the nurse case management interventions. These activities can be filtered into three broad buckets:

- Assessments
- Education, and
- Advocacy

Key Activities

Assessment, Education, Advocacy: These three board terms are often used to refer to other PHN interventions listed in Figure 1. For more details about specific nursing interventions and evidence that guides these activities, please review Public Health Interventions: Applications for Public Health Nursing Practice.

Assessment

Every enrolled client needs an initial nursing assessment and plan completed and documented. It is important to note that some assessments, like breastfeeding or environmental exposure, may overlap for your clients. In these cases, an overarching assessment is appropriate, but individual client assessment should also be documented.

Figure 4 below shows major assessment topics by population groups. Likewise, the Activities Section Table 1 includes a detailed chart of assessment by population and frequency. Assessments should be done in a HOPE-informed way.

Figure 4: Major assessment topics by population group

Education

According to Oxford dictionary, **education** is defined as “an enlightening experience." For the purposes of home visiting, client education occurs during “educational moments" when the client is engaged and participating with the home visitor in learning. The Public Health Nursing Wheel

defines some of these moments more specifically as: Counseling, Health Teaching, and Consultation. For instance, Counseling is defined as “establishing an interpersonal relationship at an emotional level, with the goal of increased or enhanced capacity for self-care and coping" and “explores the emotional response to integrating new health information into life's circumstances" (pg. 142).

Recommended topics to address by population (e.g., pregnancy, post-partum, childhood) are covered in Activities Section Table 1.

Advocacy

Advocacy is defined by Public Health Interventions: Applications for Public Health Nursing Practice manual as **the act of promoting and protecting the health of individual and communities** by collaborating with relevant stakeholders, facilitating access to health and social services, and actively engaging key decision-makers to support and enact policies to improve community health outcomes. Possible advocacy roles are:

- **Accompanying**: Speaking with people
- **Representative**: Speaking for people
- **Empowering**: Enabling people to speak for themselves
- **Mediating**: Facilitating communication between people
- **Modeling**: Demonstrating practice to people and policymakers
- **Negotiating**: Bargaining with those in power
- **Networking**: Building coalitions with other individuals or organizations

This definition of **advocacy embodies the foundation from where a Nurse provides care** coordination and case management through home visiting. Advocacy is used as a Nursing intervention after partnering with the client to assess needs to determine next steps.

Major components of care coordination involve ensuring that families are aware of services and how to access them. The care coordinator should be familiar with a wide range of community resources, including (but not limited to):

- Primary, secondary and tertiary health care (including mental health and behavioral health services)
- Speech, language, vision and hearing resources; early intervention programs
- Respite care and childcare services
- Financial assistance programs
- Parent groups

- Advocacy groups
- Transportation services
- Local, state and federal offices

HOPEful Moment: Referrals

- Celebrate what the family is already doing for PCEs in the area you are referring for.
  - E.g., early Intervention referral for ASQ follow up for communication.
- Highlight what the family is currently doing to support communication development.
  - "I see you have children's books available, and it sounds like you are reading with (child) every day. This is fantastic for development! And when (child) is listening to you read or sing, they are learning 'receptive language'. These are all important piece you are already doing! This referral may simply help give us ideas about more support and helpful tips."

Referring families to services involves much more than just giving families a brochure or number to call or a form to fill out. They may need information, support and/or follow up to navigate services and comfortably make decisions about care. In addition, the nurse or CHW need to be certain that the agency to which the family is being referred is the right one to meet the need (are they accepting clients? Are they trauma informed?) More harm than good will be done by referring already stressed families to an agency whose services do not or will not match the need. Provide follow up for families to ensure they are not experiencing barriers in receiving services to which they have been referred. **An identification of new barriers usually indicates a need for additional assessment, documentation, and possible change or shift in goals.**

Best Practice: Trauma Informed Care

- More harm than good will be done by referring already stressed families to an agency whose services do not or will not match the need.
- The nurse or CHW need to be certain that the agency to which the family is being referred is the right one to meet the need (are they accepting clients? Are they trauma informed?)

Family Leading

Family leading is at the heart client centered case management for our home visiting programs. This trauma informed approach explores and appreciates the client and family perspective of health and needs. This approach also demands that the home visiting staff and program agency have a practice in exploring and supporting cultural humility and addressing implicit and explicit bias.

Ways home visitors can support clients/families:

- Supporting and advocating for client preferences, such as pronoun use.

- Using strength-based approach and language, like the HOPE framework.
- Learn and strengthen your individual and agency's Trauma Informed Approach with support from Trauma Informed Oregon.
- Stay familiar with National resources for family-centered approaches, including assessments, reports, and approaches.

Wrap Up

The end of each home visit should include a **summary of home visiting activities,** what the client has or wants to accomplish, what both the client and home visitor have agreed to do, and the planned topics for the next visit. This is also a good time to schedule or confirm the next visit time and plan for follow up from the nurse and/or CHW. Encouraging the client to provide teach back and reviewing emergency plan between visits is also recommend.

Wrap Up Documentation Example:

Client will reach out to Nurse or CHW with any questions or concerns about plan but will contact doctor, 911, or go to emergency room for any urgent health matter. Client verbalizes understanding and agreeable to plan with next visit scheduled for 4 weeks (put exact date)

Activity Tables by Population

HOPEful moment:

Prepare your client for screenings by providing information beforehand:

- Explain the screener and the kinds of questions you will be asking.
- Explain why you are conducting the screening.
- Remind family that this is optional.

Schedule for a time in the future when parent can feel prepared to discuss.

The major population groups are:

1. Prenatal
2. Postpartum (up to one year post birth)
3. Newborn (under 1)
4. Young Child (1-5 years of age)
5. Child/Youth (5-21 years of age)

6. Caregiver
7. Community

Table 1. Activities Table

Table 1 includes a detailed chart of assessment by population and frequency.

Visit the manual online to enable links to resources.
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Pages/Services-and-Program-Activities.aspx

Assessment Topic	Population	Frequency Recommendation	Clinical Guideline Reference	Education and Advocacy Resource Link	Path
Blood Pressure	Prenatal, Postpartum	Prenatal: Every Visit Postpartum: Normotensive: every visit until 6 weeks postpartum Hypertensive: every visit until hypertension is back to baseline	Blood Pressure Assessment Guideline	CDC: High Blood Pressure During Pregnancy	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Breastfeeding Promotion	Prenatal, Postpartum, Infant	Initial Visit 3rd Trimester Postpartum, Every Visit (while breastfeeding) Infant, Every Visit (while breastfeeding) As needed	Breastfeeding Promotion and Support Guideline	La Leche League: Breastfeeding info (multiple links depending on need) NIH Breastfeeding Melanated Mammary Atlas	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Car Seat Safety	Prenatal, Infant, Toddler	Newborn; 1-2 months; 3 months; 4 months; 6 months; 12 months; 18 months; 24 months	Note: it is appropriate to ask about car seat safety in pregnancy to prepare family for baby's birth and to ensure pregnant people wear correctly	Car Seat Safety Oregon Occupant Protections Program: Child safety seat laws and resources	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

Home Health and Environmental Exposure (review for changes every visit)	Prenatal; Postpartum ; Infant; Toddler; Caregiver; Youth	Prenatal Newborn, Infant, Toddler Child, Youth, and Caregiver: Initial and every 6 months As needed	Environment and Environmental Exposure Guideline	March of Dimes: Pregnancy and RadiationCDC: Toxoplasmosis CDC: Lead Poisoning Prevention in Pregnancy CDC: Reproductive Health and the Workplace, Pesticides	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Emergency Preparedness	Prenatal; Postpartum ; Infant; Toddler; Caregiver; Youth	Initial (within first 5 visits) Every 6 months	Coming Soon	Oregon Family to Family Emergency Planning and Safety Ready.gov: Family Emergency Communication Plan	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Prenatal History and Physical Assessment	Prenatal	Initial, annually Focused Assessment As needed	Prenatal History and Physical Assessment Guideline	Just in Time Health Education: 1st Trimester 2nd Trimester 3rd Trimester Becoming a Father booklet (March of Dimes)	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Gestational Diabetes Mellitus	Prenatal; Postpartum	Initial Visit	Perinatal Gestational Diabetes Assessment Guideline	CDC: Gestational Diabetes and Pregnancy UpToDate	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Growth and Development	Infant; Toddler;	4 months; 6 months; 10 months; 12 months; 18 months; 24 months; Q 6 months; after 24 months	Newborn, Infant, Toddler Developmental Screening Guideline	Act Early: Milestones in Action Videos ASQ -3 ASQ-SE	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Weight Gain in Pregnancy *TIC Consideration	Prenatal	Every Visit	Prenatal Weight Assessment Guideline	John's Hopkins: Nutrition and Pregnancy CDC: Weight Gain During Pregnancy	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

History and Physical Assessment	Prenatal; Postpartum ; Infant; Toddler; Youth	Initial Visit As needed	Prenatal History and Physical Assessment Guideline Newborn, Infant, Toddler History and Physical Assessment	Just in Time Health Education: 1st Trimester 2nd Trimester 3rd Trimester	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Intimate Partner Violence (Unless client led, wait to initiate this topic until after a relationship with Home Visitor is established)	Prenatal; Postpartum ; Caregiver	Initial Visit(s) 1-5 3rd Trimester As needed	IPV Screening Guideline	Futures Without Violence: Healthy Mom, Happy Babies Home Visitation Safety Card Futures Without Violence: Safe Home, Safe Babies Home Visitation Safety Card	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Nutrition	Prenatal; Postpartum ; Infant; Toddler; Caregiver; Youth	Initial Visits As Needed	Prenatal, Postpartum, Infant and Toddler history and physical assessment Breastfeeding Promotion and Support	Formula Feeding Safety	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Oral Health	Prenatal; Postpartum ; Infant; Toddler; Youth	Perinatal; Newborn;1-2 months; 3 months; 4 months 12 months; 18 months; 24 months; Every 6 months after 24 months	Prenatal/Postpartum History and Physical Assessment Newborn, Infant, Toddler History and Physical Assessment Oral Health Screening Guideline	Teeth for Two Brochure Infant Oral Care 4 Month Infant Oral Care Bright Futures PocketGuide	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

Parent-Child Interaction	Postpartum; Infant; Toddler; Caregiver	Newborn; 1-2 months; 3 months; 10 months; 12 months; As needed	Parent Child Interaction guideline	The National Center for Pyramid Model Innovations (NCPMI): Family-Child Relationship Behavior Regulation	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Period of Purple Crying	Infant	Newborn; 1-2 months; 3 months		Consider Dose Two ofPeriod of Purple Crying	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Perinatal Substance Use	Prenatal; Postpartum	Initial Visit; 3rd Trimester; As needed	Substance Use Screening Guideline	CDC: Substance Use During Pregnancy WIC: Substance Use and Medication Safety CDC: Alcohol-Free PregnancyCDC Treating for TwoMarijuana and Your Baby	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

Perinatal Mood Disorders and Emotional Health	Prenatal; Postpartum ; Caregiver	Initial Visit; 3rd Trimester (for prenatal); Post-Partum; As needed	Mood Disorder Screening Guideline	HRSA: Taking Care of Mom: Nurturing Self As Well As Baby Perinatal Mental Health Resources for Oregon Families Ten Facts About Depression and Anxiety in Pregnancy and Postpartum Depression and Anxiety During Pregnancy and Postpartum Perinatal Mood and Anxiety Disorders Fact Sheet Oregon Health Authority Maternal Mental Health Postpartum Support International: Supporting Postpartum Families Tips Para La Familia Para Prevenir Una Crisis de Postparto Tips for Postpartum Dads and Partners	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Reproductive Life Plan	Prenatal; Postpartum ; Caregiver; Youth	3rd Trimester; Postpartum (up to 1 year post birth), Initial; Youth , Caregiver, A s needed	Reproductive Life Planning Guideline	CDC: Planning for PregnancyCDC: Contraception NW Portland Area Indian Health Board:Trans and Gender Affirming Care 2020 Strategic Vision and Action Plan	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table
Safe Sleep	Prenatal; Infant	Pregnancy, newborn; 1-2 months; 3 months; 4 months; 6 months; 12 months; 18		Safe Sleep	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

		months; 24 months			
Social Determinants of Health	Prenatal; Postpartum ; Infant; Toddler; Caregiver; Youth	Initial Visit; As needed	Social Determinants of Health Screening Guideline	211 Info Oregon WIC	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Activities Table

Additional Health Education Topics and Resources:

Visit the manual online to enable links to resources.
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Pages/Services-and-Program-Activities.aspx

Fetal Movement	2nd Trimester: See section on Fetal Movement	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Getting Ready for Baby	CDC: Things to Think About Before Baby Arrives CDC: Safe Sleep March of Dimes: Newborn Screening	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Immunizations	CDC: Vaccines During and After Pregnancy	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Infections	CDC: Preventing Infection During PregnancyCDC: Perinatal Transmission of Hepatitis BCDC: Hepatitis C	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources

Labor and Delivery	March of Dimes Labor and Birth	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Nutrition and Physical Activity	CDC: Recommendations on Folic Acid March of Dimes: Nutrition, Weight, and FitnessCDC: Weight Gain During Pregnancy CDC: Physical Activity, Pregnant and Postpartum Women USDA Making Healthy Food Choices CDC: Physical Activity, Pregnant and Postpartum Women	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Social Network and Support	Fathers, Partners, and Family Support Postpartum Support International: Resources for Fathers	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources
Urgent Maternal Warning Signs	CDC: Urgent Maternal Warning SignsCDC: Hear Her Campaign	oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/BABIESFIRST/Lists/Additional Health Resources

HOPEful moment:

When you screen:

- Briefly review power of the brain to change.
- Review science of Positive Childhood Experiences and the power to offset health outcomes.
- Create a safe space to share, acknowledging that parent should not feel obligated to go into detail.
- Conduct screener or assessment.

HOPEful moment:

After you screen:

- Review PCEs that you have witnessed in the family.
- Celebrate with the parent the work they are already doing to create resilience and health for their children.
- Ask parent if they are interested in brainstorming more ways to create PCEs for children.
- Close with positive, HOPEful messaging.

Working with Interpreters

Interpretation services must be provided to all clients with limited English proficiency. All people acting as interpreters must be certified by the Oregon Health Authority, per House Bill 2359. See this website for more details. A CHW may act as an interpreter at a visit if they are certified and competency validated to do so. Use best practices for working with interpreters: detailed information on best practices can be found at the Center for Excellence of for Immigrant Child Health and Well Being, 9 Best Practices for Using an Interpreter for ASQ, and Association of American Medical Colleges Guidelines for Use of Medical Interpreter Services.

Considerations for CaCoon or clients with disabilities and/or special health care needs

Please Note: While the CaCoon program is specifically designed to support children and youth with special healthcare needs (CYSHCN) in Oregon, Babies First! may also serve clients (parents or children), who have disabilities or special healthcare needs. Therefore, the guidelines and considerations outlined in this section are equally applicable to families and Home Visitors involved in both CaCoon and Babies First! Programs.

This section focuses on some of the unique considerations required for providing high-quality, evidence-based care to this population. The guidance provided aligns with the National Care Coordination Standards for CYSHCN. The National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) serve as a critical framework for guiding high-

quality care delivery to this vulnerable population. Published in 2020 by the National Academy of State Health Policy, these standards are designed to ensure that care coordination for CYSHCN is consistent, evidence-based, and holistic. They are anchored in foundational principles that emphasize health equity, family involvement, cultural competence, and the use of evidence-based practices. These standards are of paramount importance because they offer a unified approach for healthcare professionals, enabling effective collaboration across various sectors including medical, educational, behavioral, and social services. There are 6 Domains:

1. Screening, Identification, and Assessment:
    - This domain focuses on the early and accurate identification of special health care needs through various screening methods and assessments. It sets the foundation for all subsequent care.
2. Shared Plan of Care:
    - This domain emphasizes the development of a comprehensive, family-centered care plan that is shared among all stakeholders, including healthcare providers, educators, and family members. The plan outlines the objectives, roles, and responsibilities for each party involved.
3. Team-Based Communication:
    - This area stresses the importance of effective and open communication among all team members involved in a child's care. It ensures that everyone is on the same page and collaboratively working towards the child's well-being.
4. Child and Family Empowerment and Skills Development:
    - This domain aims to actively involve families in the care process and empower them with the necessary skills and knowledge to manage their child's condition effectively.
5. Care Coordination Workforce:
    - This domain deals with the training, skill set, and continuous development of the healthcare workforce involved in coordinating care for CYSHCN. It underscores the need for professionals to be well-versed in best practices and emerging trends.
6. Care Transitions:
    - This last domain addresses the challenges and strategies involved when CYSHCN move from one care setting to another, such as from pediatric to adult healthcare, or from school to the workplace. It highlights the importance of a smooth and well-prepared transition to avoid gaps in care and maintain optimal health outcomes.

Understanding these domains enables home visitors to provide more comprehensive, effective, and coordinated care for CYSHCN and their families. You can read more in depth about these Standards here.

Core Knowledge:

Home Visitors need not be experts in every disability or chronic condition, but they should be knowledgeable about commonly occurring ones, understanding their potential impacts on child and family development. Home Visitors should know how to connect families with the appropriate specialists and resources.

Understanding the “diagnostic odyssey":

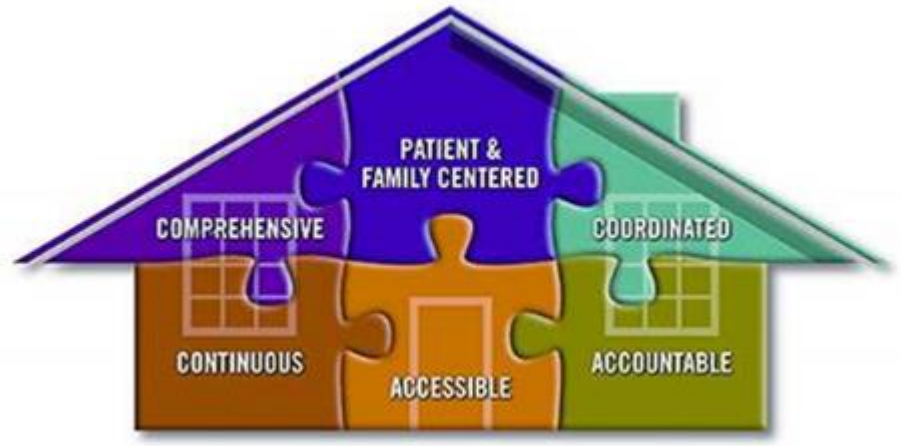
The journey to diagnose a child's disability or special health care needs varies greatly among families, both in how it begins and how it unfolds. For some, the process starts as early as during pregnancy, while for others, it might occur later in life due to an injury or noticeable developmental delays. This period of seeking answers is often termed the "diagnostic odyssey," a phase that can be emotionally taxing and prolonged, sometimes stretching over weeks, months, or even years. In some instances, families never arrive at a definitive diagnosis. The path of this diagnostic journey is highly individualized; some families may opt not to pursue a diagnosis at all, or to delay the quest for answers until their child is older. Home visitors can play a crucial role in supporting families during the "diagnostic odyssey." With their unique vantage point into the family's day-to-day life, home visitors can offer emotional support, share observations, and provide valuable resources or referrals to specialized services. They can also help families navigate the complex healthcare system by assisting with paperwork, offering guidance on questions to ask healthcare providers, or even attending medical appointments to serve as an advocate for the family. By providing a consistent presence and a knowledgeable perspective, home visitors can help alleviate some of the stress and uncertainty that families experience during this challenging time. Moreover, they can empower families with the tools and information they need to make informed decisions, whether that means pursuing further diagnostic tests or considering alternative support services.

Importance of a “Medical Home":

The concept of a Medical Home, particularly a Patient-Centered Primary Care Home (PCPCH), is of immense significance for people with disabilities and special healthcare needs. Given the higher frequency of appointments, medications, and treatments required by CYSHCN, a strong, collaborative relationship with a primary care provider is essential for coordinating and managing care effectively. The elements of a PCPCH, such as accessibility, accountability, comprehensiveness, continuity, and coordination, serve to streamline this process and ensure that families receive the holistic care they deserve.

Home visitors can act as crucial facilitators in helping families access and maintain a Medical Home. Because of inequities, economics, and other social determinants of health, not all families will have access to a permanent primary care provider. Home visitors can help identify and bridge

this gap for families by participating in conversations about community needs, advocating for more support, discussing obstacles with local health care administrators, and helping reduce barriers to care. To learn more about PCPCH click here.



Importance of Cross-Systems Care Coordination:

Cross-systems care coordination is essential for children and youth with special healthcare needs (CYSHCN) because their care often involves multiple sectors, such as healthcare, education, social services, and behavioral health. Effective coordination among these diverse systems is crucial for holistic care and optimal health outcomes. It helps to prevent the fragmentation or duplication of services, eases the family's burden of navigating complex care networks, and ultimately promotes a more efficient and impactful approach to care. Home visitors play a pivotal role in this coordination. They act as a liaison between the family and various service providers, helping to bridge gaps in communication and understanding. With their unique vantage point—being familiar with both the family's needs and the offerings of different systems—home visitors can identify potential resources, make referrals, and assist in developing a comprehensive, shared care plan. Through regular home visits, they can also monitor how well services are being coordinated and where adjustments may be needed, ensuring that the child's care remains cohesive across all involved systems.

A child's care team may be diverse, including doctors, therapists, public health nurses, home visitors, case managers, school staff, social workers, interpreters, and others. Given the diversity and potential complexity, effective cross-systems care coordination becomes paramount. You can help families create and manage a care map, which can serve as a visual guide to keep track of all providers involved in their child's care.

Leveling Up with Shared Care Planning:

Shared care plans are pivotal in establishing a structured, yet flexible roadmap for families and professionals who are collectively working to meet the healthcare needs of a child. Unlike other types of care plans, shared care plans are collaborative documents that spell out families' goals and articulate how these objectives will be reached. These comprehensive documents often include key components such as the child's brief medical history, strengths and assets, current and past interventions or treatments, recommendations, preferences, and most importantly, a well-defined plan of action specifying roles, responsibilities, and timelines.

In instances where children may have multiple care plans from different organizations, it's crucial to cross-reference these documents to ensure consistency and avoid duplication of efforts or contradictory recommendations. As a home visitor, you can facilitate this process by asking families for copies of all existing care plans. You have a unique opportunity to identify overlaps and gaps, and to liaise with other service providers to harmonize the various plans. Such coordination ensures a more cohesive, effective approach to care, eliminating redundancies and aligning efforts toward common objectives. If you notice the potential for such alignment, it's important to communicate this opportunity to your supervisors for further action.

Shared care planning, therefore, is not just a document; it is a dynamic process that fosters communication, collaboration, and shared responsibility among all stakeholders. It empowers families and streamlines the care journey, making it a vital tool in the management of children with special healthcare needs. For more information on shared care planning click here.

Transition Support:

Transition support is an essential component of care coordination for CYSHCN. Transition here refers to the crucial shift from pediatric, family-centered healthcare to adult, patient-centered healthcare. This transition process usually kicks off around the age of 14 and can extend through ages 18, 21, or even older. It involves not just changing healthcare providers—from a pediatrician to an adult-focused provider like a family practitioner—but also equipping the young adult with the skills needed to independently manage their healthcare.

Contrary to popular belief, young adults with disabilities don't indefinitely continue to see their pediatricians. Even if they are unable to manage their own care, there will be a point when transitioning to an adult healthcare provider becomes necessary. This process requires thoughtful planning and effort, which is where home visitors, play an invaluable role.

Home visitors can start by helping families understand their current pediatric clinic's transition policies. Around the age of 14, families should be encouraged to inquire about the anticipated age for transition and the preparations required. Home visitors can also utilize tools like the transition checklists developed by Got Transition, a part of The National Alliance to Advance Adolescent Health. These checklists can be reviewed periodically to monitor progress and can serve as discussion aids during medical visits.

Transition support is more than a mere administrative change; it's a complex process that demands emotional, cognitive, and logistical preparation. Your role as a home visitor can facilitate this process, ensuring a smoother, more prepared transition that sets the stage for young adults to take ownership of their health in a new healthcare setting.

Additional Training for working with clients with disabilities and/or special healthcare needs:

OCCYSHN developed a self-paced, online course for Community Health Workers, to train them on addressing the particular needs of CYSHCN and their families. Supporting Families: Navigating Care and Services for Children with Special Health Needs teaches the fundamentals of partnering with Oregon families to get what they need for their children's health and development. While the course is part of a larger Community Health Worker program, it is also available as a stand-alone training. While OCCYSHN initially designed it for CHWs, the content is relevant to a variety of professionals who work with CYSHCN, including pediatric care coordinators, home visitors, family navigators, and case managers. If you haven't already taken the course, we highly recommend doing so to enhance your skills and understanding in this critical area. Home visitors interested in taking the course can contact OCCYSHN at occyshn@ohsu.edu to request access at no cost.