Babies First!
Program Manual 2019

2019

The Babies First! Program Home Visiting Manual was created by the Oregon Health Authority (OHA) Public Health Division (PHD) Maternal and Child Health (MCH) Section

Acknowledgements

The Babies First! Program Home Visiting Manual was a collaborative effort among public health nurse consultants in the Maternal and Child Health Section of the Public Health Division and a workgroup that included local home visitors and supervisors.

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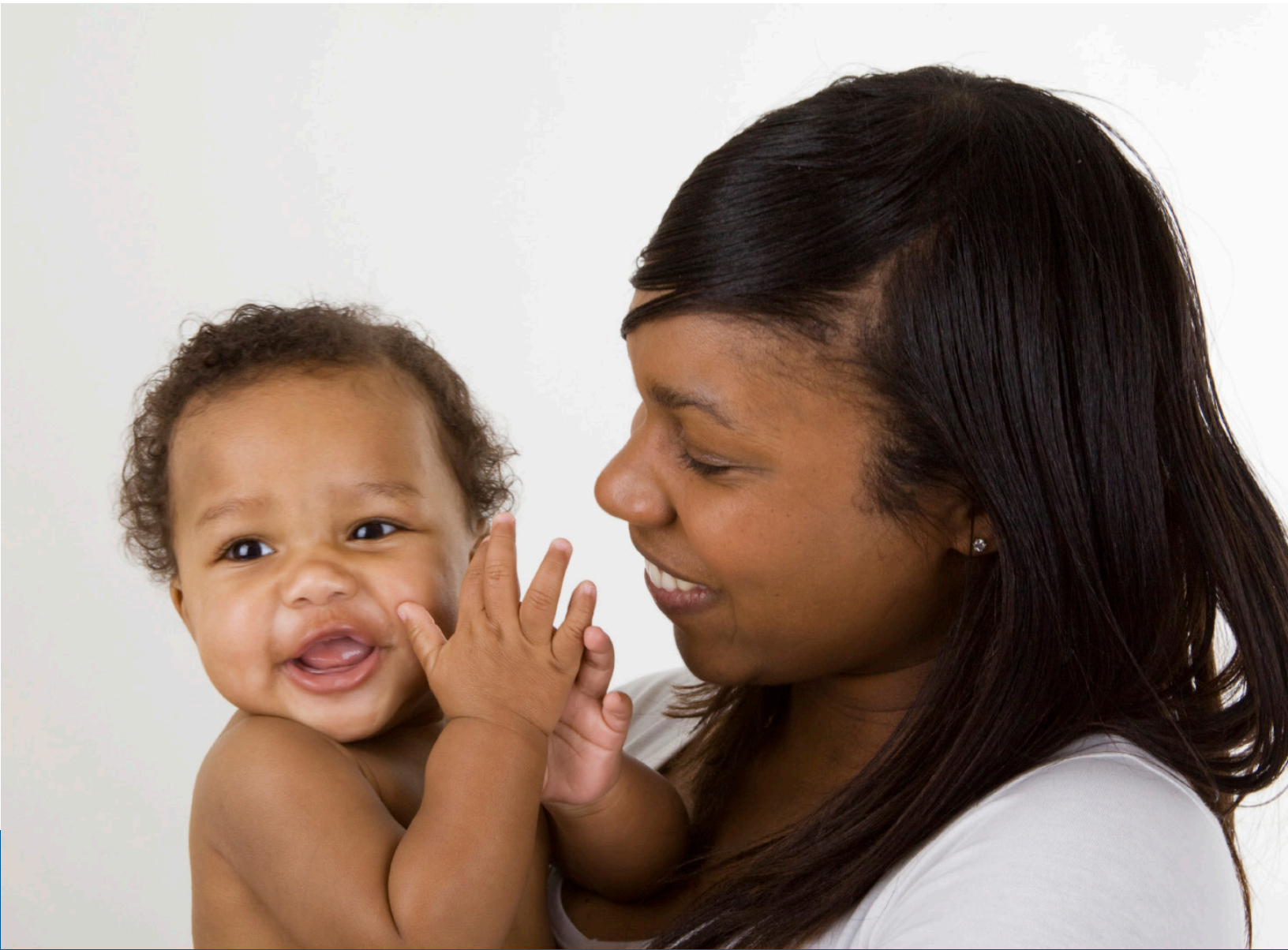
Introduction



Introduction

In this Chapter:

I. Using the Program Manual

What is the purpose of this manual?
The purpose of this manual is to provide guidelines for Public Health Nurses (PHNs), community health workers (CHWs), supervisors and administrators to use to support their work in the Babies First! Program.

How is the manual organized?
The information is organized into four chapters with interactive links for quick access to more information online:

Chapter A – Introduction
This chapter introduces the Babies First! Program, the specialty of home visiting and home visiting staff.

Chapter B – Implementing the Babies First! Program
The framework of the Babies First! Program is described in Chapter B, including the services offered, and minimum service requirements. It also grounds the program in the nursing process and home visitor competencies.

Chapter C – Activities and services
This section includes tables organizing information about activities and services offered during the perinatal and childhood periods with links to evidence-based screenings, tools and health education materials for clients.

Chapter D – Program administration, data collection and billing
This chapter describes information about the administration of the program with program requirements, as well as tools for data collection and billing.

II. The Babies First Program

What is the Babies First! Program?

The Babies First! Program is a public health nurse (PHN) home visiting program. The goals of the program are to promote health and well-being during pregnancy, infancy and early childhood. It is a voluntary program providing visits to families in their homes at no cost to the families. Non-nursing professionals may also provide services in Babies First!. These staff have several titles (e.g., community health worker, family advocate, health associate, etc.), but will be referred to as Community Health Workers (CHW) in this manual.

Public health nurses use the nursing process to assess the client's strengths, risks and needs; identify a nursing diagnosis; create a care plan using evidence-based and evidence-informed tools and practices;

implement the plan; and evaluate outcomes. Women, caregivers, and their infants are connected with needed community and health services. Women and caregivers are offered information about health during pregnancy and their child's health, development and safety.

CHWs provide support, education and case management services to families in collaboration with the PHN and following the plan developed by the PHN. Home visitors work to build therapeutic relationships that nurture the client's autonomy and confidence in parenting, decision-making, learning and navigating health and social service systems.

The Babies First! Logic Model (see Appendix A) describes the activities and outcomes of the Program.

III. Home Visiting Foundations

Core competencies

The Oregon Home Visiting Core Competencies are important for effective family-centered home-based services.

There are 10 domains within the Core Competencies:

1. Cultural and linguistic responsiveness
2. Dynamics of family relationships and engagement
3. Family health and well-being
4. Family self sufficiency
5. Human growth and development
6. Professional best practices
7. Professional well-being
8. Screening and assessment
9. Service system coordination
10. Social emotional well-being

Each domain area begins with a description followed by the competency, which is organized by attributes, knowledge and skills. Attributes are considered to be those inherent traits, values or beliefs of an individual within the home visiting field. Knowledge is defined as the information needed within each domain required to effectively work within the home visiting field. Skills are defined as strategies for application of knowledge within the home visiting field. The Babies First! Program builds and maintains these attributes, knowledge and skills through training, supervision and consultation.

The nursing process

It is important that PHNs working in this program are well prepared to use the nursing process. The five steps of the nursing process flow into a continuous loop of activities, beginning with the nursing assessment of the client's strengths and needs. Then, based on the assessment, the nursing diagnosis (or problem statement) is chosen. The diagnosis and assessment inform care planning and the choice of interventions. After interventions are begun and there has been time for action, progress toward goals is evaluated. From there further assessment may be needed and adjustments to diagnosis, planning, and interventions may be made. Periodic evaluation and adjustment provides tailored support as the client reaches for their goals.

Introduction

Developing relationships with clients and families

Do not underestimate the importance of developing strong helping relationships with clients. Prepare to invest the time to build the relationships and intentionally maintain them. The process of building helpful relationships takes time and often does not follow a straight path. It is common for a client to pull back when facing a challenge or become frustrated or tired trying to reach goals. It can help to reflect again with the client on feelings, fears, discouragements, and successes. By listening and reflecting, adjustments can be made and the client and home visitor can reconnect and continue to move ahead.

Reflective practice

Reflective practice is a way of studying your own experiences to improve the way you work. Engaging in reflective practice should help to improve the quality of care and close the gap between theory and practice. Various methods can be used for engaging in reflective practice. The Gibbs' reflective cycle is a process involving six steps: 1) Description - What happened? 2) Feelings - What did you think and feel about it? 3) Evaluation - What were the positives and negatives? 4) Analysis - What sense can you make of it? 5) Conclusion - What else could you have done? 6) Action Plan - What will you do next time? It is a 'cycle' because the action you take in the final stage will feed back into the first stage, beginning the process again.

Safety

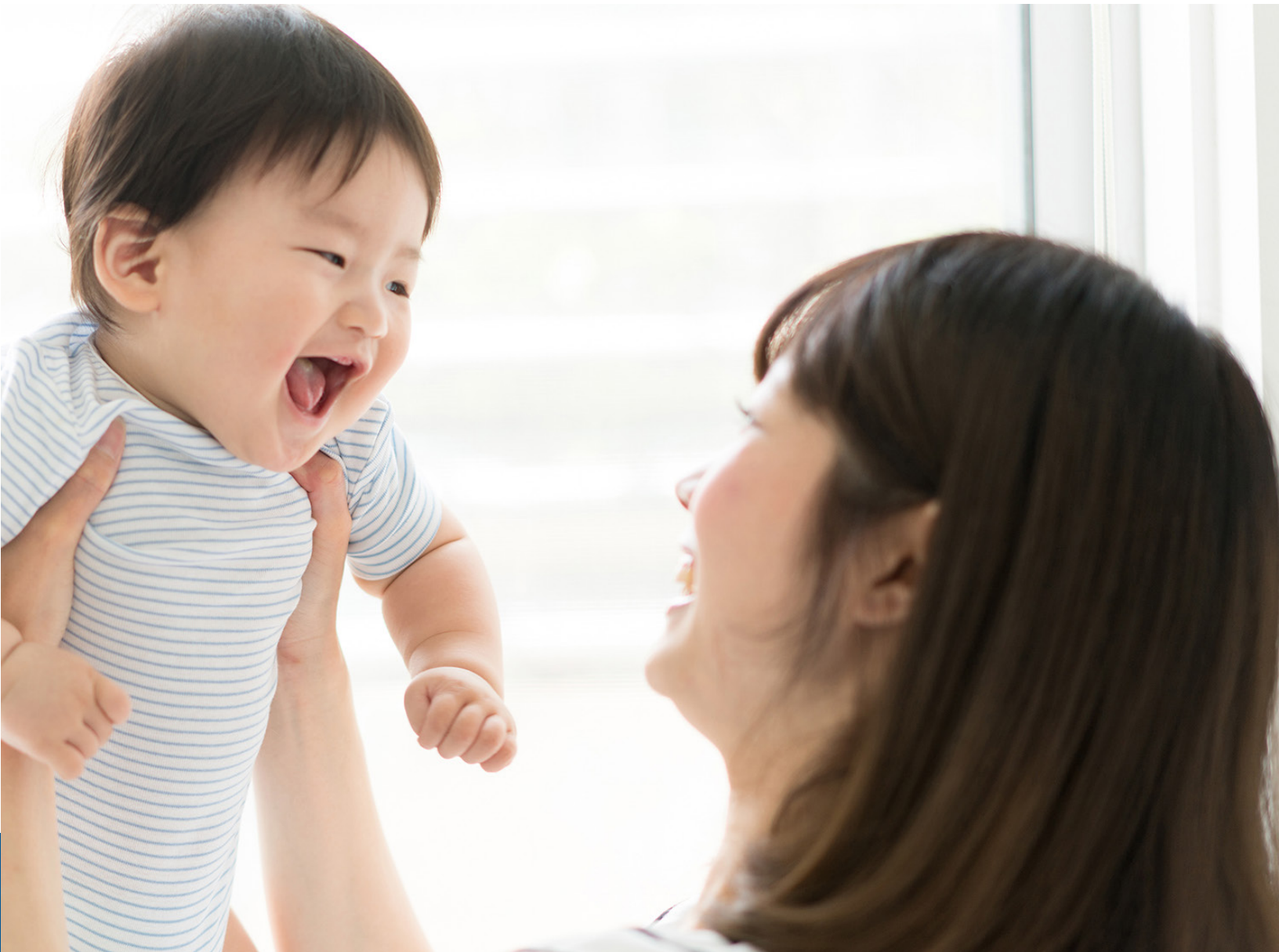
Learning to avoid dangerous situations and developing habits that prevent personal injury will give the home visitor better awareness, safety and confidence. Click here for Oregon's Home Visitor Safety Guide and click here for an 8-minute video on Home Visitor Safety.

Mandatory reporting

Public health nurses and community health workers are mandatory reporters of child abuse and neglect. When there is reasonable cause to suspect that a child has suffered abuse or there is any evidence of physical injury, neglect, sexual, or emotional abuse, they are required by law to report it to the Department of Human Services (DHS) or law enforcement.

Report child abuse to a local office of the Department of Human Services (DHS) or a local police department, county sheriff, county juvenile department, or Oregon State Police. You can also call 1-855-503-SAFE (7233). This toll-free number allows you to report abuse or neglect of any child or adult to the Oregon Department of Human Services. For more information on how to report abuse and neglect of someone of any age, click here.

Chapter B
Implementing the Babies First! Program



Implementing the Babies First! Program

In this section:

I. Target Population

The Babies First! Program provides services to perinatal women, infants and children through four years of age, and parent or primary caregivers of eligible children.

- Pregnant women who have one or more of the listed eligibility criteria: (See State Plan Amendment, Perinatal Eligibility Criteria)
- Infants and children: children through four years of age who have one or more of the listed eligibility criteria. (See State Plan Amendment, Infant and Children Eligibility Criteria)
- Parent or primary caregiver of an enrolled child. (See State Plan Amendment, Parental Eligibility Criteria)

Local programs are encouraged to assess the needs in their community, as well as their program capacity, and may target a specific population within the eligibility lists. Please inform a MCH Nurse Consultant of these plans.

II. Outreach, Referrals and Intake Process

The Babies First! Program is most effective when it is integrated into the community where it exists. Babies First! is a voluntary home visiting program; services should be offered at no cost to the family, and families enter the program through referral. Sometimes these are self-referrals, but often they are from health and social service providers in the community. It is essential that community partners who also serve pregnant and parenting women and their children are aware of the program and know how to refer eligible clients into it. This takes communication with community partners and efficient referral processes.

Communication back to the referral source about contact with the newly referred client makes coordination of services easier. To do this, the client will need to agree to allow the information exchange. Smooth and coordinated referrals take thought and planning. Local programs are required to have written policies about their referral policies and procedures that describe how the program will establish and maintain local community referral sources and assure an attempt to contact the client within 10 days of referral.

To encourage participation in the Babies First! Program consider the following recommendations from PEW (see Resources) when reaching out to families in your community:

- Change the name of the services from “home visiting” to “family support and coaching”

- When speaking to prospective participant mothers, highlight help with setting career and educational goals, reducing stress, and accessing services such as affordable day care.
- Produce literature for mothers that is simple, personal, and to the point and stresses flexibility, with equal emphasis on the mother's and child's development.

For ideas for increasing referrals and enrollments, see Appendix D: Client Enrollment.

III. Home visit schedule

Program services can be family centered and tailored to fit the needs of the clients, families, and communities. A nursing assessment and diagnosis inform the plan that becomes the foundation for client services. The PHN decides with the client on the visit schedule needed to carry out the interventions in the plan. The Babies First! Program does, however, have some specific visit expectations:

- An initial home visit should be with a PHN and should be offered within 1 month of receiving the referral.
- The PHN may choose to see clients more often than monthly, depending on their need and interest.
- At minimum, monthly home visits should be offered.
- The first postpartum home visit should be with a PHN and should be offered within the first three weeks after the infant's birth.
- When a client is discharged from the Babies First! Program, a final home visit should be made by the PHN to close out services.

IV. Initial home visit/s (to be completed by PHN within one month of client enrollment)

New clients can be enrolled in the Babies First! Program at any point during their eligibility. The most effective home visiting programs begin early in pregnancy. The first contact with a new client should be within 10 days of referral and the initial home visit should be offered within 1 month of receiving the referral. The client and family are introduced to the program and information about the client is gathered that will be the foundation of plans and goals. The visit should include:

- Establishing a relationship with the client
- Sharing information about the Babies First! Program
- Completing a Health History and Physical Assessment (See also Chapter C - Activities and Services)
- Completing an assessment of client strengths and needs
- Obtaining a signed consent for services from client (should include information about data sharing)
- Obtaining a signed release of information for communication with other service providers from client
- Sharing information about confidentiality and mandatory reporting

A care plan is a product of the initial visits and it is created by the client and the PHN with measurable goals they will be progressing toward together.

It may seem too soon, but planning for the client's graduation from the Babies First! program should begin on day 1 of enrollment as the PHN and the client begin to get to know each other and talk about options for future supports. Conversations with the client while setting goals can lead naturally into a discussion of the skills and supports the client thinks are needed for self-sufficiency. During this time, introduce the client to the likelihood of "graduating" from the Babies First! Program and/or transfer to other services. This conversation at the beginning of services can make the purpose of these program services clear and motivate clients and home visitors to reach the finish line.

It is ethical and necessary to talk with the family early about the confidentiality they can expect and the Oregon mandatory reporting law. If it becomes necessary to make a report of abuse later, this early discussion may help the family understand the decision, participate in reporting, and accept the services that will follow. For more information on how to report abuse and neglect, see Chapter A – Mandatory Reporting or click here.

While working to establish a relationship with the client, it may not be possible to complete all of these activities in one visit. Home visitors should aim to complete these initial activities within the first 1-3 visits with a client.

V. Follow-up home visits (to be completed by PHN or CHW)

After the initial visits and development of a care plan, the purpose of the home visits that follow are to work toward the goals in the client's care plan. Interventions including health education, case management, motivational interviewing, and support are provided (see also Chapter C - Activities and Services).

As the client moves toward goals, 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." Recognize and celebrate successes with the client and reinforce their strengths and skills.

VI. Closing services (PHN)

Eventually, clients will "graduate" from the Babies First! Program. This graduation can happen in a variety of ways. The home visitor may be unsuccessful in engaging the client in continued services or the client may meet goals and no longer need the program services, transfer to another program, or no longer be eligible. Ideally, the client and the PHN anticipate when the case will be ready to close and preparations can be made by strengthening other supports in the client's life.

The Babies First! Program asks that, whenever possible, the PHN makes a visit to the client to close the case. The PHN should be prepared to summarize the time the client was in the program and recognize the client's achievements. Be ready to offer help transitioning to other community services and resources.

Implementing the Babies First! Program

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. Women and infants enrolled in the Babies First! Program should be assessed on an ongoing basis for the need to continue with Babies First! services. Depending on community availability and the needs of family, consider a warm hand-off to another home visiting program that can support the program (Healthy Families, Early Head Start, etc.). When considering a warm-hand-off to another home visiting program, note that they have different eligibility criteria and plan accordingly. Establishment of relationships with other programs, such as Healthy Families, is highly encouraged and will help determine whether referral to these programs is an option in your community. You can learn more about Healthy Families Oregon here.

Perinatal women 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 shows that the client does not need services, or declines assistance accessing and/or utilizing needed services

Parent or primary caregiver

Activities and services for primary caregivers of eligible children are focused on case management. Consider discharge from the Babies First! Program if a TCM Assessment 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 when the child is two years old, seek the advice of your State MCH Nurse Consultant. Discuss transition plans with the family and review clear goals and time lines.

For children enrolled when they are older than 2 years of age, use the above criteria to determine how long they should remain in the Babies First! Program.

Chapter C
Activities and Services

Chapter C- Activities and Services

In this chapter section:

I. Screenings and Assessments
II. Interventions

Key activities and services of the Babies First! Program include: screenings and assessments and interventions, which include health education, motivational interviewing, and case management.

I. Screenings and Assessments

Perinatal

The Babies First! Program perinatal period includes pregnancy and postpartum. When a pregnant woman enrolls in Babies First!, she and the PHN explore her interests, concerns, and knowledge about her pregnancy. This is a formative time and can be challenging. The postpartum period is one of profound change for a woman and her family. Thoughtful preparation during pregnancy can help a client be confident about giving birth and feel better able to make the shift to her new role. There is much to know and learn. The support of friends and family and community resources can ease this transition and allow the new mother time to recover from birth and form a close relationship with her new baby.

- Recommended prenatal screenings and assessments (see Table 1) provide information about strengths and risks, her general health and the health of the pregnancy.
- Recommended post-partum screenings and assessments (see Table 2) provide information about strengths and risks, and her postpartum health.

Infants and Children

Bright Futures is a national initiative to promote children's health and development and prevent illness and injury. The Bright Futures Guidelines serve as the framework for the recommended screenings and assessments for infants and children.

- Recommended screenings and assessments for infants and children (see Table 3).

Parent or Primary Caregiver

Activities and services for primary caregivers of eligible children are focused on case management. Complete a TCM Assessment.

NOTE: All cited protocols may be found in Appendix B.

Table 1: Prenatal Recommended Screenings and Assessments

Recommended Screenings and Assessments (Prenatal)	Timing	Resources for Home Visitors
Prenatal History and Physical Assessment: A thorough nursing intake assessment of the client's physical and emotional health will provide essential information to enable the nurse to develop a care plan with individualized interventions to promote a healthy pregnancy and optimal birth outcomes.	Initial visit/s. Subsequent visits should include focused assessment on areas of identified need and review of any changes.	See Prenatal History and Physical Assessment Protocol (link) University of Washington First Steps Nutrition Assessment Module
Social Determinants of Health: Assess for the availability of resources to meet daily needs (safe housing, transportation, food security), social network and support and access to needed services.	Initial visit/s, TCM assessment and plan should be reviewed at every visit	See Social Determinants of Health Screening Protocol (link) See also TCM Assessment The Hunger Vital Sign
Blood Pressure: Taking an initial blood pressure reading will establish a baseline for future evaluation; successive blood pressure readings will assist in evaluating alterations that may be detrimental to the client and/or the pregnancy.	Every visit	See Blood Pressure Assessment Protocol (link) ACOG Hypertension in Pregnancy
Height, Weight, and Body Mass Index (BMI): Document client report of pre-pregnancy weight and height. Weigh client and document at initial visit. Successive measurements will assist in evaluating areas of concern.	Every visit	Prenatal Weight Assessment Protocol (link)
Gestational Diabetes Mellitus: During the pregnancy intake process, assess for diagnosis of GDM and for previous diagnosis of GDM with an earlier pregnancy.	Initial visit/s, review for changes at every visit	Perinatal Gestational Diabetes Assessment Protocol (link)

Environment and Environmental Exposure: An assessment of home environment and potential environmental exposures will augment the History and Physical assessment of the pregnant client.	Initial visit/s, 3rd trimester, any time client moves, review for changes at every visit	Perinatal Environment and Environmental Exposure Protocol (link) March of Dimes Pregnancy and Radiation Toxoplasmosis and Pregnancy
Prenatal Substance Use: Implement routine and universal screening for unhealthy substance use, including smoking. Use a reliable screening tool.	Initial visit/s, 3rd trimester, and as needed based on clinical judgement	Perinatal Substance Use Screening Protocol (link) CDC Alcohol Use During Pregnancy
Intimate partner violence: Implement routine and universal screening. Use a standardized tool to screen for IPV.	Initial visits (consider waiting until relationship established), 3rd trimester,	Perinatal IPV Screening Protocol (link) Futures Without Violence
Perinatal Mood Disorders: Implement routine and universal screening. Use a standardized tool.	Initial visit/s, 3rd trimester, and as needed based on clinical judgement	Perinatal Mood Disorder Screening Protocol (link) Oregon Maternal Mental Health Webpage Postpartum Support International
Breastfeeding Promotion: Assess the woman's breast health history, breastfeeding history, and her desires around breastfeeding.	Initial visits, throughout pregnancy	Breastfeeding Promotion and Support Protocol (link) NIH Breastfeeding
Reproductive Life Plan: assess pregnancy intention and need for contraception.	3rd trimester	Perinatal Reproductive Life Planning Protocol (link)

Table 2: Postpartum recommended screenings and assessments

Recommended Screenings and Assessments (Postpartum)	Timing	Resources for Home Visitors
Social Determinants of Health: Assess for the availability of resources to meet daily needs (safe housing, transportation, food security), social network and support and access to needed services.	Initial visit/s, TCM assessment and plan should be reviewed at every visit.	Social Determinants of Health Screening Protocol (link) TCM Assessment The Hunger Vital Sign
Postpartum History and Physical Assessment: A thorough nursing intake assessment of the client's physical and emotional health will provide essential information to enable the nurse to develop a care plan that supports the most appropriate interventions.	Initial visit/s. Subsequent visits should include focused assessment on areas of identified need and review of any changes.	Postpartum History and Physical Assessment Protocol (link)
Blood Pressure Assessment	Every visit until 6 weeks post-partum for all clients and until hypertension resolved in hypertensive clients (whichever is longer).	Perinatal Blood Pressure Assessment Protocol (link)
Gestational Diabetes Mellitus: Advise client with a GDM diagnosis that she will need to be tested 6-12 weeks postpartum to ensure her blood glucose levels have returned to normal, and screened at least every 3 years for life.	Initial visit/s, review for changes at every visit	Gestational Diabetes Protocol (link)
Substance Use: Implement routine and universal screening for unhealthy substance use, including smoking postpartum. Use a reliable screening tool.	Initial visit/s. 1-2, 6, 12 months postpartum, and as needed based on clinical judgement	Perinatal Substance Use Screening Protocol (link)
Intimate Partner Violence: Implement routine and universal screening postpartum. Use a standardized tool to screen for IPV.	Initial visit/s (consider waiting until relationship established). 1-2, 6, 12 months postpartum, and as needed based on clinical judgement.	See Perinatal IPV Screening Protocol (link)
Perinatal Mood Disorders: Implement routine and universal screening postpartum and at any other time concerns arise. Use a standardized tool.	Initial visit/s. 1-2, 6, 12 months postpartum, PRN	Perinatal Mood Disorder Screening Protocol (link)

Breastfeeding: Assess supply, latch, milk transfer, and pain. Assess for signs of mastitis: fever, erythema of breasts and flu-like symptoms.	Every visit	Breastfeeding Promotion and Support Protocol (link)
Reproductive Life Plan: assess pregnancy intention and need for contraception.	Initial visit/s. 1-2, 6, 12 months postpartum, PRN	Reproductive Life Planning Protocol (link) Preconception/Interconception Resource Guide for Clinicians One Key Question

Table 3: Recommended screening and assessment for infants and children

Recommended Screenings and Assessments		Resources for Home Visitors
Social Determinants of Health: Assess for the availability of resources to meet daily needs (safe housing, transportation, food security), social network and support and access to needed services.	Initial visit/s, TCM assessment and plan should be reviewed at every visit.	Social Determinants of Health Screening Protocol (link) TCM Assessment The Hunger Vital Sign
Parent-Child Interaction	Newborn, 1-2, 3, 7, 10, 12 months, or more often as needed based on assessment.	Parent Child Interaction Protocol (link)
Physical Assessment, including measurements	Every visit	Newborn, Infant, Toddler History and Physical Assessment Protocol (link)
Development	1-2, 3, 5, 7, 10, 12 months and then every 6 months	Newborn, Infant, Toddler Developmental Screening Protocol
Environment and Environmental Exposure: An assessment of home environment and potential environmental exposures.	Initial visit, any time client moves, review for changes at every visit	Perinatal Environment and Environmental Exposure Protocol (link)
Oral health: Perform an oral health risk assessment. Conduct a basic oral health screening and initiate appropriate preventive interventions. Refer infants and children to a dentist.	Starting at age 4-6 months, and every 6 months ongoing	Oral Health Screening Protocol (link)

II. Interventions

Case Management

Case management activities should include referral to needed health services and community resources and monitoring of referrals. Ensuring access to prenatal care and the post-partum checkup should be a focus of the perinatal period. For infants and children, case management activities should assure medical and dental home engagement to include preventive care/well-checks, dental exams, and immunizations. 211 Info is a good place to start for referral information. Babies First! activities and services for primary caregivers of eligible children are focused on case management. For the requirements of billing for case management services, see Chapter D, Targeted Case Management.

Motivational Interviewing (MI)

MI a method for facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered technique for eliciting behavior change by helping clients to explore and resolve ambivalence.

Health education

Careful and thorough information gathering can give the PHN a basis for planning care and a clue to what the first topics for health education should be. Babies First! does not have prescribed health education for clients; however, there are recommended topics by developmental phase.

- Recommended prenatal health education (see Table 4)
- Recommended postpartum health education (see Table 5)
- Recommended health education for infants and children (see Table 6)

Key resources that provide appropriate client educational material across the prenatal and early childhood period include Just in Time Parenting and CDC's Act Early or Oregon Act Early.

Table 4: Prenatal Recommended Health Education

Recommended Health Education	Resources for Home Visitors and Clients
Warning Signs	Oregon Prenatal and Newborn Resource Guide (Premature labor and delivery)
Emotional Health	Oregon Prenatal and Newborn Resource Guide (Emotional Health) Perinatal Mental Health Resources for Oregon Families (pdf) Ten Facts About Depression and Anxiety in Pregnancy and Postpartum (pdf) Depression and Anxiety During Pregnancy and Postpartum (pdf) Perinatal Mood and Anxiety Disorders Fact Sheet (pdf) Oregon Health Authority Maternal Mental Health

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Gestational Diabetes	Gestational Diabetes (See Protocol) Oregon Prenatal and Newborn Resource Guide (Gestational Diabetes) CDC Gestational Diabetes and Pregnancy
Fetal Movement	Just in Time Parenting (prenatal 2nd Trimester)
Nutrition and Physical Activity	Guidelines for safely eating fish during pregnancy and while breastfeeding can be found here and here. Oregon Prenatal and Newborn Resource Guide (Nutrition and Healthy Weight Gain) Oregon Prenatal and Newborn Resource Guide (Exercise) Oregon Prenatal and Newborn Resource Guide (Fish) WIC/USDA Making Healthy Food Choices Recommendations on Folic Acid March of Dimes Nutrition, Weight and Fitness CDC Weight Gain During Pregnancy
Infections	Oregon Prenatal and Newborn Resource Guide (Infection) Oregon Prenatal and Newborn Resource Guide (HIV) Zika (CDC) Hepatitis B (CDC) Hepatitis C (CDC)
Immunizations	Oregon Prenatal and Newborn Resource Guide (Immunizations) CDC Maternal Vaccines
Environmental Exposure	Oregon Prenatal and Newborn Resource Guide (Lead Poisoning) Oregon Prenatal and Newborn Resource Guide (Pesticides)
Reproductive Life Planning	Planning for Pregnancy (CDC)
Substance Use	Oregon Prenatal and Newborn Resource Guide (Alcohol and other drugs) Oregon Prenatal and Newborn Resource Guide (Tobacco) USDA Give Your Baby a Healthy Start CDC Treating for Two CDC Tobacco Use and Pregnancy CDC Marijuana Fact Sheet Marijuana and Your Baby

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Social Network and Support	Oregon Prenatal and Newborn Resource Guide (Fathers, partners)
Healthy Relationships	Oregon Prenatal and Newborn Resource Guide (Safe and Nurturing Relationships) Futures Without Violence
Oral Health	Oregon Prenatal and Newborn Resource Guide (Oral Health)
Labor and Delivery	March of Dimes Labor and Birth
Getting Ready for Baby	Oregon Prenatal and Newborn Resource Guide (Newborn Screening) Oregon Prenatal and Newborn Resource Guide (Hearing Screening) Oregon Prenatal and Newborn Resource Guide (Car Seat Safety) Oregon Prenatal and Newborn Resource Guide (Child Care) Oregon Prenatal and Newborn Resource Guide (Safe Sleep) Oregon Prenatal and Newborn Resource Guide (Home Safety)

Table 5: Postpartum Recommended Health Education

Recommended Health Education	Resources for Home Visitors and Clients
Warning Signs	March of Dimes Warning Signs after Birth March of Dimes Postpartum Hemorrhage
Emotional Health	Oregon Prenatal and Newborn Resource Guide (Emotional Health) Tips Para La Familia Para Prevenir Una Crisis de Postparto (pdf) Tips for Postpartum Dads and Partners (pdf)
Gestational Diabetes	See Gestational Diabetes Protocol
Breastfeeding Promotion	See Perinatal and Breastfeeding Support Protocol Oregon Prenatal and Newborn Resource Guide (Breastfeeding)
Nutrition and Physical Activity	Guidelines for safely eating fish during pregnancy and while breastfeeding can be found here and here. Oregon Prenatal and Newborn Resource Guide (Fish) WIC/USDA Making Healthy Food Choices March of Dimes Losing Baby Weight
Reproductive Life Planning	Planning for Pregnancy
Substance Use	Oregon Prenatal and Newborn Resource Guide (Tobacco) WIC materials
Social Network and Support	Oregon Prenatal and Newborn Resource Guide (Fathers, partners)
Healthy Relationships	Oregon Prenatal and Newborn Resource Guide (Safe and Nurturing Relationships)

Table 6: Recommended Health Education Infants and Children

Recommended Health Education	Resources for Home Visitors and Clients
Social Determinants of Health	Community resources: 211 Info Oregon WIC
Parent and Family Health and Well-being: Family medical care, family relationships, child care	Bright Futures Guidelines, 4th Edition, pages 25-37 Bright Futures Pocket Guide, 4th Edition. Age specific guidelines.
Behavior and Development: sleeping and waking, fussiness and attachment, media, playtime	Bright Futures Guidelines, 4th Edition, Pages 15-39 Bright Futures Pocket Guide, 4th Edition. Age specific guidelines. Healthy Children.org
Oral Health	Bright Futures Pocket Guide, 4th Edition. Age specific guidelines. Refer to Appendix on pages 113-117 Healthy Children.org
Nutrition and Feeding: feeding plans and choices, breastfeeding and formula-feeding guidance, solid food introduction	Oregon WIC
Safety: car seat safety, safe sleep, preventing falls, safe home environment	Bright Futures Pocket Guide, 4th Edition. Age specific guidelines. Handout is available in English and Spanish TIPP-The Injury Prevention Program, AAP Bright Futures Pocket Guide, 4th Edition. Age specific guidelines Healthy Children.org Oregon Public Health Safe sleep for babies Safe Kids Oregon
Home Environment	HealthyChildren.org (Environmental Hazards)

Period of Purple Crying

The Period of PURPLE Crying program is the name given to the National Center on Shaken Baby Syndrome's evidenced-based shaken baby syndrome prevention program that includes a booklet and DVD or booklet and App package. The program has two aims: to support caregivers in their understanding of early increased crying, and to reduce the incidence of shaken baby syndrome/abusive head trauma. The Period of PURPLE Crying program is based on a three dose model.

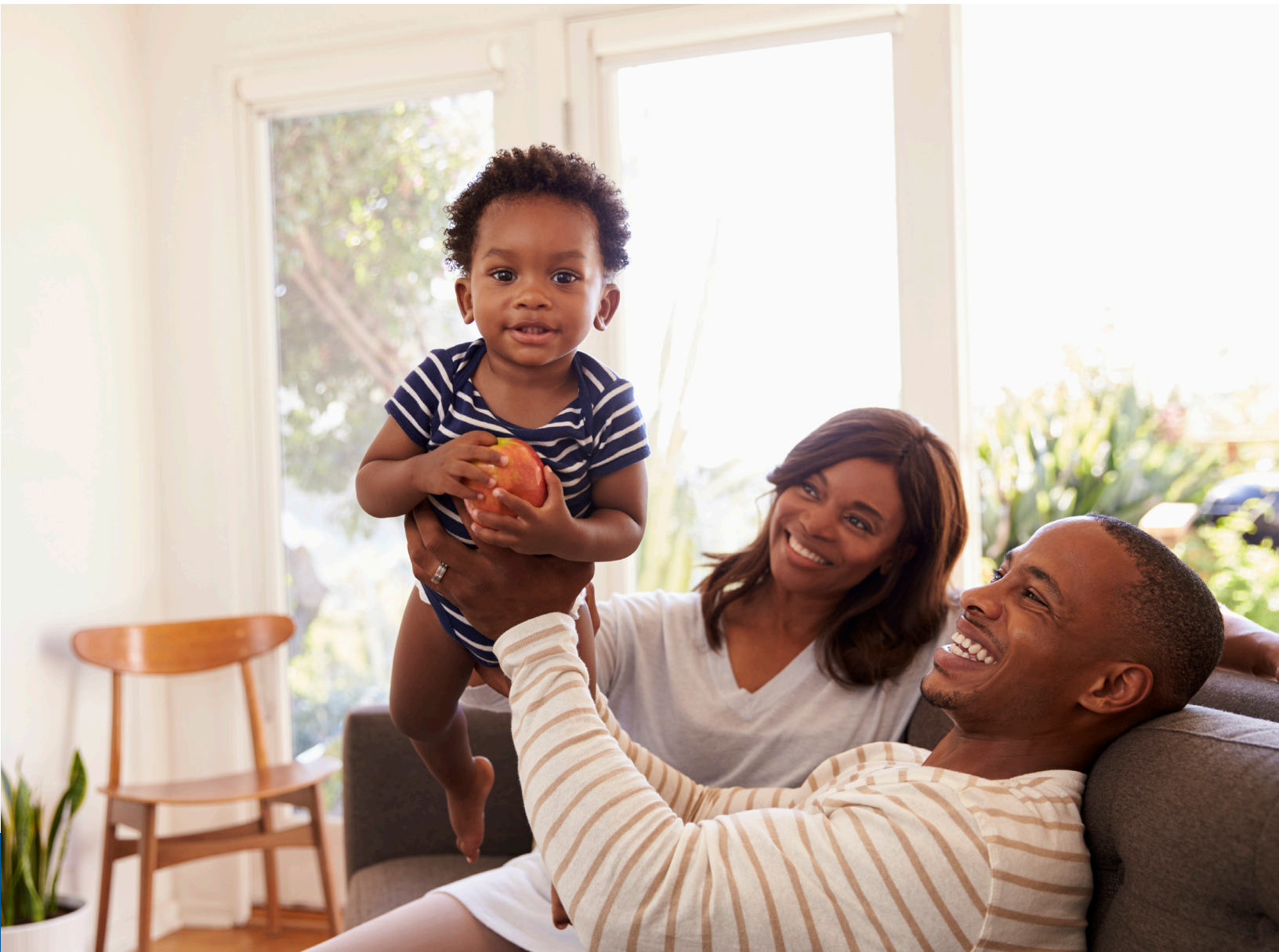
- Dose One: Delivery of the Purple Program materials by a trained educator or provider within the first 2 weeks of baby's life
- Dose Two: Reinforcement of the messages generally occurring throughout the first three months following birth
- Dose Three: Public Education Campaign to make sure that all members of community understand the Period of Purple Crying

Dose 2 should be implemented within the Babies First! Program. Please see the Dose 2 Implementation Checklist for steps to getting started. Based on our knowledge of the Dose 1 implementing hospitals in Oregon, most clients should be receiving materials in the hospital. As you work on implementing this program, please check in with your MCH Nurse Consultant regarding your need for training and materials. For more information on the Period of Purple Crying and to access program materials and training, click here: https://dontshake. org/purple-crying.

Vroom

Vroom is a free parenting tool that prompts simple, everyday moments of parent-child interactions that are fun brain-building activities. Based on the latest science and designed to fit into parents' existing routines, Vroom's brain-building tips can be accessed via its free Smartphone app (Daily Vroom) or other free materials in English, Spanish, Chinese, Russian, and Vietnamese at www.joinvroom.org. Vroom is also available via text by sending the keyword "CHILD" in English or "HIJO" in Spanish to 48258. The Oregon Department of Education's Early Learning Division has partnered to launch Vroom in Oregon. For more about promoting brain science using VROOM go to: http://www.brainbuildingoregon.com/project/vroom/

Chapter D
Program Adminstration



Chapter D- Program Administration

The culture and diversity of participants in the Babies First! Program should be considered and addressed with policies, staff training and support to assure equal access, equitable services, and non-discriminatory practices.

I. Target Population

Local programs are encouraged to assess the needs in their community, as well as their program capacity, and may target a specific population within the eligibility lists. Please inform the MCH Nurse Consultant of these plans.

II. Staffing

Public Health Nurse (PHN)

Babies First! relies on PHNs for assessing clients' strengths and needs, making plans with the client for care and case management, and evaluating progress toward goals.

To implement a Babies First! Program in a community, the minimum required staffing is .5 FTE PHN and at least 20 clients enrolled. If a local program is unable to meet the minimum staffing or caseload requirement, contact a Babies First! MCH Nurse Consultant for discussion.

Community Health Worker (CHW)

The Babies First! Program may include CHW staff whose role is to provide health education and case management services to meet the client goals according to the plan developed by the PHN. If a local program is considering a CHW to meet some part of the required .5FTE, contact a Babies First! MCH Nurse Consultant for discussion.

Supervisor

Reflective staff supervision is an important activity that is part of the Babies First! Program. It is an evidence-based method shown to retain staff as well as support staff continued learning and effective practice. Minimum supervision for all home visitors includes two hours of reflective supervision per month, four charts reviewed per nurse per year, and one observed home visits per year. If a local program is unable to meet the supervisor staffing requirements, contact a Babies First! MCH Nurse Consultant for discussion.

Reflective supervision promotes and supports the development of a relationship-based program. The approach expands on the idea that supervision is a context for learning and professional development. See the Three Building Blocks of Reflective Supervision from Zero to Three for more information.

Supervisors are encouraged to participate in monthly calls with Babies First! Public Health Nurse Consultant team. These monthly phone calls will include updates, information sharing, and program support from the MCH Nurse Consultant*.

***For Supervisors working in both the Nurse Family Partnership and Babies First! home visiting programs, contact a MCH Nurse Consultant for discussion of requirement.**

III. Team Meetings

All Babies First! Programs are required to have monthly team meetings at a minimum. Some time at team meetings should be devoted to case conferencing.

Case Conferencing

Home visitors are asked to share a specific situation that they would like to reflect upon. The team supports the home visitor in reflecting on what went well and what can be learned and applied in the future, or it can be a challenging situation in which the home visitor would like support to process the situation and arrive at satisfying next steps for action and solutions.

IV. Training and Technical Assistance

Recommended training for new home visitors (PHNs and CHWs):

- Complete Public Health Home Visitor Orientation Checklist* (See Appendix F)

  * For PHNs working in both the Nurse Family Partnership and Babies First! home visiting programs, contact a MCH Nurse Consultant for discussion.

Recommended training for current home visitors (PHNs and CHWs):*

- Babies First! Introduction (Recorded Webinar)
- Self-assessment of learning needs and plan (see Appendix C)
- 3 Acheive On-Demand Self-Paced Courses (of their choosing) to be completed within one year

  * For PHNs working in both the Nurse Family Partnership and Babies First! home visiting programs, contact a MCH Nurse Consultant for discussion.

Recommended training for supervisors:*

- Complete MCH Home Visitor Supervisor Orientation Checklist* (See Appendix F)

  * For Supervisors working in both the Nurse Family Partnership and Babies First! home visiting programs, contact a MCH Nurse Consultant for discussion.

The Oregon Public Health Division Maternal and Child Health Section provides training and technical assistance to nurses working in the Babies First! Program. MCH Nurse Consultants are available to give technical assistance and provide useful resources. You can find contact information for the Babies First! Public Health Nurse Consultants here.

V. Policies and Procedures

Local programs should have the following policies and procedures in place:

Adminstrative	Clinical
• Referrals and intake process • Home visitor safety/Emergency Preparedness • Consent for services • Timeliness of documentation • Data collection and reporting • Social media use and texting • Chart review policy • Mandatory reporting • Medical records and confidentiality • Nurse scope of practice and supervision of CHW practice • Cultural and linguistic competency • Service for persons with disabilities • Communication with persons with limited English proficiency	• Prenatal History and Physical Assessment • Postpartum History and Physical Assessment • Newborn History and Physical Assessment • Blood Pressure Measurement • Height/Weight/BMI Measurement

VI. Data collection

By September 30 each year, all client visit data for the previous state fiscal year (July 1- June 30) must be entered into the Oregon Child Health Information Data System (ORCHIDS) or other state-designated data system. More information about ORCHIDS can be found here.

Local Babies First! programs must transmit data in an electronic file structure defined by OHA. Electronic transmission of visit data files may be submitted quarterly; however, all client visit data from the previous state fiscal year must be complete and transmitted to OHA by September 30 of each year.

Client data reports shall include, at a minimum: the number of clients served, the demographic profile of clients, number of visits or encounters, the types of services provided, and source of payment for services. The Babies First! Client Data Form provided by OHA lists details of the required data elements.

VII. Targeted Case Management (TCM)

TCM Services

Providing Targeted Case Management (TCM) services offers an agency a way to reimburse some of the costs of nurse home visiting program delivery. The Oregon Health Authority, Health Services Division (HSD) reimburses Public Health Nurse home visiting through the Oregon Health Plan (Oregon's Medicaid program). Babies First!, CaCoon and Nurse-Family Partnership are programs eligible for TCM reimbursement. Regardless of whether billing for services occurs, the Babies First! Program must be offered at no cost to the family.

Effective January 1, 2017, The Centers for Medicare & Medicaid Services (CMS) approved the Oregon State Plan Amendment (SPA) to provide Targeted Case Management (TCM) services to Medicaid eligible perinatal women, infants and children through four years of age who have one or more risk factors for poor perinatal, birth and other poor health outcomes, or parent of said child listed in Table 1 (See State Plan Amendment).

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs. These annual assessment activities (more frequent with significant change in condition) include:

- Evaluation of the individual's history.
- Evaluation of the extent and nature of the individual's needs (medical, social, educational, and other services) and completing related documents.
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Annual review, or more often as indicated by change in individual needs.

Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

- Specifies the goals and actions to address the medical, psycho-social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (Such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services (including food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan.

Monitoring and follow-up activities: activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities and contacts may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring. Monitoring and follow-up activities are ongoing and include:

- Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the service plan is effectively implemented;
- Services are being furnished in accordance with the individual's care plan;
- Services in the care plan are adequate; and
- Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- Frequency of monitoring is based on the documented client needs.

Case management includes contacts with non-eligible individuals, who are directly related to identifying the eligible individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)

These are the only TCM-billable activities. Provision of direct nursing services is not billable.

TCM activities (assessment, plan, referral and monitoring) must be well documented. Use of the forms posted here is highly recommended. If using an electronic charting system, please ensure all data elements from the forms are captured and easily retrievable for auditing purposes.

TCM Billing

All claims (requests for reimbursement) are processed within the OR-MMIS (Oregon Medicaid Management Information System), which is Oregon's Medicaid database. Each reimbursement covers services connected to one visit, or a single date of service. A client must have Oregon Health Plan coverage on the day of the visit for the visit to be reimbursable, and the visit must include at least one of the required activities noted above: assessment, care plan development, referral, monitoring or follow- up activities.

Entering claims directly into the MMIS provider portal or billing through an electronic health record are fast, efficient ways to bill and receive payment for Medicaid claims. All claims that enter the MMIS throughout a week undergo financial processing on Friday night. An estimate of benefit document (EOB), a remittance advice document (RA), and payment typically arrive early the following week.

Payment may be through a paper check or through an electronic transfer of funds.

Note that Medicaid is always the payer of last resort. This means that services for clients with the Oregon Health Plan and another type of health insurance must be billed to the other insurance first. If the client's other insurance denies the claim, then the denial should be submitted to the MMIS along with the claim. For specific information about Targeted Case Management requirements, please see:

Oregon Administrative Rules 410-138-0000 through 410-138-0390

TCM Services Program (HSD website)

Targeted Case Management Services Administrative Rulebook, effective 4/1/2017

For help with MMIS logins and information about claim denials, contact HSD Provider Services: 1-800-336-6016. For questions about documenting services and whether specific services are reimbursable, contact your MCH State Nurse Consultant.

For further information, see the TCM Frequently Asked Questions document.

Resources

Resources

Resources – Introduction (Chapter A)

The Babies First Program

- MCH Section – Home Visiting, Oregon Public Health Division – Connects to the webpages describing Oregon's public health home visiting system
- Public Health Nurse Home Visiting FAQ, Oregon Public Health Division – Connects to FAQs describing Oregon public health nurse home visiting
- A Brief History of Home Visiting in the United States – California Center for Infant-Family and Early Childhood Mental Health
- The MIECHV Program – Description of the MIECHV Program, Health Resources & Services Administration (HRSA)

Home Visiting Foundations

- The Oregon Home Visiting Core Competencies 2015 - Oregon Health Authority Public Health Division
- The Definition and Practice of Public Health Nursing, Public Health Nursing Section of the American Public Health Association, November 11, 2013
- Core competencies for public health nurses - Quad Council of Public Health Nursing Organizations. (2011). Washington, D.C.
- Oregon's Home Visitor Safety Guide (May 2014) – Oregon Health Authority Public Health Division Center for Prevention & Health Promotion Maternal and Child Health Section
- Home Visitor Safety Video- Oregon Health Authority Public Health Division Center for Prevention & Health Promotion Maternal and Child Health Section
- Oregon's Mandatory Reporting Law – Oregon Revised Statute 419B.005
- Guide for Mandatory Reporters – Oregon Department of Human Services – Mandatory Reporting
- Minor Rights: Access and Consent to Health Care-Oregon Health Authority, Adolescent Health Program

Resources – Implementing the Babies First! Program (Chapter B)

Outreach

- Family Support and Coaching Programs, Crafting the Message for Diverse Stakeholders (PEW)

Nursing Process

- Elements of the Nursing Process – ADPIE NurseFrontier.com
- NANDA International – North American Nursing Diagnosis Association
- NANDA-Approved Nursing Diagnoses 2018-2020 (for purchase)
- University of IOWA College of Nursing Center for Nursing Classification and Clinical Effectiveness (CNC) - Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC)

Resources

Resources-Activities and Services (Chapter C)

Screening and assessment

- Developmental screening resources
- Bright Futures Pocket Guide (may be requested from MCH Nurse Consultants)
- Eliciting Parental Strengths and Needs
- Home visiting training resources – Includes screening and assessment tools
- Newborn Hearing Screening and follow-up

Nutrition

- Oregon WIC Program
- Breastfeeding resources and information

Child care

- Central Coordination for Child Care Resource and Referral
- Child Care assistance and Family Support

Safety

- Safe sleep for babies
- IPV Safer Planning: Advocacy Beyond Leaving: A Guide for Domestic Violence Advocates
- Victim-Defined Safety Planning: A Summary
- Washington State Coalition Against Domestic Violence Home Visitor Reference

Health and wellness

- Oral Health
- Vaccines and Immunizations

Environmental exposure

- Healthy Homes and Neighborhoods

Special health needs

- Children's mental health system
- Oregon Center for Children and Youth with Special Health Needs (OCCYSN)

Resources—Program Administration (Chapter D)

- Zero to Three Home Visiting Community Planning Tool

Training and technical support

- Home Visiting Training Resources, Oregon Public Health Division
- Home Visiting MIECHV Orientation, Oregon Public Health Division
- Home Visitation Guidelines on Domestic Violence 2014 , Strong Families AZ, Arizona's home visiting alliance
- Oregon Health Authority Approved Traditional Health Worker (THW) Training and Continuing Education Unit (CEU) Programs – Information about how to become a certified traditional health worker in Oregon.
- Traditional Health Worker Program – Policies, Rules and Guidelines – Oregon Health Authority Office

of Equity and Inclusion

- Georgetown University - National Center for Cultural Competence
- Three Building Blocks of Reflective Supervision - Zero to Three

Targeted Case Management

- Targeted Case Management Documentation Forms
- Oregon Administrative Rules 410-138-0000 through 410-138-0390
- TCM Services Program (HSD website)
- Targeted Case Management Services Administrative Rulebook, effective 4/1/2017
- State Plan Amendment

Home visiting sustainability

- Medicaid Financing of Home Visiting Services for Women, Children, and Their Families, National Academy for State Health Policy, August 2017

Oregon Public Health Nurse Home visiting program outcomes

- Maternity Case Management (MCM) A Public Health Nurse Home Visiting Program Reduced Early Preterm Births for High Risk Pregnant Women (2009-2012)
  Oregon Public Health Division Report
- Maternity Case Management (MCM) A Public Health Nurse Home Visiting Program Timely and Adequate Pregnant Women (2009-2012)
  Oregon Public Health Division Report
- Babies First! Outcomes for High-Risk Children up to Age 5
  Oregon Public Health Division Report
- CaCoon: Evidence-Based Outcomes for Serving Children with Special Health Needs
  Oregon Center for Children and Youth with Special Health Needs Report
- CaCoon: Medicaid Diagnosis Comparison between Children with Special Health Needs Who Did and Did Not Receive CaCoon Services
  Oregon Center for Children and Youth with Special Health Needs Report
- CaCoon: Emergency Room Use Comparison between Medicaid Children with Special Health Needs Who Did and Did Not Receive CaCoon Services
  Oregon Center for Children and Youth with Special Health Needs Report

Appendices

A. Logic Model
B. Protocols
C. Self Assessment of Learning Needs
D. Client Enrollment
E. Client Support
F. Staff Orientation
G. Contacts

Appendix A: Logic Model

Inputs: Program Support	Inputs: Program Administration	Outputs: Program Activities (process measures)	Outcomes *Short*	Outcomes *Medium*	Our Long Term Vision for Outcomes
Funds: State general fund, TCM, Title V (in some LPHAs), MAC, local funds **State (PHD):** PHN Consulting Team (program guidance, training and technical support, review), Data Collection Processes and System (ORCHIDS/THEO) **State (HSD):** TCM Processes **Local Public Health:** supervisors and home visitors, data entry, billing **Partners:** MIECHV Workforce Development and Quality Improvement	**Program Demographics** • Number of Counties • Number (demographics and retention) of Home Visitors **Professional Dev** • # of Home Visitors and Supervisors participating in training/workforce development **Quality Improvement** • Number of CQI activities completed in the last year • Percentage of local programs with active CQI projects **Client Enrollment** • # referrals, referral source, demographics • # enrolled (referral conversion) • percent of clients enrolled prenatally **Clients served** • Number • Demographics • # home visits **Percentage of programs meeting established guidelines**	**Health and SDOH** # of screenings completed, and referrals made for: • Housing/Home Environment • Food Insecurity • Smoking* • Substance Use* • Mental Health* • IPV* • Medical Care (PNC, PP, Medical Home) • Developmental* • Parent Child Interaction • Social support **Substance Use** • Education, motivational interviewing, problem solving	**Improved Health Behaviors** # clients demonstrating follow through for: • Smoking • Substance Use • Mental Health • IPV • Developmental **Substance Use** • # of clients with smoking rules in place • # of clients with Relapse plan in place	**Improved Health Behaviors** # of clients with: • Early and adequate PNC • PP Visit complete • Medical Home established (mom and baby) • Annual Well Woman Visit • Well Child Check completed • Immunizations UTD • Oral Health Care (mom and child) **Improved maternal social support** • # clients who state they have resources to help **Decreased Substance Use** • # of clients with decreased smoking	**Improved birth outcomes** **Improved family nutrition** **Improved growth and development** **Increased pregnancy intention**
		Infant Nutrition • Education, motivational interviewing, problem solving	**Improved Infant Nutrition** • # of prenatal clients taking PNV/Folic Acid • # of Prenatal clients with stated Breastfeeding Intention	**Improved Infant Nutrition** • # of prenatal clients taking PNV/Folic Acid • # clients initiating Breastfeeding • Length of time exclusively BF	
		Reproductive life Planning • Education, motivational interviewing, problem solving	**Reproductive life Planning** • # clients with documented plan in place	**Use of Reproductive Life Plan** • # clients who use effective contraception	
		Injury Prevention • # clients receiving safe sleep education • # clients receiving car seat education	**Improved Injury Prevention** • # infants placed to sleep with Safe Sleep Practices • # infants with good Car Seat Practices	**Improved Injury Prevention** • # infants requiring Emergency Medical Care	

Appendix B.1: Protocols: Prenatal History and Physical Assessment: Nursing

Protocol Title:	Prenatal History and Physical Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors
Date Updated:	01/2019
Date of Next Review:	01/2020

PURPOSE: A thorough nursing intake assessment of the client's physical and emotional health will provide essential information to enable the nurse to develop a care plan that supports the most appropriate interventions to promote a healthy pregnancy and optimal birth outcomes.

PROCESS: A basic nursing head to toe assessment should be done at the initial prenatal visit. It may not be possible to complete the full assessment in one visit, and not all of these issues may be pertinent to every client. However, as an important component of the nursing process, consider assessing the following systems delineated in Table 1, and attempt to assess them in a timely manner. Some areas might require waiting until rapport is established to assess (e.g., IPV and Substance Use). Some of these areas may be assessed through therapeutic conversation, rather than hands-on assessment, per nurse's discretion. Any areas that require further assessment and follow up should be noted and explored in further visits as soon as possible. Physical and mental health not within normal limits should have continued follow up at subsequent visits as needed. The body systems to consider for a head to toe assessment are listed in Table 1. Blood pressure and weights should be monitored at each pre-natal visit (see also Perinatal Blood Pressure Assessment Protocol).

Clients with chronic health issues (e.g., asthma, renal disease, cardiac disease, orthopedic issues) may need some additional case management services; however, clinical care responsibilities lie with the medical care provider. Signs and symptoms of concern or client concerns should be referred to the appropriate medical care provider, and the referral should be documented (see Table 1 guidelines for when to refer). Please see Protocol: Pregnancy Warning Signs for list of specific signs to report to physician immediately.

Prenatal Assessment Considerations		Considerations for referral to physician
General Health Status	Vital Signs (blood pressure and weight per protocol; and temperature, heart rate, and respirations as needed if abnormality suspected); Cognitive state: mood, orientation; Pain; Medications. Medical hx (e.g., Gestational or Diabetes Type II, anemia, hypo/hyperthyroidism, seizures) Immunizations, allergies)	*BP: SBP >130 mm Hg or DBP > 80 mm Hg Weight: increase or decrease not consistent with diet Temp: <96 or >101°F Pain not controlled with meds Progression of chronic disease Change in orientation or level of consciousness
Reproductive	EDD; Gravida, term, preterm, SAB, TAB, Living; Pregnancy planned or not planned; Prenatal care; Birth plan; Childbirth class plan; Reproductive plan; Contraceptive plan; Vaginal or pelvic pain; Vaginal or pelvic infections/Sexually Transmitted Infections/risk for infection	Pain Bloody discharge Discharge concerning for infection

Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Skin pale, diaphoretic, cold; cap refill >3 seconds; contusions not explained, or not healing properly
HEENT	Vision; hearing; dental care; pain	Vision changes Persistent headache
Breasts	Breast surgery hx; breastfeeding plan	Signs of infection
Respiratory	Respiratory rate, effort, pattern; hx of disease, such as Asthma	RR <12 /min or >24/ min Shallow breaths, feeling short of breath, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	*BP: SBP >130 mm Hg or DBP > 80 mm Hg HR: <50, >100 at rest, with consideration of what is normal for client Detection of new murmur or abnormal rhythm. (See also Perinatal Blood Pressure Assessment Protocol)
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/vomiting; indigestion	Abdomen tender/painful Bowel movement type/amount abnormal for patient Persistent nausea/vomiting
Diet and Exercise	Appetite; dietary intake; special dietary needs; food safety risks; folic acid use; weight; height; BMI; activity level	Loss of appetite affecting weight, not enough weight gain (See also Prenatal Weight Assessment Protocol)
Urinary	Voiding characteristics (amount, color, odor, pain). History of UTIs.	Pain with urination Increased frequency not associated with intake Oliguria or anuria (should void 0.5 to 1 ml/kg/hr) Blood or clots in urine
Peripheral Vascular	Edema; Varicosities; Leg pain	2+ edema not resolving, or in conjunction with other signs (BP, headache, blurred vision, HR changes, SOB). Persistent leg pain
Musculoskeletal	Extremity strength; extremity movement; Activity level; Limitations to activity; Pain	Unexpected weakness (<4/5 strength) in one or more limbs Unexpected change in mobility Persistent pain
Neurologic	Extremity sensation, seizure history; fatigue/sleep	Numbness or tingling in extremities Seizures Extreme fatigue, especially in

		conjunction with anemia
Mental Health	History of treatment for mental illness; History of depression/anxiety; Suicide ideation/attempts; History of abuse; Stress level; Self-esteem; Support system; Current affect	Within first 5 visits, conduct depression screening, suicide screening, intimate partner violence screening (see also Perinatal IPV Screening Protocol, and Perinatal Mood Disorders Screening Protocol), make referral as appropriate
Behavioral	Tobacco use/exposure; Substance use/exposure; Risky behaviors	As early as possible after establishing rapport, but within four weeks of enrollment, and at 36 weeks gestational age use a validated tool to screen all clients for use of alcohol, illicit drugs, prescription drugs, and tobacco and make referral as appropriate (see also Perinatal Substance Use Screening Protocol)

References:

1. Bates' Nursing Guide to Physical Exam and History Taking (2011).
2. NICE Clinical Guidelines, No. 62. National Collaborating Centre for Women's and Children's Health (UK). 2008 Mar. Accessed https://www.ncbi.nlm.nih.gov/books/NBK51890/

Appendix B.2: Protocols: Prenatal Weight Assessment: Nursing

Protocol Title:	Prenatal Weight Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: Supporting healthy weight gain during pregnancy promotes healthy birth outcomes. Women with either a rapid or slow weight gain during later pregnancy are at increased risk for preterm births. Women with high pre-pregnancy BMI have increased risk for gestational diabetes, hypertension, and preeclampsia, among other risks. Using the World Health Organization BMI calculations, the Institute of Medicine recommends *total* pregnancy weight gain based upon pre-pregnancy weight or weight at the first prenatal care appointment.

PROCESS (Singleton Pregnancy):

- Assure that scales are calibrated at least annually
- Document client self-report of pre-pregnancy weight
- Measure height, without shoes, during initial assessment. If the home visitor has no means to measure height, use client self-report or obtain information from pregnancy care provider.
- If a scale is available, weigh client and document weight at every prenatal visit. If reliable scales are not available, work with pregnancy care provider to ensure weight is measured. Weight gain should be slow:
    - 1 to 4 pounds total in first 3 months
    - 2 to 4 pounds each month from 4 months to delivery
- Using pre-pregnancy weight, compute BMI. There are several websites that will quickly provide the calculation: http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm
- Plot weight gain using the following grids, by pre-pregnancy BMI: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WIC/Documents/611-612-613-weight-gain-grids.pdf
- If Community Health Workers take weight and height measurements, local health authorities should have policies in place to provide procedures for reporting abnormal measurements to the Nurse Home Visitor.
- Alert prenatal care provider if client is losing weight or gaining weight excessively.

Table 1. Pregnancy Weight Gain for Singleton Pregnancy		
Pre-pregnancy Weight	**Total Weight Gain**	**Weekly Weight Gain for 2nd and 3rd Trimesters**
Underweight (BMI < 18.5)	28-40 pounds	1 pound (range 1.0 to 1.3)
Normal weight (BMI 18.5 to 24.9)	25-35 pounds	1 pound (Range 0.8 to 1.0)
Overweight (BMI 25.0 to 29.9)	15-25 pounds	0.6 pounds (Range 0.5 to 0.7)
Obese (BMI ≥ 30.0)	11-20 pounds	0.5 pounds (0.4 to 0.6)

PROCESS (Twin Pregnancy):

- If scales are available, assure that scales are calibrated at least annually.
- Document client report of pre-pregnancy weight.
- Measure height, without shoes, during initial assessment. If the home visitor has no means to measure height, use client self-report or obtain information from pregnancy care provider.
- If a scale is available, weigh client and document weight at every visit. If scales are unavailable, obtain weight from primary care provider.
- Using pre-pregnancy weight, compute BMI. There are a number of websites that will quickly provide the calculation: http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm
- Alert prenatal care provider if client is losing weight or gaining weight excessively.
- Support clients in maintaining a healthy weight between pregnancies. Weight should be assessed via scale, self-report, or primary care office up to 12 weeks post-partum.

Table 2. Pregnancy Weight Gain for Twin Pregnancy		
Pre-pregnancy Weight	**Total Weight Gain - Twins**	**Weekly Weight Gain for 2nd and 3rd Trimesters - Twins**
Underweight women (BMI < 18.5)	Individualized – Speak to PN Care Provider	Individualized – Speak to PN Care Provider
Normal weight women (BMI 18.5 to 24.9)	37-54 pounds	1.1 to 1.7 pounds
Overweight women (BMI 25.0 to 29.9)	31-50 pounds	1.0 to 1.6 pounds
Obese women (BMI ≥ 30.0)	25-42 pounds	0.8 to 1.4 pounds

REFERENCES:

1. Institute of Medicine and National Research Council. 2009. *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12584
2. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-weight-gain.htm, accessed 12/19/2017.
3. Weight gain during pregnancy. Committee Opinion No. 548. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:210–2. (reaffirmed 2018).

Appendix B.3: Protocols: Perinatal Blood Pressure Assessment: Nursing

Protocol Title:	Perinatal Blood Pressure Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: Taking an initial blood pressure reading will establish a baseline for future evaluation; successive blood pressure readings will assist in evaluating alterations that may be detrimental to the client and/or the pregnancy.

PROCESS:

- Blood Pressure should be measured and recorded at each visit prenatally and up to 6 weeks postpartum. In hypertensive clients, BP should be monitored at least 6 weeks postpartum and further until hypertension is resolved.
- Measure blood pressure after client has been sitting quietly for five minutes with arm resting at heart level. Back should be straight and legs should be uncrossed with feet flat on the floor. Attempt to take a blood pressure reading at least 30 minutes after the client has exercised, consumed caffeine, or used tobacco. Client should not be talking at the time of the reading.
- Assess size of cuff required. A cuff that is too large will give a falsely low reading, and a cuff that is too small will give a falsely high reading. The length of the cuff bladder should be at least 80% of the arm's circumference.
- Ideally, a reading should be taken on both arms and the higher reading should be recorded.
- If Community Health Workers take blood pressures, local health authorities should have policies in place to provide procedures for reporting abnormal blood pressures to the Nurse Home Visitor.
- Hypertension in pregnancy is greater than or equal to 130 mmHg systolic or 80 mmHg diastolic in a woman 20 weeks or greater with a previously normal blood pressure*.
- **Prenatal or postnatal blood pressure readings greater than 130 mmHg systolic or 80 mmHg diastolic should be immediately reported to the prenatal care provider.**
- **Prenatal or postnatal acute onset of blood pressure readings of 160 mmHg systolic or 110 mmHg diastolic (sustained 15 minutes or more) constitutes a medical emergency and should be addressed immediately.**
- **Take a blood pressure, and alert prenatal care provider if client reports any of these symptoms (may indicate preeclampsia**):** Persistent severe headaches, changes in vision, right upper quadrant abdominal pain, or sudden weight gain of more than 2 pounds in a week.

*Note: the BP recommendation for adults was updated by the American College of Cardiology and the American Health Association in 2017. Many on-line resources still reference the BP of 140/90.

** Note: **Preeclampsia** is defined as gestational hypertension combined with proteinuria after 20 weeks gestation. A 24-hour urine specimen is necessary to reliably measure urine protein excretion for a diagnosis of proteinuria; a conventional urine dipstick test is not adequate.

References:

1. Institute for Clinical Systems Improvement (07/2012), National Institutes of Health.
2. The American College of Obstetricians and Gynecologists. Hypertension in Pregnancy (2013). https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy.
3. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA. Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. *Journal of the American College of Cardiology*. Vol 71, no. 19, 2018.
4. Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. Committee Opinion No. 692. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017:129:e90–5.
5. Interpregnancy care. Obstetric Care Consensus No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e51-72. https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Interpregnancy-Care

Appendix B.4: Protocols: Perinatal Breastfeeding Promotion and Support

Protocol Title:	Perinatal Breastfeeding Promotion and Support
Target Audience:	Public Health Maternal-Child Health Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: Breastfeeding is the biological norm for infant nutrition and the ideal method for feeding infants. Breast milk not only meets the specific nutritional needs of human babies, it also provides enzymes, growth factors, antibodies and hormones not found in formula. It is easy for babies to digest, supports healthy growth and development, and provides health benefits for mothers, too. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months, and then continued breastfeeding for one year and beyond, even as solid foods are introduced.

PROCESS:

- During the pregnancy intake process, use open-ended questions to assess the woman's breast health history (breast surgery may impact her success with breastfeeding), breastfeeding history, desires around breastfeeding and plan for feeding her infant, and impact of previous experience and preconceptions about breastfeeding.
- Encourage breastfeeding throughout the pregnancy visits, as client permits and barring contraindications (referenced below).
- Provide education to support successful breastfeeding, based on assessment. Personalized education based on the woman's needs is most effective. The woman's partner and/or other family members may benefit from education: the woman's mother may be of particular importance in influencing breastfeeding practices. The La Leche League and Oregon WIC websites offer good educational materials on a variety of topics:
    - http://www.llli.org/nb.html
    - http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/BREASTFEEDING/Pages/support.aspx
- Postpartum, continue to monitor and support breastfeeding (see contraindications below), ensuring mother has access to lactation consultation, as needed. Highlight that breastfeeding takes practice, and that solutions are available for problems or concerns that arise.

GUIDANCE RELATED TO CONTRAINDICATIONS:

- Opioids: The AAP supports breastfeeding by narcotic-dependent mothers while enrolled in a supervised methadone maintenance program and who are negative for HIV and illicit drugs, especially PCP, cocaine and cannabis. Prescribed opioid use for limited duration are not contraindicated.
- Marijuana: Although marijuana is legal in Oregon, the use of marijuana while breastfeeding is discouraged. Tetrahydrocannabinol (THC) can pass from the mother's

breast milk to the infant and may harm the infant. Potential also exists for impairment in the mother's ability to care for the infant.

- Tobacco: It is always best for a mother to NOT smoke. However, if she cannot quit smoking, breastfeeding will decrease her baby's risk for respiratory problems, allergies, and Sudden Infant Death Syndrome. Mothers who smoke are encouraged to breastfeed, **and** to keep secondhand smoke away from the baby – not smoking near her baby, in the house or car, to change her shirt after smoking, etc. Mothers who smoke may also have lower milk production.
- Hepatitis B and C: Mothers with Hepatitis B or C can breastfeed. If a mother has an open sore on her breast, or a cracked and bleeding nipple, she can breastfeed from the side that is not affected, and express and discard any milk she collects from the affected side until the sore heals. Ensure the lesion is covered carefully so the baby has no risk of contact.
- HIV-AIDS: The AAP recommends no breast milk if the mother is HIV-positive.
- Active, untreated Tuberculosis: May give expressed milk; may resume breastfeeding when mother is treated for 2 weeks and is documented she is no longer infectious.
- Active herpes simplex lesions on breast: May give expressed milk.
- Varicella 5 days before through 2 days after birth: mothers should be separated from infants but may give expressed milk.
- Infant metabolic disorder, such as galactosemia: No breast milk.
- Mothers positive for human T-cell lymphotrophic virus type I or II or untreated Brucellosis may not breastfeed or give expressed milk.

REFERENCES:

1. Breastfeeding and the Use of Human Milk. SECTION ON BREASTFEEDING. Pediatrics Mar 2012, 129 (3) e827-e841.
2. Centers for Disease Control and Prevention. *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies*. Atlanta: U.S. Department of Health and Human Services; 2013.

Appendix B.5: Protocols: Perinatal Environment and Environmental Exposures Evaluation

Protocol Title:	Perinatal Environment and Environmental Exposures Evaluation
Target Audience:	Public Health Maternal-Child Health Home Visitors
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: An evaluation of home environment and potential environmental exposures will augment the History and Physical assessment of the client. Community Healthy Workers who are performing this evaluation should have a process in place to communicate their findings with the Nurse Home Visitor. This additional shared knowledge will inform the development of a nursing care plan that supports the most appropriate interventions to promote a healthy pregnancy, optimal birth outcomes, and child development.

PROCESS: It may not be possible to complete the full environmental evaluation in one visit, and not all of these issues may be pertinent to every client. Consider evaluating the following issues in a timely manner. It will be necessary to continue to reevaluate many of these issues throughout the management of the case.

Housing Considerations	
Shelter Status	Home owner; Apartment; Mobile home; Living with extended family; Neighborhood safety; Homeless; Number of bedrooms/persons; Bathroom access; Safe stairs/Trip hazards; Safe egress/Locking entrance; Fire hazards;
Heating/Cooling	Ventilation; Type of heat; Wood or pellet stove/Fireplace safety; Funds to pay for heat source; Broken windows/doors
Cleanliness	Clutter; Trash accumulating; Mold/Mildew
Water	City services; Well water; Hauling and storing water; lead exposure
Sewage/Garbage	City curbside services; Self-transport to landfill
Food Storage	Refrigerator; Cupboards; Pests
Food Preparation	Counter space; Stove/Oven; Sink
Safety Considerations	
Smoke and Carbon monoxide Alarms	Carbon monoxide alarms and Smoke alarms are required (landlords required to provide); Installed/Working order; Batteries replaced
Smoking	Family members smoke; Allowed inside/Confined to outside
Lead Exposure	Paint; Pipes; Eating/Serving dishes; Hobbies; Occupational exposure (mine, smelter, lead-glazed ceramic potter, auto repair, paint, batteries, plastics), soil (pica), canned food, toys made outside United States
Toxin Exposure	Asbestos; Mercury (including in fish: https://www.fda.gov/Food/ResourcesForYou/Consumers/ucm393070.htm); Occupational chemicals; Household cleaners; Radon; Rodent poisons;
Pets	Variety; Number; Responsibility for care of animals (e.g., pregnant women should not empty cat litter boxes d/t risk Toxoplasmosis); pet products (flea and tick shampoo with pesticides); wild or pet rodents (stay away from droppings d/t lymphocytic choriomeningitis virus)

Food	Unpasteurized foods; Raw meat, fish, eggs; Contaminated fish; Refrigerated patés and smoked fish; Non-food cravings, improper washing
Guns	Possession; Locked/Unloaded
Phone	Possession/Access

References:

1. https://www.marchofdimes.org/pregnancy/lead-poisoning.aspx accessed 4/25/2018
2. Based upon guidelines from OAR 410-130-0595

Appendix B.6: Protocols: Perinatal Gestational Diabetes Mellitus Assessment: Nursing

Protocol Title:	Perinatal Gestational Diabetes Mellitus Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE:

Gestational diabetes mellitus (GDM) is a common disorder of pregnancy. Between 2% and 10% of pregnancies are impacted by GDM. Currently, there is discussion about lowering the threshold for diagnosis, especially in high-risk ethnic populations with a higher prevalence of GDM. The American Diabetes Association encourages providers to test women with risk factors for type 2 diabetes at the first prenatal appointment; a diagnosis of diabetes at this time is considered overt diabetes, not GDM. Untreated or poorly controlled GDM can lead to many complications including preeclampsia and/or preterm delivery. Complications for the baby may include macrosomia (very large at birth), neonatal hypoglycemia, and risks for future development of obesity and diabetes. Fifty percent of women with GDM will develop type 2 diabetes later in life.

PROCESS:

- During the pregnancy intake process, assess for diagnosis of GDM and any diagnosis of GDM with previous pregnancies, as applicable.
    - Clients should be tested for GDM at 24-28 weeks of gestation in women not previously known to have diabetes. Some clients may receive testing earlier in pregnancy depending on assessment and risk factors.
    - Diagnostic criteria for GDM are based on a “One-step” 75 g oral glucose tolerance test (OGTT) OR a “Two-step” Glucose Challenge test (or glucose screening test).
    - Women with risk factors for Type 2 Diabetes (see Table 1) should be screened for diabetes at their first prenatal visit.
- Provide education about diagnostic testing to clients, as applicable. Connect clients to resource for GDM testing if needed.
- Provide education about the risks associated with GDM.
- Advise client of risk factors for development of GDM:
    - ✓ African American, American Indian/Alaska Native, Asian American, Hispanic, or Pacific Islander
    - ✓ Overweight (BMI ≥ 25 kg/m2 or ≥ 23 kg/m2 in Asian Americans)

- ✓ Older than 25 years
- ✓ Parent or sibling with diabetes
- ✓ Previous pre-diabetes diagnosis
- ✓ History of GDM in a previous pregnancy
- ✓ History of delivery of a baby who weighed 9 pounds or more

- Encourage client with a diagnosis of GDM to adhere to primary care provider's plan, which may include a healthy diet, physical activity, routine monitoring and testing (including urine ketone levels and daily blood glucose checks), referrals to specialists (e.g., dietician, diabetes educator), and possibly medication.
- Advise client with a GDM diagnosis that she will need to be tested 6-12 weeks postpartum to ensure her blood glucose levels have returned to normal, and screened at least every 3 years for life.
- Provide education on prevention or delay of type 2 diabetes later in life, including importance of breastfeeding.

Table 1. Risk factors for Type 2 Diabetes

Overweight (BMI ≥25 kg/m^2*) **and** have additional risk factors*:
• physical inactivity
• first-degree relative with diabetes
• high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
• women who delivered a baby weighing >9 lb or were diagnosed with GDM
• hypertension (≥140/90 mmHg or on therapy for hypertension)
• HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
• women with polycystic ovary syndrome
• A1C ≥5.7%, IGT, or IFG on previous testing
• other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
• history of CVD

*American Diabetes Association. Classification and diagnosis of diabetes. Sec. 2. In *Standards of Medical Care in Diabetes—2015*. Diabetes Care 2015;38(Suppl. 1):S8–S16

References:

1. American Diabetes Association. Classification and diagnosis of diabetes. Sec. 2. In *Standards of Medical Care in Diabetes—2015*. Diabetes Care 2015;38(Suppl. 1):S8–S16
2. https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes/gestational/after-your-baby-is-born, accessed on 12/18/2017
3. https://www.cdc.gov/diabetes/basics/gestational.html, accessed on 12/19/2017

Appendix B.7: Protocols: Social Determinants of Health Screening

Protocol Title:	Social Determinants of Health Screening
Target Audience:	Public Health Maternal-Child Health Home Visitors
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE:
Scientific research has made it clear that access to good health care is not sufficient to produce a healthy society. The social determinants of health (e.g., income, education, transportation, housing, food, community safety) have a profound impact on child and adult health and mental health. The research on adverse childhood experiences (ACEs) and early brain development has demonstrated that psychosocial stressors are "toxic" to the developing brain and metabolic systems of the young child, resulting in poor mental health, cognitive disability, and chronic disease. Home visitors are uniquely positioned to address these challenges. By directly focusing on these needs, home visitors can buffer the impact of stressors on the brain through promoting responsive, nurturing relationships.

PROCESS:

Assess for the availability of resources to meet daily needs (e.g. safe housing, transportation, food security), social network/support system and ability to access and/or utilize needed services. The TCM Assessment should be used for all clients for whom Targeted Case Management services will be provided and billed. Additional (optional) screening instruments include:

- The Oregon Family Well Being Assessment was developed by the Oregon Perinatal Collaborative as a response to the need to integrate behavioral health, social determinants of health and awareness of Adverse Childhood Events (ACEs) into maternity care.
- The American Academy of Family Physicians offers a social determinants of health screening tool, available in short- and long-form in English and Spanish. The short-form(bit.ly) includes 11 questions. It can be self-administered or administered by clinical or nonclinical staff.
- The Centers for Medicare & Medicaid Services Accountable Health Communities' 10-question Health-Related Social Needs Screening Tool(innovation.cms.gov) (AHC-HRSN) is meant to be self administered.

- The Hunger Vital Sign offers 2 standardized questions to screen for food insecurity.

In collaboration with the client, the home visitor and client should develop goals and activities/interventions to address the social determinants of health.

RESOURCES:

American Academy of Pediatrics: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Social-Determinants-of-Health.aspx

Oregon Primary Care Association: https://www.orpca.org/initiatives/social-determinants-of-health/251-sdoh-tools-resources

Appendix B.8: Protocols: Perinatal Reproductive Life Planning

Protocol Title:	Perinatal Reproductive Life Planning
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE:

Reproductive life plans are intended to promote planned, healthy pregnancies, positive birth outcomes, and overall health and well-being for women, men, and infants. The Centers for Disease Control and Prevention recommends that all women, men, and couples be encouraged to have a reproductive life plan. (1)

PROCESS:

Reproductive life planning can be initiated at any time (e.g., prenatal, postpartum or interconception) and should be offered to everyone, irrespective of assumptions or biases about individual circumstances. Furthermore, reproductive life plans should be considered fluid, and updated regularly per changing goals, needs, and life circumstances (or updated at least annually). Addressing reproductive life planning during the perinatal periods offers an opportunity to provide education, support, and resources to help the women and families they serve achieve optimal pregnancy goals.

Discuss client's reproductive life plan about becoming pregnant by asking questions like:

a) Do you want to have (more) children?
b) How many (more) children would you like to have and when?

If yes, discuss patients' readiness for pregnancy, overall health and opportunities for improving health, and potential risk factors for adverse pregnancy outcomes. If the client desires pregnancy testing, then provide or refer for pregnancy testing and preconception counseling. All options counseling should be made available to all pregnant clients.

If no, provide counseling about family planning, and provide or refer for birth control. Provide evidence-informed counseling about the full range of contraceptive methods for postpartum use**.**

If unsure, using a client-centered approach, continue to explore clients' readiness for pregnancy, goals, needs and life circumstances.

REFERENCE:

(1) Centers for Disease Control and Prevention (CDC) Planning for Pregnancy
https://www.cdc.gov/preconception/planning.html

RESOURCES

Before, Between and Beyond Pregnancy, Resource Guide for Clinicians
https://beforeandbeyond.org/toolkit/reproductive-life-plan-assessment/

Centers for Disease Control and Prevention Contraceptive Method Guidance
https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/training.htm

MMWR Update: Providing Quality Family Planning Services — Recommendations from CDC and the U.S. Office of Population Affairs, 2015
https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm

March of Dimes
One Key Question

Appendix B.9: Protocols: Perinatal Mood Disorder Screening

Protocol Title:	Perinatal Mood Disorder Screening
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	1/2019
Date of Next Review:	10/2019

PURPOSE:

Perinatal mood disorders, which include major and minor depressive episodes and anxiety that occur during pregnancy or in the first 12 months after delivery, are one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women (1). It is important to identify pregnant and postpartum women with mood disorders because untreated perinatal mood disorders can have devastating effects on mothers, infants and families.

PROCESS:

Use a validated tool to screen all clients for perinatal mood disorders. Examples of validated tools are below.

- Patient Health Questionnaire-9 (PHQ-9) 9-item screener for DSM-IV depression criteria and other leading major depressive symptoms.
- Edinburgh Postnatal Depression Scale (EPDS) 10- item non-standardized self-report measure assessing maternal postnatal/postpartum depression.

Both the EPDS and the PHQ-9 are validated for use in the perinatal population, and there is no fee. The benefits are that they are self-administered, translated into many languages, and easy to complete. The EPDS addresses the anxiety component of perinatal mood disorders as well as depressive symptoms and suicidal thoughts. The PHQ-9 does not have the anxiety component but includes suicidal ideation.

Depression or anxiety is recognized as one of the presenting symptoms of perinatal mood disorders and should be a part of a mood disorder assessment.

If Community Health Workers screen for IPV, local health authorities should have policies in place to provide procedures for reporting positive screens to the Nurse Home Visitor.

The screens should be administered at intervals according to the guidelines of the home visiting program and any time concerns arise. Communicate screening results to prenatal care provider and document. Determine need for further assessment. If the screening results suggest a perinatal mood disorder share concerns with the client and develop a plan of care to:

- Continue to establish a supportive relationship
- Recognize and reassure. She is not alone, it is not her fault, and with help she will get better. Help her reach out.
- Educate the client.
- Educate on possible treatment options;
- Plan interventions based on need.

REFERENCES:

(1) American College of Obstetricians and Gynecologists Committee Opinion https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression?IsMobileSet=false

RESOURCES:

Oregon Maternal Mental Health Webpage https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALTH/pages/index.aspx

Postpartum Support International http://www.postpartum.net/

Appendix B.10: Protocols: Perinatal Intimate Partner Violence Screening

Protocol Title:	Perinatal Intimate Partner Violence Screening
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: Intimate Partner Violence (IPV) impacts women and men across all age groups, educational levels, races, ethnicities, socioeconomic backgrounds, and cultures; the number of individuals affected can only be estimated because many instances of IPV are never reported. The Centers for Disease Control and Prevention (CDC) suggests that nearly 3 in 10 women and 1 in 10 men in the U.S. have experienced rape, physical violence, and/or stalking by a partner; these numbers do not reflect people subjected to psychological abuse. Pregnancy and the postpartum period is a particularly dangerous time for women impacted by IPV. Home visiting nurses are in unique positions to assess, educate, and support safety.

PROCESS:

- Local health authorities should have written guidelines in place that delineate safety procedures for home visitors during IPV assessments.
- Guidelines may include safety measures such as:
  - Arrange time to screen woman alone, *never* with partner, friends or family.
  - Use professional interpreter if needed, *never* a family member.
  - Never leave domestic violence information around without first finding out if it is safe to do so.
- Attempt to normalize the screening process to promote comfort with the discussion and encourage candid responses: use a framing statement such as, "We've started talking to all of our clients about safe and healthy relationships, because these have such a large impact on your health."
- Note that non-structured discussions that focus on parenting, safety or healthy relationships are more likely to illicit disclosure of violence, so it is most helpful to establish a therapeutic relationship before using the IPV screening tool.
- After establishing rapport and creating a safe environment, use a validated tool to screen for IPV during the intake process, postpartum, and at any other time concerns arise. Examples of validated tools include:
  - Futures Without Violence Relationship Assessment Tool https://www.futureswithoutviolence.org/wp-content/uploads/E-Relationship-Assessment-Tool1.pdf (This is the same form as on the Oregon MIECHV Data Collection website).
  - For NFP program, use the Clinical IPV Assessment form.

- If Community Health Workers screen for IPV, local health authorities should have policies in place to provide procedures for reporting positive screens to the Nurse Home Visitor.

- Ensure patients also know that what they say is confidential unless what they tell you falls within the mandatory reporting guidelines. Among others, this includes child abuse or neglect: if you suspect a child with whom you have had contact is being abused or neglected, or that a person has abused a child, you must report it.
    - For full mandatory reporting information, go to: http://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx
- When IPV is identified, support the client in making a safety plan. See the Futures Without Violence Safety Plan and Instructions at http://www.futureswithoutviolence.org/userfiles/file/Maternal_Health/Safety%20plan%20English-Consensus%20Guidelines.pdf. The plan covers:
    - ✓ Safety during a violent incident
    - ✓ Safety when preparing to leave
    - ✓ Safety in client's own home
    - ✓ Safety with a protection order
- Provide client with community resources for IPV advocacy support and services; remember to evaluate safety risks for client before leaving print IPV materials in the home.

REFERENCES:

1. Healthy Moms, Happy Babies: Using the Relationship Assessment Tool and Universal Education. https://www.futureswithoutviolence.org/healthy-moms-happy-babies-using-the-relationship-assessment-tool-and-universal-education/
2. How to Screen for Intimate Partner Violence: Tools from ACOG. http://www.obgyn.net/young-women/how-screen-intimate-partner-violence-tools-acog
3. Module 3 (Young Mom's Version). Assessment and Safety Planning for Domestic Violence in Home Visitation. https://www.futureswithoutviolence.org/youngmomsmodule/.
4. Tools for improving maternal health and safety in a multicultural context. https://www.futureswithoutviolence.org/tools-for-improving-maternal-health-safety-in-a-multicultural-context/, accessed 12/27/2017.

Appendix B.11: Protocols: Perinatal Substance Use Screening

Protocol Title:	Perinatal Substance Use Screening
Target Audience:	Public Health Maternal-Child Health Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	1/2019
Date of Next Review:	1/2020

PURPOSE: Evidence directly links prenatal exposure to drugs, alcohol and tobacco with negative impacts on the developing fetus and/or the pregnancy outcome and child development. Mothers and caregivers are strongly discouraged from using these substances. In pregnancy, researchers frequently find an *association* between drug use and adverse pregnancy outcomes; however, they are challenged to find a *causal* relationship. For instance, marijuana is composed of many different chemicals and can be mixed with other drugs; women may use multiple substances and may also exhibit other risky behaviors; and, it is difficult to effectively measure and monitor substance use. Because we cannot be certain what outcomes are related to which substances and behaviors, we are not able to determine the dose relationship; therefore, women are discouraged from using *any* quantity of anything not prescribed by the prenatal care provider.

PROCESS:

Assessment, Diagnosis and Planning:

- As early as possible after establishing rapport, screen for substance use according to program (Babies First!, Nurse Family Partnership) guidelines.
- Use a validated tool to screen all clients for use of alcohol, drugs including prescription drugs, and tobacco. Examples of validated tools are below, but this is not an exhaustive list.
    - Alcohol: SBIRT, AUDIT, Abbreviated AUDIT-C, or a single question such as “How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?”; others screening tools include the CAGE-AID, CAGE, T-ACE, and ASI.
    - Alcohol and Drugs: 4 P’s Plus; Screening to Brief Interventions (S2BI); CRAFT (age 26 or younger); Brief Screener for Alcohol, Tobacco and Drugs (BSTAD); and NIDA Quick Screen.
    - The MIECHV Substance use risk Profile-Pregnancy Scale form and the NFP Health Habits form should be used as appropriate per program guidelines.
- If Community Health Workers screen for substance use, local health authorities should have policies in place to provide procedures for reporting positive screens to the Nurse Home Visitor.
- Consider repeating the screen if your nursing assessment suggests this need, even if not according to program guidelines.
- Assess cognitive status, especially changes in mood that might be a sign of preexisting or coexisting conditions such as multi-substance use, depression, or mental health concerns. Just eliminating one substance may not solve the problem.
- Communicate screening results to pregnancy care provider and document. Determine need for further assessment by pregnancy care provider. Determine with provider need for

screening of STDs, hepatitis B and C, and tuberculosis, especially if there are signs of co-existing conditions.

- If the screening results suggest substance use, share concerns with the client and develop a plan of care to:
    - Continue to establish a supportive relationship.
    - Educate the client on effects of substance use during pregnancy: Ask the client to describe her understanding of the situation, link substance use to any signs or symptoms client has (there may be none), describe importance of stopping, explain what could happen with continued use.
    - Educate on possible treatment options such as medication assisted treatment and behavioral therapy like skill-building and problem-solving (medically supervised withdrawal is not recommended at this time due to association with high relapse rate).
    - Plan interventions based on need (see below).

Interventions:

- Depending upon the substance, the level of use, and the outcome of the communication with the prenatal or primary care provider, assist the client in accessing drug and/or alcohol rehabilitation supports. Treatment with methadone or buprenorphine may be recommended by physician.
- Engage all clients in a conversation giving education, feedback and advice on the potential harmful effects of substance use. Some clients may need more intensive motivational interviewing, or Brief Interventions conversation (see the MIECHV Substance use risk Profile – Pregnancy Scale tool or the NFP Visit-to-Visit Guidelines, as allowed by program area)
- For women using tobacco, implement the 5As framework for counseling (Ask, Advise, Assess, Assist, Arrange); provide education and refer as appropriate; continue to monitor and support the client in achieving cessation. The CDC website has education resources for this purpose: https://www.cdc.gov/reproductivehealth/MaternalInfantHealth/TobaccoUsePregnancy/index.htm
- Provide emotional support to clients who becomes abstinent during pregnancy, as they may struggle with strong feelings related to exposing the fetus to potentially harmful substances.
- Opiates, alcohol, and nicotine can be passed to infants through mother's breast milk. Advise pregnant women of these risks and discourage breastfeeding mothers from using substances. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics supports breastfeeding by women who are prescribed opioids while enrolled in substance use treatment.
- Oregon law does not consider substance use during pregnancy to be child abuse under child-welfare statutes, and there is not a requirement for health care professionals to report suspected prenatal drug use. Oregon's mandatory child abuse and neglect reporting law can be found here: https://www.oregonlegislature.gov/bills_laws/ors/ors419B.html

REFERENCES:

1. Five Major Steps to Intervention (The "5 A's"). Content last reviewed December 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html
2. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*, 2d ed. NIH Pub. No. 03–3745. Washington, DC: U.S. Dept. of Health and Human Services, Public Health Service. Revised 2003, may be accessed online at http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.htm.)
3. Chart of Evidence-Based Screening Tools for Adults and Adolescents. https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults, updated September 2017, accessed 12/27/2017.
4. National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy.
5. Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81–94.

Appendix B.12: Protocols: Postpartum History and Physical Assessment: Nursing

Protocol Title:	Postpartum History and Physical Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors
Date Updated:	01/2019
Date of Next Review:	01/2020

PURPOSE: A thorough nursing assessment of the client's physical and emotional health after the birth of her child will provide essential information to enable the nurse to develop a care plan that supports the most appropriate interventions to promote health and the nurturing of a positive parent-infant relationship postpartum. The postpartum period is also a key time to monitor for pregnancy-associated problems and provide early interventions: the maternal mortality rate has been steadily increasing since 1999 and reached 21.5 deaths per 100,000 births in 2014. The top causes of pregnancy related deaths in the United States are due to heart conditions, infections, bleeding, blood clots and high blood pressure. The risk of pregnancy-related deaths in African-American women is three to four times higher than those of white women. Providing thorough nursing assessments in the post-partum period may be an essential part of reducing maternal morbidity and mortality.

PROCESS: A basic nursing head to toe assessment should be done at the first visit post-partum. Areas that require further assessment and follow up (such as mental health status), should be noted and explored in further visits as soon as possible. Some of these areas may be assessed through therapeutic conversation, rather than hands-on assessment, per nurse's discretion. Physical and mental health not within normal limits should have continued follow up at subsequent visits as needed. The body systems to consider for a head to toe assessment are listed in Table 1. Blood pressure should be monitored at each visit up to 6 weeks postpartum. In hypertensive clients, BP should be monitored at least 6 weeks postpartum and further until hypertension is resolved (see Perinatal Blood Pressure Assessment Protocol).(See Perinatal Blood Pressure Assessment Protocol). Note that secondary postpartum hemorrhage can happen between 24 hours and 12 weeks after giving birth.

Clients with chronic health issues (e.g., asthma, renal disease, cardiac disease, orthopedic issues) may need some additional case management services; however, clinical care responsibilities lie with the medical care provider. Signs and symptoms of concern or client concerns should be referred to the appropriate medical care provider, and the referral should be documented (see Table 1 guidelines for when to refer).

Postpartum Assessment Considerations		Considerations for referral to physician
General Health Status	Vital Signs (blood pressure per protocol; and temperature, heart rate, and respirations as needed if abnormality suspected); Cognitive state: mood, orientation; Pain; Medications. Medical hx (e.g., Gestational or Diabetes Type II, anemia, hypo/hyperthyroidism)	*BP: SBP >130 mm Hg or DBP > 80 mm Hg Weight: increase or decrease not consistent with diet Temp: <96 or >101°F Pain not controlled with medication Progression of chronic disease Change in orientation or level of consciousness

Reproductive	Contraceptive plan; Vaginal or pelvic pain; Vaginal or pelvic infections/Sexually Transmitted Infections/risk for infection; vaginal discharge (lochia)	Dark red lochia more than 4 days after delivery; > 1 pad soaked per hour; lochia serosa (pink/brown) > 2 weeks after delivery (can indicate hemorrhaging); clots bigger than a golf ball; foul odor Pain not controlled with medication, or experiencing pain for > 2 weeks
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Skin pale, diaphoretic, cold; cap refill >3 seconds; contusions not explained, or not healing properly; if cesarean, scar red, inflamed, warm, or with pus
HEENT	Vision; hearing; dental care; pain	Vision changes Persistent headache
Breasts	Breastfeeding plan; breast tissue firm, venous pattern increased, areola color dark, nipple everted; no signs infection.	Inverted nipples, poor let down, pain with feeding may need referral to lactation specialist Redness, burning, itching, pus refer to physician
Respiratory	Respiratory rate, effort, pattern; hx of disease, such as asthma	RR <12 /min or >24/ min Shallow breaths, feeling short of breath, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	*BP: SBP >130 mm Hg or DBP > 80 mm Hg HR: <50, >100 at rest, with consideration of what is normal for client Detection of new murmur or abnormal rhythm
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/vomiting; indigestion; status of uterus.	Abdomen unusually tender Bowel movement type/amount abnormal for patient Persistent nausea/vomiting Uterus hard umbilicus or not decreasing in size
Diet and Exercise	Appetite; special dietary needs/preferences; food safety risks; weight; activity level	Loss of appetite affecting weight Weight gain, especially in conjunction with changes in BP,

		edema, headache, or vision changes
Urinary	Voiding characteristics (amount, color, odor, pain). History of UTIs.	Pain with urination Increased frequency not associated with intake Oliguria or anuria (should void 0.5 to 1 ml/kg/hr) Blood or clots in urine (not associated with vaginal bleeding)
Peripheral Vascular	Edema; Varicosities; Leg pain	2+ edema not resolving, or in conjunction with other signs (BP, headache, blurred vision, HR changes, SOB) Persistent leg pain
Musculoskeletal	Extremity strength; extremity movement; Activity level; Limitations to activity; Pain	Unexpected weakness (<4/5 strength) in one or more limbs Unexpected change in mobility Persistent pain
Neurologic	Extremity sensation, seizure history; fatigue/sleep	Numbness or tingling in extremities Seizures Extreme fatigue, especially in conjunction with anemia
Mental Health	History of treatment for mental illness; History of depression/anxiety; Suicide ideation/attempts; History of abuse; Stress level; Self-esteem; Support system; Current affect	By 4 – 6 weeks post-partum and at 3-4 months, conduct depression screening, suicide screening, intimate partner violence screening, make referral as appropriate
Behavioral	Tobacco use/exposure; Substance use/exposure; Risky behaviors	As needed, conduct substance use screening and make referral (See Substance Abuse Protocol)
Developmental	Education level; reading level; special needs	

REFERENCES:

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Appendix B.13: Protocols: Newborn, Infant, Toddler History and Physical Assessment: Nursing

Protocol Title:	Newborn, Infant, Toddler History and Physical Assessment: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Updated:	01/2019
Date of Next Review:	01/2020

PURPOSE: Thorough assessments are an important component of the nursing process, and are an essential component of Babies First! program expectations. Assessments provide information on the child's physical, emotional, and developmental health, which enables the nurse to develop a care plan that supports the most appropriate interventions to promote healthy growth and development.

PROCESS: The newborn head to toe assessment should be completed at the first post-partum visit. It may not be possible to complete the full assessment in one visit, and not all of these issues may be pertinent to every client. However, as an important component of the nursing process, consider assessing the following systems. Systems to assess are listed in Table 1 (Newborn and Infant) and Table 2 (Toddler).

Blood pressure and temperature for infants and toddlers are not required; the local implementing agency may decide to take BP and temperatures on a case-by-case basis (e.g., if a client is on blood pressure medication, or for teaching parents how to take temperature). For that reason, considerations for referrals to the primary care physician are listed and include parameters for BP and temperature. Referrals should always be made based on nursing judgment, even if the criteria listed in the table are specifically met (or not met).

Growth (weight, length and head circumference) should be recorded and plotted on appropriate growth grid (see recommended growth grids here: https://www.cdc.gov/growthcharts/index.htm).

If providing blood pressure and temperature monitoring, pay special attention to Vital Sign (VS) abnormalities in infants < 1 month, as a single VS abnormality may be the only sign of serious illness.

Table 1. Newborn and Infant Assessment Considerations (0-11 months)

Newborn and Infant Assessment Considerations		Considerations for referral to physician
General Health Status	Vital Signs (weight, recumbent length, head circumference (recommended monthly up to three years of age); and temperature, heart rate, blood pressure, and respirations as needed if abnormality suspected; Medical hx (e.g., type of birth, newborn blood tests, major or minor anomalies suggesting need for genetic evaluation)	**SBP*: <50 mmHg or >100 mmHg (<3 months); < 75 or >115 mmHg (3-11 months) *Heart Rate*: <80 or >190 (< 3 months); <80 or >160 (3-11 months) *RR*: <20 or >60 (< 3 months); <20 or >50 (3-11 months) *Temp*: <96 or >101°F Weight loss of >10% birth weight for normal weight or >15% for preterm infants, failure to gain any weight after 72 hours Larger than expected increase in head circumference
Cognitive	Alertness Congenital anomalies	Lethargy, unresponsive or minimal responsiveness to touch No tracking with eyes Minimal responsiveness to interactions
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Skin jaundice Lesions, bruising, rashes (not diaper rash) Mottled skin (especially in conjunction with fever or lethargy and not normal for infant)
HEENT	Head size/shape, sutures, fontanels Vision, fixate and follow response Ears Nose Hearing screen done by 1 mo Oral care provided	Enlarged or sunken fontanel, prematurely closed sutures (<2 mo for posterior; < 9 mo for anterior) Lack of tracking Ears with pits or tags Nose patency
Respiratory	Respiratory rate, effort, pattern	Tachypnea/ bradypnea Shallow breaths, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	Hyper/hypotension Tachy/bradycardia Detection of new murmur or abnormal rhythm.

Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/vomiting; indigestion	Abdomen unusually tender Umbilical site not healing Bowel movement type/amount abnormal for patient Projectile vomiting
Diet	Appetite Breastfeeding or bottle feeding success Weight (Normal: immediate after birth loss = 10%; regained within 7 days; gain 1 oz per day first 3 mo; 4-5 oz/week from 3-6 months) Length (gains 1 inch/mo up to 6 mo)	Weight loss Lack of weight gain (for pre-term infants, see https://www.oregon.gov/oha/ph/healthypeoplefamilies/wic/documents/preterm.pdf for indications for referral and promoting caloric requirements) Signs of dehydration
Urinary	Voiding characteristics (amount, color, odor, pain)	Apparent pain with urination Oliguria or anuria (should void at least 6 soaked diapers days 5-28 or 1ml/kg/hr) Blood or clots in urine
Peripheral Vascular	Femoral pulses Temperature of extremities	Weak femoral pulse Cool extremities not related to room temperature or lack of clothing, esp with fever, mottling or lethargy.
Musculoskeletal	Spine formation Formation/movement of extremities	Torticollis Noted abnormalities of leg length or thigh-fold asymmetry at 4 mo
Neurologic	Reflexes: Suck, blink, gag, rooting, extrusion, Babinski, Moro, startle, plantar/palmar, stepping Tonic neck Symmetry of limbs/movement Muscle tone	Absence or change in reflex Asymmetry in movement Decreased muscle tone
Developmental	Social/Verbal/Gross/Fine motor development Sleep habits	See Newborn, Infant, Toddler Developmental Screening Protocol

*change in vital signs may be the first and only sign of an infection

Table 2. Toddler Assessment Considerations

Toddler Assessment Considerations		Considerations for referral to physician
General Health Status	Vital Signs (weight, recumbent length, head circumference (recommended up to three years of age); and axillary temperature, heart rate, blood pressure and respirations as needed if abnormality suspected); Medical hx (e.g., type of birth, newborn blood tests, major or minor anomalies suggesting need for genetic evaluation)	*SBP*: <75 mmHg or >125 *Heart Rate*: <80 or >125 *RR*: <20 or >40 *Temp*: <96 or >101°F Failure to gain weight
Cognitive	Alertness Congenital anomalies	Lethargy, unresponsive or minimal responsiveness to touch No tracking with eyes Minimal responsiveness to interactions
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Lesions, bruising, rashes (not diaper rash) Mottled skin (especially in conjunction with fever or lethargy and not normal for toddler)
HEENT	Head size/shape, sutures, fontanels Vision, fixate and follow response Ears Nose Oral care provided – fluoride given	Prematurely closed anterior fontanel (<9 mo) Lack of tracking Ears with pits or tags Nose patency decreased
Respiratory	Respiratory rate, effort, pattern	Tachypnea/ bradypnea Shallow breaths, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	Hyper/hypotension Tachy/bradycardia New murmur or abnormal rhythm
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/ vomiting; indigestion	Abdomen tender Bowel movement type/amount abnormal for patient Vomiting/Diarrhea leading to dehydration
Diet	Appetite Breastfeeding and solid foods	Weight loss Lack of weight gain

	Weight (Normal: 3-5 oz/week from 6-18 mo) Length	Signs of dehydration
Urinary	Voiding characteristics (amount, color, odor, pain)	Apparent pain with urination Oliguria or anuria (expect 1ml/kg/hr) Blood or clots in urine
Peripheral Vascular	Femoral pulses Temperature of extremities	Weak femoral pulse Cool extremities not related to room temperature or lack of clothing, esp with fever, mottling or lethargy
Musculoskeletal	Spine formation Formation/movement of extremities	Abnormal movements By 2.5, not able to run without falling
Neurologic	Reflexes: deep tendon Symmetry of limbs/movement Muscle tone	Absence, asymmetrical, or change in reflex Asymmetry in movement Decreased muscle tone
Developmental	Social/Verbal/Gross/Fine motor development Sleep habits Parent-Child Interaction; assess behaviors for positive attachment	See protocol Newborn, Infant, Toddler Developmental Screening See protocol Parent Child Interaction

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4. Nutrition Practice Care Guidelines for Preterm Infants in the Community. https://www.oregon.gov/oha/ph/healthypeoplefamilies/wic/documents/preterm.pdf

Appendix B.14: Protocols: Newborn, Infant, Toddler Developmental Screening

Protocol Title:	Newborn, Infant, Toddler Developmental Screening
Target Audience:	Public Health Maternal-Child Health Home Visitors
Date Updated:	01/2019
Date of Next Review:	01/2020

PURPOSE: Assessing child development from newborn through toddler stage helps identify developmental delays early. Early intervention is key to reducing the impact of delay on the child and their family. Parent-child interaction and attachment will be improved when parents understand the child's developmental status.

PROCESS: Administration of a valid screening tool: identifies children that are developing on schedule; identifies areas children would benefit from practice/support; and identifies children at risk for developmental delays. Results of screening will inform you that: most children are on-schedule and doing great; some children will benefit from practice in an area of development; and a few children will need referral for evaluation. Screening does not diagnose delays or disabilities.

Home Visitors in the Babies First! and Nurse Family Partnership programs are encouraged to use the Ages and Stages Questionnaires (ASQ)-3 and the Ages and Stages Questionnaires (ASQ): Social Emotional (SE)-2 for screening. The screens should be administered at intervals according to the guidelines of the home visiting program (Babies First!, NFP) and anytime concerns arise.

The ASQ-3 is a series of questionnaires for children ages 1 month to 5 ½ years. These are valid tools that are known to accurately identify children at risk for developmental delays. There are 21 age-based ASQ-3 questionnaires but not all ages need to be administered for each child. The 9-month questionnaire was designed for use in health care settings and is not recommended for use in home visiting.

The ASQ:SE-2 is composed of nine questionnaires that can be used with all children from 1 month to 72 months of age.

Step one: Introduce the screening tool to families, explain the purpose of the screening, who will have access to the screening information and how the results will be used.

Step two: Home visitors should carefully calculate a child's age at administration in months and days. See ASQ-3 and/or ASQ:SE-2 User's Guides for detailed guidance. There is an age calculator that the publisher of the ASQ provides at the following website. www.agesandstages.com. Age adjustments must be made when a child is born more than 3 weeks premature, up to, but not including 24 months.

Step three: The questionnaire is completed. Accuracy is improved when a familiar caregiver reports on observable behaviors in a familiar, comfortable environment over time. The child should be given some time to play with materials and the caregiver should try out the majority of the items. Studies suggest that parents are highly reliable reporters on developmental screening tools. The questionnaires are designed to encourage parent/caregiver involvement in the

screening process. Home Visitors report that completing the ASQ-3/ASQ: SE-2 with parents offers an important opportunity to educate parents about whether their child's development and behavior is similar to that of same-age peers.

Step four: Score the questionnaire. Review responses. If there are any missing items, try to obtain answers. If an item is inappropriate, omit the item. Calculate area totals. If any items omitted, calculate new area total (See ASQ-3/ASQ:SE-2 User's Guide for detailed guidance). Review any parent comments.

Step five: Score interpretation and follow-up. Consider culture and family values when interpreting the results. Discuss results with family. If score is above the monitoring zone: Provide follow-up activities and rescreen according to program schedule. If the score is in the monitoring gray zone: Provide activities to practice skills in specific areas and rescreen in 2 months or sooner. Make community referrals as appropriate if the score is below cutoff in one of more areas.

In consultation with family, provide referral to Early Intervention and share results with the primary care provider. The summary sheet (score form) provides a complete summary of ASQ information. The summary sheet can be used to share information with other providers. When sharing results with the summary sheet only, the optional individual item response section should be completed.

If a parent expresses concern, respond and refer if necessary.

Follow-up activities may include:

- ASQ Play activities found in the Appendix of the ASQ-3 User's Guide. They are in a chart format, and each age interval contains activities across developmental areas.
- ASQ Learning Activities are a separate publication. The learning activities contain actions by developmental area.
- ASQ: SE-2 Learning Activities are found in Appendix E of the ASQ-SE2 User's Guide. The Learning Activities include age-by-age handouts and activities to support parents.

Information about how to refer a child to EI/ECSE can be found here:

https://www.oregon.gov/ode/students-and-family/specialeducation/earlyintervention/pages/default.aspx

Appendix B15: Protocols: Oral Health Screening for Infants and Children: Nursing

Protocol Title:	Oral Health Screening for Infants and Children: Nursing
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Nurse-Family Partnership and Babies First! Nurses
Date Created:	1/2019
Date of Next Review:	1/2020

PURPOSE:

Having a healthy mouth plays a vital role in developing and maintaining the overall health and wellness of children, and good oral health starts with a child's baby teeth. Having healthy baby teeth allows a child to chew and eat properly; speak more clearly; guides adult teeth into place; helps to shape a child's face; and keeps future dental costs to a minimum. The purpose of a screening is to identify normal versus abnormal oral conditions and to make referrals for dental care.

PROCESS:

Starting at age 4-6 months, and every 6 months ongoing perform an oral health screening. Recommended screening tools include those endorsed by the Oregon Oral Health Coalition (e.g., The First Tooth Caries Risk Assessment), the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics.

An oral health screening is comprised of two parts:

1. Reviewing oral health history/risk assessment
2. Performing a physical examination of the child's teeth and gums

The oral health history review should cover a child's and his/her caregiver's past and current oral health practices and experiences to help discover risk for oral problems. This review can include the following:

- Previous oral problems.
- Diet and nutrition.
- Fluoride intake:
    - Primary source of drinking water
    - Past fluoride treatment
    - Fluoride supplements (e.g. tablets or rinse)
- Dental visit history.
- Medications that affect the mouth.
- Baby bottle or sippy cup use.

An oral health screening involves a physical examination of a child's mouth, including the lips, tongue, teeth, gums and tissues. For a child less than 3 year of age: the home visitor and the caregiver should sit facing each other with their knees touching. Lay the child on the home visitor's lap with his/her head securely nestled against the screener's abdomen. With gloved hands, the screener should lift the child's lips, feel the soft tissues, check the physical condition of the teeth and gum and look throughout the mouth. For a child 3 year of age or older: the child can be checked while sitting closeand across from the screener. A tongue depressor can be used to move the lips to view the teeth and gums.

INTERVENTIONS:

- Provide age and culturally appropriate anticipatory guidance.
- If local policies and procedures are in place, apply fluoride varnish.
- Refer children for regular dental care or immediate care if assessed to be at increased risk for oral disease. Every child should have a dental visit by age 1. OHP cover dental care from birth.

REFERENCES:http://www.fromthefirsttooth.org/https://www.mchoralhealth.org/pocket/7-risk-01.php https://www.orohc.org/first-tooth/

Appendix B.16: Protocols: Parent Child Interaction Assessment

Protocol Title:	Parent Child Interaction Assessment
Target Audience:	Public Health Maternal-Child Health Nurse Home Visitors including: Maternity Case Management, Nurse-Family Partnership and Babies First! Nurses
Date Updated:	01/2019
Date of Next Review:	01/2020

PURPOSE:

A healthy relationship between a caregiver and their infant is essential for the infant's positive physical, cognitive, social and emotional development. Infants are born with innate biological behaviors that signal a caregiver to respond and aid. When a caregiver can respond sensitively over and over, the infant learns trust and forms an attachment to the caregiver. Attachment is an interaction and emotional experience between the child and caregiver. This first relationship experience forms the basis for infant's understanding of how relationships work, and secure attachment requires warm, nurturing and consistent caregiving. Promoting positive parent-child interaction is a key component of home visiting, as home visitors are in a unique position to assess and enhance parent-child interactions during the first year of life.

PROCESS:

Assessment:

- Nurse home visitors with training in a validated parent-child interaction (PCI) assessment tool (e.g., DANCE, Parent Child Relationship Assessment/NCAST, KIPS) should use that assessment tool. Use the tool-specific scores to identify when parents would benefit from interventions (see Interventions section below).
- It is recommended that programs who are planning to provide parent education and attachment promotion seek training and certification in a validated PCI tool like the ones noted above; however, when a validated parent-child assessment tool is not in use by an agency, the Bright Futures Age Specific Observations of Parent-Child Interactions may be used: https://www.brightfutures.org/mentalhealth/pdf/professionals/in/observation.pdf.
- It is not possible to determine a cutoff point for referral without using a validated tool; however, it is important to make sure that parent-child interactions are positive and opportunities for improvement are not missed; nurses should have a low threshold for instituting strength-based interventions. MCH State Nurse Consultants trained in validated tools are available for consultation as needed.
- Parent-child interaction assessments should be culturally sensitive and completed per program guidelines or more often as needed based on assessment.
- Each parent-child assessment should have accompanying documentation that includes assessment results, nursing diagnosis, expected outcomes, planning and interventions.

Interventions:

1) When a concern is identified by the nurse or parent, provide follow-up. Follow-up may include:
   a) Interventions from evidenced based curriculums designed to strengthen attachment and overall parent-child interaction:
      i) Circle of security (parent education handouts and videos available online: https://www.circleofsecurityinternational.com/)
      ii) Partnering in Parenting Education (PIPE) curriculum (materials must be purchased)
      iii) Promoting First Relationships

iv) Zero-3 (parent education handouts available under specific topics) https://www.zerotothree.org/resources/series/parent-favorites#social-emotional-development

b) Referral to a mental health provider trained to address parent child interaction (see a list of sites that provide Parent-Child Psychotherapy and Parent Child Interaction Therapy)

c) Treatment of underlying conditions contributing to PCI interruption such as toxic stress, substance use disorder, or other mental health disorders.

Additional Training resources:

1) Oregon Infant Mental Health Association
2) Achieve OnDemand Trainings (contact the MCH Workforce Development team for access) include some courses that relate to this topic:
   a) Foundations of Infant Mental Health Practice in Home Visiting
   b) Exploring Values and Beliefs around Parenting
   c) Home Visiting with Families During Pregnancy
   d) Promoting Effective Parenting with Motivational Interviewing

REFERENCES:

Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017.

Appendix C: Babies First! Self-Assessment of Learning Needs:

Review the list below and determine areas of strength and areas for enhancement/growth.

Topics	Self-Assessment Rate 1-5*	Individual Education Plan Write N/A if no support is needed in this area.	Target date for Completion	Date Completed
Cultural and linguistic responsiveness				
Understanding culture, cultural responsiveness				
Health disparities and health equity				
Trauma-informed approaches to working with families				
Dynamics of family relationships and engagement				
Father engagement				
Building relationships with families				
Family health and well-being				
Pregnancy Wellness, Danger Signs				
ACES				

Topics	Self-Assessment Rate 1-5*	Individual Education Plan Write N/A if no support is needed in this area.	Target date for Completion	Date Completed
Substance Use				
Intimate Partner Violence				
Injury Prevention				
Period of Purple Crying/Shaken Baby				
Reproductive life planning (contraception/ birth intervals				
Child abuse and neglect				
Immunizations				
Sudden Unexplained Infant Death (SUID)/Sudden Infant Death Syndrome (SIDS)				
Food insecurity				
Family self sufficiency				
Establishing family goals				

Topics	Self-Assessment Rate 1-5*	Individual Education Plan Write N/A if no support is needed in this area.	Target date for Completion	Date Completed
Case management and assisting families to access basic needs				
Human growth and development				
Fetal Development				
Nutrition-prenatal, infants, children				
Breastfeeding				
Infant cues				
Normal infant and child growth and development				
Professional best practices				
Motivational Interviewing				
Reflective Practice/Supervision				
Documentation and data collection				

Topics	Self-Assessment Rate 1-5*	Individual Education Plan Write N/A if no support is needed in this area.	Target date for Completion	Date Completed
Continuous Quality Improvement				
Professional well-being				
Home Visitor Safety				
Self-care				
Screening and assessment				
Assessment of pregnant women/ postpartum women				
Assessment of neonate/infant/ toddler health and development				
Service system coordination				
Choosing childcare				
Transition/ Discharge planning				
Health and Human Services-housing, legal aid, health insurance,				

Topics	Self-Assessment Rate 1-5*	Individual Education Plan Write N/A if no support is needed in this area.	Target date for Completion	Date Completed
TANF, SNAP, WIC				
Social emotional well-being				
Attachment				
Parent Child Interaction				
Maternal mental health				
Infant mental health				
Behavior/ Discipline				

* **Scoring:** 1- not confident and limited experience with this topic, 5- very confident and a lot of experience with this topic. Area of strength 5, Area for Enhancement 3-4, Area for Growth 1-2. Supervisors will need to provide additional support for home visitors scoring in 1-4 range. Determine if you or your team can provide support or if you need to access outside resources. Determine a plan to assure home visitor feels supported and knows what to do or who to ask when questions arise.

Appendix D: Client Enrollment

Ideas for increasing referral to enrollment

Many factors influence whether an eligible woman or families will enroll in home visiting services. These include things like trust, functional status and parenting confidence, as well as age, race, education and mental health history. Provider and community-level factors also influence enrollment, including strength of relationships between providers and home visiting program, level of follow-up for hard to reach families, and level of poverty. Below are some ideas to help support conversion of referrals to enrollment at the client, provider, and community level.

Client Level

- Conduct follow up in a timely manner (within 2 days of receiving referral is optimal; required per BF! manual within 10 days).
- Engage in relationship-building techniques at first contact: create time to listen and add open-ended questions related to what the client has heard about Babies First!, and what they are feeling about their pregnancy or their baby (if enrolling after baby is born) and what the person desires for themselves and their baby.
- Highlight the program in terms of what it can do for the **mother or caregiver.**
- Develop a program "pitch" that stresses program flexibility. Some things to consider:
    - An opening statement that makes it clear you are open to meeting them wherever they feel comfortable: "I'd love to talk to you about the things you interested in about [becoming a mom, about your baby, taking care of your child]. We do visits in the home – or wherever works for you".
    - An overview of program, stressing that the schedule and place can be "whatever works best for you" and that it is no cost to the client.
    - Provide the pitch in-person in a safe environment (e.g., waiting room area).
- Ensure potential client that you would not approach her in public unless she says it's okay (e.g., if a pregnant mother, she may not have told people she's pregnant).
- If over the phone, make the focus more about listening to the potential client and what they are interested in (the open-ended questions are good to help facilitate this).
- End the call with a promise to call or have a meeting time set and normalize that people need to think about this. E.g., "Some people need a little time to think about whether they would like a program like this. May I call you next week to talk about what you want to do?"
- Be willing to follow up with further outreach (e.g., a letter and subsequent phone call).

Provider Level

- Doing outreach to providers can be helpful because if a client hears their provider talking positively about the program, they may be more willing to engage. Some outreach to provider ideas:
    - Ask to present about the program at provider staff meetings.
    - Develop contact person at provider offices who you can follow up with about referrals.
    - Bring information sheets, brochures about program to leave at provider offices.
    - Create “office time” at a provider office on a regular basis so you can be there to engage directly with potential clients and be a known entity.

Community Level

Promote community acceptance by:

- Encouraging community engagement (e.g., Community Advisory Boards)
- Outreach to multiple types of referral agencies (e.g., WIC, Schools, Pediatric or OB Clinics, Hospital)
- Connecting with early childhood education programs

References

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Appendix E: Client Support

How can your nurse support you?

I would like support for:

☐ Getting Medicaid/WIC/Food Stamps

☐ Scheduling pregnancy appointments

☐ Accessing transportation

☐ Finding affordable/nutritious food

☐ Finding stable housing

☐ Finding a counselor

☐ Lowering my stress

☐ Working to quit smoking

☐ Finding drug or alcohol treatment

☐ Dealing with an abusive relationship

☐ Finding resources for my other children

☐ Setting goals for myself/my family

☐ Other: _____

I would like to find:

☐ Doula or pregnancy support

☐ Childbirth or Lamaze classes

☐ Baby supplies

☐ Job-seeking support

☐ English As A Second Language classes

☐ Childcare

☐ Playgroups

☐ Support groups for moms

☐ Other:_____

I wish I knew more about:

☐ What to expect during pregnancy

☐ What to eat during pregnancy

☐ Making a birth plan

☐ Labor and Delivery

☐ How my baby grows and learns

☐ Baby care

☐ Birth control and family planning

☐ Breastfeeding

☐ Healthy relationships

☐ Reducing stress

☐ Child support

☐ Immunizations

☐ Making my home safe for my baby

☐ Other_____

Everything is okay right now, but I would like:

☐ Someone to check on the progress of my pregnancy

☐ Someone to check on my baby's development

☐ Someone to talk to

☐ Other: _____

Appendix F.1: Staff Orientation: Public Health Home Visitor Orientation Checklist

I. Recommended Orientation and Training for New Babies First! Home Visitors

Within One Month of Hire	DATE	NOTES
Locate and Review Resource Materials		
• Employee Handbook		
• Nursing Policies and Procedures, including documentation expectations		
• Safety Protocols		
• Babies First! Manual		
Review Orientation Materials		
• Babies First! Introduction Recorded Webinar		
• PHN 100 materials (obtain from MCH Nurse Consultant)		
• PHN 300 materials (obtain from MCH Nurse Consultant)		
• Achieve OnDemand: Basics of Home Visiting Self-paced course		
• Reflection Questions (in development)		
Complete Shadow Orientation		
• At least one shadow visit with mentor nurse (may need to connect with neighboring counties to schedule visit)		
Complete Learning Assessments		
• Self-assessment of learning needs and plan (see Appendix C)		
• 30-60 minute phone call with Supervisor and Babies First! MCH Nurse Consultant to review training plan		
Locate and Understand Community Services		
• Get to know the resources in your community and how to connect clients to them. Some examples: o OB and PCP providers o Food Stamps/WIC/ Food Pantries o Housing/ Rent help o Mental health services o Support for those experiencing IPV o Alcohol and drug recovery o Employment assistance o Parenting classes/ Teen parent services o Child care services o Other home visiting programs		

Within Nine Months of hire	DATE	NOTES
Review Education Materials: Ounce Achieve On Demand Self-Paced Courses		
• Building Relationships with Families		
• Home Visiting during Pregnancy		
• Domestic Violence		
• Substance Abuse		
• Foundations in Infant Mental Health		
• Impact of Trauma		
• ASQ Best Practice		
Complete Assessments		
• 30-60 minute phone call with Babies First! MCH Nurse Consultant to discuss ongoing training needs and continuous improvement of your practice		

Appendix F.2: Staff Orientation: Public Health Home Visitor Supervisor Orientation Checklist

II. Recommended Orientation and Training for New Babies First! Supervisors

Within One Month of Hire	DATE	NOTES
Locate and Review Resource Materials		
• Employee Handbook		
• Nursing Policies and Procedures, including documentation expectations		
• Safety Protocols		
• Babies First! Manual		
Review Orientation Materials		
• Babies First! Introduction (Recorded Webinar)		
• PHN 100 materials		
• PHN 300 materials		
• Achieve OnDemand: Basics of Home Visiting Self-paced course		
• Reflection Questions (in development)		
Complete Learning Assessments		
• Self-assessment of learning needs and plan (see Appendix C)		
• Set up 30-60 minute monthly phone calls with Babies First! MCH Nurse Consultant		
Staff Orientation		
• Ensure staff have reviewed resource and orientation materials		
• Ensure staff are oriented to safety plan; create team safety plan if agency safety plan not already in place		
• Ensure learning self-assessments completed, identify knowledge gaps for team		
• Establish contact with referral sources; develop relationships to engage referral sources to reach clients		
Locate and Understand Community Services		
• Get to know the resources in your community and to connect clients to them. Some examples: ○ OB and PCP providers ○ Food Stamps/WIC/ Food Pantries ○ Housing/ Rent help ○ Mental health services ○ Support for those experiencing IPV ○ Alcohol and drug recovery ○ Employment assistance ○ Parenting classes/ Teen parent		

Appendix F: Contacts

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To access the recommended Ounce Self-Paced Courses contact:

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For ORCHIDs support and help with provider enrollment, trading partner agreements, and general billing questions, contact:

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