Screening and Referrals Review and Forms Updates for MIECHV EHS/HFA LIAs

September 2020

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Agenda

- Welcome
- Background: MIECHV Data Collection & Performance Measures
- Review of screening and referrals performance measures
- Closing and Evaluation

Objective: Increase home visitor knowledge and ability to collect and document screening and referrals data, resulting in improved performance measure outcomes

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Objectives

Short-term (today)

Increase understanding of **when** and **how** to complete and document screening and referrals for tobacco cessation, maternal depression, intimate partner violence and child development

Medium-term

Demonstrate through data the incredible work home visitors engage in to provide screening and referrals to families they serve

Long-term

Continue to maintain or increase MIECHV funding for home visiting services in Oregon

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What are some of the measures (or topics) we collect data on?

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Why do we collect these data?

- Required for all MIECHV grantees
- Demonstrates the work of MIECHV at a national level
- Supports quality improvement efforts
- Demonstrate measurable improvement over time

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19 Performance Measures across 6 Benchmarks

- I. Maternal and Newborn Health
  - 1. Preterm Birth*
  - 2. Breastfeeding
  - 3. Depression Screening
  - 4 .Well-Child Visit
  - 5. Postpartum Care
  - 6. Tobacco Cessation Referrals
- II. Child Injuries, Maltreatment & Reduction of ED Visits
  - 7. Safe Sleep
  - 8. Child Injury*
  - 9. Child Maltreatment*
- III. School Readiness and Achievement
  - 10. Parent-Child Interaction
  - 11. Early Language and Literacy Skills
  - 12. Developmental Screening
  - 13. Behavioral Concerns
- IV. Crime or Domestic Violence
  - 14. Intimate Partner Violence (IPV) Screening
- V. Family Economic Self-Sufficiency
  - 15. Primary Caregiver Education
  - 16. Continuity of Health Insurance
- Coordination and Referrals
  - 17. Completed Depression Referrals
  - 18. Completed Developmental Referrals
  - 19. IPV Referrals

*lower number is better

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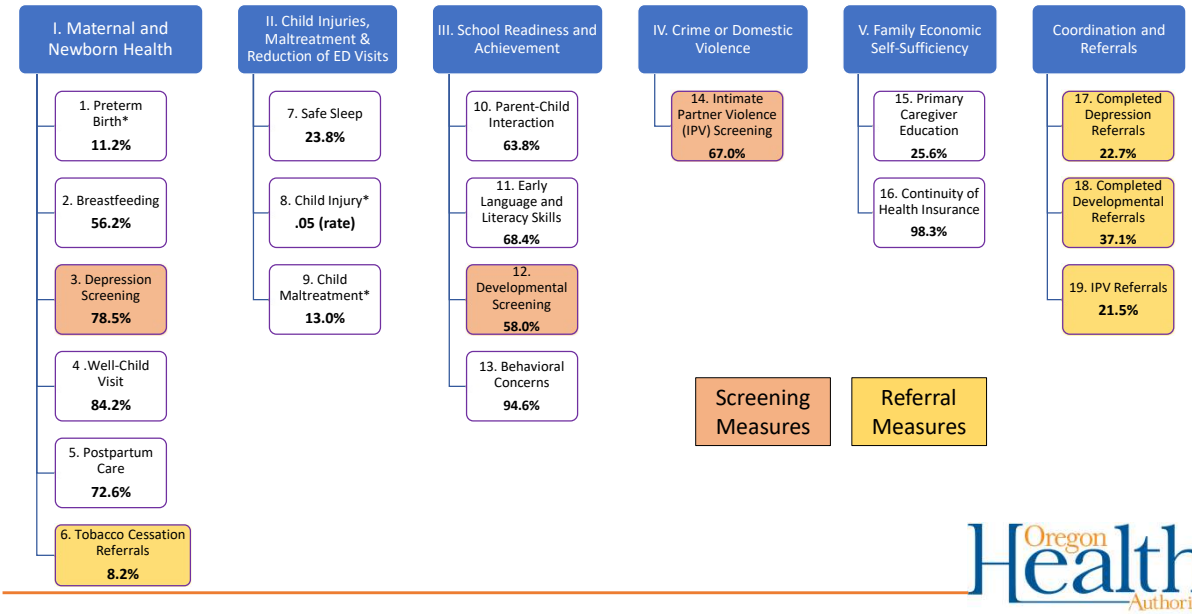
FY 2019 Oregon Annual Data



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Screening and Referrals Measure Data

Measure type	Measure	FY 2018	FY 2019
Screening	#3: Maternal Depression	56.7%	78.5%
Screening	#12: Child Development	64.5%	58.0%
Screening	#14: Intimate Partner Violence	70.3%	67.0%
Referral	#6: Tobacco Cessation	10.4%	8.2%
Referral	#17: Completed Depression Referrals	5.7%	22.7%
Referral	#18: Completed Developmental Referrals	30.9%	37.1%
Referral	#19: Intimate Partner Violence Referrals	25.6%	21.5%

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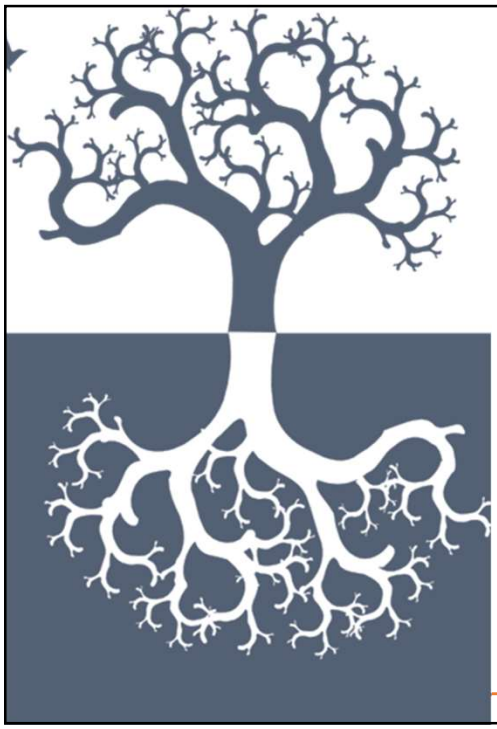

Root cause analysis on screening and referrals

- Virtual meetings held with volunteer HV and HVS between May –and June 2020. THANK YOU VOLUNTEERS!
- Brainstormed root causes for lower performance (than previous year and/or compared to national average) on these measures and began identifying possible solutions
- Outcomes included this webinar, revised MIECHV data forms and other technical assistance and resources

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Types of changes made to October 2020 forms

- Added instructions (e.g. if client is positive for IPV, give referral information)
- Added definitions (e.g. what counts as a maternal depression referral")
- Added clarifications (e.g. "Current tobacco use"; MIECHV timeframes)
- Reduced response options (e.g. reasons why screening did not occur)
- Reordered questions (e.g. Part A: IPV Screening, Part B: IPV Referrals)
- Simplified referrals forms (e.g. removed additional lines for referral entries for maternal depression and ASQs)

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Tobacco Cessation Referrals

Performance Measure #6

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Performance Measure #6: Tobacco Cessation Referrals

Measure Definition	FY 2019
Percent of primary caregivers who reported using tobacco or cigarettes at enrollment and who were referred to tobacco cessation counseling services within three months of enrollment.	8.2% (5/61)

- EHS agencies = 7.1%
- HFA agencies = 5.9%

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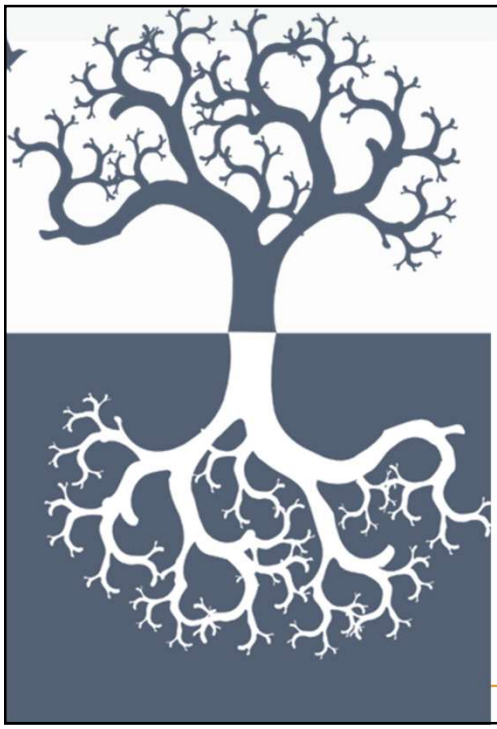

Root Causes: low rates of tobacco cessation referrals

- Initial enrollment form missing data on current tobacco use → counts against measure
- M2B form not completed with referral date or submitted by HV
- Lack of information on when a referral is needed and what counts as a referral

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What Counts as Tobacco Use?

- Based on self-report, if the mother **currently** uses tobacco products or has been identified as using tobacco through a substance abuse screening administered during intake.
- Tobacco includes combustibles (cigarettes, cigars, pipes, hookahs, and bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and Electronic Nicotine Delivery Systems (ENDS).

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Tobacco Use Data Collection: M1: Enrollment-Parent form

M1-THEO
MIECHV ENROLLMENT
Index Parent

10. Does Index Parent currently use tobacco products? (Tobacco includes combustibles [cigarettes, cigars, pipes, hookahs, and bidis], non-combustibles [chew, dip, snuff, snus, and dissolvables], and ENDS)

☐ Yes→ *Go to Question 10a.* ☐ No→ *Go to Question 11.* ☐ Unknown→ *Go to Question 11.*

10a. If yes, is parent currently receiving tobacco cessation services?

☐ Yes
☐ No
☐ Unknown

To meet Tobacco Cessation Referral Measure: Record Date Referred to Tobacco Cessation Services within 3 months of Enrollment on M2B-MIECHV Referrals Tracking & Follow-up form.

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What counts as a tobacco cessation referral?

Recommended referrals include those made for tobacco cessation counseling or services:

- tobacco quit line
- primary care provider
- other tobacco cessation programs

Note: Clients who are *currently* receiving tobacco cessation services do not need a referral

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Current

M2B

MIECHV REFERRALS TRACKING & FOLLOW-UP – INDEX PARENT

Please complete this form with Referral and/or Service Dates as updates occur and enter in THEO (EHS/HFA) or send to State (NFP)

Type of Service	INITIAL REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
1) Depression	/ / 20	/ / 20
1A) Depression	/ / 20	/ / 20
1B) Depression	/ / 20	/ /
1C) Depression	/ / 20	/ 20
2) Tobacco Cessation	/ / 20	/ / 20
2A) Tobacco Cessation	/ / 20	/ / 20
2B) Tobacco Cessation	/ / 20	/ / 20
2C) Tobacco Cessation	/ / 20	/ / 20

Revised Version

*To meet **Tobacco Cessation** Referral Measure: Client must receive a Referral for Tobacco Cessation Counseling or Services within 3 months of Enrollment in MIECHV. Only ONE Referral is required for MIECHV; the service does not have to be started or received.*

Recommended referrals include those made for tobacco cessation counseling or services. These referrals may include:
- *tobacco quit line,*
- *primary care provider,*
- *other tobacco cessation programs.*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

*To meet **Depression** Referral Measure: Client must receive a Referral AND at least one Service. Only ONE Referral and ONE Receipt of Service is required for MIECHV.*

Recommended referral services include:
- *Internal referral to self or other staff member trained in Mothers and Babies intervention*
- *Internal referral to self or other staff member trained in Mental Health Intervention (for NFP programs)*
- *Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT) using cognitive behavioral therapy or another evidence-based treatment*
- *Medication therapy from a primary care provider, psychiatrist, or women's health provider*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Depression	/ / 20	/ / 20

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NEW M2B Survey in THEO

*To meet **Tobacco Cessation** Referral Measure: Client must receive a Referral for Tobacco Cessation Counseling or Services within 3 months of Enrollment in MIECHV. Only ONE Referral is required for MIECHV; the service does not have to be started or received.*

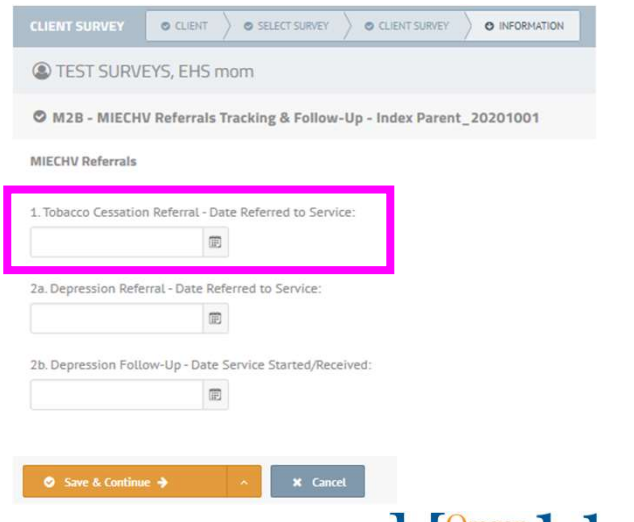
Recommended referrals include those made for tobacco cessation counseling or services. These referrals may include:
- *tobacco quit line,*
- *primary care provider,*
- *other tobacco cessation programs.*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

*To meet **Depression** Referral Measure: Client must receive a Referral AND at least one Service. Only ONE Referral and ONE Receipt of Service is required for MIECHV.*

Recommended referral services include:
- *Internal referral to self or other staff member trained in Mothers and Babies intervention*
- *Internal referral to self or other staff member trained in Mental Health Intervention (for NFP programs)*
- *Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT) using cognitive behavioral therapy or another evidence-based treatment*
- *Medication therapy from a primary care provider, psychiatrist, or women's health provider*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Depression	/ / 20	/ / 20



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- Be sure to record the status of your client's tobacco use on the M1: Enrollment-Parent form
- Complete or update a M2B form with a Referral date and enter in THEO
- Provide a referral within 3 months of client enrollment in MIECHV
- The service does not have to be started or received to meet measure, just provided
- Only one referral is needed to count towards the measure

Tips for ensuring tobacco cessation referrals count

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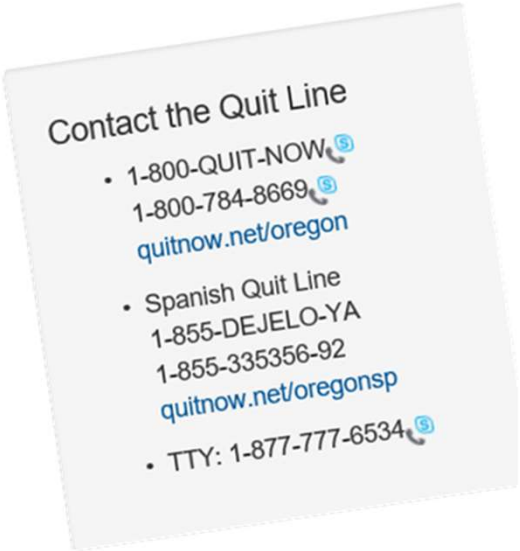

Tobacco Cessation Resources

Tobacco Prevention:

https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Pages/index.aspx

Oregon Tobacco Quit Line:

https://www.oregon.gov/oha/ph/preventionwellness/tobaccopreventionn/gethelpquitting/pages/oregonquitline.aspx

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Developmental Screening and Referrals

Performance Measures #12 and #18

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Performance Measure #12: Developmental Screening

Measure Definition	FY 2019
Percent of children with a timely screen for developmental delays	58% (296/510)

Differences by screening time period (all models):

- 9/10 months = 58.0%;
- 18 months = 67.1%;
- 24 months = 59.1%;
- 30 months = 72.7%

- EHS = 66.7%
- HFA = 52.5%

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Root Causes: low rates of developmental screening

- **Screening not completed with client**
  - **Home visitors not filling out forms as required/needed**
  - **Home visitor leave and turnover**
- **Screening occurred outside of window period**
  - **Clients unavailable/can't be located (e.g. creative outreach)**
  - **HVs complete wrong ASQ Questionnaire**
- **Paper forms not easy to use or understand**
- **HVs need additional information on data required**
  - Which screening time points are MIECHV
  - Exact timeframes by ASQ screen
  - 8/9/10 month ASQ confusion
  - Age adjusting correctly and marking on form
  - Screening based on actual child age

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When do ASQ screenings occur for MIECHV?

9/10 month
- conducted between child's age 9 months 0 days through 10 months 30 days
- *2019 HFA on-time completion rate is 44%; EHS is 77%*

18 months
- conducted between child's age 17 months 0 days through 18 months 30 days

24 months
- conducted between child's age 23 months 0 days through 24 months 30 days

30 months
- conducted between child's age 29 months 0 days through 30 months 30 days

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ASQ Screening
For 9 or 10, 18, 24 & 30 Months of Age
Index Child

Complete this form along with an age appropriate screen during each of the following intervals:
between child's age of 9 months 0 days through 10 months 30 days;
between child's age of 17 months 0 days through 18 months 30 days;
between child's age of 23 months 0 days through 24 months 30 days;
between child's age of 29 months 0 days through 30 months 30 days.

Current

1. **ASQ Screening Completed?** ☐ Yes → *Complete Questions 2-5 & Scores.* ☐ No → *Complete Questions 6a&b.*
2. **Date ASQ Screening scored and discussed with parent:** ___/___/ 20___
3. **Age level of ASQ Questionnaire used:** ___ Months
4. **ASQ Screening scores indicate monitoring is needed or child is at risk for developmental delay?** ☐ Yes → *Complete ASQ-Referral Tracking & Follow-up.* ☐ No
5. **Is child currently enrolled in EI services?** ☐ Yes ☐ No

DOMAIN	Screening Completed?	TOTAL Domain Score
Communication	☐ Yes ☐ No	
Gross Motor	☐ Yes ☐ No	
Fine Motor	☐ Yes ☐ No	
Problem Solving	☐ Yes ☐ No	
Personal-Social	☐ Yes ☐ No	

6a. **If No, reason why ASQ Screening was not completed (*Check all that apply*):**
☐ Child is currently receiving Early Intervention (EI) services
☐ Child is currently receiving other services → *Please Specify:*_____
☐ Parent declined screening
☐ No contact with client at this time
☐ Other → *Please Specify:*_____

6b. **If ASQ Screening not completed, date Question 6a completed:** ___/___/ 20___

Revised Version

Part A: Developmental Screening

To meet Developmental Screening Measure: Child must receive an age-appropriate, on-time ASQ Screening, unless child has a previously identified developmental delay (prior to enrollment or prior to reaching this age-recommended screening).

1. **ASQ Screening Completed?**
☐ Yes, completed → **Date ASQ Screening scored and discussed with parent:** ___/___/ 20___ → *Complete Questions 2-4.*
☐ No, not completed → *Complete Questions 1a&b.*
1a. If No, reason why ASQ Screening was not completed:
☐ Child has a previously identified developmental delay (an ASQ screening is not required).
☐ No, other reason → *If possible, complete Screening at future visit before the window closes, then complete another ASQ Screening form and update in THEO.*
1b. If ASQ Screening not completed, date Question 1a completed: ___/___/ 20___
2. **Age level of ASQ Questionnaire used:** ___ Months.
3. **Scoring:**

DOMAIN	Screening Completed?	TOTAL Domain Score
Communication	☐ Yes ☐ No	
Gross Motor	☐ Yes ☐ No	
Fine Motor	☐ Yes ☐ No	
Problem Solving	☐ Yes ☐ No	
Personal-Social	☐ Yes ☐ No	

Part B: Developmental Referrals

4. **Do ASQ Screening scores indicate child is at risk for developmental delay?** *Child is at risk if they score 2 or more domains in gray (monitoring), or 1 or more domains in black (at-risk), or a combination of these.*
☐ Yes → *A referral is required: Complete ASQ-Referral Tracking & Follow-up Form.* ☐ No

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Adjusting age for premature infants*:

Screening still occurs during the MIECHV time points, but is adjusted based on number of weeks premature

*Follow the ASQ-3 tool guidance for age-adjusting

Example: infant is 9 months 14 days old at home visit and is due for the MIECHV 9 or 10-month ASQ screening. The infant was born 4 weeks premature. Conduct ASQ screening between infant's age 9 months 0 days through 10 months 30 days, using the 8-month ASQ screening form to account for its prematurity

→ **On Q2 of ASQ Screening form, write in "8" to note age-adjusted screening**

1. **ASQ Screening Completed?**
☐ Yes, completed → **Date ASQ Screening scored and discussed with parent:** ___/___/ 20___ → *Complete Questions 2-4.*
☐ No, not completed → *Complete Questions 1a&b.*
1a. If No, reason why ASQ Screening was not completed:
☐ Child has a previously identified developmental delay (an ASQ screening is not required).
☐ No, other reason → *If possible, complete Screening at future visit before the window closes, then complete another ASQ Screening form and update in THEO.*
1b. If ASQ Screening not completed, date Question 1a completed: ___/___/ 20___
2. **Age level of ASQ Questionnaire used:** ___ Months.

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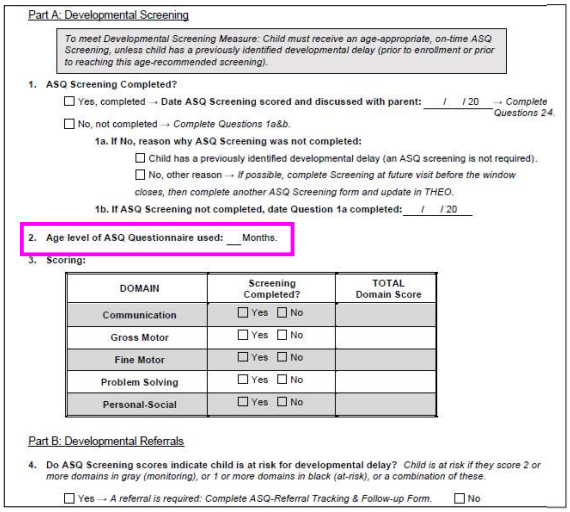
NEW ASQ Screening Survey in THEO



Part A: Developmental Screening

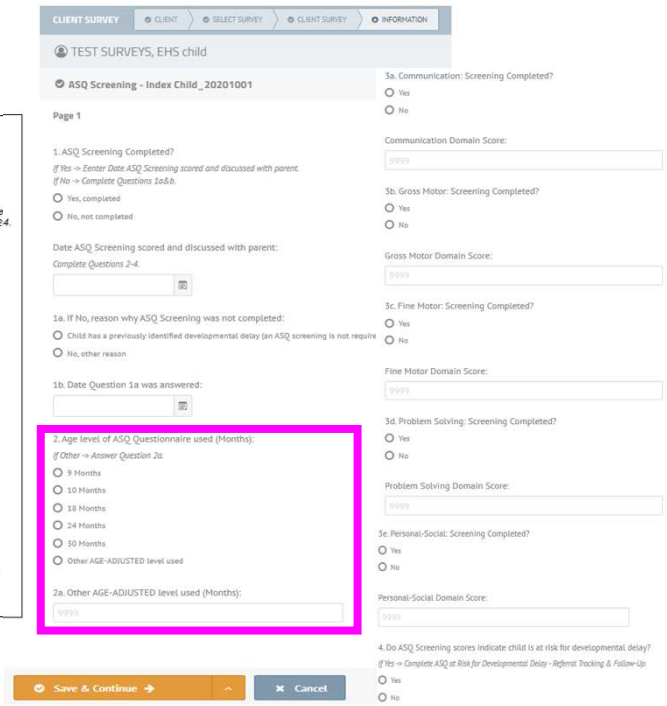
To meet Developmental Screening Measure: Child must receive an age-appropriate, on-time ASQ Screening, unless child has a previously identified developmental delay (prior to enrollment or prior to reaching this age-recommended screening).

1. **ASQ Screening Completed?**
   - ☐ Yes, completed → **Date ASQ Screening scored and discussed with parent:** ___/___/20___ → *Complete Questions 2-4.*
   - ☐ No, not completed → *Complete Questions 1a&b.*
     - **1a. If No, reason why ASQ Screening was not completed:**
       - ☐ Child has a previously identified developmental delay (an ASQ screening is not required).
       - ☐ No, other reason → *If possible, complete Screening at future visit before the window closes, then complete another ASQ Screening form and update in THEO.*
     - **1b. If ASQ Screening not completed, date Question 1a completed:** ___/___/20___
2. **Age level of ASQ Questionnaire used:** ___ Months.
3. **Scoring:**

DOMAIN	Screening Completed?	TOTAL Domain Score
Communication	☐ Yes ☐ No	
Gross Motor	☐ Yes ☐ No	
Fine Motor	☐ Yes ☐ No	
Problem Solving	☐ Yes ☐ No	
Personal-Social	☐ Yes ☐ No	

Part B: Developmental Referrals

4. **Do ASQ Screening scores indicate child is at risk for developmental delay?** *Child is at risk if they score 2 or more domains in gray (monitoring), or 1 or more domains in black (at-risk), or a combination of these.*
   - ☐ Yes → *A referral is required: Complete ASQ-Referral Tracking & Follow-up Form.* ☐ No



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Tips for ensuring developmental screenings count

- Ensure screening occurs during the time window provided in the client schedule
- Remember to indicate if an age-adjusted ASQ questionnaire is being used

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Developmental Screening Resources

Developmental Screening Resources (For Parents, Early Childhood Professionals, Primary Care):

https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HEALTHSCREENING/ABCD/Pages/abcd_toolkit.aspx

Remote ASQ screening resources:

https://institutefsp.org/covid-19-rapid-response-resources-screening

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Performance Measure 18: Completed Developmental Referrals

Measure Definition	FY 2019
Percent of children positive screens for developmental delays who receive services in a timely manner	37.1%* (23*/62)

*Of the 23:
-15 received individual support
-9 received Early Intervention
-2 received other community service

EHS = 29.4%
HFA = 22.7%

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Public Health Division

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Root Causes: low rates of completed developmental referrals

- HVs need additional information on:
  - what counts as a positive ASQ screen
  - when an ASQ Referrals Tracking & Follow-up form should be completed
  - how individual developmental support counts towards measure
- HVs forget to go back to form, update with referral received dates and update in THEO
- Clients decline referral
- Confusion with referral tracking form
- Challenges with community referrals

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When to complete the ASQ Referral Tracking and Follow-up form

1. for a child screened by a MIECHV home visitor…
2. using the ASQ for a MIECHV-timed screening…
3. who scored 2 or more in the grey (“monitoring”) and/or 1 or more in the black (“at-risk”) zones
4. And does not have a previously identified developmental delay

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Three ways to complete a developmental referral

Completing any one or more of the following types of developmental support will meet the criteria for this measure:

1. Received individualized developmental support from a home visitor.
2. Received a referral to Early Intervention services and received an evaluation or individualized service plan within 45 days of that referral.
3. Received a referral to another community service and received services from that provider within 30 days of that referral.

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ASQ REFERRAL TRACKING & FOLLOW-UP – INDEX CHILD
****For Children who Screened at Risk for Developmental Delay****
Please complete this form with Referral and/or Service Dates as updates occur and enter in THEO (EHS/HFA) or send to State (NFP)

To count towards the Developmental Referral performance measure: Children screened positive for being at risk must receive at least one of the supports/services below (according to timelines found in Follow-Up information).

Type of Service	FOLLOW-UP Date Provided	INFORMATION About Individualized Developmental Support
1) Individualized Developmental Support	/ / 20	Individualized Developmental Support can be done at any time by a home visitor and counts as a completed referral regardless of whether the client is also referred to Early Intervention or another community service. Examples of this include activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen.

Type of Service	INITIAL REFERRAL CONTACT Date Service Referral Contacted	FOLLOW-UP Date Service Started/Received	INFORMATION About Another Community Service
2) Another Community Service: Type:	/ / 20	/ / 20	A community services must be started or received within 30 days of initial contact to count towards the measure. Examples may include referrals to health or mental health services, speech, occupational or physical therapy services, parent-child groups, parent classes or early literacy supports.

Type of Service	INITIAL REFERRAL CONTACT Date EI Referral Contacted	FOLLOW-UP Date of EI Evaluation	INFORMATION About Early Intervention Services
3) Early Intervention Services	/ / 20	/ / 20	An EI evaluation must occur within 45 days of initial contact to count towards the measure.

Current

Type of Service	INITIAL REFERRAL CONTACT Date Service Referral Contacted	FOLLOW-UP Date Service Started/Received	If Service NOT received within 30 days of in… REASON:
1) Individualized developmental support from a home visitor	N/A	/ / 20	N/A
1a) Individualized developmental support from a home visitor	N/A	/ / 20	N/A
2) Another Community Service: Type:	/ / 20	/ / 20	☐ Parent declined the referral or did not take action ☐ Child is waiting for service ☐ Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) ☐ Other:
2a) Another Community Service: Type:	/ / 20	/ / 20	☐ Parent declined the referral or did not take action ☐ Child is waiting for service ☐ Parent was unable to access service due to barriers (such as transportation, cost, time, child care, etc.) ☐ Other:

Type of Service	INITIAL REFERRAL CONTACT Date EI Referral Contacted	FOLLOW-UP Date of EI Evaluation	If EI Evaluation NOT completed within 45 days of initial referral contact -- REASON:	Enrolled in EI?
3) Early Intervention Services	/ / 20	/ / 20	☐ Parent declined the EI referral or did not take action ☐ Child is waiting for EI evaluation ☐ Other:	☐ Yes ☐ No
3a) Early Intervention Services	/ / 20	/ / 20	☐ Parent declined the EI referral or did not take action ☐ Child is waiting for EI Evaluation ☐ Other:	☐ Yes ☐ No

Revised Version

Completed Developmental Referrals Data Collection: ASQ Referral Tracking & Follow-up form

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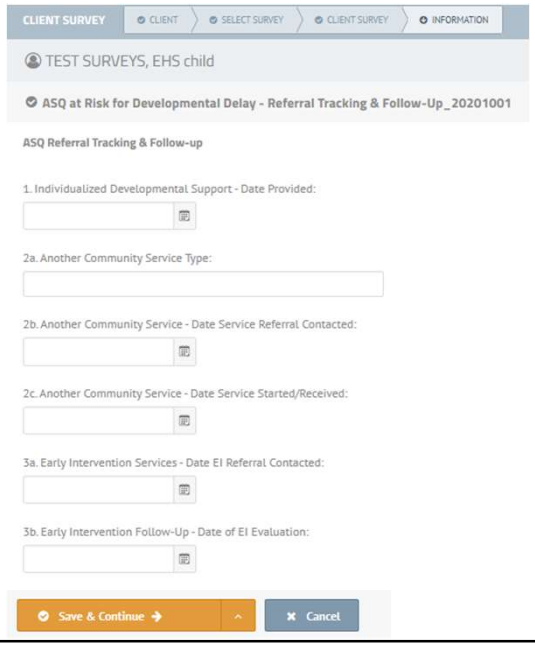
NEW ASQ-Developmental Referral Tracking & Follow-up Survey in THEO

To count towards the Developmental Referral performance measure: Children screened positive for being at risk must receive at least one of the supports/services below (according to timelines found in Follow-Up information).

Type of Service	FOLLOW-UP Date Provided	INFORMATION About Individualized Developmental Support
1) Individualized Developmental Support	/ / 20	Individualized Developmental Support can be done at any time by a home visitor and counts as a completed referral regardless of whether the client is also referred to Early Intervention or another community service. Examples of this include activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen.

Type of Service	INITIAL REFERRAL CONTACT Date Service Referral Contacted	FOLLOW-UP Date Service Started/Received	INFORMATION About Another Community Service
2) Another Community Service: *Type:* _____	/ / 20	/ / 20	A community services must be started or received within 30 days of initial contact to count towards the measure. Examples may include referrals to health or mental health services, speech, occupational or physical therapy services, parent-child groups, parent classes or early literacy supports.

Type of Service	INITIAL REFERRAL CONTACT Date EI Referral Contacted	FOLLOW-UP Date of EI Evaluation	INFORMATION About Early Intervention Services
3) Early Intervention Services	/ / 20	/ / 20	An EI evaluation must occur within 45 days of initial contact to count towards the measure.



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Referral method #1: Individualized developmental support

Emotional, social, or physical development activities home visitor conducts with the caregiver and/or child

Examples include:

- More frequent screenings
- Activities by model curriculum
- ASQ activities
- CDC materials

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Individualized Developmental Support, cont.

- Can be done at any time by a home visitor and counts as a completed referral, regardless of whether the client is also referred to Early Intervention or another community service.
- Enter the date the support was provided; it may be the same day as the screening took place or a future home visit

	FOLLOW-UP	INFORMATION
Type of Service	Date Provided	About Individualized Developmental Support
1) Individualized Developmental Support	/ / 20	Individualized Developmental Support can be done at any time by a home visitor and counts as a completed referral regardless of whether the client is also referred to Early Intervention or another community service. Examples of this include activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen.

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Referral Method #2: Community Service

Includes referrals made to a community service other than Early Intervention, that provide support to enhance a child's development.

A community service must be started or received within 30 days of initial contact to count towards the measure.

Examples may include referrals to health or mental health services, speech, occupational or physical therapy services, parent-child groups, parent classes or early literacy supports.

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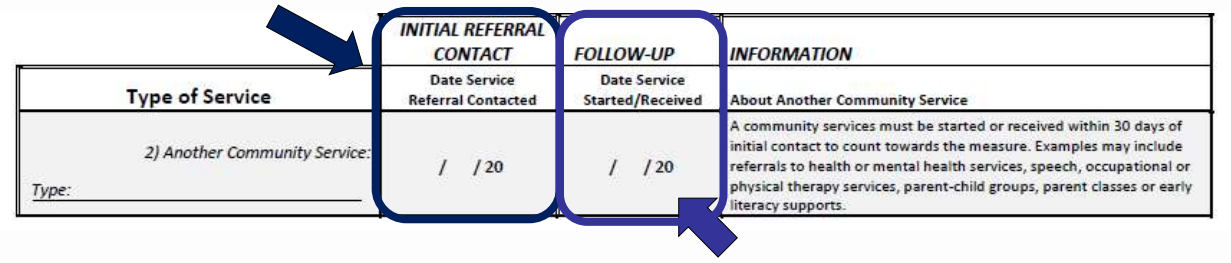
Referral Method #2: Community Service

Enter the date the community service was contacted; it may or may not be the same day the screening took place



Type of Service	INITIAL REFERRAL CONTACT Date Service Referral Contacted	FOLLOW-UP Date Service Started/Received	INFORMATION About Another Community Service
2) Another Community Service: Type: _____	/ / 20	/ / 20	A community services must be started or received within 30 days of initial contact to count towards the measure. Examples may include referrals to health or mental health services, speech, occupational or physical therapy services, parent-child groups, parent classes or early literacy supports.

Follow up with client during next visits to find out if/when client received the community services; enter information in THEO

Oregon Health Authority

Referral Method #3: Early Intervention Services

- EI services can be contacted by the home visitor, client or other person on behalf of the client
- The referral can be made on the same day as the screening or at a later date
- An Early Intervention evaluation must be completed within 45 days of initial contact to count towards the measure

Referral Method #3: Early Intervention Services

Enter the date Early Intervention was contacted; it may not be the same day as the screening

Type of Service	INITIAL REFERRAL CONTACT Date EI Referral Contacted	FOLLOW-UP Date of EI Evaluation	INFORMATION About Early Intervention Services
3) Early Intervention Services	/ / 20	/ / 20	An EI evaluation must occur within 45 days of initial contact to count towards the measure.

Follow up with client during next visits to find out if/when client received an EI evaluation; enter information in THEO

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Always document individualized support provided by the HV – this counts!!

Set a calendar or paper reminders to check back in with client and to update survey in THEO

Tips for completing developmental referrals

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Maternal Depression Screening and Referrals

Performance Measures #3 and #17

Maternal & Child Health Section
Public Health Division

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Performance Measure #3: Maternal Depression Screening

Measure Definition	FY 2019
Percent of primary caregivers who are screened for depression using a validated tool within three months of enrollment (for those not enrolled prenatally) or within three months of delivery (for those enrolled prenatally).	**78.5%** **332/423**

Bright spot: this measure increased from 2018 (56.7%)!

EHS = 76.7%

HFA = 83.3%

Oregon Health Authority

44

Root Causes: low rates of maternal depression screenings

- **Screening not completed with client**
  - **Home visitors decide not to complete PHQ-9 screening with client**
    - Providers are doing 6-week PP screenings, if they did HVs might just note the results rather than screen again
  - **Having available reasons to check for why not completed on form makes it seem acceptable not to complete screening**
  - **Client not comfortable completing screening**
- **Screening occurred outside of window period**
  - Lack of clarity/challenges with timing for screening

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When do maternal depression screenings occur for MIECHV?

Within 90 days of enrollment (for those not enrolled prenatally)

OR

Within 90 days of delivery (for those enrolled prenatally)

→ See client schedule for window period; if screened before or after this period, doesn't count for measure

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What is required for maternal depression screening?

- All clients should receive a PHQ-9 screening - regardless of whether they are currently or have previously received mental health services
- A PHQ-9 screen has to be offered and completed to meet the measure.

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M5
MIECHV Child's Enrollment Tool
Index Parent

To be completed within 90 days of enrollment (for those not enrolled prenatally)
OR within 90 days of infant birth (for those enrolled prenatally)

Current

1. **PHQ-9 completed (with *mother*)?**
   - ☐ Yes, completed → **Date tool completed:** ___/___/20___ → *Go to Question 1a.*
     - **1a. If Yes, result of PHQ-9:**
       - ☐ Score of 10 or higher → *Go to Question 1b.*
       - ☐ Score of 9 or lower
     - **1b. If a Score of 10 or higher, did you give referral information?**
       - ☐ Yes → *Complete M2B-MIECHV Referral Tracking & Follow-up Form*
       - ☐ No, client declined or is not ready for a referral and/or services
       - ☐ No, an earlier referral is still in process
       - ☐ No, the client is currently receiving services
       - ☐ No, other reason
   - ☐ No, not completed → *Go to Question 1c.*
     - **1c. If No, reason why PHQ-9 not completed:**
       - ☐ Concern previously identified
       - ☐ Other

Revised Version

Part A: Depression Screening

*To meet the measure, **all clients must receive a PHQ-9 screening** within 90 days of enrollment or infant birth regardless of whether they are currently receiving or have previously received depression services.*

1. PHQ-9 completed?
   - ☐ Yes, completed → **Date tool completed:** ___/___/20___ → *Go to Question 1a.*
     - **1a. If Yes, result of PHQ-9:**
       - ☐ Score of 10 or higher → *Go to Part B: Depression Referral.*
       - ☐ Score of 9 or lower
   - ☐ No, not completed → *Complete Screening at future visit before the 90-day window closes, then complete another M5 form and update in THEO.*

Part B: Depression Referral

*To meet the measure, **client must receive a Referral AND at least one Service** if the client scores 10 or higher on the PHQ-9 during a MIECHV screening and is not currently receiving depression services.*

2. **If a Score of 10 or higher, did you provide a referral?** *See examples below
   - ☐ Yes → *Complete M2B-MIECHV Referral Tracking & Follow-up Form.*
   - ☐ No, the client is currently receiving services *(Clients who are currently receiving depression services do not need to be referred).*
   - ☐ No, other reason → *Clients who screen positive should be offered and start/receive at least 1 referral service. Continue to follow up with client at future visits to track referral and follow-up on M2B-MIECHV Referral Tracking & Follow-up Form.*

*Recommended referral services include:
- Internal referral to self or other staff trained in Mothers and Babies intervention;
- Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT);
- Medication therapy from a primary care provider, psychiatrist, or women's health provider.

Maternal Depression Screening Data Collection: M5 MIECHV Child's Enrollment Tool

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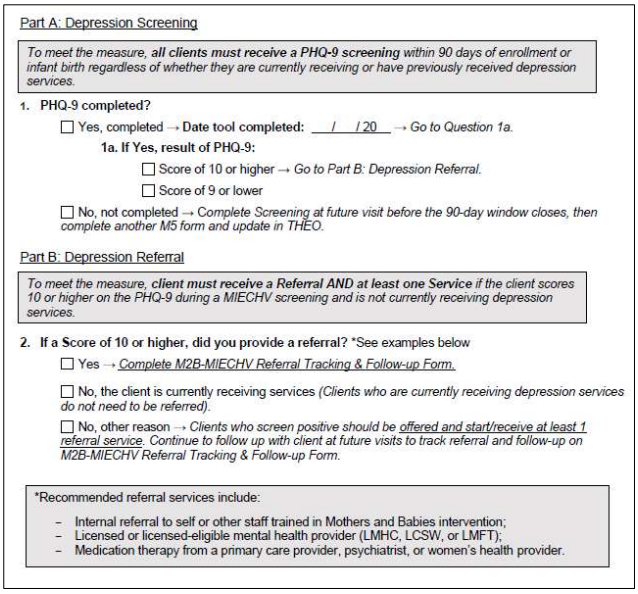
NEW M5 Survey in THEO



Part A: Depression Screening

*To meet the measure, **all clients must receive a PHQ-9 screening** within 90 days of enrollment or infant birth regardless of whether they are currently receiving or have previously received depression services.*

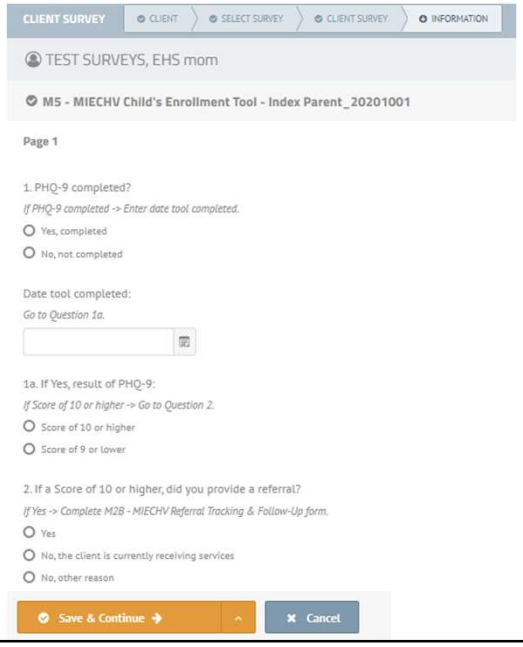
1. PHQ-9 completed?
   - ☐ Yes, completed → **Date tool completed:** ___/___/20___ → *Go to Question 1a.*
     - **1a. If Yes, result of PHQ-9:**
       - ☐ Score of 10 or higher → *Go to Part B: Depression Referral.*
       - ☐ Score of 9 or lower
   - ☐ No, not completed → *Complete Screening at future visit before the 90-day window closes, then complete another M5 form and update in THEO.*

Part B: Depression Referral

*To meet the measure, **client must receive a Referral AND at least one Service** if the client scores 10 or higher on the PHQ-9 during a MIECHV screening and is not currently receiving depression services.*

2. **If a Score of 10 or higher, did you provide a referral?** *See examples below
   - ☐ Yes → *Complete M2B-MIECHV Referral Tracking & Follow-up Form.*
   - ☐ No, the client is currently receiving services *(Clients who are currently receiving depression services do not need to be referred).*
   - ☐ No, other reason → *Clients who screen positive should be offered and start/receive at least 1 referral service. Continue to follow up with client at future visits to track referral and follow-up on M2B-MIECHV Referral Tracking & Follow-up Form.*

*Recommended referral services include:
- Internal referral to self or other staff trained in Mothers and Babies intervention;
- Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT);
- Medication therapy from a primary care provider, psychiatrist, or women's health provider.



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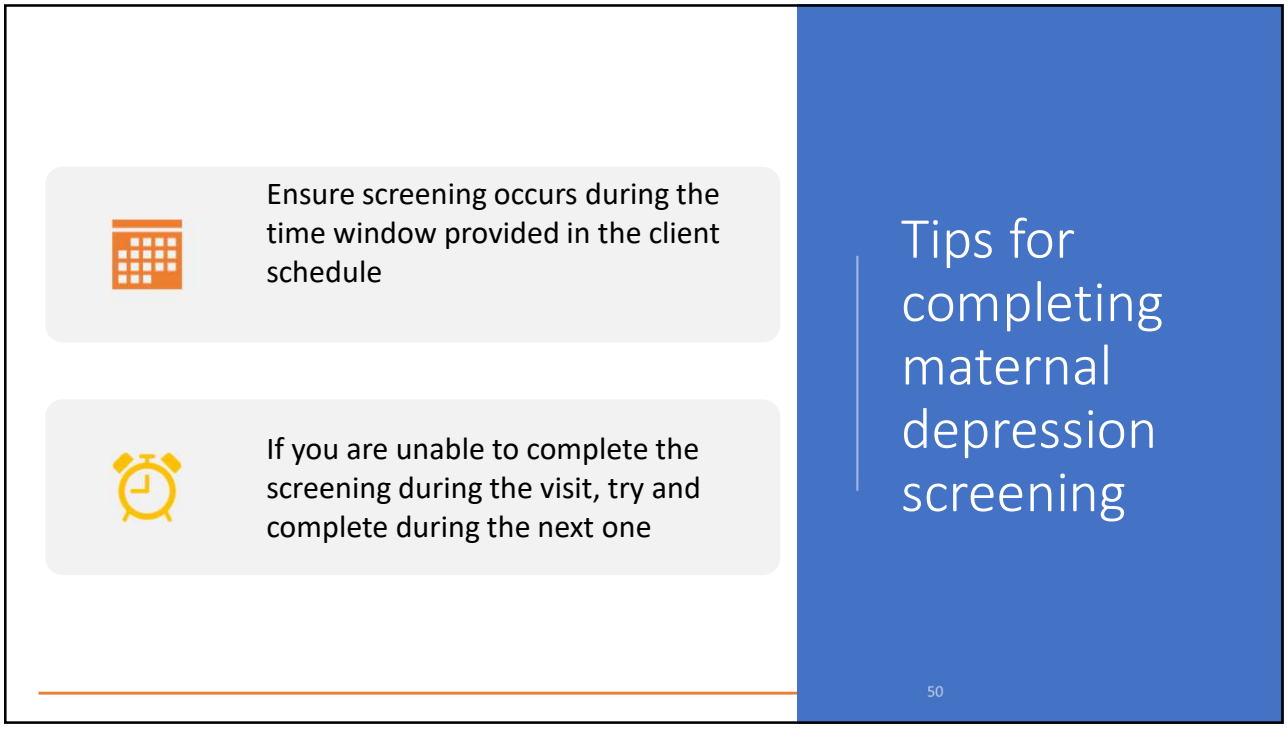

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Maternal Depression Screening Resources

PHQ-9 and Maternal Depression Screening training and resources:

https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HOMEVISITING/MIECHV/Pages/miechv-orientation.aspx (scroll down webpage)

Remote maternal depression screening resources:

Screenings in Virtual Visits created by the Rapid Response-Virtual Home Visiting Collaborative

IPV HV CoIIN memo: Coronavirus/COVID-19 and Implications for Maternal Depression and Intimate Partner Violence Screening and Referral

Oregon Health Authority

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Performance Measure #17: Maternal Depression Referrals

Measure Definition	FY 2019
Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.	**22.7%** (15/66)

Bright spot: this measure increased from 2018!

EHS = 12.5%

HFA = 7.1%

Oregon Health Authority

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Root Causes: low rates of maternal depression referrals

- **Not understanding what will meet the MD referral requirement**
- **Confusion with forms**
  - Having reasons to check on form for why referral information not given makes it seem acceptable not to provide referral
  - M2B form requires HV to come back and complete received date – easy to forget/not resubmit/lose
- **Clients decline/refuse referral**
  - Clients look to/prefer HV as their "referral." Clients expect the HV can provide that service
- **Lack of referral options, particularly in rural communities**
- **Few Spanish-speaking resources for counseling and services**

Oregon Health Authority

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When are maternal depression referrals needed?

- If the client scores a 10 or higher on the PHQ-9 during the MIECHV screening and is not currently receiving depression services

If the client receives a referral and then receives referral service:

- Update the M2B-MIECHV Referral Tracking and Follow-up form in THEO: For "Depression", record when referral was given as "Date Referred to Service"; and when service received as "Date Service Started/Received"

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Considerations for meeting the maternal depression measure

Caregivers who screen positive for maternal depression will remain in the measure denominator until they receive a service ("referral contact").

There is no timeframe for when the client must receive a referral contact → continue to follow up with client to support them in accessing service

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What Counts as a Depression Referral??

Caregiver must receive a referral and at least one service

- **Recommended referral services include:**
  - Internal referral to self or other staff member trained in Mothers and Babies intervention
  - Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT) using cognitive behavioral therapy or another evidence-based treatment
  - Medication therapy from a primary care provider, psychiatrist, or women's health provider

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Maternal Depression Referrals Data Collection form: M2B

Current

Type of Service	INITIAL REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
1) Depression	/ / 20	/ / 20
1A) Depression	/ / 20	/ / 20
1B) Depression	/ / 20	/ / 20
1C) Depression	/ / 20	/ / 20
2) Tobacco Cessation	/ / 20	/ / 20
2A) Tobacco Cessation	/ / 20	/ / 20
2B) Tobacco Cessation	/ / 20	/ / 20
2C) Tobacco Cessation	/ / 20	/ / 20

Revised Version

M2B

MIECHV REFERRALS TRACKING & FOLLOW-UP – INDEX PARENT

Please complete this form with Referral and/or Service Dates as updates occur and enter in THEO (EHS/HFA) or send to State (NFP)

*To meet **Tobacco Cessation** Referral Measure: Client must receive a Referral for Tobacco Cessation Counseling or Services within 3 months of Enrollment in MIECHV. Only ONE Referral is required for MIECHV; the service does not have to be started or received.*

Recommended referrals include those made for tobacco cessation counseling or services. These referrals may include:
- *tobacco quit line,*
- *primary care provider,*
- *other tobacco cessation programs.*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

*To meet **Depression** Referral Measure: Client must receive a Referral AND at least one Service. Only ONE Referral and ONE Receipt of Service is required for MIECHV.*

Recommended referral services include:
- *Internal referral to self or other staff member trained in Mothers and Babies intervention*
- *Internal referral to self or other staff member trained in Mental Health Intervention (for NFP programs)*
- *Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT) using cognitive behavioral therapy or another evidence-based treatment*
- *Medication therapy from a primary care provider, psychiatrist, or women's health provider*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Depression	/ / 20	/ / 20

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NEW M2B Survey in THEO

*To meet **Tobacco Cessation** Referral Measure: Client must receive a Referral for Tobacco Cessation Counseling or Services within 3 months of Enrollment in MIECHV. Only ONE Referral is required for MIECHV; the service does not have to be started or received.*

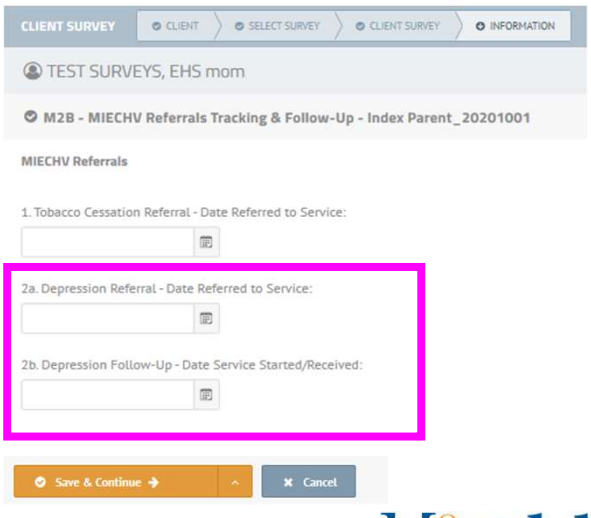
Recommended referrals include those made for tobacco cessation counseling or services. These referrals may include:
- *tobacco quit line,*
- *primary care provider,*
- *other tobacco cessation programs.*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

*To meet **Depression** Referral Measure: Client must receive a Referral AND at least one Service. Only ONE Referral and ONE Receipt of Service is required for MIECHV.*

Recommended referral services include:
- *Internal referral to self or other staff member trained in Mothers and Babies intervention*
- *Internal referral to self or other staff member trained in Mental Health Intervention (for NFP programs)*
- *Licensed or licensed-eligible mental health provider (LMHC, LCSW, or LMFT) using cognitive behavioral therapy or another evidence-based treatment*
- *Medication therapy from a primary care provider, psychiatrist, or women's health provider*

TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Depression	/ / 20	/ / 20



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Tips for completing maternal depression referrals

Set a calendar or paper reminders to check back in with client and update M2B survey in THEO

Complete or update a M2B form with Referral and/or Service Dates as updates occur and enter in THEO

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Intimate Partner Violence Screening and Referrals

Performance Measures #14 and #19

Maternal & Child Health Section
Public Health Division

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Performance Measure #14: Intimate Partner Violence Screening

Measure Definition	FY 2019
Percent of primary caregivers who are screened for intimate partner violence (IPV) within six months of enrollment.	**67%** (284/424)

- EHS = 82.4%
- HFA = 65.3%

61

Root Causes: low rates of IPV screenings

- Lack of consistent, ongoing training in IPV and healthy relationships across home visitors (including within a team)
- Home visitors uncomfortable with topic of IPV and/or conducting screening
- Home visitors aren't screening if client says she is not in a relationship or if they believe client not ready for referral
- Home visitors offer RAT and discuss it generally but don't have client circle a number for a score

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Root Causes: low rates of IPV screenings (cont.)

- Clients experiencing IPV may be seen less often due to complex needs, so more to get done when visits do occur
- Having available reasons on form to check for why not completed makes it seem acceptable not to complete screening
- Form not completed correctly or understood by HV
- Form not entered into THEO or updated
- Client not comfortable completing screening
- Perpetrator or other person present in room

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MIECHV Definition of IPV

- IPV refers to physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a **current or former intimate partner.**

- An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following: emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives.

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Who should be screened for IPV?

- **All** primary caregivers should be screened for IPV regardless of relationship status, gender or previous IPV disclosure or positive screen
  - Relationship Assessment Tool is pronoun neutral; can be used with male caregivers and caregivers in same-sex relationships
    - Available in English and Spanish

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When must IPV screenings occur for MIECHV?

- **An IPV screen has to be offered and completed during the first 6 months of enrollment**
  - Best practice: consider waiting to screen until 3-4 months post-enrollment once relationship is established
- Caution: Currently no research indicates virtual IPV screenings are safe. We encourage you to use your best practice judgement when determining whether it is appropriate or safe to screen.
  - See IPV CoIIN memo from April 15, 2020

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M3
MIECHV ENROLLMENT TOOL
Index Parent

To be completed within 6 months of parent's enrollment

Current

1. **Relationship Assessment Tool completed (with *mother*)?**
   - ☐ Yes, completed → **Date tool completed:** ___/___/ 20___ → *Go to Question 1a.*
     - **1a. If Yes, result of Relationship Assessment Tool:**
       - ☐ Score of 20 or higher → *Go to Question 1b.*
       - ☐ Score of 19 or lower
     - **1b. If a Score of 20 or higher, did you give referral information?**
       - ☐ Yes
       - ☐ No, client declined or is not ready for a referral and/or services
       - ☐ No, an earlier referral is still in process or the client is currently receiving services
       - ☐ No, other reason
   - ☐ No, not completed → *Go to Question 1c.*
     - **1c. If No, reason why Relationship Assessment Tool not completed:**
       - ☐ Concern previously identified
       - ☐ Other

Revised Version

Part A: IPV Screening

IPV refers to physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner.

*To meet the measure, **all clients must be screened for IPV** within 6 months of enrollment, regardless of relationship status or if IPV has been previously identified.*

1. **Relationship Assessment Tool completed?**
   - ☐ Yes, completed → **Date tool completed:** ___/___/ 20___ → *Go to Question 1a.*
     - **1a. If Yes, result of Relationship Assessment Tool:**
       - ☐ Score of 20 or higher → *Go to Part B: IPV Referral.*
       - ☐ Score of 19 or lower
   - ☐ No, not completed → *Complete IPV Screening at future visit before the client reaches 6-months post-enrollment, then complete another M3 form and update in THEO.*

Part B: IPV Referral

*To meet the measure, **IPV Referral information must be given** if the client scores 20 or higher on the Relationship Assessment Tool during a MIECHV screening.*

2. **If a Score of 20 or higher, did you give referral information?** *See examples below
   - ☐ Yes
   - ☐ No → *Clients who screen positive should be provided information on available referral services. The focus is on provision of information, not whether the client received IPV referral services, as a client may not be ready or able to safely access a referral service. Provide Referral Information at future visit and update M3 form in THEO: Q2. Change Selection to "Yes".*

*Referral Information can include:
- Domestic violence advocacy program, shelter or hotlines
- "Healthy Moms, Happy Babies" cards
- Housing options or emergency shelter services
- Legal advocacy and assistance
- Crisis assistance
- Support groups
- Counseling services to address related needs such as depression or substance use

MIECHV Enrollment Tool – Index Parent Page 1 of 1 rev. 10/01/2020

IPV Data Collection form: M3 MIECHV Index Parent Enrollment Tool

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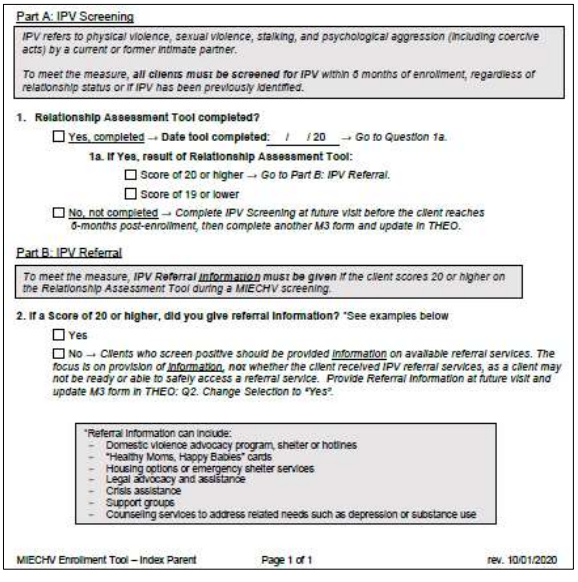
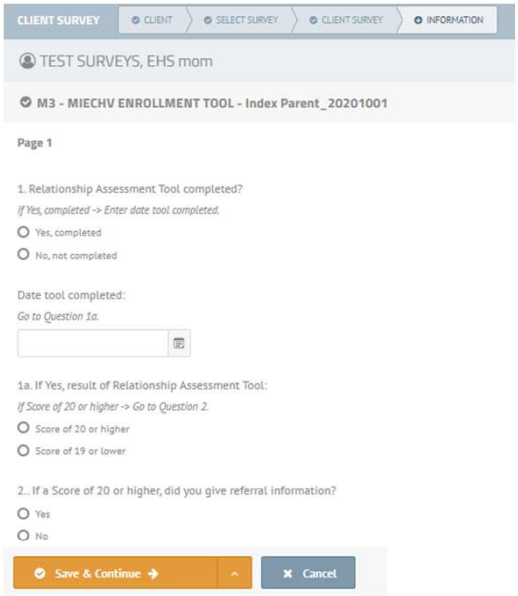
NEW M3 Survey in THEO





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Tips for completing IPV screening

Ensure screening occurs within first 6-months of enrollment: will not count if conducted prior to enrollment in MIECHV

Consider developing a policy for when to conduct this screening, such as at the 5th visit.

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IPV Screening and Referral Resources

IPV Screening training and resources:

Relationship Assessment Tool: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/HOMEVISITING/MIECHV/Pages/miechv-orientation.aspx (scroll down webpage)

Futures Without Violence:

https://www.futureswithoutviolence.org/home-visitation/

Remote IPV screening guidance and resources:

IPV CoIIN memo: Coronavirus/COVID-19 and Implications for Maternal Depression and Intimate Partner Violence Screening and Referral

Future Without Violence webinar and resources for Supporting clients experiencing Intimate Partner Violence in the Time of COVID-19 https://www.futureswithoutviolence.org/Home-visitation-remote-support-during-covid-19

Oregon Health Authority

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Performance Measure #19: Intimate Partner Violence Referrals

Measure Definition	FY 2019
Percent of primary caregivers with positive screens for IPV who receive referral information to IPV resources.	**21.5%** (14/65)

- EHS = 0% (0/5)
- HFA = 50% (5/10)

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Root Causes: low rates of IPV referrals

- Not understanding what will meet the IPV referral (information) requirement
  - Lack of clarity that it is information that needs to be provided, not the client accessing a referral
- Having reasons to check on the form for why referral information not given makes it seem acceptable not to provide referral information
- IPV topic challenging for home visitors
  - Clients might be willing to create safety plan but not receive referral to other agency for assistance

Maternal & Child Health Section
Public Health Division

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When does IPV referral information need to be given?

- If, during a MIECHV IPV screening, the client scores a 20 or higher on the Relationship Assessment Tool
- For any client who screened at risk in a prior reporting period but did not receive information
  - If the client receives referral information at a later time than the positive screening:
    - Update the M3 form in THEO: Q1b. If a Score of 20 or higher, did you give referral information? Change selection to "Yes"

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Considerations for meeting the IPV measure

Caregivers who screen positive for IPV will remain in the measure denominator until they receive IPV **information**.

The focus is **on provision of information**, not whether the client received IPV referral services. This is because of the recognition that a client may not be ready or able to safely access a referral service.

There is no timeframe for when the client must receive referral information; provide referral information to any caregiver who screened positive for IPV even if it was at a previous visit.

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What Counts as IPV information? Referral information can include:

- Domestic violence advocacy program, shelter or hotlines
- "Healthy Moms, Happy Babies" cards
- Housing options or emergency shelter services
- Legal advocacy and assistance
- Crisis assistance
- Support groups
- Counseling services to address related needs such as depression or substance use

Health Authority

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M3
MIECHV ENROLLMENT TOOL
Index Parent

Current | *To be completed within 6 months of parent's enrollment* | **Revised Version**

1. **Relationship Assessment Tool completed (with *mother*)?**
   - ☐ Yes, completed → **Date tool completed:** ___/___/ 20___ → *Go to Question 1a.*
   - **1a. If Yes, result of Relationship Assessment Tool:**
     - ☐ Score of 20 or higher → *Go to Question 1b.*
     - ☐ Score of 19 or lower
   - **1b. If a Score of 20 or higher, did you give referral information?**
     - ☐ Yes
     - ☐ No, client declined or is not ready for a referral and/or services
     - ☐ No, an earlier referral is still in process or the client is currently receiving services
     - ☐ No, other reason
   - **1c. If No, reason why Relationship Assessment Tool not completed:**
     - ☐ Concern previously identified
     - ☐ Other

IPV Data Collection form: M3 MIECHV Index Parent Enrollment Tool

Part A: IPV Screening

IPV refers to physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner.

*To meet the measure, **all clients must be screened** for IPV within 6 months of enrollment, regardless of relationship status or if IPV has been previously identified.*

1. **Relationship Assessment Tool completed?**
   - ☐ Yes, completed → **Date tool completed:** ___/___/ 20___ → *Go to Question 1a.*
   - **1a. If Yes, result of Relationship Assessment Tool:**
     - ☐ Score of 20 or higher → *Go to Part B: IPV Referral.*
     - ☐ Score of 19 or lower
   - ☐ No, not completed → *Complete IPV Screening at future visit before the client reaches 6-months post-enrollment, then complete another M3 form and update in THEO.*

Part B: IPV Referral

*To meet the measure, **IPV Referral information must be given** if the client scores 20 or higher on the Relationship Assessment Tool during a MIECHV screening.*

2. **If a Score of 20 or higher, did you give referral information?** *See examples below
   - ☐ Yes
   - ☐ No → *Clients who screen positive should be provided information on available referral services. The focus is on provision of information, not whether the client received IPV referral services, as a client may not be ready or able to safely access a referral service. Provide Referral Information at future visit and update M3 form in THEO: Q2. Change Selection to "Yes".*

*"Referral Information can include:
- Domestic violence advocacy program, shelter or hotlines
- "Healthy Moms, Happy Babies" cards
- Housing options or emergency shelter services
- Legal advocacy and assistance
- Crisis assistance
- Support groups
- Counseling services to address related needs such as depression or substance use

MIECHV Enrollment Tool – Index Parent Page 1 of 1 rev. 10/01/2020

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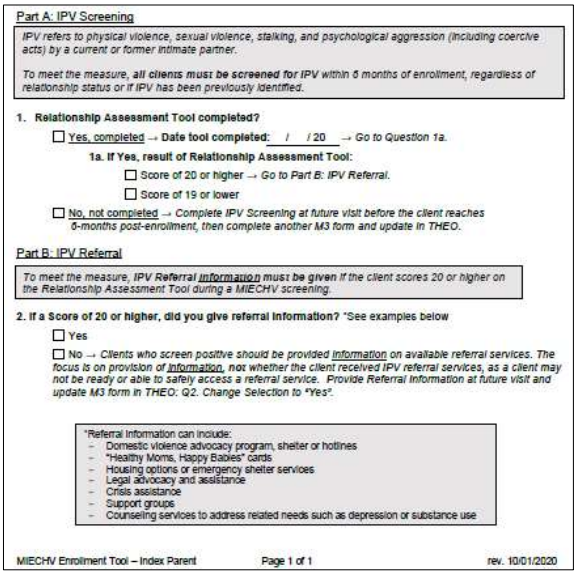
NEW M3 Survey in THEO



Part A: IPV Screening

IPV refers to physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner.

*To meet the measure, **all clients must be screened for** IPV within 6 months of enrollment, regardless of relationship status or if IPV has been previously identified.*

1. Relationship Assessment Tool completed?

☐ Yes, completed → **Date tool completed:** ___/___/20___ → *Go to Question 1a.*

1a. If Yes, result of Relationship Assessment Tool:

☐ Score of 20 or higher → *Go to Part B: IPV Referral.*

☐ Score of 19 or lower

☐ No, not completed → *Complete IPV Screening at future visit before the client reaches 6-months post-enrollment, then complete another M3 form and update in THEO.*

Part B: IPV Referral

*To meet the measure, **IPV Referral information must be given** if the client scores 20 or higher on the Relationship Assessment Tool during a MIECHV screening.*

2. If a Score of 20 or higher, did you give referral information? *See examples below

☐ Yes

☐ No → *Clients who screen positive should be provided information on available referral services. The focus is on provision of information, not whether the client received IPV referral services, as a client may not be ready or able to safely access a referral service. Provide Referral Information at future visit and update M3 form in THEO: Q2. Change Selection to "Yes".*

*Referral Information can include:
- Domestic violence advocacy program, shelter or hotlines
- "Healthy Moms, Happy Babies" cards
- Housing options or emergency shelter services
- Legal advocacy and assistance
- Crisis assistance
- Support groups
- Counseling services to address related needs such as depression or substance use

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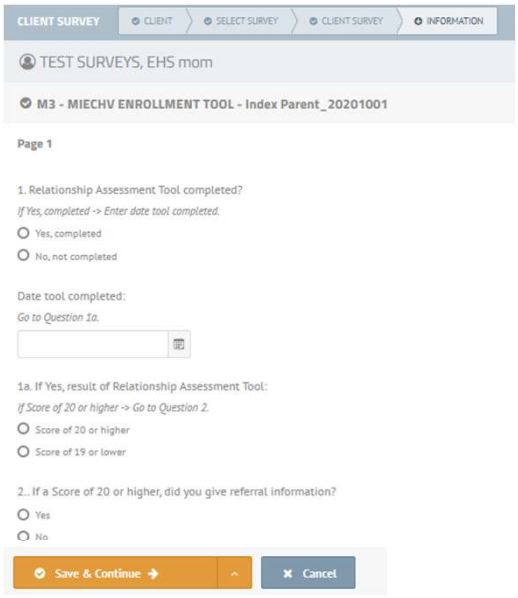

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The focus is **on provision of information**, not whether the client received IPV referral services.

"Healthy Moms, Happy Babies" cards are an easy and great way to provide referral information: give the client 2; 1 for them and 1 for a friend

Tips for completing IPV referrals

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Thank You!

For more information about Oregon MIECHV Program's data collection, please contact:

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