Screening and Referrals Review and Forms Updates for MIECHV NFP LIAs

September 2020

Oregon Health Authority

1

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

Oregon Health Authority

2

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

Oregon Health Authority

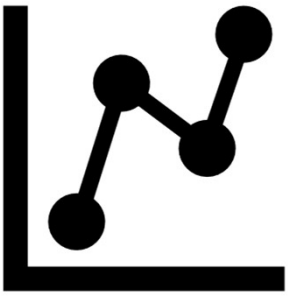
3

What are some of the measures (or topics) MIECHV collects data on?

4

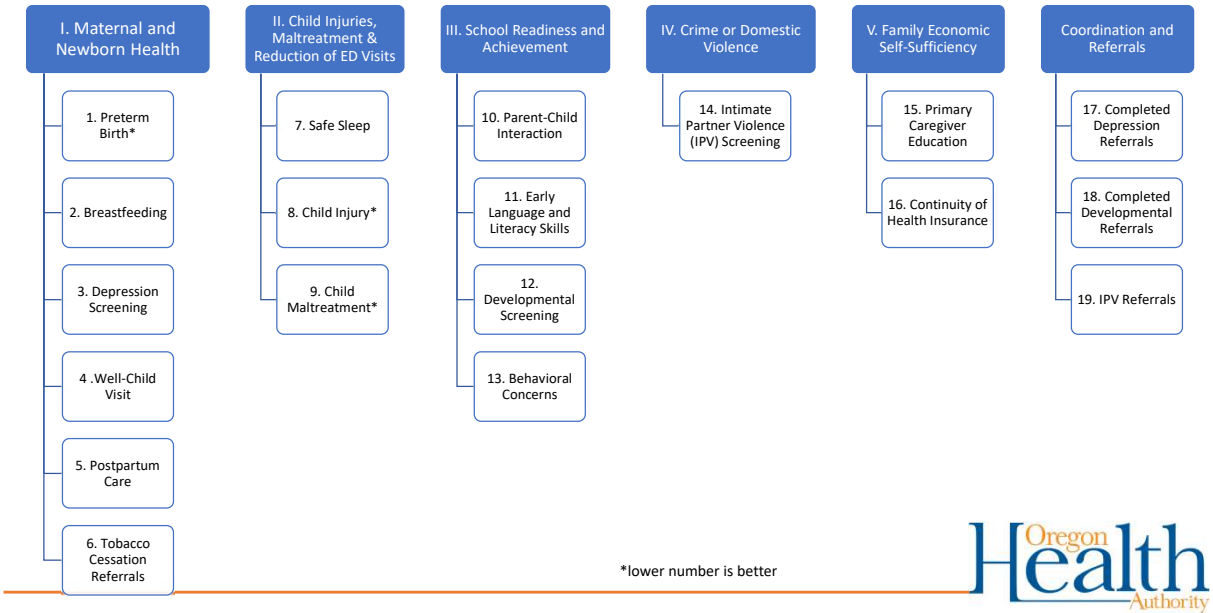
Why do we collect these data?

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



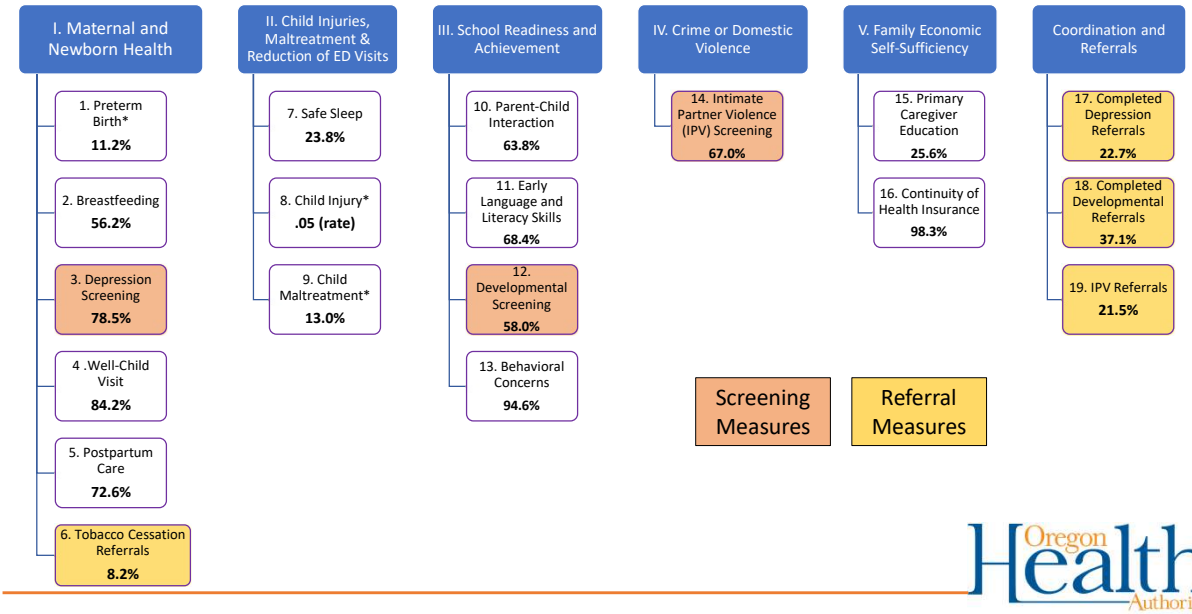
5

19 Performance Measures across 6 Benchmarks



6

FY 2019 Oregon Annual Data

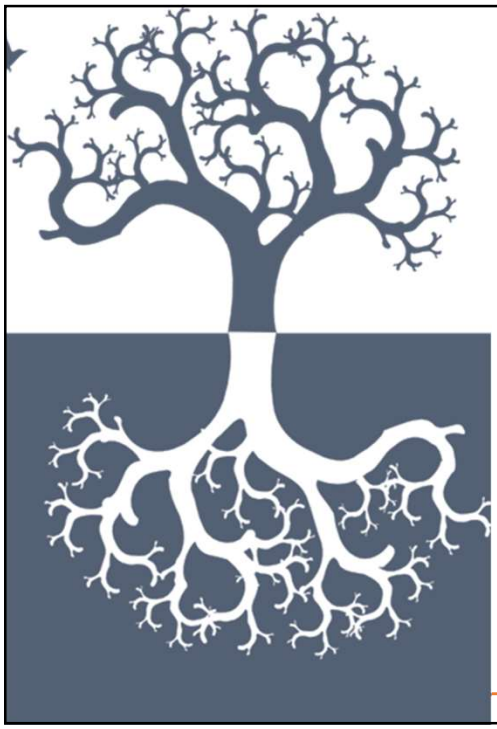


7

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%

8



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

Oregon Health Authority

9

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)

Oregon Health Authority

10

Tobacco Cessation Referrals

Performance Measure #6

11

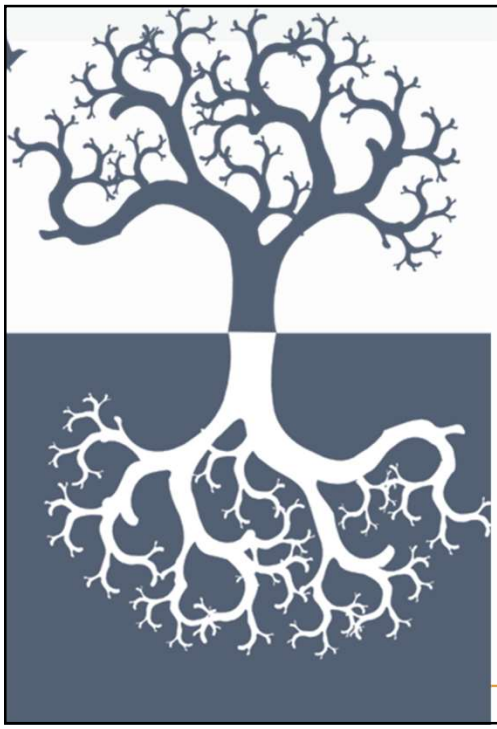
Performance Measure #6: Tobacco Cessation Referrals

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)

- NFP sites = 19.4% (6/31)

Oregon Health Authority

12



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

Oregon Health Authority

13

13

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).

Oregon Health Authority

14

Tobacco Use Data Collection: MIECHV Demographics: Pregnancy-Intake Form

MIECHV Demographics: Pregnancy–Intake

M7. Do you currently use tobacco products? (Tobacco includes combustibles [cigarettes, cigars, pipes, hookahs, and bidis], non-combustibles [chew, dup snuff, snus, and dissolvables], and ENDS)

☒ Yes

If Yes, are you currently receiving tobacco cessation services?

☐ Yes

☒ No → 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.

☐ No

Provide Tobacco Referral and Complete M2B

15

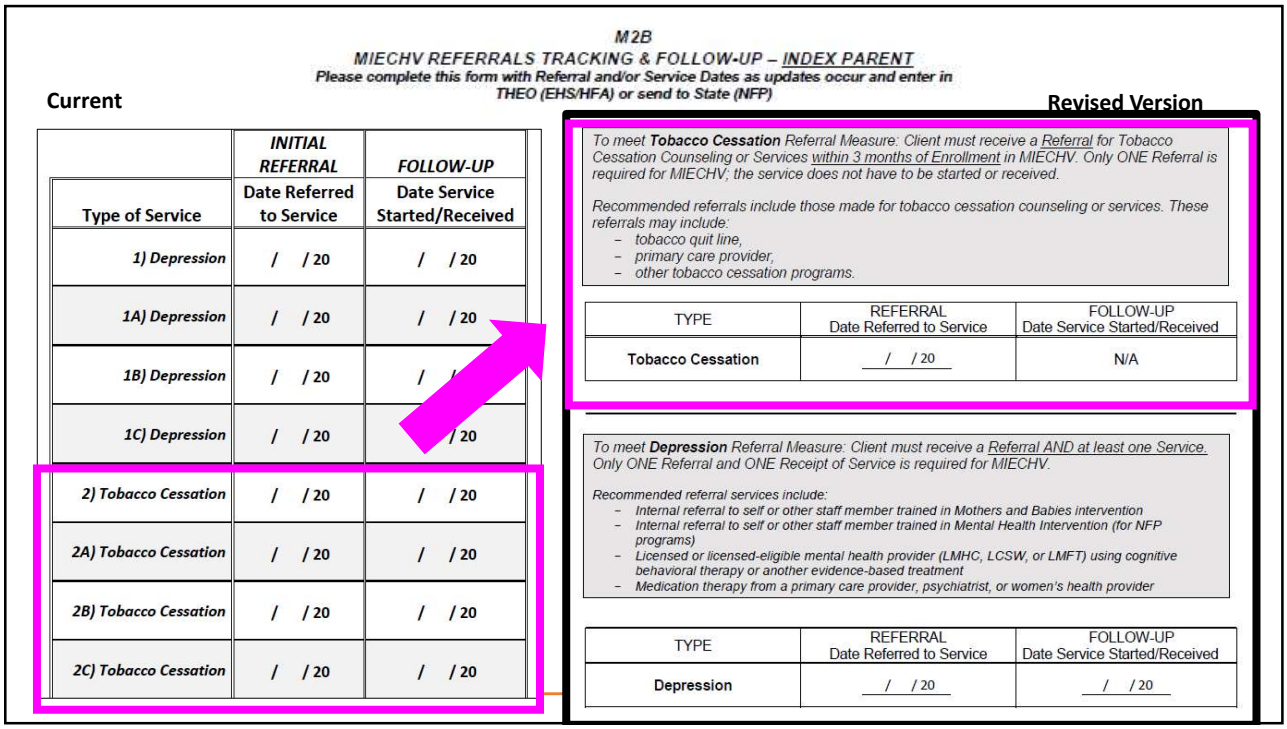
What counts as a tobacco cessation referral?

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

16



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)

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	/ /
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.

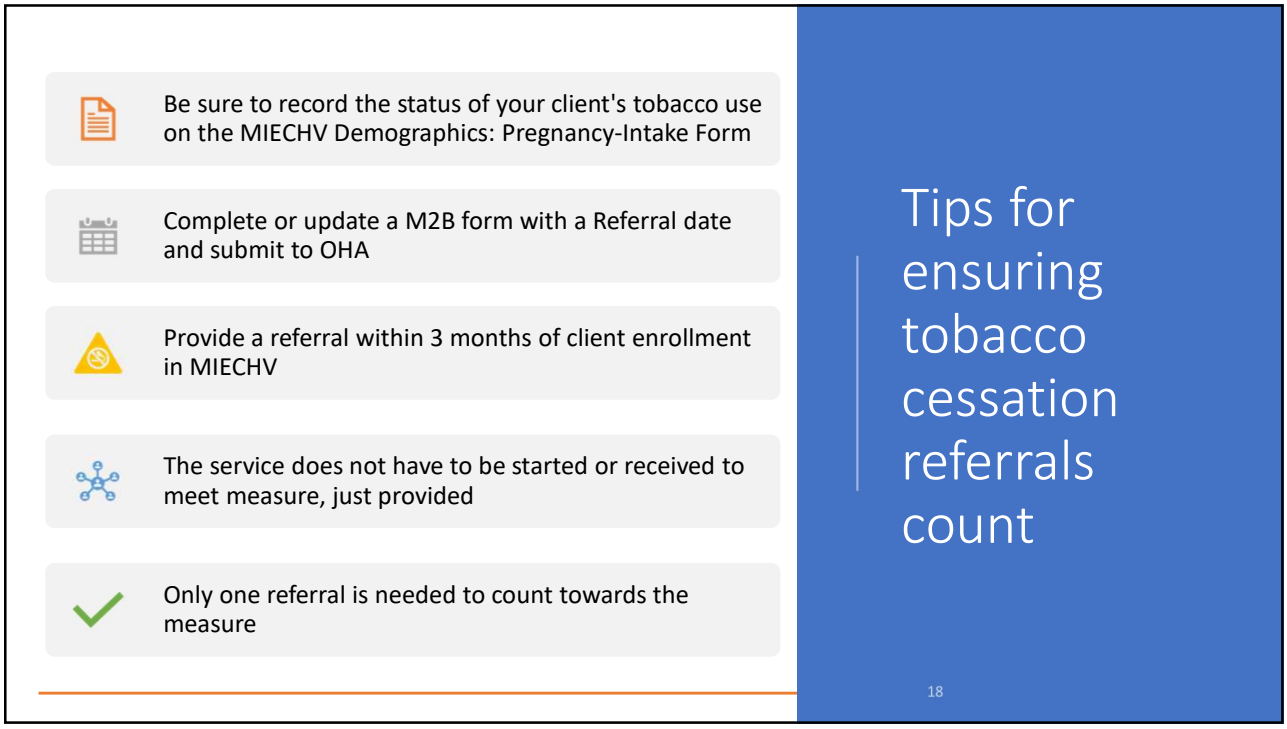
TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

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

17



Be sure to record the status of your client's tobacco use on the MIECHV Demographics: Pregnancy-Intake Form

Complete or update a M2B form with a Referral date and submit to OHA

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

18

18

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

19

20

Performance Measure #12: Developmental Screening

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

NFP = 56.1%

Oregon Health Authority

21

Root Causes: low rates of developmental screening

- **Screening not completed with client**
  - **Home visitors not filling out forms as needed**
    - recently completed a non-MIECHV time period one
    - NHV doesn't have a developmental concern for child
    - ASQ completed by PCP
- **Paper forms not easy to use or understand**
  - combined ASQ Questionnaire with referral tracking form on back is confusing as to when each are necessary to complete
- **Screening occurred outside of window period**
  - Clients unavailable/can't be located
- **HVs need more information on:**
  - Which screening time points are MIECHV
  - Exact timeframes by ASQ screen
  - Age adjusting correctly and marking on form

Oregon Health Authority

22

When do ASQ screenings occur for MIECHV?

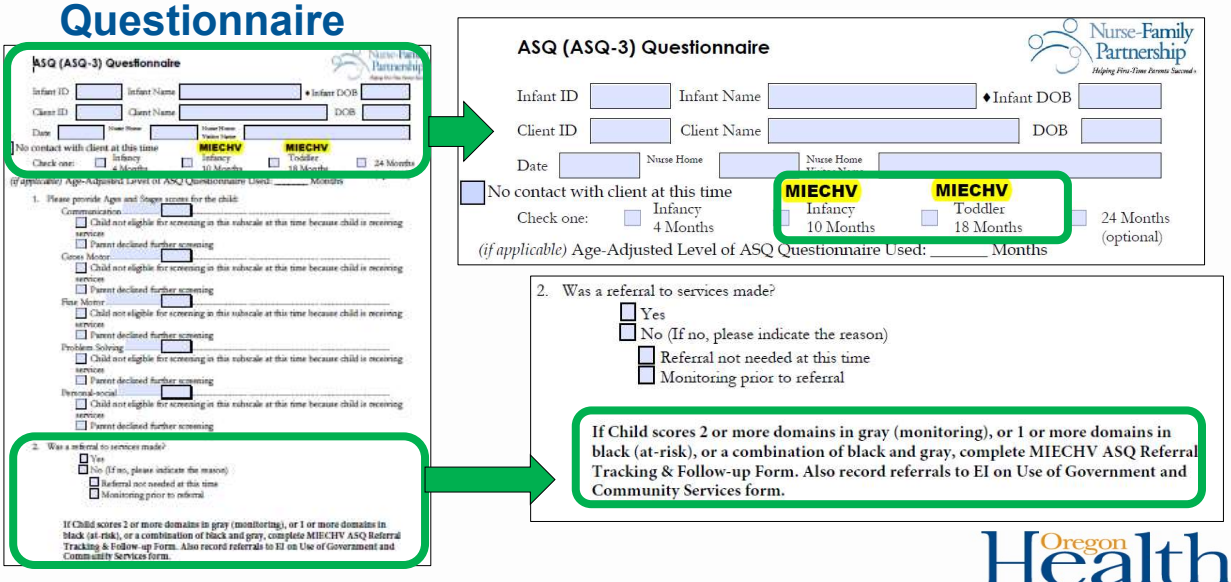
10 months
- conducted between child's age 9 months 0 days through 10 months 30 days

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

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

23

Developmental Screening Data Collection: ASQ Questionnaire



24

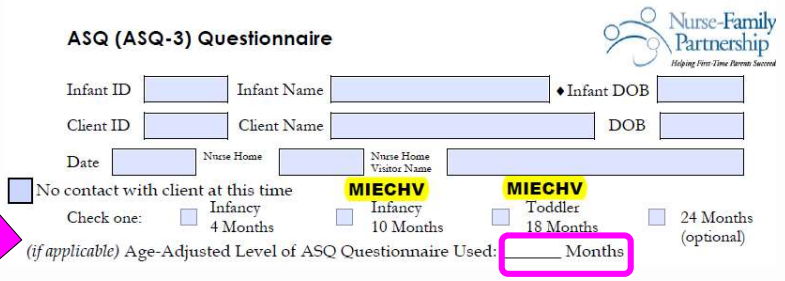
Adjusting age for premature infants*:

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 10-month ASQ screening. The infant was born 4 weeks premature. Conduct ASQ screening, using the 8-month ASQ Questionnaire to account for its prematurity

→ **On ASQ** Questionnaire, **write in "8" to note age-adjusted screening**


ASQ (ASQ-3) Questionnaire

Nurse-Family Partnership

Infant ID | Infant Name | ♦Infant DOB

Client ID | Client Name | DOB

Date | Nurse Home | Nurse Home Visitor Name

☐ No contact with client at this time

Check one: ☐ Infancy 4 Months (MIECHV) ☐ Infancy 10 Months (MIECHV) ☐ Toddler 18 Months ☐ 24 Months (optional)

(if applicable) Age-Adjusted Level of ASQ Questionnaire Used: _____ Months

Oregon Health Authority

25

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

26

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

Oregon Health Authority

27

Performance Measure 18: Completed Developmental Referrals

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

NFP = 56.5%

*Of the 23:
-15 received individual support
-9 received Early Intervention
-2 received other community service
**includes 5 children from previous reporting years

Maternal & Child Health Section
Public Health Division

Oregon Health Authority

28

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 resend to OHA
- Clients decline referral
- Confusion with referral tracking form
- Challenges with community referrals

29

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

1. for a child screened by a MIECHV home visitor…
2. during 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

30

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.

31

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)

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

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.

Revised Version

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

32

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

33

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.

34

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.

35

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 on form & resend to OHA

36

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

37

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 on form & resend to OHA

38

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

Set a calendar or paper reminders to check back in with client and send updated form to OHA

Tips for completing developmental referrals

39

39

Maternal Depression Screening and Referrals

Performance Measures #3 and #17

Maternal & Child Health Section
Public Health Division

40

40

Performance Measure #3: Maternal Depression Screening

Measure Definition	FY 2019
Percent of primary caregivers who are screened for depression within three months of delivery (for those enrolled prenatally).	**78.5%** 332/423

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

NFP = 74.7%

41

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; NHVs don't screen again
    - By postpartum, this is third PHQ-9 screening for NFP, might skip MIECHV time point
    - MD screening not a priority for immediate postpartum visit
    - Client not comfortable completing screening
  - **NFP clients are disengaging from services postpartum and not seen**
  - **Form options make it seem acceptable not to complete screening**
- **Screening occurred outside of window period**
  - Lack of clarity/challenges with timing for screening

Maternal & Child Health Section
Public Health Division

42

42

When do maternal depression screenings occur for MIECHV?

Within 90 days of delivery (for those enrolled prenatally)

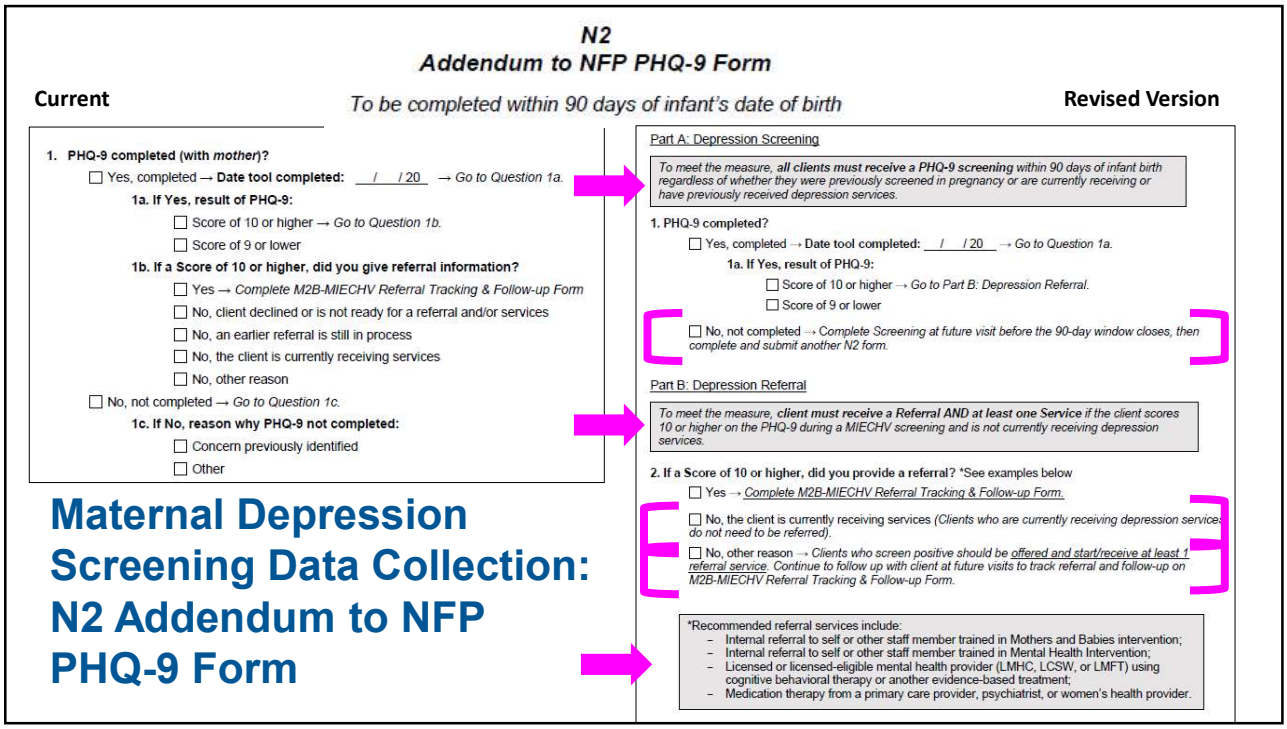
→See client schedule for window period; if screened before or after this period, doesn't count for measure

43

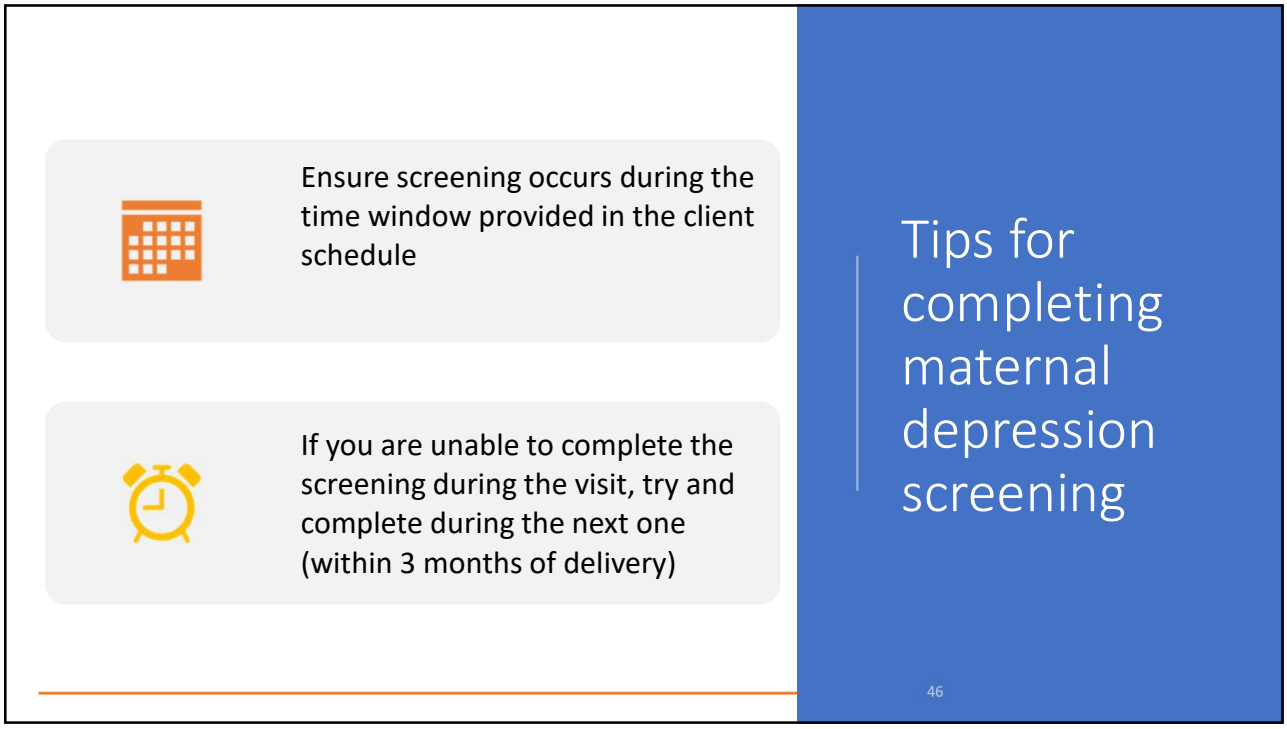
What is required for maternal depression screening?

- 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 should be offered and completed to meet the measure.

44


N2
Addendum to NFP PHQ-9 Form
Current
To be completed within 90 days of infant's date of birth
Revised Version
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
Part A: Depression Screening
To meet the measure, all clients must receive a PHQ-9 screening within 90 days of infant birth regardless of whether they were previously screened in pregnancy or 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 and submit another N2 form.
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 member trained in Mothers and Babies intervention;
Internal referral to self or other staff member trained in Mental Health 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.
Maternal Depression Screening Data Collection: N2 Addendum to NFP PHQ-9 Form

45


Ensure screening occurs during the time window provided in the client schedule
If you are unable to complete the screening during the visit, try and complete during the next one (within 3 months of delivery)
Tips for completing maternal depression screening
46

46

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

47

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!

NFP = 50%

Oregon Health Authority

48

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 NHV to come back and complete received date – easy to forget/not resubmit/lose
- **Clients decline/refuse referral**
  - Clients look to/prefer NHV as their "referral." Clients expect the NHV can provide that service
- **Lack of referral options, particularly in rural communities**
- **Few Spanish-speaking resources for counseling and services**

Oregon Health Authority

49

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: For "Depression, record when referral was given as "Date Referred to Service"; and when service received as "Date Service Started/Received" and send to OHA

50

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

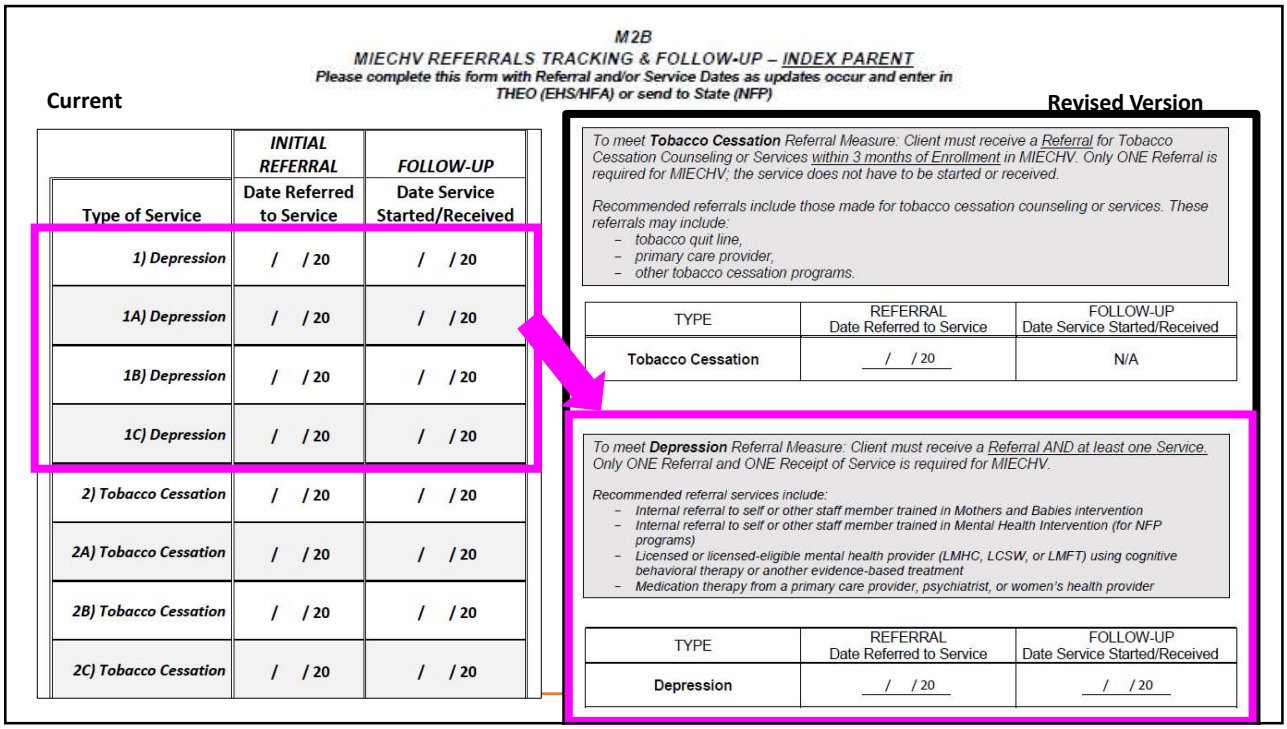
51

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
  - 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

52



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)

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

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.

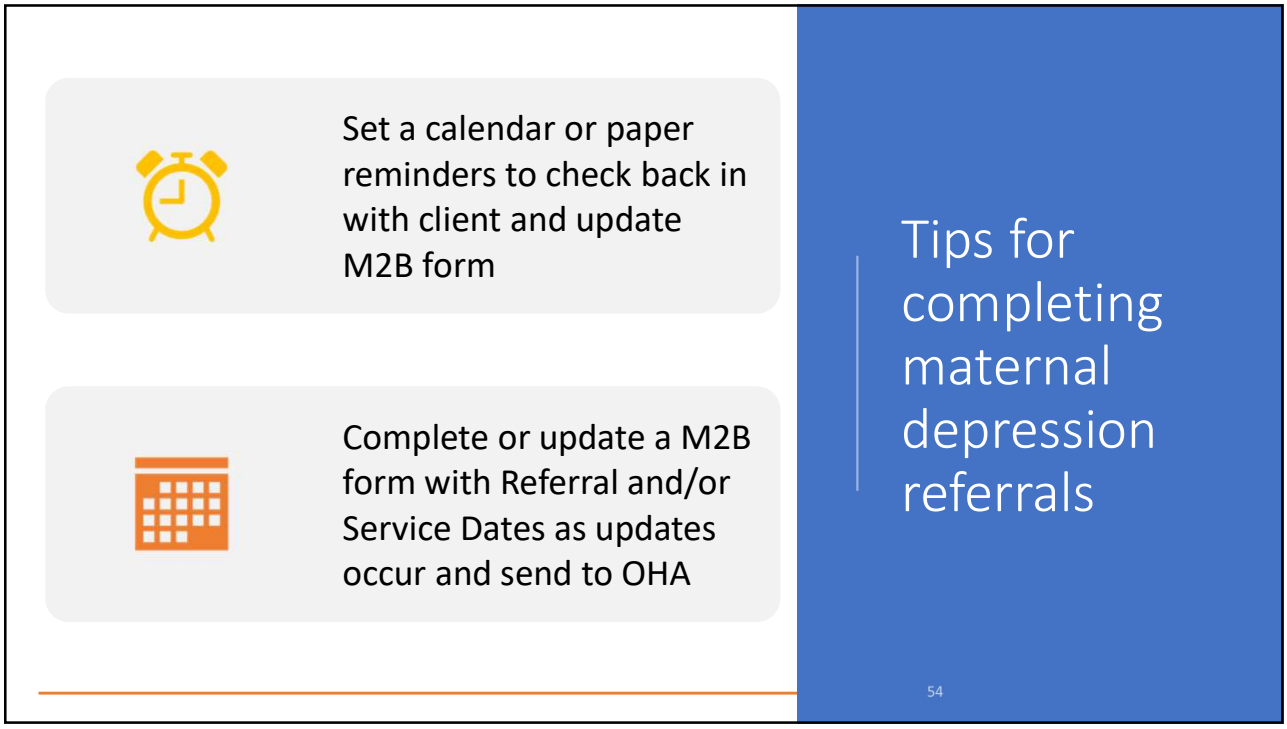
TYPE	REFERRAL Date Referred to Service	FOLLOW-UP Date Service Started/Received
Tobacco Cessation	/ / 20	N/A

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

53



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

Complete or update a M2B form with Referral and/or Service Dates as updates occur and send to OHA

Tips for completing maternal depression referrals

54

54

Intimate Partner Violence Screening and Referrals

Performance Measures #14 and #19

55

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)

- NFP = 63.7%

Oregon Health Authority

56

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
- Clients experiencing IPV may be seen less often due to complex needs, so more to get done when visits do occur

57

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

- 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
- Client not comfortable completing screening
- Perpetrator or other person present in room

58

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.

59

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

60

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

61

IPV Data Collection forms: N1 OR N4

N1 Addendum to Clinical IPV Assessment Form

5th – 7th VISIT

To be completed within 6 months of parent's enrollment

N4 Addendum to Clinical IPV Assessment Form

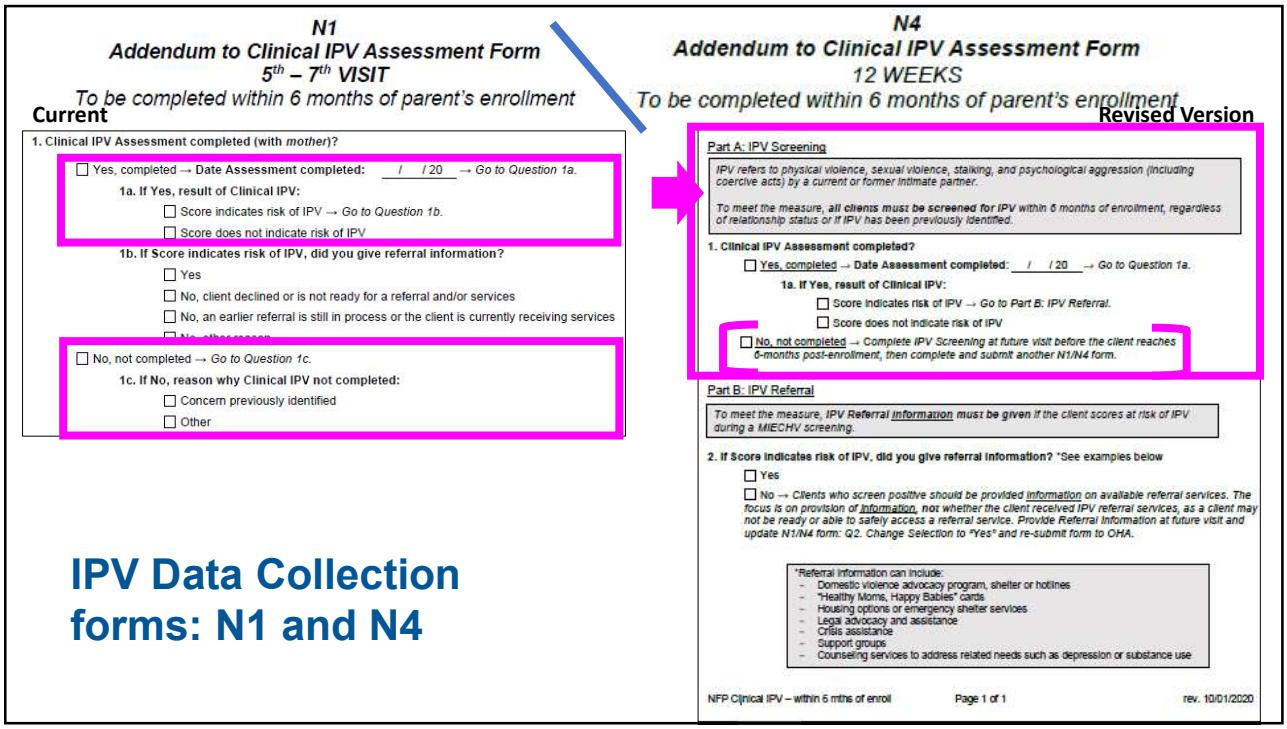
12 WEEKS

To be completed within 6 months of parent's enrollment

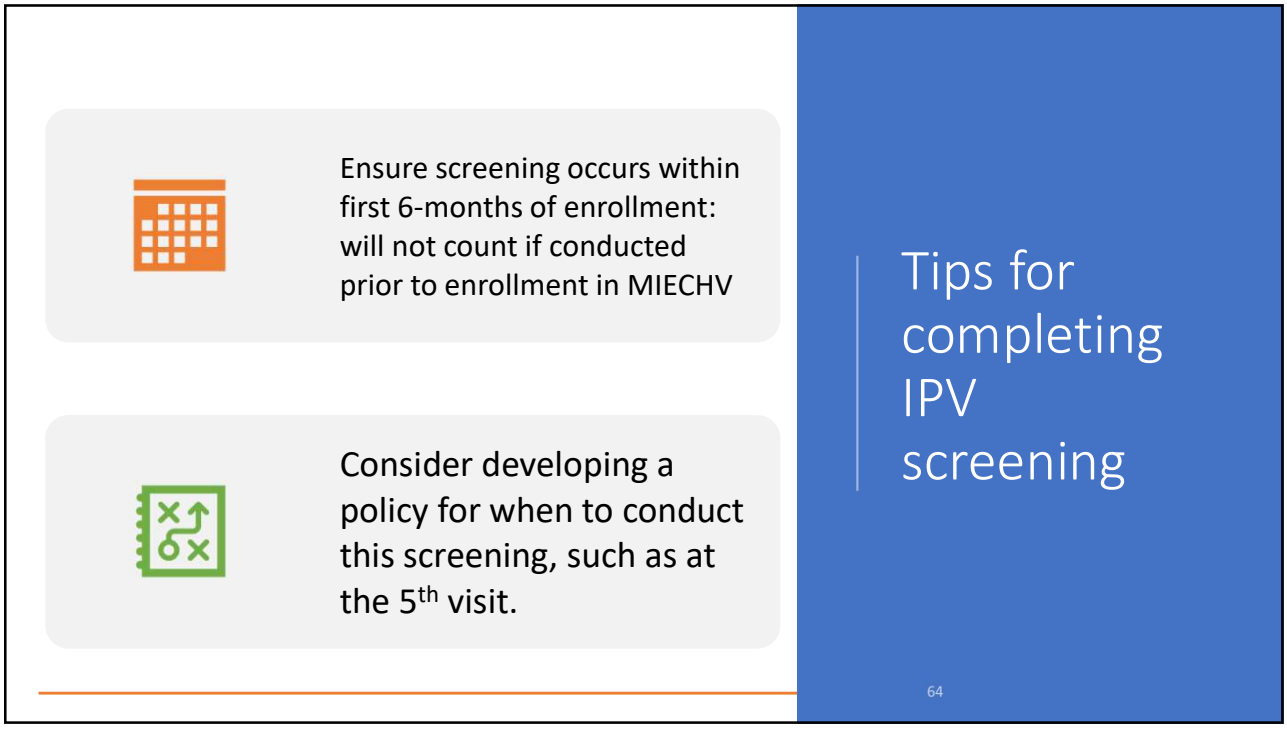
TIP: EITHER the N1 OR N4 form can be completed and sent to OHA – you do NOT need to do both

Oregon Health Authority

62


N1
Addendum to Clinical IPV Assessment Form
5th – 7th VISIT
To be completed within 6 months of parent's enrollment
Current
1. Clinical IPV Assessment completed (with mother)?
Yes, completed → Date Assessment completed: / / 20 → Go to Question 1a.
1a. If Yes, result of Clinical IPV:
Score indicates risk of IPV → Go to Question 1b.
Score does not indicate risk of IPV
1b. If Score indicates risk of IPV, 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, not completed → Go to Question 1c.
1c. If No, reason why Clinical IPV not completed:
Concern previously identified
Other
N4
Addendum to Clinical IPV Assessment Form
12 WEEKS
To be completed within 6 months of parent's enrollment
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. Clinical IPV Assessment completed?
Yes, completed → Date Assessment completed: / / 20 → Go to Question 1a.
1a. If Yes, result of Clinical IPV:
Score indicates risk of IPV → Go to Part B: IPV Referral.
Score does not indicate risk of IPV
No, not completed → Complete IPV Screening at future visit before the client reaches 6-months post-enrollment, then complete and submit another N1/N4 form.
Part B: IPV Referral
To meet the measure, IPV Referral information must be given if the client scores at risk of IPV during a MIECHV screening.
2. If Score indicates risk of IPV, 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 N1/N4 form: Q2. Change Selection to "Yes" and re-submit form to OHA.
*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
NFP Clinical IPV – within 6 mths of enroll
Page 1 of 1
rev. 10/01/2020
IPV Data Collection forms: N1 and N4

63


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.
Tips for completing IPV screening
64

64

IPV Screening and Referral Resources

IPV Screening training and resources:

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

65

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)

- NFP = 13.2%

Oregon Health Authority

66

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

67

When does IPV referral information need to be given?

- If the score from a MIECHV IPV screening indicates at risk for IPV
- For any client who screened at risk for IPV 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 N1/N4 form and resubmit to OHA

68

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.

69

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

70

N1
Addendum to Clinical IPV Assessment Form
5th – 7th VISIT
To be completed within 6 months of parent's enrollment

N4
Addendum to Clinical IPV Assessment Form
12 WEEKS
To be completed within 6 months of parent's enrollment

Current

1. Clinical IPV Assessment completed (with *mother*)?

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

1a. If Yes, result of Clinical IPV:

☐ Score indicates risk of IPV → *Go to Question 1b.*

☐ Score does not indicate risk of IPV

1b. If Score indicates risk of IPV, 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 Clinical IPV not completed:

☐ Concern previously identified

☐ Other

Revised Version

Part B: IPV Referral

To meet the measure, IPV Referral information must be given if the client scores at risk of IPV during a MIECHV screening.

2. If Score indicates risk of IPV, 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 N1/N4 form: Q2. Change Selection to "Yes" and re-submit form to OHA.*

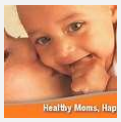
*Referral information can include:
- Domestic violence advocacy program, shelter or hotlines
- "Healthy Moms, Happy Babies" cards
- Housing options or emergency shelter services
- Legal advocacy and assistance
- Crisis assistance
- Support groups
- Counseling services to address related needs such as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

NFP Clinical IPV – within 6 mths of enroll Page 1 of 1 rev. 10/01/2020

IPV Data Collection forms: N1 and N4

71

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

72

72

Thank You!

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

Tina Kent, MIECHV Data Manager: Tina.m.kent@dhsoha.state.or.us

Drewallyn Riley, CQI Coordinator: Drewallyn.b.riley@dhsoha.state.or.us

Public Health Division
Maternal & Child Health

Oregon Health Authority

73