

Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children

Session Law 2017-57, Section 11H.14.(a)



**Report to the
Joint Legislative Oversight Committee on Medicaid
and NC Health Choice
and the
Fiscal Research Division
by
North Carolina Department of Health and Human Services**

January 24, 2018

Reporting Requirement

Session Law 2017-57, Section 11H.14. (a) states:

It is the intent of the General Assembly to provide Medicaid and NC Health Choice coverage for evidence-based home visits for pregnant women and families with young children designed to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness that are consistent with the model used by Nurse-Family Partnership. No later than July 1, 2018, the Department of Health and Human Services, Division of Medical Assistance (Department), shall begin providing Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.

The Department shall develop a plan to implement changes necessary to provide Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program; however, consistent with G.S. 108A-54(e)(4), the Department is not authorized to make any changes to eligibility for the Medicaid or NC Health Choice programs. The plan shall detail the design and scope of coverage for the home visits for pregnant women and families with young children and include the identification of any State Plan Amendments or waivers that may be necessary to submit to the Centers for Medicare and Medicaid Services.

Session Law 2017-57, Section 11H.14.(b) states:

No later than November 1, 2017, the Department shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division a report containing the following information:

- (1) As required by subsection (a) of this section, a copy of the plan to provide, no later than July 1, 2018, Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.
- (2) A detailed description of the coverage to be provided, including the proposed service definition, the home visit schedule, the scope of the covered service, and the anticipated reimbursement rate to be paid.
- (3) An analysis of the total fiscal impact of adding Medicaid and NC Health Choice coverage for the home visits for pregnant women and families with young children. This shall include an outline of both costs and savings to the Medicaid and NC Health Choice programs, as well as any savings to other programs provided by the State.
- (4) A description of how the Department intends to leverage any private funding that may be currently utilized to provide coverage for evidence-based home visits for pregnant women and families with young children.

- (5) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e) or whether additional appropriations are required.
- (6) Any plans to include pay-for-success initiatives as part of the Medicaid and NC Health Choice funding for the covered service.
- (7) An anticipated time line for the implementation of the Department's plan and the submission of any necessary State Plan Amendments or waivers to the Centers for Medicare and Medicaid Services.

Executive Summary

Plan for Pilots of Coverage for Home Visits for Pregnant Women and Families with Young Children

The North Carolina Department of Health and Human Services has a longstanding collaboration among its Divisions and community providers across the state to deliver maternal and child health services. When the 2017 Appropriations Act was enacted, the Division of Medical Assistance convened a team to begin planning how to address the requirements of Section 11H.14. This report describes the proposed plan for conducting Pilot Projects on coverage for home visiting services within targeted areas of the state that are consistent with the model used by Nurse-Family Partnership. Collaborators include: the Division of Public Health's Women's and Children's Health Section; Community Care of North Carolina (CCNC); the Division of Medical Assistance; the Division of Child Development and Early Education; and service providers.

The Pilot Project on home visits, as proposed, will operate for a period of one year during SFY2019, in advance of the state's Medicaid Managed Care transition in SFY2020. DHHS recommends a Pilot Program to compare coverage for home visits for first pregnancies to risk-based coverage for all pregnancies (providing home visits to the highest risk women). The first pilot project will implement coverage for home visiting in one county which presently has home visiting services funded by private grants. The second pilot project will implement coverage for home visiting in one county which does not presently have home visiting by enhancing the existing Medicaid Pregnancy Care Management and Care Coordination for Children. Any home visit program implemented in North Carolina will be in addition to NC's foundation of evidence-based, risk-driven maternity care and case management and early childhood pediatric care and risk-based case management. Once Medicaid Prepaid Health Plans (PHPs) are implemented, home visit programs will be in addition to the PHP's maternal and child programs. Upon completion of the pilots, DHHS will provide an assessment of the feasibility of maintaining or expanding coverage for home visiting services.

ACRONYMS FOUND IN THIS DOCUMENT

ACRONYM	DEFINITION
CC4C	Care Coordination for Children
CCNC	Community Care of North Carolina
CDSA	Children's Developmental Services Agencies
CMIS	Case Management Information System
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DMCN	Disease Management Coordination Network
DPH	Division of Public Health
FFS	Fee-For-Service
HC	Health Check
HV	Home Visiting
IC	Informatics Center
LME/MCO	Local Management Entities/Managed Care Organizations
LSP	Life Skills Progression
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MOA	Memorandum of Agreement
NCHC	NC Health Choice
NFP	Nurse-Family Partnership
OBCM	Pregnancy Care Management
PMH	Pregnancy Medical Home
PMPM	Per Member Per Month

1) Background

a) Federal Home Visiting Programs

Home visiting, as defined by the Health Resources and Services Administration (HRSA), U.S. DHHS, is an evidence-based program that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women and families with children ages birth to five years. Home visiting targets numerous outcomes, including: improved maternal and child health; prevention of child injuries, child abuse, or maltreatment; reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in coordination and referrals for other community resources and supports; and improvements in parenting skills related to child development.

b) Home Visiting Programs in North Carolina

North Carolina has a history of access to home visits to support maternal and child health. As national home visiting models have evolved, the NC Division of Public Health (DPH) has kept pace and participated in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) development and programs. The following evidence-based home visiting programs are currently implemented in North Carolina:

- Nurse-Family Partnership;
- Healthy Families America;
- Parents as Teachers;
- Child First;
- Early Head Start Home Visiting; and
- Family Connects.

The map in Attachment B shows the distribution of evidence-based home visiting models across the State, and Attachment C includes a description of each program.

The NC Home Visiting Consortium

Since 2014, the Division of Public Health has been convening the NC Home Visiting Consortium as a means of bringing together state sponsoring agencies, funders, and model developers for coordinating MIECHV home visiting services as part of a system of care for young children. The Consortium meets quarterly and addresses expansion of home visiting services in North Carolina, coordination of services when more than one model is implemented in each service area, and updates on State and federal legislation. State agencies and funders represented include the NC Division of Public Health, North Carolina Partnership for Children, Prevent Child Abuse North Carolina, Blue Cross and Blue Shield Foundation of North Carolina, the Winer Foundation, the Duke Endowment, and the Kate B. Reynolds Charitable Trust. Model developers include Nurse-Family Partnership, Healthy Families America, Parents as Teachers, Early Head Start Home Visiting, Family Connects, and Child First.

c) North Carolina Context for Service Delivery

Since 2011, the Divisions of Public Health and Medical Assistance have collaborated on the Pregnancy Medical Home (PMH) model, which focuses on the prevention of preterm birth and low birth weight. PMH provides prenatal care and community-based care coordination to most pregnant Medicaid beneficiaries in the state.¹ It also includes the Pregnancy Care Management (OBCM) Program, which serves women based on their level of need during pregnancy and the postpartum period. NC Medicaid covers more than 55% of NC births.² In SFY2015, Medicaid covered more than 66,000 births.

All PMH practices use a standardized, comprehensive risk assessment tool (See Attachment E) for pregnant Medicaid beneficiaries. Risk screening data, combined with other data sources, are used to calculate a Maternal-Infant Impactability Score (MIIS) from 0 to 1,000 for each pregnant Medicaid beneficiary. Higher MIIS scores reflect the potential for Pregnancy Care Managers to impact the birth outcomes by reducing the risk of low birth weight (LBW). One in four women in the “high impactability” priority group (MIIS score ≥ 500) have a risk of having a LBW infant, and have been shown to benefit the most from OBCM services when they receive intensive, *face-to-face*, pregnancy care management with at least 10 interactions with the care manager during pregnancy.

Following birth, the care of the child is assumed by pediatric care providers (pediatricians and family physicians). At-risk children and their families receive care management services through Care Coordination for Children (CC4C). Care Coordination for Children consists of a set of evidence-based interventions and activities that address the health of the birth-to-age five population with the goal of promoting wellness, improving health outcomes, improving the quality of care, and promoting cost-effective care for the targeted population.¹

In preparation for developing a pilot, the DHHS team compared the characteristics and content of the existing home visiting programs (See Attachment C). The team also prepared a direct comparison of OBCM and CC4C visit topics, content, and Medicaid coverage with those of the Nurse-Family Partnership, which is the most visit intensive home visiting program in NC (See Attachment D). The collaborating Divisions developed the following criteria for a pilot home visit model:

- Integrate with the existing MCH infrastructure for the Medicaid population;
- Continue the existing relationships with obstetric and pediatric providers;
- Screen the entire pregnant population to establish the risk for LBW;
- Target the highest risk women;
- Avoid duplication of services;
- Reduce Cost; and
- Improve maternal and child outcomes.

¹ Source: North Carolina Community Care Network Quarterly Report SFY2017 Quarter 3 Pregnancy Medical Home (PMH) and Pregnancy Care Management.

² Source: State Center for Health Statistics, NC Department of Health and Human Services <http://www.schs.state.nc.us/schs/births/matched/2015/medicaid.html>.

2) Pilot Program Design

As a result of the insight gained from studying national models and considering current NC services, the DHHS interdisciplinary team is proposing to implement two pilot projects. The first, County Pilot A, will implement Medicaid coverage for the nurse visits of the NFP model for all first-time mothers and their infants. The second, County Pilot B, will implement coverage for home visits for all pregnant women at high risk and their infants, as an enhancement to existing OBCM and CC4C services. The second model will minimize duplication of services and support continuity of care with obstetric and pediatric providers.

For County Pilot A, the home visits covered for the NFP model will be provided according to the evidence-based model which includes multiple home visits for the woman in her first pregnancy and her infant.

County Pilot A Design Elements:

The first segment during the pregnancy includes visits every other week during the pregnancy to address health behavior issues such as the effects of alcohol and smoking on fetal growth, nutrition and exercise, and other risk factors for preterm birth. The second segment includes home visits every two weeks postpartum until the baby reaches 21 months of age, then monthly visits until the child is 2 years of age. During these visits, the nurse focuses on topics such as parent or infant and toddler nutrition, health, growth and development and environmental safety. NFP model fidelity is maintained for intake for eligibility, standardized assessment, plan of care, and some visiting schedule. Staff ratios, reporting requirements, and other program details are specified for the model.

In County Pilot A, the NFP project is currently in place with staffing of one NFP nurse supervisor, one administrative staff, and four nurse home visitors with the expectation of serving 100 clients. This is a timely opportunity for piloting Medicaid coverage for the nurse home visits, since the remainder of program funding is in place via private and state funding and financial data are available to DPH.

For County Pilot B, the team recommends the following design elements and program enhancements:

County Pilot B Design Elements:

- a) Leverage the existing service delivery of PMH, OBCM, and CC4C and existing relationships with obstetric and pediatric practices, Children's Developmental Services Agencies (CDSAs), the Departments of Social Services, and LME/MCO providers of behavioral and substance use services.
- b) Include all pregnancies, not just first pregnancies.
- c) Base the home visiting interventions on beneficiary Maternal-Infant Impactability Scores, and target the women with MIIS scores >500.
- d) Build an enhanced NC model based on the elements of successful home visiting established by MIECHV programs, using the existing NC programs for the Medicaid

population as the foundation. Start with existing OBCM services; add enhanced home visiting; transition to CC4C with enhanced home visiting during the postpartum period and the infant's first year of life; and continue CC4C services through age 5 for at-risk children.

County Pilot B Enhancements to Existing Programs

The risk-based home visiting pilot will include:

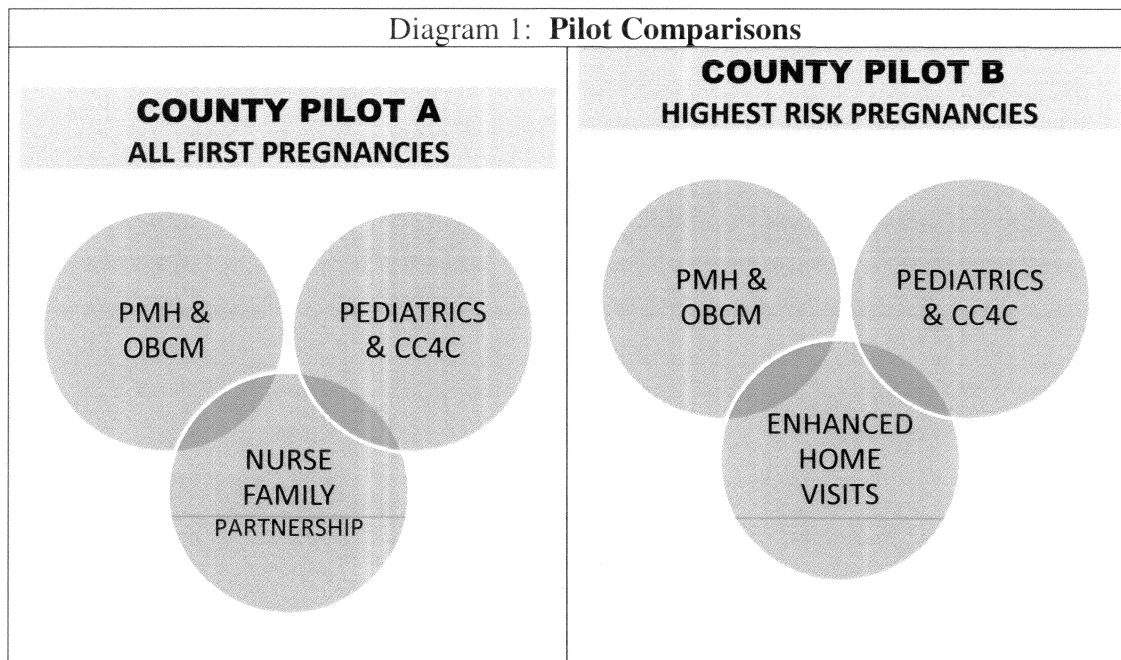
- a) Transitioning from phone or office to face-to-face interventions, including structured home visits;
- b) Staff training;
- c) Engaging a multi-disciplinary team for each family;
- d) Augmenting social determinants of health screening and interventions (transportation, food, etc.);
- e) Using the Life Skills Progression Tool (See Attachment F) for intake and ongoing assessment of families of infants and young children; and
- f) Using the MIECHV Centralized Intake and Referral Tool (See Attachment G)

The MIECHV Centralized Intake and Referral Tool was developed as an integral part of the NC Medicaid State Plan for Home Visiting. Participating families will be able to find resources based on their specific pregnancy and early childhood needs and referrals will be generated to the agencies that fit their needs.

The County Pilot B will incorporate two existing Medicaid home-based nurse visits—the Home Visit for Postnatal Assessment and Follow-Up Care and the Home Visit for Newborn Care and Assessment—into a more comprehensive, coordinated, intensive home visiting program for the target population. Care managers will also work with patients in the medical setting. If patients miss one or more medical visits, additional home visits will be conducted to assess for and address barriers that are affecting the patient's ability to receive appropriate obstetric and pediatric care. The Pilot elements are all consistent with the MIECHV evidence base for successful home visiting models; some are newly implemented innovations.

3) Pilot Plan

DHHS's Divisions of Medical Assistance and Public Health will implement two one-year pilots, as described above. The limited duration is due to anticipated implementation of managed care contracts in July 2019. County Pilot A has an existing NFP project, along with PMH, OBCM, and CC4C. In this county, home visits for first time mothers and their infants will be covered by Medicaid. County Pilot B has PMH, OBCM, and CC4C but no current MIECHV home visiting programs. In this county, the target population will be all pregnant women with Medicaid coverage who are at high risk of having a low birth weight infant, based on a Maternal-Infant Impactability Score of 500 or greater. (See Diagram 1) The service definition for home visits and schedule of home visits for both pilots are described below under Section 4, *Coverage*. The home visiting details for County Pilot B are in Attachment F.



4) Pilot Coverage Plan

a) Service Definition

The goal of home visits for pregnant women and families with young children is provision of services that will improve maternal outcomes and overall child health. A nurse or social worker in the role of Care Manager will provide one-on-one education and support beginning in early pregnancy and throughout, facilitating a crucial supportive bond between mothers and Care Managers. Care Managers will provide support, education, counseling on health behavior and self-management, and community referrals.

Care Managers will also conduct a thorough assessment and develop a care plan to address any medical or psychosocial issues identified. Home visits during early pregnancy will allow barriers and health risks in the home to be addressed early in the prenatal period. Health risks may include food insecurity, tobacco use, and substance abuse. The home setting will also allow the Care Manager to assess and identify needs of the pregnant woman's family, including other children who may be in the home.

After the delivery, Care Managers will facilitate post-partum follow up, including the woman's choice of family planning methods. They will provide support regarding infant and toddler nutrition, health, growth, development, and environmental safety. They will also provide guidance to new parents about building and fostering social support networks. Care Managers will assist the families by helping parents set goals related to future pregnancies, continued education, or employment. In addition, Care Managers will help parents set realistic goals for education and work, and identify strategies for attaining those goals.

b) Schedule of Visits

The NFP model used in County Pilot A, includes the visit schedule listed below. Visit total is at least 58 visits, depending on when women enroll.

NFP Nurse Visit Schedule for All First Pregnancies:

1. Weekly visits in the first month of enrollment
2. Every other week until the child is born
3. Weekly for the first six weeks after the child is born
4. Every other week through the child's first birthday
5. Every other week until the child is 21 months
6. Monthly until the child is 2 years old

A total of 58 visits should occur if the mother is enrolled by the 28th week of pregnancy and graduates the program when the child turns 2 years of age, per the NFP model. If the mother is enrolled prior to the 28th week, additional every-other-week visits would be delivered. These visits are in addition to risk-based OBCM visits, well child visits, and CC4C visits for children at risk.

For County Pilot B, which targets all pregnancies at high risk, Table 1 outlines the proposed visiting schedule for a participating mother and her child. In addition to the Existing Well-Child Care schedule (no color), Existing Home Visiting (HV) Services (blue) and Enhanced HV Services (pink) will be provided.

Table 1: Pilot B Home and Well-Child Visits Periodicity Schedule

Billing Code	Service		Number of Visits
		Entry to Prenatal care (no later than 24 weeks - Birth 40 weeks)	
99600	Enhanced HV Services	Two of the required 10 face-to-face visits during pregnancy with the pregnancy care manager must occur in the home. Additional home visits will be performed as needed for patients who miss one or more medical prenatal appointments.	2
		Postpartum Period/Months 1 & 2	
99501	Existing HV Services	Home Visit for Postnatal Assessment and Follow-up Care (P-code 99501) – maternal health; assessment of mother and infant	1
99502	Existing HV Services	Home Visit for Newborn Care and Assessment (P-code 99502) -child health; assessment of mother and infant	1
99600	Enhanced HV Services	Postpartum home visit by pregnancy care manager	1
	Well-Child Care Visit *	2 to 5 days	1

	Well-Child Care Visit *	4th week Care Management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	6th week	1
Billing Code	Service		Number of Visits
	Well-Child Care Visit *	8th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
		3rd month - 12th month	
99600	Enhanced HV Services	10th week	1
99600	Enhanced HV Services	14th week	1
	Well-Child Care Visit *	16th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	18th week	1
99600	Enhanced HV Services	22th week	1
	Well-Child Care Visit*	24th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	26th week	1

99600	Enhanced HV Services	30th week	1
99600	Enhanced HV Services	34th week	1
Billing Code	Service		Number of Visits
	Well-Child Care Visit *	36th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	38th week	1
99600	Enhanced HV Services	42nd week	1
99600	Enhanced HV Services	46th week	1
	Well-Child Care Visit *	48th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1

- c) Reimbursement Rates – The home visits for both pilots will be billed individually as fee-for-service claims for services provided prenatally, during the immediate postpartum period, and through the end of the infant’s first year of life. Reimbursement will be made with an unlisted CPT code 99600 (which will be billed per home visit). This will allow Medicaid to track expenses for the pilot directly. The enhanced visit reimbursement rate will be \$83.72 per visit.

5) Fiscal Analysis Plan

County Pilot A

The chart below shows costs for reimbursement of nurse home visits only, not total program cost. For County Pilot A (NFP model) the following costs are presently covered by private funding but will shift to State appropriations in 2018. In the future, if this model were

implemented statewide, the salaries of nurse consultants could be considered for inclusion in the Division of Medical Assistance Interagency Memorandum of Agreement with the Division of Public Health. Private funding or State appropriations would be needed for costs not coverable by Medicaid.

- 1) Two NFP State Nurse Consultants = Approximately \$200,000
- 2) Service Fees Paid to NFP National Service Office = \$75,000
- 3) Travel for NFP State Nurse Consultants (NFP Required Education) = \$5,320
- 4) Local Travel for NFP State Nurse Consultants = \$13,356

Note that the total visits for both pilots are less than the length of the pregnancy plus the first year of life for the infant, because the one-year pilot will end before the infants first year one of life is completed.

COUNTY PILOT A	One County Pilot-NFP Model
Projected Number of First Pregnancies Per Year:	100
<u>Fee For Service:</u>	
CPT Code 99600 – Unlisted Home Visit Service or Procedure (Cost/Visit):	\$ 83.72
Number of Visits Prenatal (28-40 Weeks):	8
Number of Visits Postpartum (Months 1 through 9):	22
Total Number of Home Visits (1 Yr. Pilot) Per Pregnancy	30
Total Cost Per Pregnancy	\$ 2,511.60
(Costs are for visits only, not total program costs.)	
Fiscal Impact (State dollars)–NFP Model (1 County, 1 yr. Pilot):	\$ 251,160.00

County Pilot B

COUNTY PILOT B	Hybrid Model-Enhanced Visits Analysis
Projected Number of High Risk Pregnancies Per Year:	100
Fee for Service:	
CPT Code 99600 – Unlisted Home Visit Service or Procedure (Cost/Visit):	\$83.72
Number of Prenatal Home Visits	2
Number of Postpartum Home Visits (Months 1 through 9):	9
Total Number of Enhanced Visits per Participant (1 Yr. Pilot)	11
Total Cost Per Pregnancy	\$920.92
State Dollar Fiscal Impact – Enhanced Visits for High Risk Pregnancies (1 Yr. Pilot)	\$92,092.00

- The pilots will be funded with State dollars only; no additional appropriations are required at this time. No waiver or State Plan Amendment will be required.
- Pay for success will not be implemented in the pilots. However, if the pilots lead to statewide implementation, transition to a per member per month capitated reimbursement would be appropriate and could be implemented with withholds or some form of pay for performance.

Preliminary Analysis of Cost of Statewide Home Visit Program

The legislation also requests an estimate of providing Medicaid and NC Health Choice coverage for home visits statewide. Using cost estimates provided by Nurse-Family Partnership for implementation of their model for home visits for all first-time mothers and data on the number of first time mothers cared for in Pregnancy Medical Home (about 17,000), DHHS estimates the total cost of the NFP model to be between \$197,049,996 and \$321,363,200 for each 2.25 year cycle of mothers and their infants. (See Table 2) With each annual group of approximately 17,000 first time mothers, *the cycle will begin again, so in the second year, cost would be doubled.*

Table 2: Statewide Implementation Financial Estimate for NFP Model

	Year 1	Year 2	Year 3 (13 Weeks)	Total (2.25 Years)
Lower Cost Range:				
# of First Pregnancies	17,012	17,012	17,012	17,012
# of Home Visits	30	25	3	58
NFP Avg. Cost Per Child	\$ 11,583	\$ 11,583	\$ 11,583	
Weighted Cost Per Pregnancy	\$ 5,991	\$ 4,993	\$ 599	\$ 11,583
Total Impact	\$ 101,922,412	\$ 84,935,343	\$ 10,192,241	\$ 197,049,996
Higher Cost Range:				
# of First Pregnancies	17,012	17,012	17,012	17,012
# of Home Visits	30	25	3	58
NFP Avg. Cost Per Child	\$ 13,600	\$ 13,600	\$ 13,600	
Weighted Cost Per Pregnancy	\$ 7,034.48	\$ 5,862.07	\$ 703.45	\$ 13,600
Total Impact	\$ 119,670,621	\$ 99,725,517	\$ 11,967,062	\$ 231,363,200

Assumptions:

Year 1 = 28 Weeks Prenatal through Month 9 Postpartum

Year 2 = Month 10 through Month 21 (Postpartum)

Year 3 = Month 22 through Month 24 (Postpartum)

Data Sources:

1. \$11,583 NFP Avg. Cost Per Child: Data Source: NC DHHS/DPH. This is the average cost per participant at NC NFP sites. The cost varies based on market rates for personnel and cost of living in various counties. The total is based on cost over the 2.25 years that a mother/child are enrolled in the program.

2. \$13,600 NFP Avg. Cost Per Child: Data Source: Coalition for Evidence-Based Policy. Top Tier Evidence: Nurse Family Partnership, 2015

Workforce Impact of Statewide Home Visit Program

Looking at the program from the perspective of workforce, NFP's model calls for a ratio of one RN to 25 pregnant women and one master's RN supervisor for every eight RNs. With a projection of approximately 17,000 first time mothers per year, 680 RNs would be needed to implement the model statewide. In addition, 85 master's prepared RN supervisors would be needed. The same number would be needed in the second year to visit the next cohort of first time mothers and their infants.

6) Recommendations for Pilot Assessment

DHHS and the collaborating agencies will establish a monitoring team to oversee the Pilot Projects. The team will assure appropriate training, data collection, tracking, and communications with county, project, and State staff. The monitoring team will meet monthly July through September 2018, then quarterly during the duration of the pilot projects. The team, with assistance from DHHS/DMA analytic staff, will prepare an assessment of the pilots for coverage of home visits and will make recommendations regarding ongoing coverage.

TABLE 2: PROJECT TIME LINE

August 2017	• Review evidence-based model(s) & legislation • Select services and correlate with legislative components • Identify geographic area and target population(s) • Facilitate discussions with key collaborating Divisions and agencies to create service definitions • Finalize the scope of the Pilot Project
September 2017	• Engage pilot county to discuss readiness and operational needs. • Engage comparison county
October 2017	• Revise Pilot Project Plan • Develop tracking and clear comparison for Pilot Project based on divisions and departmental feedback • Identify site liaison
November 2017	• Conduct informational sessions with interested agency, programs, and subject matter experts • Revise plan based on feedback from Legislature and stakeholders
December 2017 -February 2018	• Communications Plan • Finalize Pilot Project Plan, key collaborators, strategies and owners • Begin development of processes for startup, implementation, monitoring and reporting • Identify any system or operation modifications for payment
February - March 2018	• Incorporate system or operational changes • Present overview of pilot to participating county staff • Work with CCNC for processes and documentation needs • Developing the intensive home visiting model and program standards and expectations • Assess training and professional development needs
April 2018	• Engage any fiscal staff from each site to clarify appropriate billing. • Finalize OBCM, CC4C, LHD, DPH, CCNC and DMA oversight for tracking and evaluation
May 2018	• Establish Pilot Project status tools for county and state (DMA, DPH, CCNC) updates. • Review timelines and plan kick-off meeting for pilot. • Confirm contacts and discuss communication and participation • Complete any system operation or Project planning details.
June 2018 June 2018 (continued)	• Local staff training • Prepare for startup by conducting site visits and conference calls with all staff and providers • Content: - Overview - Roles and documentation - Communications - Contact persons at state level for troubleshooting

ATTACHMENTS

- A. Session Law 2017-57, Section 11H.14.
- B. North Carolina Evidence-Based Home Visiting Map
- C. North Carolina Evidence-Based Home Visiting Models
- D. Comparison of NFP Visit Content, Current Medicaid Coverage, and Care Entities
- E. Pregnancy Medical Home Risk Screening Tool
- F. Life Skills Progression
- G. NC MIECHV Centralized Intake and Referral System
- H. MIECHV Benchmarks Summary

Attachment A: S.L. 2017-57, Section 11H.14.

PLAN TO IMPLEMENT COVERAGE FOR HOME VISITS FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN

SECTION 11H.14.(a) It is the intent of the General Assembly to provide Medicaid and NC Health Choice coverage for evidence-based home visits for pregnant women and families with young children designed to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness that are consistent with the model used by Nurse-Family Partnership. No later than July 1, 2018, the Department of Health and Human Services, Division of Medical Assistance (Department), shall begin providing Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.

The Department shall develop a plan to implement changes necessary to provide Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program; however, consistent with G.S. 108A-54(e)(4), the Department is not authorized to make any changes to eligibility for the Medicaid or NC Health Choice programs. The plan shall detail the design and scope of coverage for the home visits for pregnant women and families with young children and include the identification of any State Plan Amendments or waivers that may be necessary to submit to the Centers for Medicare and Medicaid Services.

SECTION 11H.14.(b) No later than November 1, 2017, the Department shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division a report containing the following information:

(1) As required by subsection (a) of this section, a copy of the plan to provide, no later than July 1, 2018, Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.

(2) A detailed description of the coverage to be provided, including the proposed service definition, the home visit schedule, the scope of the covered service, and the anticipated reimbursement rate to be paid.

(3) An analysis of the total fiscal impact of adding Medicaid and NC Health Choice coverage for the home visits for pregnant women and families with young children. This shall include an outline of both costs and savings to the Medicaid and NC Health Choice programs, as well as any savings to other programs provided by the State.

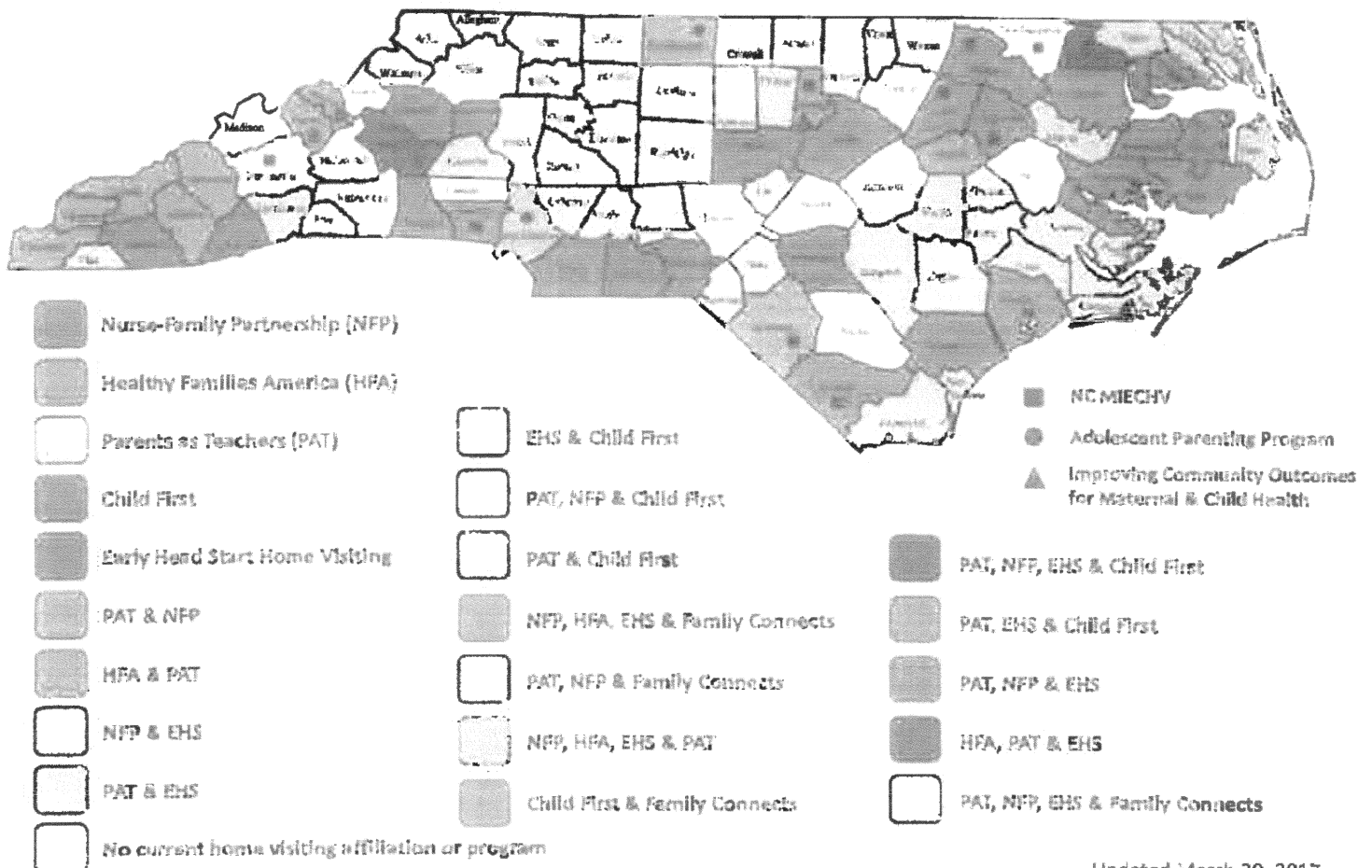
(4) A description of how the Department intends to leverage any private funding that may be currently utilized to provide coverage for evidence-based home visits for pregnant women and families with young children.

(5) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e) or whether additional appropriations are required.

(6) Any plans to include pay-for-success initiatives as part of the Medicaid and NC Health Choice funding for the covered service.

(7) An anticipated time line for the implementation of the Department's plan and the submission of any necessary State Plan Amendments or waivers to the Centers for Medicare and Medicaid Services.

North Carolina Evidence-Based Home Visiting



Updated March 29, 2017

Nurse-Family Partnership

Average caseload: At least 25 first-time mothers per Nurse Home Visitor

Eligibility

- First-time mothers enrolled before 28 weeks gestation
- Family must meet low-income criteria
- Families enrolled the child turns 2
- High Risk (teen pregnancy, unemployment, maternal health risks, poverty, unstable housing, limited support, etc.)

Healthy Families America

Average caseload: 12- 30 families, depending on service level

Eligibility

- Eligibility occurs either prenatally or within the first two weeks after the birth of the baby
- Parents determined at risk using a systematic screening tool or Parent Survey Assessment
- Some HFA sites offer Universal Home Visiting services where all families are considered eligible regardless of risk factors

Parents as Teachers

Average caseload: 18 - 30 families based on the frequency of visits

Eligibility

PAT is designed to be used in any community
Enrollment beginning prenatally and continues until the child enters school.
Some affiliates target specific populations or families with multiple high needs characteristics

Family Connects

Average caseload:

Eligibility

Child First

Average caseload: 10-12 families per team

Eligibility

Children from birth through five years of age
Children with very difficult behaviors or delays in their development or learning (e.g., trauma)
Families with many stresses (e.g., drug use, homelessness, involvement with the child welfare system)

Early Head Start Home Visiting

Average caseload: 10-12 families per team

Eligibility

- Pregnant women and children from birth to age three who are from families with incomes below the poverty guidelines are eligible for Early Head Start services
- Children from homeless families, and families receiving public assistance such as TANF or SSI are also eligible. Foster children are eligible regardless of their foster family's income.

Attachment C: Evaluation-Based Horizon Vetting Models in NC and Current DHS Programs

[illegible]

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

PMHM Home visits weekly the first month following program enrollment then every other week until birth of infant. Nurses address:	LIFE SKILL Progression Parent Scale Measures	NC DMA COVERS	WHO DELIVERS	
Effects of smoking, alcohol and illicit drugs on fetal growth, and assist women in identifying goals and plans for reducing cigarettes smoking, etc.;	Substance Use/Abuse (drugs and alcohol) – No Hx or current use/abuse Tobacco Use – None or never	YES	LHD/CCNC	
Nutritional and exercise requirements during pregnancy and monitor and promote adequate weight gain;	Attitudes to Pregnancy – Planned, prepared and welcomed. Prenatal – Care started in 1 st trimester and keeps most appointments	YES	LHD/CCNC	Special needs, foster care, adverse childhood experiences, poverty, single parent family, drugs alcohol, born and placed in NICU or in the foster care system, violence exposures in the home
Other risk factors for re-term delivery/low birth weight (e.g., genitourinary tract infections, pre-eclampsia);	Attitudes to Pregnancy – Planned, prepared and welcomed. Prenatal – Care started in 1 st trimester and	YES	LHD/CCNC	

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

	keeps most appointments	YES		
Preparation for labor and delivery/childbirth education;	Attitudes to Pregnancy – Planned, prepared and welcomed. Prenatal – Care started in 1 st trimester and keeps most appointments		LHD/CCNC	
Basics of Newborn care and newborn states;	Child Well Care – Keeps regular CHDP/wee-child appointments with same provider. Child Sick Care – Obtains optimal care/control for acute or chronic conditions. Child Dental Care – Has dental home, regular preventive care and timely TX	YES	LHD/CCNC	
	Child Immunizations – Complete and up-to-date?			

2 | Page

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

Family planning/birth control following delivery of infant;	Family Planning – Regular use of FP methods, plans/spaces pregnancies	YES	LHD/CCNC	
Adequate use of office-based prenatal care; and	Attitudes to Pregnancy – Planned, prepared and welcomed. Prenatal – Care started in 1 st trimester and keeps most appointments	YES (prenatal visit)	LHD/CCNC	
Referrals to other health and human services as needed.	Use of Information – Actively seeks/uses information for HV, HC, and other sources Use of Resources – Identifies needs, uses resources independently, keeps or reschedules appointments.	YES	Statewide Providers	

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

Home visits weekly postpartum period, every 2 weeks until toddler is 21 months, monthly until child is 2 years. Nurses:	NC DMA COVERS	WHO DELIVERS	
Educate parent on infant/toddler nutrition, health, growth, development and environmental safety;	Communication, Gross Motor, Fine Motor, Problem Solving, Personal-Social – Above average development for ASA or CA Social-Emotional – Responsive, social, alert, communicates needs/feelings, emotionally connect to parent Regulation – Happy, content, easily consoled, well connected to parent, explores, plays, shares delight	LHD/CCNC	
Role model PIPE activities to promote sensitive parent-child	Communication, Gross Motor, Fine Motor, Problem	Lifeskills assessment, goals, parent child interaction A Home Visit required. RN	15-18% of our babies are born with high needs; most of the

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

interactions facilitative of developmental progress;	Solving, Personal-Social – Above average development for ASA or CA Social-Emotional – Responsive, social, alert, communicates needs/feelings, emotionally connect to parent Regulation – Happy, content, easily consoled, well connected to parent, explores, plays, shares delight	LIFE SKILLS PROGRESSION—Need staff to implement. Add a cohort of children when they entered the system on July 2017 then evaluate every 6 months throughout	charts the findings in the pts plan; then RN does home visits every 6 months to see if there is any progress positively up the scale	time it's the 2 nd or 3 rd child when this appears. Also the 2 nd or 3 rd pregnancy
Assess parent-child interaction, using NCAST sleeping and teaching scales and provide guidance as needed;	Communication, Gross Motor, Fine Motor, Problem Solving, Personal-Social – Above average development for ASA or CA Social-Emotional – Responsive, social, alert	YES		

COMPARISON OF NRP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

	Communicates needs/feelings, emotionally connect to parent Regulation – Happy, content, easily consoled, well connected to parent, explores, plays, shares delight		
Assess infant/toddler's developmental progress at selected intervals using Ages and Stages Questionnaire or DDSII, and provide guidance as needed;	Communication, Gross Motor, Fine Motor, Problem Solving, Personal-Social – Above average development for ASA or CA Social-Emotional – Responsive, social, alert, communicates needs/feelings, emotionally connect to parent Regulation – Happy, content, easily consoled, well connected to	YES	

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

	parent, explores, plays, shares delight				
Promote adequate use of well-child care;	Child Well Care -- Keeps regular CHDP/well-child appointments with same provider	YES (Health Ck. well visit)	LHD/CCNC/Any providers		
Guidance to new parents in building and fostering social support networks;	Friends/Peers -- Many close friends, extensive support network	YES	CC4C		Domains for life skill progression
Guidance assessing safety of potential/actual child care arrangements; and	Child Safety -- Child protected, no injury, home/car safe, teaches safety, seeks/uses information for age	YES	CC4C		
Referrals to other health and human services needed.	Use of Information -- Actively seeks/uses information from HV, HC, and other sources. Use of Resources -- Identifies needs, uses resources independently, keeps or reschedules appointments.	YES	Statewide Providers		

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

Home visits weekly during postpartum period every 2 weeks until toddler is 21 months, monthly until child is 2 years. Nurses	NC DMA COVERS	WHO DELIVERS	
Facilitate decision-making regarding planning of future children and selection of birth control to achieve goals.	Family Planning – Regular use of FP methods, plans/spaces pregnancies YES	LHE/CCNC	
Assist parents to self-realistic goals for education and work, and identify strategies for attaining goals;	<12 Grade Education – Attends regularly at grade level. Education – Attends and/or graduated college or grad school. YES	Toxic stress & goals to be resilient, back in school, employment. Helps the family set goals for they already PMPM CC4C	PMPM already covers
Coaching parents in building and fostering relationships with other community services;	Friends/Peers – Many close friends, extensive support network. YES	CCNC through PMPM helps family be resilient; this is Care Management	PMPM already
Parents' family planning, education and work goals; and	Attitudes to Pregnancy – Planned, prepared and welcomed. Family Planning – Regular use of FP methods. YES	Not education unless its life skills to get back into the workforce; child care goal so mom can go to school: no Family Planning	Family planning can be covered in postpartum services through FP clinic

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

COMPARISON OF NFP VISIT CONTENT, CURRENT MEDICAID COVERAGE AND CARE ENTITIES

	plans/spaces pregnancies			
Referrals to other health and human services as needed.	Use of Information – Actively seeks/uses information from HV, HC, and other sources. Use of Resources – Identifies needs, uses resources independently, keeps or reschedules appointments.	YES	Statewide Providers	

(**) This table specifically addresses services provided by home visiting/care management programs. Many providers in our state incorporate some or all of this education in their interactions with families.

CCNC Pregnancy Home Risk Screening Form

Practice Name: _____
 First name: _____ MI _____ Last name: _____ Medicaid ID#: _____ Today's date: ____/____/____
 EDC: ____/____/____ By what criteria: ☐ LMP ☐ 1st trimester U/S ☐ 2nd trimester U/S ☐ Other: _____
 Height: _____ Pre-pregnancy weight: _____ Gravidity: _____ Parity: _____
 Insurance type: ☐ Medicaid ☐ None ☐ Other: _____ Date of birth: ____/____/____

CURRENT PREGNANCY

- ☐ *Multifetal gestation
 - ☐ *Fetal complications:
 - ☐ Fetal anomaly
 - ☐ Fetal chromosomal abnormality
 - ☐ Intrauterine growth restriction (IUGR)
 - ☐ Oligohydramnios
 - ☐ Polyhydramnios
 - ☐ Other: _____
 - ☐ *Chronic condition which may complicate pregnancy:
 - ☐ Diabetes
 - ☐ Hypertension
 - ☐ Asthma
 - ☐ Mental illness
 - ☐ HIV
 - ☐ Seizure disorder
 - ☐ Renal disease
 - ☐ Systemic lupus erythematosus
 - ☐ Other(s): _____
 - ☐ *Current use of drugs or alcohol/recent drug use or heavy alcohol use (month prior to learning of pregnancy)
 - ☐ *Late entry into prenatal care (>14 weeks)
 - ☐ *Hospital utilization in the antepartum period
 - ☐ *Missed 2+ prenatal appointments
 - ☐ Cervical insufficiency
 - ☐ Gestational diabetes
 - ☐ Vaginal bleeding in 2nd trimester
 - ☐ Hypertensive disorders of pregnancy
 - ☐ Eclampsia
 - ☐ Preeclampsia
 - ☐ Gestational hypertension
 - ☐ HELLP syndrome
 - ☐ Short interpregnancy interval (<12 months between last live birth and current pregnancy)
 - ☐ Current sexually transmitted infection
 - ☐ Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
 - ☐ Communication barriers:
 - ☐ Literacy
 - ☐ Disability
- Explain: _____
- ☐ Non-English speaking
- Primary language: _____

Items marked with a * will trigger follow-up by a pregnancy care manager.

Practice phone no: _____
 Next prenatal appt: ____/____/____ ☐ No changes since last screen

OBSTETRIC HISTORY

- ☐ *Preterm birth (<37 completed weeks)
 Gestational age(s) of previous preterm birth(s): _____ weeks, _____ weeks, _____ weeks
- ☐ At least one spontaneous preterm labor and/or rupture of the membranes¹
¹If this is a singleton gestation, this patient is eligible for 17P treatment.
- ☐ *Low birth weight (<2500g)
- ☐ *Very low birth weight (<1500g)
- ☐ Fetal death >20 weeks
- ☐ Neonatal death (within first 28 days of life)
- ☐ Second trimester pregnancy loss
- ☐ Three or more first trimester pregnancy losses
- ☐ Cervical insufficiency
- ☐ Gestational diabetes
- ☐ Postpartum depression
- ☐ Hypertensive disorders of pregnancy
 - ☐ Eclampsia
 - ☐ Preeclampsia
 - ☐ Gestational hypertension
 - ☐ HELLP syndrome

☐ *Provider requests pregnancy care management

Reason(s): _____

Provider comments/notes: _____

Name of person completing form: _____ Signature: _____

CCNC Pregnancy Home Risk Screening Form

Complete this side of the form and give it to the nurse or doctor. Please answer as honestly as possible so we can provide the best care for you and your baby. The care team will keep this information private.

Name: _____		Date of birth: _____		Today's date: _____	
Physical Address: _____			City: _____		ZIP: _____
Mailing Address (if different): _____			City: _____		ZIP: _____
County: _____		Home phone number: _____		Work phone number: _____	
Cell phone number: _____			Social security number: _____		
Race: ☐ American-Indian or Alaska Native ☐ Asian ☐ Black/African-American ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Other (specify): _____					
Ethnicity: ☐ Not Hispanic ☐ Cuban ☐ Mexican American ☐ Puerto Rican ☐ Other Hispanic					

1. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
 - ☐ I wanted to be pregnant sooner.
 - ☐ I wanted to be pregnant now.
 - ☐ I wanted to be pregnant later.
 - ☐ I did not want to be pregnant then or any time in the future.
 - ☐ I don't know.
2. *Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No
3. *Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No
4. *Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? ☐ Yes ☐ No
6. *Is your living situation unsafe or unstable? ☐ Yes ☐ No
7. *Which statement best describes your smoking status? Check one answer.
 - ☐ A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
 - ☐ B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
 - ☐ C. *I stopped smoking AFTER I found out I was pregnant and am not smoking now.
 - ☐ D. *I smoke now but have cut down some since I found out I was pregnant.
 - ☐ E. *I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use? ☐ Yes ☐ No
9. Do any of your friends have a problem with alcohol or other drug use? ☐ Yes ☐ No
10. Does your partner have a problem with alcohol or other drug use? ☐ Yes ☐ No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ☐ Yes ☐ No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs? ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

(For Pregnancy Care Management use only) Date risk screening form was received: ____/____/____

What is the Life Skills Progression (LSP)?

The LSP is an outcome measurement instrument designed for use by programs serving low income parents of children aged 0-3 years, but it can extend to age 60 months. There are 43 parent and child scales which describe a spectrum of skills and abilities over six major categories of functioning. The LSP is used to collect outcomes data, to monitor client strengths and needs, to plan clinical interventions, and provide data for research purposes.

In order to use the LSP you will need the LSP handbook, training to ensure reliable use, and use a standardized developmental screening tool such as the Ages and Stages Questionnaire (ASQ) (www.agesandstages.com)

What does the LSP measure?

LSP monitors 35 parental life skills in these areas:

- Relationships
- Education & Employment
- Parent & Child Health
- Mental Health & Substance Use
- Basic Essentials

The LSP tracks 3 aspects of child development, attachment and regulation, and use of the Ages and Stages Questionnaire (ASQ- Brookes Publishing) to establish developmental screening skill levels is recommended.

The Department of Health and Human Services DOHVE TA released the "Evidence- Based Model Crosswalk to Benchmarks" on 6/1/10. The document is available at DOHVE TA: http://www.andrc.org/project_72_pcs.htm. The LSP appears in the PATN program model as a measure for most of the benchmarks (outcomes for Federally funded programs)

Attachment: Attachment Theory

THE LIFE SKILLS PROGRESSION (LSP)

Parent Scale

Family record ID # _____ Indiv. # _____ 2. Initial / / _____ Months of service _____

Web ID # _____ q Ongoing # _____ No. attempted visits _____ No. completed visits _____

Client name _____ q Closing / / _____ Home visitor _____

(last name, first name) _____ Next LSP due / / _____ Agency/program _____

Client DOB / / q Female q Male Race _____ Ethnicity _____ Medical codes _____

Item Score		Areas of Life Skill Development												High
RELATIONSHIPS WITH FAMILY AND FRIENDS														
RELATIONSHIPS WITH FAMILY														
1	Family/Extended Family	Hostile, violent, or physically abusive family relationships	Separated. No contact. Not available for support	Conflicted, critical, or verbal abuse; frequent arguments. Reluctant support or in crisis	Inconsistent or conditional support. Emotionally distant but available	Very supportive. Mutually nurturing family relationships								
2	Boyfriend, FOB, or Spouse	Hostile, violent, or physically abusive; multiple partners or uncertain paternity	Separated. No contact. Not available for support	Conflicted, critical, or verbal abuse; frequent arguments. Reluctant support or in crisis	Inconsistent or conditional support. Emotionally distant but available	Very supportive. Loving, committed (unmarried, married, or common law)								
3	Friends/Peers	Hostile, violent, or highrisk friends; friends gang linked	Very few or no friends. Socially isolated and lonely	Conflicted, casual, or brief friendships. Some crisis support from friends	A few close friends who can be counted on for support	Many close friends. Extensive support network								
RELATIONSHIPS WITH FRIENDS														
4	Attitudes to Pregnancy	Unplanned and unwanted. Abortion or adoption plan	Unplanned, ambivalent, fearful. Coerced to keep child	Unplanned and accepted	Planned but unprepared	Planned, prepared, welcomed								
5	Nurturing	Hostile, unable to nurture, bond, or love child; very limited responsiveness	Indifference, apathy, depression, or DD impair nurturing	Lacks information/modeling of love. Afraid nurturing "spoils." Marginal connectedness	Bonded; loves, responds inconsistently. Some reciprocal connections	Loving, responsive, praises; regulates child well. Reciprocal connections								
6	Discipline	Has shown reportable levels of physical abuse or severe neglect	Uses physical punishment. Frequent criticism; verbal abuse	Mixture of impatient/ critical and appropriate discipline	Inconsistent limits. Ineffective boundaries. Teaches desired behavior effectively sometimes	Uses age-appropriate discipline. Teaches, guides, and directs behavior effectively								
7	Support of Development	Poor knowledge of child development. Unrealistic expectations. Ignores or refuses information	Little knowledge of child development. Limited interest in development. Passive parental role	Open to child development information. Provides some toys, books, and play for age	Applies child development ideas. Interested in child's development skills, interests, and play	Anticipates child development changes. Uses appropriate toys/books; plays and reads with child daily								

Lili

High

EDUCATION & RELATIONSHIPS										
WILL										
RELATIONSHIPS WITH										
CHILD EXPLOITED OR TX OF UNINTENTIONAL INJURY, HAS PERMANENT DAMAGE										
OUTPATIENT/ER TX OF UNINTENTIONAL INJURY TO CHILD. NO PERMANENT DAMAGE										
NO UNINTENTIONAL INJURY TO CHILD. HOME/CAR UNSAFE; NOT CHILDPROOFED										
NO UNINTENTIONAL INJURY TO CHILD. HOME PARTIALLY SAFE. USES CAR SEAT. USES INFORMATION FOR AGE										
CHILD PROTECTED, NO INJURY. HOME/CAR SAFE. TEACHES SAFETY. SEEKS/USES INFORMATION FOR AGE										
TRUSTS, WELCOMES VISITS; ASKS FOR INFORMATION, KEEPS APPOINTMENTS										
ACTIVELY SEEKS/USES INFORMATION FROM HV, HC, AND OTHER SOURCES										
IDENTIFIES NEEDS. USES RESOURCES INDEPENDENTLY. KEEPS OR RESCHEDULES APPOINTMENTS										
FULLY BILINGUAL										
ATTENDS REGULARLY AT GRADE LEVEL. HS/ALT HS GOAL: HSD										
ATTENDS AND/OR GRADUATED COLLEGE OR GRAD SCHOOL										
CAREER OF CHOICE WITH POTENTIAL GOOD SALARY AND BENEFITS										

Item	Score	0	Low	1	1.7	2	2.7	3	3.7	4	4.7	5	High
16	Immigration			Undocumented. No permit/card. Frequent moves/trips disrupt services, work, or education	Has work permit/card. In U.S. < 5 years. Migrant. Plans return to country of origin		Has work permit/card. In U.S. > 5 years. Migrant. Plans to live in U.S.		Has work permit/card or temporary visa. Applying for citizenship		Obtained U.S. citizenship		
	HEALTH & MEDICAL CARE												
17	Prenatal Care			No prenatal care	Care starts 2nd-3rd trimester. Keeps some appointments		Care starts 2nd-3rd trimester. Keeps most appointments		Care starts in 1st trimester. Keeps most appointments		Keeps postpartum appointments		

Life Skills Progression™ (LSP): An Outcome and Intervention Planning Instrument for Use with Families at Risk, by L. Wollesen and K. Peifer. Copyright © 2006 Paul H. Brookes Publishing Co., Inc. All rights reserved.

HEALTH & MEDICAL CARE													
HEALTH & MEDICAL CARE													
18	Parent Sick Care			Acute/chronic conditions go without Dx/Tx. No medical home	Seeks care only when very ill. Uses ER for care. No medical home		Seeks care inconsistently; inconsistent Tx follow-up. Unstable medical home		Seeks care appropriately. Follows Tx recommended. Has medical home		Seeks care appropriately. Care or control obtained. Has medical home		
19	Family Planning			No FP method used. Lacks information about FP	FP method use rare. Limited understanding of FP		Occasional use of FP methods. Some understanding of FP		Regular use of FP methods. Good understanding of FP		Regular use of FP methods. Plans/spaces pregnancies		
20	Child Well Care			None; no medical home	Seldom; no medical home		Occasional appointments. Unstable medical home		Has annual exam only. Has stable medical home		Keeps regular CHDP/ well-child appointments with same provider		
21	Child Sick Care			Medical neglect. No Dx/Tx for acute or chronic conditions	Has care only when very ill. Uses ER for care		Timely care for minor illness but inconsistent Tx f/u		Timely care of minor illness. Follows Tx recommended		Obtains optimal care/control for acute or chronic conditions		
22	Child Dental Care			No dental home or care with serious ECC. Poor hygiene	No dental home or care with some ECC and inadequate Tx/hygiene		Has dental home and hygiene but late Tx of ECC		Has dental home. Some preventive care/timely Tx		Has dental home. Regular preventive care and timely Tx		
23	Child Immunizations			None or refused	IZ history uncertain. Records lost		IZ begun, but no return appointment		IZ delayed, has return appointment		Complete or up-to-date IZ		
	MENTAL HEALTH/ SUBSTANCE USE/ ABUSE												
24	Substance Use/ Abuse (drugs and/ or alcohol)			Chronic Hx drug and/or alcohol abuse with addiction	Drug/alcohol binge or intermittent use, without apparent addiction		Rare or experimental use of drugs or clean; in recovery group or Tx program		Occasional use of legal substances; stops if pregnant		No Hx or current use/abuse		

THE LIFE SKILLS PROGRESSION (LSP) Family record ID # _____ Date # _____ Parent Scale _____

Item	Score	0	Low	1	1.7	2	2.7	3	3.7	4	4.7	5	High
25	Tobacco Use		Chain smokes; >2 packs/day; uses smokeless; heavy second-hand exposure		Non-chain use or some second-hand exposure		Decreases amount when pregnant. Controls second-hand exposure		No use or second-hand exposure in past 6 months or current pregnancy		None or never		
26	Depression/Suicide		Recurrent chronic depression with suicidal attempts/thoughts. Severe problem with ADL, parenting, and insight/perception		Recurrent chronic depression without suicidal attempts/thoughts; Moderate problem with ADL, parenting, and insight/perception		Recent postpartum or situational depression. Some problem with ADL, parenting, and insight/perception		Manages or controls depression with Tx and/or medications or has recovered. Adequate ADL, parenting, and insight/perception		Not depressed; optimistic		
27	Mental Illness		Severe symptoms of MI with/without Dx/Tx (medications). Severe problem with ADL, parenting, and insight/self-perception		Symptoms of MI. Diagnosed but Tx inconsistent or ineffective. Moderate problem with ADL, parenting, and insight/perception		Symptoms under control. Diagnosed and in Tx. Some problem with ADL, parenting, and insight/self-perception		Situational or short-term MI. Recovered without relapse. Adequate ADL, parenting, and insight/self-perception		No observed mental illness		

MENTAL HEALTH

Life Skills Progression™ (LSP): An Outcome and Intervention Planning Instrument for Use with Families at Risk by L. Wollesen and K. Peifer. Copyright © 2006 Paul H. Brookes Publishing Co., Inc. All rights reserved.

Item	Score	0	Low	1	1.7	2	2.7	3	3.7	4	4.7	5	High
28	Self-Esteem		Poor; self-critical. Anticipates criticism from others. Rarely initiates; avoids trying new skills		Copes sometimes but with limited confidence and flat affect. Limited initiative for learning new skills		Irritable/defensive. Makes excuses, blames others. Initiates/starts using new skills but gives up easily		Beginning to actively initiate. Develops skills and recognizes own competence. Emerging confidence visible		Confident in skill and ability to learn. Expresses pride in achievements and successes		
29	Cognitive Ability		Suspected mild-moderate DD. No Dx or support services. Severe problem with ADL, parenting, and judgment		Diagnosed DD or LD; has education and/or support services. Moderate problem with ADL, parenting, and judgment		Diagnosed or suspected mild DD/LD. Needs some support by others. Some problem with ADL, parenting, and judgment		Suspected or known special education or LD. Support by others not needed. Adequate ADL, parenting, and judgment		Average or above average cognitive ability. Competent ADL		
30	Housing		Homeless; in shelter, or extremely substandard place		Unstable/inadequate, crowded housing with frequent moves		Stable rental. Lives with strangers or friends		Lives with family/extended family (own or FOBs). Shares expenses		Rents/owns apartment or house		
31	Food/Nutrition		Relies on emergency food banks/charity; runs out of food		Inadequate or unavailable resources. Worried about amount/quality of food		Regularly uses government resources; WIC and/or food stamps		Low family income provides adequate amount/quality of food		Income provides optimal amount and quality of food		

MENTAL HEALTH

MENTAL HEALTH AND WELL-BEING

Item	Score	0	Low	1	1.7	2	2.7	3	3.7	4	4.7	5	High
32	Transportation		None or inadequate resources, or unable to use resources	Uses public transport	Some access to shared car. Rides with others, no license	Has own license/drives. Borrows car	Has own car and drives with license and insurance						
33	Medical/Health Insurance		None/unable to afford care or coverage	Medicaid for pregnancy or emergency only	Medicaid full-scope benefits with or without Share of Cost	State-subsidized or partial-pay coverage	Private insurance with or without co-pay for self/others						
34	Income		None or illegal income only	TANF and/or child support; SDI	Employed with low income. Seasonal or 200% FPL	Employed with moderate income; meets expenses most of time	Adequate salary						
35	Child Care		None used yet or no resources available	Multiple sources Occasional use. Unsafe or inadequate environment	Uses caring friend/relative with safe/stable environment, but limited developmental support	Uses caring friend/relative with safe/stable environment and good developmental support	High-quality child care center with safe environment and good developmental support						

BASIC ESSENTIALS

THE LIFE SKILLS PROGRESSION (LSP)

Child Scale

Family record ID # _____ Indiv. # _____ q Initial / / _____ Parent's months of service _____

Web ID # _____ q Ongoing # / / _____

Child's name _____ q Closing / / _____
(Last name, first name)

Child's DOB / / q Female q Male Age / / (years/months)

Medical codes

Areas of Life Skill Development		0	Low	1	1.5	2	2.5	3	3.5	4	4.5	5	High
INFANT/TODDLER DEVELOPMENT (4 MONTHS 3 YRS)													
Item	Score	CHILD DEVELOPMENT											
36		Communication*		Below AA/CA and EI criteria. Referred to EI Not enrolled or attending		Delays; meets EI criteria. Referred; enrolled. Sometimes attends		Delays; meets EI criteria. Referred; enrolled. Attends regularly		No delays. Average development for AA or CA		Above average development for AA or CA	
37		Gross Motor*		Below AA/CA and EI criteria. Referred to EI Not enrolled or attending		Delays; meets EI criteria. Referred; enrolled. Sometimes attends		Delays; meets EI criteria. Referred; enrolled. Attends regularly		No delays. Average development for AA or CA		Above average development for AA or CA	
38		Fine Motor*		Below AA/CA and EI criteria. Referred to EI Not enrolled or attending		Delays; meets EI criteria. Referred; enrolled. Sometimes attends		Delays; meets EI criteria. Referred; enrolled. Attends regularly		No delays. Average development for AA or CA		Above average development for AA or CA	
39		Problem Solving		Below AA/CA and EI criteria. Referred to EI Not enrolled or attending		Delays; meets EI criteria. Referred; enrolled. Sometimes attends		Delays; meets EI criteria. Referred; enrolled. Attends regularly		No delays. Average development for AA or CA		Above average development for AA or CA	
40		Personal-Social*		Below AA/CA and EI criteria. Referred to EI Not enrolled or attending		Delays; meets EI criteria. Referred; enrolled. Sometimes attends		Delays; meets EI criteria. Referred; enrolled. Attends regularly		No delays. Average development for AA or CA		Above average development for AA or CA	
41		Social-Emotional**		Shows signs of neurological or environment-linked concerns. No IMH services		Shows signs of neurological or environment-linked concerns. Referred to court ordered IMH. Limited participation		Shows signs of neurological or environment-linked concerns. Regular participation in IMH with positive results		No signs of neurological or environment-linked concerns requiring referral to IMH		Responsive, social, alert; communicates needs/feelings. Emotionally connected to parent	
42		Regulation		Irritable; hard to console or poor self-regulation. Cues unclear. Non- or overly responsive to environment		Passive/flat affect; little exploration. Does not seek comfort or share delight often		Anxious, withdrawn; clingy. Relies on coregulation. Limited self-regulation		Quiet or changeable moods; seeks comfort and uses self-regulation, exploration, and play		Happy, content; easily consoled. Well connected to parent. Explores, plays, shares delight	

THE LIFE SKILLS PROGRESSION (LSP)

					regulation, exploration, and play		
43	Breast Feeding	Not breast-fed or breastfed < 2 weeks	Breast-fed/expressed < 1 month	Breast-fed/expressed for 1-3 months	Breast-fed/expressed 3-6 months, with or without supplement	Breast-fed/expressed > 6 months with some supplement	

* Rating should be based on a developmental screening or assessment (e.g., ASQ, Denver-II, Bayley, BRIGANCE) or ** on a social-emotional screening (ASQ:SE).
 Instructions: Complete on primary parent and infant/toddlers : 3 yrs at intake, every 6 months, and at closure. Circle applicable scale categories and enter numerical score. Send to data clerk and file original in chart.

Life Skills Progression™ (LSP): An Outcome and Intervention Planning Instrument for Use with Families at Risk, by L. Wollesen and K. Peifer. Copyright © 2000 Paul H. Brookes Publishing Co., Inc. All rights reserved.

Attachment G: NC MIECHV Centralized Intake and Referral System

In efforts to better serve families in the counties funded by the NC Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, the NC MIECHV Team has developed a Centralized Intake and Referral Tool. This tool will continue to support evidence-based home visiting along with other early childhood and pregnancy services during the critical perinatal and early childhood stages for high need and underserved individuals and families in various parts of the state. The MIECHV Centralized Intake and Referral Tool was developed as an intricate part of the NC State Plan for Home Visiting, as it is a grant requirement from U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). All MIECHV funded sites must have an existing mechanism for screening, identifying, and referring families and children to home visiting programs in the community; and referral resources currently available and needed in the future to support families residing in the communities. Through the utilization of the NC MIECHV Centralized Intake and Referral tool, families will be able to find resources based on their specific pregnancy and early childhood needs as well as generate a referral to the agencies (non-MIECHV funded agencies included) that fit their needs. Also, the Centralized Intake and Referral Tool will reduce duplicate referrals, provide a faster and secure method of generating and receiving referrals as well as increase the number of appropriate referrals to organizations in the MIECHV funded counties. Furthermore, the MIECHV Centralized Intake and Referral Tool will aid in the development of building and/or strengthening community partnerships among early childhood and pregnancy service providers in the MIECHV funded counties.

The MIECHV Centralized Intake and Referral Tool was focus tested in June 2014 by community members (with children ages 0-5 yrs.); to test terminology used, design, and usefulness. Beta testing was conducted February 2015 on mobile technologies (cell phone & tablets) and computers with community members and early childhood and pregnancy service providers. Overall, the community members and service providers stated that they understood the utility and purpose of the MIECHV Centralized Intake and Referral Tool as well as found it easy to use and visually appealing.

System components include a directory with descriptions of all perinatal and early childhood services and programs in a defined geographic space; a process for matching parental and/or the child's needs with available resources; and a referral system to that resources. The System is administered at the local level with State support. In addition, all inquiries and referrals are trackable via standardized reports in the System.

MIECHV BENCHMARKS SUMMARY

BENCHMARK AREA: MATERNAL & NEWBORN HEALTH

1. Percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment
2. Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age
3. Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally)
4. Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics (AAP) schedule
5. Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery
6. Percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.

BENCHMARK AREA: CHILD INJURIES, ABUSE, NEGLECT, AND MALTREATMENT AND EMERGENCY DEPARTMENT VISITS

7. Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing or soft bedding.
8. Rate of injury-related visits to the Emergency Department (ED) since enrollment among children enrolled in home visiting
9. Percent of children enrolled in home visiting with at least 1 investigated case of maltreatment following enrollment within the reporting period

BENCHMARK AREA: SCHOOL READINESS AND ACHIEVEMENT

10. Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool
11. Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day
12. Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool
13. Percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning

BENCHMARK AREA: CRIME OR DOMESTIC VIOLENCE

14. Percent of primary caregivers enrolled in home visiting who are screened for interpersonal violence (IPV) within 6 months of enrollment using a validated tool

BENCHMARK AREA: FAMILY ECONOMIC SELF-SUFFICIENCY

15. Percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent during their participation in home visiting.
16. Percent of primary caregivers enrolled in home visiting who had continuous health insurance coverage for at least 6 consecutive months.

BENCHMARK AREA: COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

17. Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.
18. Percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner.
19. Percent of primary caregivers enrolled in home visiting with positive screens for IPV (measured using a validated tool) who receive referral information to IPV resources.

Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Home Visiting and Early Childhood Systems. *The Maternal, Infant, and Early Childhood Home Visiting Program: Form 2 Performance and Systems Outcome Measures*; 2016.