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

Legislative 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.

<u>The NC Home Visiting Consortium</u>

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 $\geq$ 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)

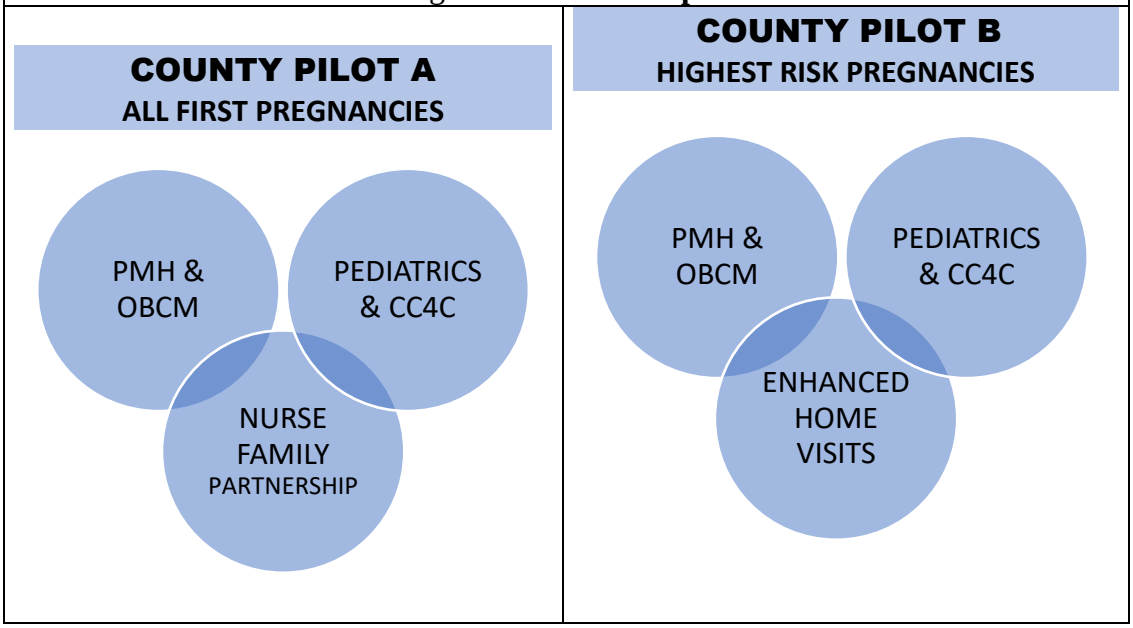
The MIECHV Centralized Intake and Referral Tool was developed as an integral part of the NC Medicaid State Plan for Home Visiting. Participating families will be able to find resources based on their specific pregnancy and early childhood needs and referrals will be generated to the agencies that fit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

Diagram 1: **Pilot Comparisons**



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
Fee For Service:	
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 Projects
September 2017	• Engage pilot counties to discuss readiness and operational needs.
October 2017	• Revise Pilot Project Plan • Develop tracking and clear comparison for Pilot Project based on divisions and departmental feedback • Identify site liaisons
November 2017	• Conduct informational sessions with interested agencies, programs, and subject matter experts • Revise plan based on feedback from Legislature and stakeholders
December 2017 -February 2018	• Develop and deploy 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 • Develop the intensive home visiting model and program standards and expectations • Assess training and professional development needs
April 2018	• Engage 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

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.

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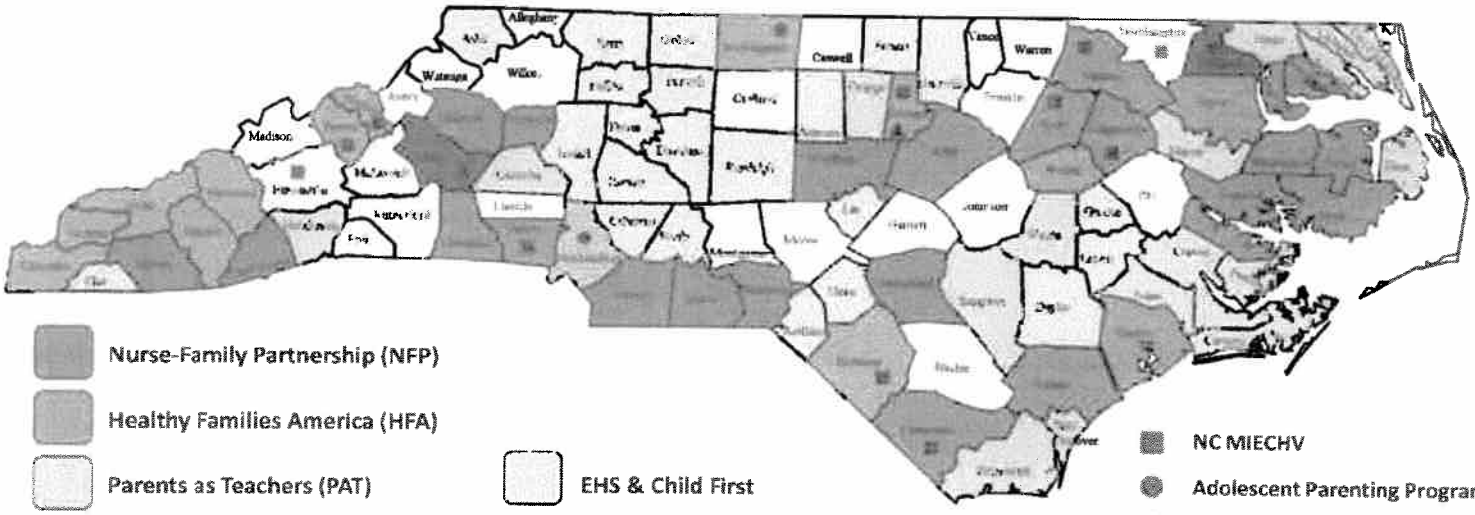
(7) An anticipated time line for the implementation of the Department's plan and the submission of any necessary State Plan Amendments or waivers to the Centers for Medicare and Medicaid Services.

North Carolina Evidence-Based Home Visiting



- Nurse-Family Partnership (NFP)
- Healthy Families America (HFA)
- Parents as Teachers (PAT)
- Child First
- Early Head Start Home Visiting
- PAT & NFP
- HFA & PAT
- NFP & EHS
- PAT & EHS
- No current home visiting affiliation or program
- EHS & Child First
- PAT, NFP & Child First
- PAT & Child First
- NFP, HFA, EHS & Family Connects
- PAT, NFP & Family Connects
- NFP, HFA, EHS & PAT
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- NC MIECHV
- Adolescent Parenting Program
- Improving Community Outcomes for Maternal & Child Health
- PAT, NFP, EHS & Child First
- PAT, EHS & Child First
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- PAT, NFP, EHS & Family Connects

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.)

Family Connects

Average caseload:

Eligibility

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

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)

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

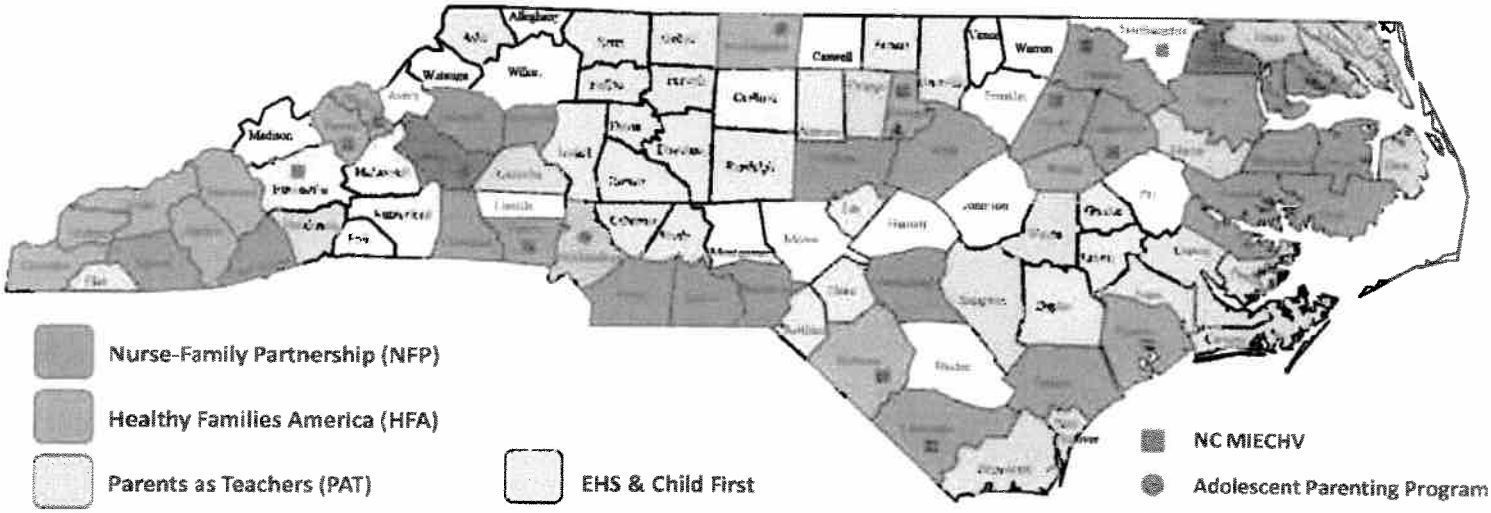
Early Head Start Home Visiting

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.

North Carolina Evidence-Based Home Visiting



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

PMPM 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 1st 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 1st trimester and	YES	LHD/CCNC	

(**) 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.

	keeps most appointments			
Preparation for labor and delivery/childbirth education;	Attitudes to Pregnancy – Planned, prepared and welcomed. Prenatal – Care started in 1st trimester and keeps most appointments	YES	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 Child Immunizations – Complete and up-to-date IZ	YES	LHD/CCNC	

(**) 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.

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 1st 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	

(**) 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.

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	YES	LHD/CCNC	
Role model PIPE activities to promote sensitive parent-child	Communication, Gross Motor, Fine Motor, Problem	YES	Lifeskills assessment, goals, parent child interaction A Home Visit required. RN	15-18% of our babies are born with high needs; most of the

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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 2nd or 3rd child when this appears. Also the 2nd or 3rd 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		

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	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.

	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.

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	LHD/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.

	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 membranes[1]

  [1]*If 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 <u>just before you got pregnant</u>, 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 8 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 6/1/20. The document is available at DOHVE TA http://www.nrdrs.org/project_12_134.html. The LSP appears in the PATN program model as a measure for most of the benchmarks (outcomes for Federally funded programs)

(www.lifeskillsprogression.com)

THE LIFE SKILLS PROGRESSION (LSP) — Parent Scale

Family record ID # _____ Indiv. # _____ q 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	0 Low	1	1.5	2	2.5	3	3.5	4	4.5	5 High
		RELATIONSHIPS WITH FAMILY AND FRIENDS										
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 CHILD(REN)										
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	

RELATIONSHIPS

THE LIFE SKILLS PROGRESSION (LSP) Family record ID # _____ Indiv. # _____ Parent Scale (Circ

Item Score 0 Low 1 1.7 2 2.7 3 3.7 4 4.7 5 High

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.*

RELATIONSHIPS HC ILD(REN) CONT

WII

RELATIONSHIPS	8		Safety		Child hospitalized for 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	Child protected, no injury. Home/car safe. Teaches safety. Seeks/uses information for age
			RELATIONSHIPS WI H		**PPORTIVE RESOURCES**				
	9		**Relationship with Home Visitor**		Hostile, defensive. Refuses HV services	Guarded, distrustful. Frequent broken appointments	Passively accepts information and visits. Forgets some appointments	Seeks/uses information. Calls for help or to cancel appointments	Trusts; welcomes visits; asks for information; keeps appointments
	10		**Use of Information**		Refuses information from HV or HC	Uses inaccurate information from informal sources	Passively accepts some information from HV and HC	Accepts/uses most information from HV or HC	Actively seeks/uses information from HV, HC, and other sources
	11		**Use of Resources**		Resource needs unrecognized. Community resources not used or refused; hostile	Resource needs unrecognized. Limited use when assisted by others. Misses most appointments	Accepts help to identify needs; uses resources when assisted by others. Keeps some appointments	Identifies needs. Uses resources with little assistance. Keeps most appointments	Identifies needs. Uses resources independently. Keeps or reschedules appointments
			EDUCATION & OY EMP		**ENT**				
	12		**Language (for non-English speaking only)**		Low/no literacy in any language	Literate in primary language. Some verbal English skills	Takes ESL classes. Verbal ESL established	Takes ESL classes. Written ESL established	Fully bilingual
EDUCATION	13		**<12th Grade Education**		Not enrolled	Enrolled, limited attendance any program. Not at grade level	Enrolled, attends regularly any program. Not at grade level	Attends regularly; at grade level. Adult school or independent study. Goal: GED	Attends regularly at grade level. HS/Alt HS Goal: HSD
	14		**Education**		<12th grade education in any country	Has graduated with GED or HSD	Attends and/or graduated job/tech training	Attends and/or graduated community college	Attends and/or graduated college or grad school
	15		**Employment**		Unemployed, unskilled, or no work experience	Occasional, seasonal, or multiple entry level jobs	Stable employment in low-income job	Stable employment with adequate salary and benefits	Career of choice with potential good salary and benefits

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

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

HEALTH & MEDICAL CARE (cont.)

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. Cure 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

	Item	Score		0	Low 1	1.7 2	2.7 3	3.7 4	4.7 5 High
MENTAL HEALTH	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 secondhand 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/SUBSTANCE ABUSE CONT &						
MENTAL HEALTH	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
			BASIC ESSENTIALS						
	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

THE LIFE SKILLS PROGRESSION (LSP) Family record ID # _____ Indiv. # ____ Parent Scale Page 3

	Item	Score		0	Low 1	1.7 2	2.7 3	3.7 4	4.7 5 High
BASIC ESSENTIALS	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

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 _____

Item	Score	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-3ARS) YE										
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 or 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-		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

							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.*

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 MEICHV 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.