# Office of Child Development and Early Learning

# Family Supports

# Pennsylvania Family Support Program Data System

# Data Collection Forms – Performance Measures

Updated March 23rd, 2020

Contents

**[Measure 2 – Breastfeeding](#_Toc84918981)** [3](#_Toc84918981)

[**Measure 3 – Depression Screening** 4](#_Toc84918982)

[**Measure 4 – Well Child Visit** 6](#_Toc84918983)

[**Measure 5 – Postpartum Care** 7](#_Toc84918984)

[**Measure 6 – Tobacco Cessation Referrals – Non NFP** 8](#_Toc84918985)

[**Measure 6 – Tobacco Cessation Referrals – NFP** 9](#_Toc84918986)

[**Measure 7 – Safe Sleep** 10](#_Toc84918987)

[**Measure 8 – Child Injury** 11](#_Toc84918988)

[**Measure 10 – Parent Child Interaction** 12](#_Toc84918989)

[**Measure 11 – Early Literacy and Language Activities** 13](#_Toc84918990)

[**Measure 12 – Developmental Screening** 14](#_Toc84918991)

[**Measure 13 – Behavioral Concerns and Home Visits** 15](#_Toc84918992)

[**Measure 14 – Intimate Partner Violence Screening** 16](#_Toc84918993)

[**Measure 16 – Continuity of Insurance Coverage** 17](#_Toc84918994)

[**Measure 17 – Completed Depression Referrals** 18](#_Toc84918995)

[**Measure 18 – Completed Developmental Referrals** 20](#_Toc84918996)

[**Measure 19 – Intimate Partner Violence Referrals** 21](#_Toc84918997)

[**Measure 20 – Substance Use Screening** 22](#_Toc84918998)

[**Measure 21 – Completed Substance Use Referrals** 25](#_Toc84919002)

## **Measure 2 – Breastfeeding**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ 3 Months Post Birth (All EBHV)

☐ 6 Months Post Birth (All EBHV)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Are you (Caregiver) currently breastfeeding (any amount) or feeding pumped milk (any amount) to your child?**

☐ Yes (End) ☐ No (Continue to 2)

**2. If No, do any of the following apply?**

☐ Medical Issue[[1]](#footnote-1)

☐ Could not produce enough milk

☐ Chose not to

Other

☐ Other medical issue

☐ Latching difficulty

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Measure 3 – Depression Screening**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ 3 Months Post Birth if Enrolled Prenatally (All EBHV)

☐ 3 Months Post Enrollment (All Non-NFP EBHV)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Screening tool used:**

☐ Edinburgh Postnatal Depression Scale (EPDS)

☐ Patient Health Questionnaire-9 (PHQ-9)

☐ Center for Epidemiologic Studies Depression Scale (CES-D)

☐ Brief Symptom Inventory (BSI)

☐ Brief Depression Inventory-II (BDI-II)

☐ Composite International Diagnostic Inventories (CIDI) - Short Form- Major Depression, Generalized Anxiety Disorder, Alcohol Dependence, Drug Dependence

☐ Depression Anxiety Stress Scales (DASS)

☐ Postpartum Depression Screening Scale TM (PDSSTM)

☐ Zung Self-Rating Depression Scale

☐ **DID NOT SCREEN (Skip to 7)**

**\*Date of Screening**: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

**1. Did the Caregiver enroll in home visiting prenatally?**

☐ Yes (Continue) ☐ No (Skip to 3)

**2. Was a depressions screening completed within 3 months postpartum if enrolled prenatally?**

☐ Yes (Continue to 4)

☐ No

**3. If no to Q1 Was a depression screening completed within 3 months’ post enrollment?**

☐ Yes (Continue to 4)

☐ No

**4. Did the Caregiver screen positive for depressive symptoms?**

☐ Yes (Continue to 5)

☐ No (End)

**5. If yes, is the Caregiver already receiving services for depression?**

☐ Yes (End, no additional screenings required)

☐ No (Continue to 6)

**6. If no, did you (home visitor) refer the Caregiver to services for depression?**

☐ Yes

☐ No

**7. Reason Not Screened**

☐ Home Visitor Unable to Screen (End/Rescreen in 3 months)

 Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Family Refused (End/Rescreen in 3 months)

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (End/Rescreen in 3 months

## **Measure 4 – Well Child Visit**

**Child Measure**

**Data Collection Time Point(s)++**

☐ 3 Months Post Birth+ ☐ 6 Months Post Birth+ ☐ 9 Months Post Birth

☐ 1 Year Post Birth+ ☐ 15 Months Post Birth+ ☐ 18 Months Post Birth

☐ 21 Months Post Birth+ ☐ 2 Years Post Birth+ ☐ 27 Months Post Birth

☐ 30 Months Post Birth ☐ 33 Months Post Birth ☐ 3 Years Post Birth

☐ 4 Years Post Birth ☐ 5 Years Post Birth

+For NFP this is collected at each home visit, in the data system the report to submit the information will populate every 3 months until 24 months or 2 years past the birth of the child.

++ Please note that this measure populates every 3 months after the birth or enrollment of a child based on their birthday in the system. The measure is not based on when the screenings are due. It is asking which screenings were completed over a 3-month time period.

**\*Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Have you (Caregiver) taken your child for a well-child visit in the last 3 months?**

☐ Yes (Continue) ☐ No (End)

**2. If Yes, indicate which well-child visits[[2]](#footnote-2) were completed?**

☐ 3-7 days Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 2-4 weeks Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 2-3 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 4-5 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 6-7 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 9-10 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 12-13 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 15-16 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 18-19 months Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 2-2.5 years Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 3-3.5 years Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

☐ 4-4.5 years Approx. Date of Well Child Visit: \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

## **Measure 5 – Postpartum Care**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ 8 Weeks Post Birth (If enrolled prenatally) (All EBHV)

☐ 8 Weeks Post Birth (Within 8 weeks of delivery if enrolled within 30 days of giving birth) (All Non-NFP EBHV)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Have you (Caregiver) received a postpartum visit with a health care provider?**

☐ Yes (Continue) ☐ No (End)

**2. If yes, date of Postpartum visit:**

\_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

## **Measure 6 – Tobacco Cessation Referrals – Non NFP**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ Entry

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Are you (Caregiver) currently using tobacco, cigarettes, or other forms of nicotine[[3]](#footnote-3)?**

☐ Yes, Cigarettes

☐ Yes, Other

☐ No (End)

**2. If yes, did you (home visitor) refer the client to tobacco cessation counseling or services?**

☐ Yes (End)

☐ No (End)

## **Measure 6 – Tobacco Cessation Referrals – NFP**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ Entry ☐ 36 Weeks Gestation (NFP) ☐ 12 Months Post Birth (NFP)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Entry (NFP) Date Assessed:** \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

**1. Was the Primary Caregiver using tobacco, cigarettes, or other forms of nicotine[[4]](#footnote-4) at entry?**

☐ Yes ☐ No

**2. Was the Primary Caregiver already receiving tobacco cessation counseling or services?**

☐ Yes ☐ No

**3. If no, did you (home visitor) refer the client to tobacco cessation counseling or services?**

☐ Yes ☐ No

**36 Weeks Gestation (NFP) Date Assessed:** \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

**1. Was the Primary Caregiver using tobacco, cigarettes, or other forms of nicotine at 36 Weeks Gestation?**

☐ Yes ☐ No

**2. Was the Primary Caregiver already receiving tobacco cessation counseling or services?**

☐ Yes ☐ No

**3. If no, did you (home visitor) refer the client to tobacco cessation counseling or services?**

☐ Yes ☐ No

**12 Months Post Birth (NFP) Date Assessed:** \_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

**1. Was the Primary Caregiver using tobacco, cigarettes, or other forms of nicotine at 12 Months Post Birth?**

☐ Yes ☐ No

**2. Was the Primary Caregiver already receiving tobacco cessation counseling or services?**

☐ Yes ☐ No

**3. If no, did you (home visitor) refer the client to tobacco cessation counseling or services?**

☐ Yes ☐ No

## **Measure 7 – Safe Sleep**

**Child Measure**

**Data Collection Time Point(s)**

☐ 3 Months Post Birth (All Non-NFP EBHV)

☐ 6 Months Post Birth (All Non-NFP EBHV)

☐ 9 Months Post Birth (All Non-NFP EBHV)

☐ 12 Months Post Birth (All Non-NFP EBHV)

☐ 0 Months Post Birth (NFP) / Entry of the Child

☐ 6 Months Post Birth (NFP)

☐ 12 Months Post Birth (NFP)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. How often do you (Caregiver) place your child to sleep on his/her back?**

☐ Always ☐ Sometimes ☐ Never

**2. How often do you (Caregiver) or others bed-share with your child?**

☐ Always ☐ Sometimes ☐ Never

**3. How often does your child sleep with soft bedding?**

☐ Always ☐ Sometimes ☐ Never

## **Measure 8 – Child Injury**

**Child Measure**

**Data Collection Time Point(s)+**

☐ 3 Months Post Enrollment+ ☐ 6 Months Post Enrollment

☐ 9 Months Post Enrollment+ ☐ 1 Year Post Enrollment

☐ 15 Months Post Enrollment+ ☐ 18 Months Post Enrollment

☐ 21 Months Post Enrollment + ☐ 2 Years Post Enrollment

☐ 27 Months Post Enrollment ☐ 30 Months Post Enrollment

☐ 33 Months Post Enrollment ☐ 3 Years Post Enrollment

+For NFP this is collected at each home visit, in the data system the report to submit the information will populate every 3 months until the child second birthday or 2 years post enrollment for the child.

 **After 3 Years Post Enrollment (All Non-NFP EBHV)**

☐ 42 Months Post Enrollment ☐ 4 Years Post Enrollment

☐ 54 Months Post Enrollment ☐ 5 Years Post Enrollment

☐ 66 Months Post Enrollment ☐ 6 Years Post Enrollment

☐ 78 Months Post Enrollment ☐ 7 Years Post Enrollment

**\*Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Has your (Caregiver) child had an injury related[[5]](#footnote-5) emergency room visit in the last three months? (DO NOT include urgent care visits)**

☐ Yes

☐ No

## **Measure 10 – Parent Child Interaction**

**Child Measure**

**Data Collection Time Point(s)**

Collected Based on Timeline of Tool

*Captured in system (All Non-NFP EBHV)*

☐ When Child is 1 Year of Age ☐ When Child is 2 Years of Age

☐ When Child is 3 Years of Age ☐ When Child is 4 Years of Age

☐ When Child is 5 Years of Age ☐ When Child is 6 Years of Age

*Captured in system (NFP)*

☐ When Child is 3 Months of Age

☐ When Child is 10 Months of Age

☐ When Child is 17 Months of Age

☐ When Child is 23 Months of Age

**\*Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Screening tool used:**

☐ CHEEERS-Based Validated Tool

☐ Child Well-Being Scales

☐ (PICCOLO-D)Dads' Parenting Interactions with Children: Checklist of Observations Linked to Outcomes

☐ (DANCE) Dyadic Assessment of Naturalistic Caregiver-Child Experiences

☐ Home Observation for Measurement of the Environment (HOME) – Infant/Toddler Inventory, 3rd Ed.

☐ (KIPS) Keys to Interactive Parenting Scale

☐ (NCAST) Nursing Child Assessment Teaching Scale

☐ (PICCOLO) Parenting Interactions with Children: Checklist of Observations Linked to Outcomes

☐ (EAS) Emotional Availability Scale

☐ PCI Feeding and Teaching Scales (formerly NCAST)

☐ Not Screened **(Continue to 3)**

**2. Date of Screening:**

\_ \_ / \_ \_ / \_ \_ \_ \_ MM/DD/YYYY

**3. If No, do any of the following apply?**

☐ Home visitor unable to screen ☐ Family refused

☐ Child too young or too old for screening tool ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Measure 11 – Early Literacy and Language Activities**

**Child Measure**

**Data Collection Time Point(s) (All Non-NFP EBHV)**

☐ 3 Months Post Enrollment ☐ 6 Months Post Enrollment

☐ 9 Months Post Enrollment ☐ 1 Year Post Enrollment

☐ 15 Months Post Enrollment ☐ 18 Months Post Enrollment

☐ 21 Months Post Enrollment ☐ 2 Years Post Enrollment

☐ 27 Months Post Enrollment ☐ 30 Months Post Enrollment

☐ 33 Months Post Enrollment ☐ 3 Years Post Enrollment

**Data Collection Time Point(s) After 3 Years Post Enrollment (All Non-NFP EBHV)**

☐ 42 Months Post Enrollment ☐ 4 Years Post Enrollment

☐ 54 Months Post Enrollment ☐ 5 Years Post Enrollment

☐ 66 Months Post Enrollment ☐ 6 Years Post Enrollment

☐ 78 Months Post Enrollment ☐ 7 Years Post Enrollment

**Data Collection Time Point(s) NFP Collection**

☐ 0 Months Post Enrollment ☐ 6 Months Post Enrollment

☐ 12 Months Post Enrollment ☐ 18 Months Post Enrollment

☐ 24 Months Post Enrollment

**\*Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. During a typical week, how many days do you (Caregiver) or a family member read, tell stories, and/or sing songs to or with your child?**

☐ 0 Days

☐ 1 Days

☐ 2 Days

☐ 3 Days

☐ 4 Days

☐ 5 Days

☐ 6 Days

☐ 7 Days

## **Measure 12 – Developmental Screening**

**Child Measure**

**Data Collection Time Point(s)**

☐ 9 Months Post Birth ☐ 18 Months Post Birth ☐ 30 Months Post Birth (Non-NFP)

**\*Child Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Family ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Does the child have a previously identified developmental delay prior to enrollment or prior to reaching an age-recommended screening?**

☐ Yes (Continue) ☐ No (Skip to 3)

**2. Is the child already receiving services for the previously identified developmental delay?**

☐ Yes (End) ☐ No (Continue to 3)

**3. Did you (Home visitor) screen the Child?**

☐ Yes (Continue to 5) ☐ No (Continue to 4)

**4. If No, do any of the following apply?**

☐ Home visitor unable to screen (End)

☐ Family refused (End)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (End)

**5. What were the results of the screening?**

**Communication**

☐ Above the cut off (white shaded area) ☐ Close to the cut off (gray shaded area)

☐ Below the cut off (black shaded area)

**Gross Motor**

☐ Above the cut off (white shaded area) ☐ Close to the cut off (gray shaded area)

☐ Below the cut off (black shaded area)

**Fine Motor**

☐ Above the cut off (white shaded area) ☐ Close to the cut off (gray shaded area)

☐ Below the cut off (black shaded area)

**Problem Solving**

☐ Above the cut off (white shaded area) ☐ Close to the cut off (gray shaded area)

☐ Below the cut off (black shaded area)

**Personal-Social**

☐ Above the cut off (white shaded area) ☐ Close to the cut off (gray shaded area)

☐ Below the cut off (black shaded area)

**If any scores fall below the cut off:**

**6. Did you (Home visitor) refer the child to early intervention services?**

☐ Yes ☐ No ☐ N/A – Child did not score below the cut off

**7. Did you (Home visitor) refer the child to other community services?**

☐ Yes ☐ No ☐ N/A – Child did not score below the cut off

## **Measure 13 – Behavioral Concerns and Home Visits**

**Caregiver Measure**

**Data Collection Time Point(s)**

Every Home Visit (All EBHV)

**\*Caregiver Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Family ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**M13 Question:** Did you (Home visitor) ask if the Caregiver has any concerns regarding his/her child’s development, behavior, or learning? (Only asked during Postpartum Home Visits)

**Date of Home Visit Type of Home Visit Measure 13 Caregiver Telehealth or**

 **Question Asked Response Virtual Visit**

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

\_ \_ /\_ \_ / \_ \_ \_ \_ (MM/DD/YYYY) ☐Prenatal ☐Postpartum | ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

## **Measure 14 – Intimate Partner Violence Screening**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ Within 6 Months Post Enrollment (All EBHV) (in data system will display at 6months)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Screening tool used:**

☐ Harassment in Abusive Relationships: A Self-Report Scale (HARASS)

☐ Hurt, Insulted, Threatened with Harm and Screamed (HITS) / Nurse-Family Partnership IPV TOOL

☐ Profile of Psychological Abuse (PPA)

☐ Women's Experience with Battering (WEB)

☐ Severity of Violence Against Women Scale (SVAWS)

☐ Abuse Behavior Inventory (ABI)

☐ Abuse Assessment Screen (AAS)

☐ Humiliation, Afraid, Rape, Kick, Child (HARK-C)

☐ Ongoing Abuse Screening (OAS)

☐ Universal Violence Prevention Screening Protocol-Adapted

☐ Domestic Violence Evaluation (DOVE)

☐ Partner Violence Screen (PVS)

☐ The Relationship Chart

☐ **Did Not Screen** (Continue to 4)

**2. Date of screening:** \_ \_ / \_ \_ / \_ \_ \_ \_ | MM/DD/YYYY

**3. Did the Caregiver screen positive for intimate partner violence?**

☐ Yes (End) ☐ No (End)

**4. Reason Not Screened:**

☐ Home visitor unable to screen

☐ Safety Concerns

☐ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Privacy Concerns

☐ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Reason required)

☐ Family refused

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Reason required)

## **Measure 16 – Continuity of Insurance Coverage**

**Caregiver Measure**

**Data Collection Time Point(s) (All EBHV)**

☐ 3 Months Post Enrollment ☐ 6 Months Post Enrollment

☐ 9 Months Post Enrollment ☐ 1 Year Post Enrollment

☐ 15 Months Post Enrollment ☐ 18 Months Post Enrollment

☐ 21 Months Post Enrollment ☐ 2 Years Post Enrollment

☐ 27 Months Post Enrollment ☐ 30 Months Post Enrollment

☐ 33 Months Post Enrollment ☐ 3 Years Post Enrollment

**After 3 Years Post Enrollment (All EBHV)**

☐ 42 Months Post Enrollment ☐ 4 Years Post Enrollment

☐ 54 Months Post Enrollment ☐ 5 Years Post Enrollment

☐ 66 Months Post Enrollment ☐ 6 Years Post Enrollment

☐ 78 Months Post Enrollment ☐ 7 Years Post Enrollment

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Have you (Caregiver) had health insurance coverage for the past 3 consecutive months?**

☐ Yes ☐ No

## **Measure 17 – Completed Depression Referrals**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ Six Months Postpartum if screened positive and enrolled during pregnancy (ALL EBHV)

☐ Six Months Post Enrollment if screened positive (ALL EBHV)

**If no services are received screen every three months until the Caregiver no longer screens positive and/or is referred and enters services.**

☐ 9 Months Postpartum ☐ 12 Months Postpartum ☐ 15 Months Postpartum

☐ 18 Months Postpartum ☐ 21 Months Postpartum ☐ 24 Months Postpartum

☐ 27 Months Postpartum ☐ 30 Months Postpartum ☐ 33 Months Postpartum

☐ 36 Months Postpartum ☐ 39 Months Postpartum ☐ 42 Months Postpartum

☐ 45 Months Postpartum ☐ 48 Months Postpartum ☐ 51 Months Postpartum

☐ 54 Months Postpartum ☐ 57 Months Postpartum ☐ 60 Months Postpartum

☐ 63 Months Postpartum ☐ 66 Months Postpartum ☐ 69 Months Postpartum

☐ 72 Months Postpartum

☐ 9 Months Post Enrollment ☐ 12 Months Post Enrollment ☐ 15 Months Post Enrollment

☐ 18 Months Post Enrollment ☐ 21 Months Post Enrollment ☐ 24 Months Post Enrollment

☐ 27 Months Post Enrollment ☐ 30 Months Post Enrollment ☐ 33 Months Post Enrollment

☐ 36 Months Post Enrollment ☐ 39 Months Post Enrollment ☐ 42 Months Post Enrollment

☐ 45 Months Post Enrollment ☐ 48 Months Post Enrollment ☐ 51 Months Post Enrollment

☐ 54 Months Post Enrollment ☐ 57 Months Post Enrollment ☐ 60 Months Post Enrollment

☐ 63 Months Post Enrollment ☐ 66 Months Post Enrollment ☐ 69 Months Post Enrollment

☐ 72 Months Post Enrollment

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Did you (home visitor) refer the Caregiver to services for depression?**

☐ Yes (Continue) ☐ No (Skip to 4)

**2. If yes, did you (Caregiver) receive recommended services for depression?**

☐ Yes (End) ☐ No (Continue to 3)

**3. If no, why?**

☐ Caregiver refused (End/Rescreen in 3 months) ☐ Caregiver on waiting list (End/Rescreen in 3 months)

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (End/Rescreen in 3 months)

**4. Did you rescreen the Caregiver?**

☐ Yes (Skip to 6) ☐ No (Continue to 5)

**5. If no, why?**

☐ Caregiver refused (End/Rescreen in 3 months) ☐ Caregiver on waiting list (End/Rescreen in 3 months)

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (End/Rescreen in 3 months)

**6. Did the Caregiver screen positive for depression?**

☐ Yes (Rescreen in 3 months / Continue to 7) ☐ No (Continue to 7 and End collection of this measure)

**7. Screening Tool Used**

☐ Edinburgh Postnatal Depression Scale (EPDS)

☐ Patient Health Questionnaire-9 (PHQ-9)

☐ Center for Epidemiologic Studies Depression Scale (CES-D)

☐ Center for Epidemiologic Studies Depression Scale Revised (CESD-R)

☐ Patient Health Questionnaire-2 (PHQ-2)

☐ Brief Symptom Inventory (BSI)

☐ Brief Depression Inventory-II (BDI-II)

## **Measure 18 – Completed Developmental Referrals**

**Child Measure**

**Data Collection Time Point(s)** (ALL EBHV)

☐ 12 Months Post Birth ☐ 21 Months Post Birth ☐ 33 Months Post Birth (Non-NFP)

**\*Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Did the child score below the cutoff on any area of the developmental screening?**

☐ Yes (Continue) ☐ No (End)

**2. If yes, have you (Caregiver) received individualized developmental support from a Home visitor for the child?**

☐ Yes (Continue) ☐ No (Continue)

**3. If yes, did you (Home visitor) refer the child to early intervention services?**

☐ Yes (Continue) ☐ No (Continue to Question 5)

**4. If yes, did the child receive an evaluation within 45 days?**

☐ Yes (Continue to Question 6) ☐ No (Continue to Question 5)

**5. If No, why?**

☐ Child on waiting list ☐ Caregiver refused

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. If yes, did you (home visitor) refer the Caregiver to other community services for this child?**

☐ Yes (Continue to 7) ☐ No (End)

**7. If yes, did the child receive other community services within 30 days of the developmental screening?**

☐ Yes (End) ☐ No (Continue to Question 8)

**8. If No to Question 6, why?**

☐ Caregiver refused ☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Measure 19 – Intimate Partner Violence Referrals**

**Caregiver Measure**

**Data Collection Time Point(s)**

☐ 9 Months Post Enrollment (ALL EBHV)

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. If Caregiver screen positive, did you (Home visitor) provide intimate partner violence referral information to the Caregiver?**

☐ Yes (End) ☐ No (Continue)

**2. If no, why?**

☐ Unsafe for information to be provided

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Measure 20 – Substance Use Screening**

## **Caregiver Measure**

**Data Collection Time Point(s)**

☐ 6 Months Post Enrollment

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Measure 20 – Part 1 – Unhealthy Drug Use**

**Did you the (Home Visitor) screen the Caregiver for unhealthy drug use?**

☐ Yes (Continue to Screening Tool)

☐ No (Skip to Question 4)

**Screening tool used for unhealthy drug use screening:**

## ☐ The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

☐ The Alcohol Use Disorders Identification Test Self-Report (AUDIT Self-Report Version)

☐ The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

☐ The Alcohol, Smoking, and Substance Involvement Screening Test- Frequency & Concern Items (ASSIST-FC)

☐ Cut Down, Annoyed, Guilty, Eye opener -Adapted to Include Drugs (CAGE-AID)

☐ The Drug Abuse Screening Test (DAST-10)

☐ National Institute on Drug Abuse (NIDA) Quick Screen

☐ Parents, Partners, Past and Pregnancy (The 4Ps) Plus

☐ Tolerance Annoyance Cut Down Eye Opener (T-ACE)

☐ Tolerance, Worried, Eye-opener, Amnesia, Cut Down (TWEAK)

**Date of Screening**: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

**1. Did the Caregiver screen positive for unhealthy drug use (based on the definition within the selected tool)?**

☐ Yes (Continue to 2)

☐ No (End)

**2. If no, did you (home visitor) refer the Caregiver to services for unhealthy drug use?**

☐ Yes (Continue to Measure 21 at 9 months post enrollment)

☐ No (Continue to 3)

**3. Reason Caregiver was not referred?**

☐ Caregiver already receiving services

☐ Caregiver refused referral

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Reason Not Screened for unhealthy drug use?**

☐ Agency is currently not collecting this data during the optional period.

☐ Home Visitor Unable to Screen

 Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Family Refused

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Continue to Measure 20 Part 2**

\*\*\* Recommended services: Specific techniques and intervention models delivered in the context of client characteristics, culture, and preferences that have shown to have positive effects on outcomes through rigorous evaluations and have demonstrated to achieve positive outcomes for the caregiver.

**Data Collection Time Point(s)**

☐ 6 Months Post Enrollment

**Measure 20 – Part 2 – Unhealthy Alcohol Use**

**Did you the (Home Visitor) screen the Caregiver for unhealthy alcohol use?**

☐ Yes (Continue to Screening Tool)

☐ No (Skip to Question 4)

**Screening tool used for unhealthy alcohol use screening:**

## ☐ The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

☐ The Alcohol Use Disorders Identification Test Self-Report (AUDIT Self-Report Version)

☐ The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

☐ The Alcohol, Smoking, and Substance Involvement Screening Test- Frequency & Concern Items (ASSIST-FC)

☐ Cut Down, Annoyed, Guilty, Eye opener -Adapted to Include Drugs (CAGE-AID)

☐ The Drug Abuse Screening Test (DAST-10)

☐ National Institute on Drug Abuse (NIDA) Quick Screen

☐ Parents, Partners, Past and Pregnancy (The 4Ps) Plus

☐ Tolerance Annoyance Cut Down Eye Opener (T-ACE)

☐ Tolerance, Worried, Eye-opener, Amnesia, Cut Down (TWEAK)

**Date of Screening**: \_ \_ / \_ \_ / \_ \_ \_ \_ (MM/DD/YYYY)

**1. Did the Caregiver screen positive for unhealthy alcohol use (based on the definition within the selected tool)?**

☐ Yes (Continue to 2)

☐ No (End)

**2. If no, did you (home visitor) refer the Caregiver to services for unhealthy alcohol use?**

☐ Yes (Continue to Measure 21 at 9 months post enrollment)

☐ No (Continue to 3)

**3. Reason Caregiver was not referred?**

☐ Caregiver already receiving services

☐ Caregiver refused referral

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Reason Not Screened for unhealthy alcohol use?**

☐ Agency is currently not collecting this data during the optional period.

☐ Home Visitor Unable to Screen

 Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Family Refused

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\* Recommended services: Specific techniques and intervention models delivered in the context of client characteristics, culture, and preferences that have shown to have positive effects on outcomes through rigorous evaluations and have demonstrated to achieve positive outcomes for the caregiver.

##

## **Measure 21 – Completed Substance Use Referrals**

## **Caregiver Measure**

**Data Collection Time Point(s)**

☐ 9 Months Post Enrollment

**\*Caregiver Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Family ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Measure 21 – Part 1 – Unhealthy Drug Use**

**1. If Caregiver screen positive for unhealthy drug use, did the Caregiver receive recommended services\*\*\*?**

☐ Yes (End) ☐ No (Continue)

**2. If no, why?**

☐ Caregiver refused services

☐ Caregiver currently on waitlist for services

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Measure 21 – Part 2 – Unhealthy Alcohol Use**

**1. If Caregiver screen positive for unhealthy alcohol use, did the Caregiver receive recommended services\*\*\*?**

☐ Yes (End) ☐ No (Continue)

**2. If no, why?**

☐ Caregiver refused services

☐ Caregiver currently on waitlist for services

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\* Recommended services: Specific techniques and intervention models delivered in the context of client characteristics, culture, and preferences that have shown to have positive effects on outcomes through rigorous evaluations and have demonstrated to achieve positive outcomes for the caregiver.

1. Infected with human immunodeficiency virus (HIV), Taking antiretroviral medications, have untreated, active tuberculosis, infected with human T-cell lymphotropic virus type I or type II, Using or is dependent upon an illicit drug, taking prescribed cancer chemotherapy agents, such as antimetabolites that interfere with DNA replication and cell division, Undergoing radiation therapies [↑](#footnote-ref-1)
2. Dates are not entered into the system but are including on the forms to help home visitors calculate the correct well-child visit based on the birthdate of the child. Well-Child visits follow the AAP Schedule at <https://www.aap.org/en-us/Documents/periodicity_schedule.pdf> [↑](#footnote-ref-2)
3. Combustibles (Cigars, Pipes, Hookahs, Bidis), Non-Combustibles (Chew, Dip, Snuff, Snus, Dissolvable), Electronic Nicotine Delivery Systems (ENDS) aka Vaping [↑](#footnote-ref-3)
4. Combustibles (Cigars, Pipes, Hookahs, Bidis), Non-Combustibles (Chew, Dip, Snuff, Snus, Dissolvable), Electronic Nicotine Delivery Systems (ENDS) aka Vaping [↑](#footnote-ref-4)
5. Motor vehicle, Suffocation, Drowning, Poisoning, Fire/burns, Falls, Sports and Recreation, and intentional injuries, such as Child Maltreatment. [↑](#footnote-ref-5)