Plan to Establish Medicaid Coverage for Ambulance Transports to Alternate Appropriate Care Locations

Session Law 2017-57, Sec. 11H.14A.(b)

Report to the

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

By

NC Department of Health and Human Services

December 1, 2017

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I. Introduction

Session Law 2017-57, Section 11H.14A.(b) (see ***Appendix A***), requires the Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA) to submit a report on a plan to establish Medicaid coverage for ambulance transports to alternative appropriate care locations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017.

Currently, Medicaid only covers ambulance transport when medically necessary to hospitals and other facilities capable of rendering emergency care in accordance with the Medicaid State Plan and DMA's Clinical Coverage Policy No. 15, Ambulance Services. Medicaid does not currently cover ambulance transport of beneficiaries in behavioral health crisis to behavioral health clinics or other alternative behavioral health care locations. However, DHHS has examined the Community Behavioral Health Paramedicine Pilot program and its ability to redirect care from hospital emergency departments to alternative locations, such as crisis facilities. DMA believes it is good public policy for the behavioral health system to provide a cost-effective, quality patient care experience which supports a more integrated system.

This report explores expanding Medicaid coverage to allow reimbursement for ambulance transport of beneficiaries in behavioral health crisis to alternate appropriate care locations. It describes current Medicaid coverage, outcomes of the Community Behavioral Health Paramedicine Pilot, and a plan to add coverage for ambulance transport to alternative appropriate care locations, including a proposed provider reimbursement methodology, fiscal impact, and other considerations.

II. Current Medicaid Coverage of Ambulance Transportation Services

The North Carolina Medicaid State Plan[1] and DMA's Clinical Coverage Policy No. 15, Ambulance Services[2] outline the covered services and reimbursement methodologies approved by the federal Centers for Medicare and Medicaid Services (CMS). Emergency ambulance transportation is only covered when determined medically necessary. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

Emergency transportation by an ambulance to a physician's office is covered only if all the following conditions are met:

1. The patient is en route to a hospital;
2. There is medical need for a professional to stabilize the patient's condition; and
3. The ambulance continues the trip to the hospital immediately after stabilization.

Therefore, under the existing North Carolina State Plan, ambulance diversion from hospital emergency departments to alternative appropriate locations for behavioral health care is not currently reimbursable with a federal match from CMS; claims could only be paid with 100% State dollars. If North Carolina wants to draw down a federal match for new coverage, then the State would need to submit a State Plan Amendment to change current coverage and reimbursement policies.

[1] See North Carolina Medicaid State Plan, Attachment 3.1-A.1, Page 18, http://www.ncdhhs.gov/DMA/plan/sp.pdf.
[2] See Clinical Coverage Policy No: 15, Ambulance Services, https://files.nc.gov/ncdma/documents/files/15.pdf.

There are no State Medicaid programs in the country that currently cover ambulance transport to locations like those under consideration here. However, DHHS has initiated conversations with CMS to determine whether ambulance transport to an alternative appropriate care location can be a Medicaid covered benefit within the context of federal regulations. As DHHS prepares this report, CMS is still considering the benefit coverage question.

III. Community Behavioral Health Paramedicine Pilot Program

DHHS has studied the potential benefits of this type of diversion program. The Community Behavioral Health Paramedicine Pilot Program managed by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) began in SFY 2015 with the goal of using specially trained Emergency Medical Services (EMS) staff to intervene with patients experiencing behavioral health crises, and provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives to hospital emergency departments. The program received appropriations of $225,000 and Federal block grant funds to:

- provide awards of $5,000 to establish partnerships and protocols between Emergency Medical Services (EMS), Local Management Entity-Managed Care Organizations (LME-MCOs), and crisis providers;
- provide Crisis Intervention Team (CIT) Training to paramedics in 11 counties;
- draft standardized clinical guidelines and Advanced Practice Paramedic protocols; and
- study and elect reimbursement mechanisms for services provided by EMS agencies.

Wake County EMS was the first system to join the Community Behavioral Health Paramedicine pilot. Since 2009, Wake County EMS has utilized Advanced Practice Paramedics (APP) to redirect care for people with mental health or substance use crises to facilities other than the emergency department when no other medical emergency exists.[3] The goal is to ensure that patients move directly to the care venue that is most appropriate for their condition, ensuring timely care at the right place and time and avoiding a costly emergency department visit. For appropriate beneficiaries, the APP will determine the best alternative treatment location and arrange for the beneficiary's transportation and admission. Beneficiaries may be transported to alternative treatment locations by ambulance, by law enforcement, or by family or friends.

Currently, there are 13 EMS sites participating in the pilot across the seven LME-MCOs. LME-MCOs contract with the EMS providers who serve their catchment area under a two-tiered rate structure. The first tier is $164 per event, where treatment is provided on scene with no transportation. Outside of the pilot program, there is no Medicaid reimbursement mechanism available to pay EMS providers for interventions in which they do not transport an individual to the ED. DMH/DD/SAS data show that approximately 21% of EMS interventions result in the individual being treated on scene and not transported. The second tier is $211 per event, where both treatment and ambulance transport to an alternative site are provided. DMA reviewed SFY2016 and SFY2017 pilot data for Wake County specifically because it has participated in the program for the longest duration and has APPs and existing facilities that serve as alternate transportation destinations. Data from SFY 2016

[3] http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx

show that out of 1,477 transports for both Medicaid and non-Medicaid individuals, 200 (13.5%) were to alternate locations. Among those 200 transports, 35 (17.5%) were for Medicaid beneficiaries. Ambulances were used for 43% of the transports to alternate locations; law enforcement vehicles were used for the remaining 57%. Data from SFY2017 show that out of 1,267 transports, 248 (19.5%) were to alternate locations. Among those 248 transports, 48 (19.3%) were for Medicaid beneficiaries. Ambulances were used for 54% of the transports to alternate locations; law enforcement vehicles were used for the remaining 46%.

Several other states have implemented programs that allow for Medicaid reimbursement of Community Paramedicine programs that treat at the scene without transport. However, no state has received approval for Medicaid reimbursement of behavioral health transportation under ambulance transportation services.

IV. Plan to Add Coverage for Ambulance Transport to Appropriate Alternative Locations

Although it is not yet known whether CMS will approve a State Plan Amendment or Waiver for coverage of ambulance transportation to appropriate alternative care locations for beneficiaries in behavioral health crisis, DMA has drafted the following plan for implementation, including a proposed rate methodology and fiscal impact.

A. Proposed Rate Methodology

The proposed rate methodology for alternative ambulance transport service will be to reimburse in accordance with the current Medicaid State Plan, Attachment 4.19-B, Section 23 and DMA fee schedule.[4] The procedure codes used for these services are shown in **Table 1**.

	TABLE 1	
Procedure Code	**Definition**	**Medicaid Maximum Allowable**
A0425	GROUND MILEAGE, PER STATUTE MILE	$3.03
A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1(ALS 1)	$70.75
A0427	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1(ALS 1 - EMERGENCY)	$124.68
A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT (BLS)	$70.75
A0429	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)	$70.75
A0433	ADVANCED SERVICE, ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)	$129.36

Ambulance transport other than to an emergency department is reimbursable only up to 45 miles by secondary road and 60 miles by primary road from the beneficiary pickup location. If longer distances are required, another transportation method must be used. Mileage is only reimbursable when transport is outside of the limits of the county in which the transport originated.

4 https://dma.ncdhhs.gov/ambulance-services-cpthcpcs

B. Fiscal Impact

In SFY2017, the Medicaid program paid for 21,085 ambulance transports. However, DMA cannot quantify the percentage of those transports that could have been diverted to alternate locations of care because there is currently no reimbursement mechanism. Therefore, there are no corresponding EMS claims in NCTracks to analyze. To determine the potential fiscal impact of adding coverage, DMA applied the known percentage of ambulance transports to alternate locations from the SFY2017 Pilot Program data. The fiscal impact uses the following assumptions:

1. The percentage of Medicaid beneficiary transports to alternative locations will be 11.8%. This assumption is based on SFY2017 data from all participating Pilot Program counties (Buncombe; Durham; Forsyth; Guilford; Halifax; Lincoln; McDowell; Onslow; Stokes; and Wake) where, out of 3,346 transports for Medicaid and non-Medicaid individuals, 396 were to alternate sites.
2. The growth factor for the number of transports will be 4%. This is the compounded annual growth rate (CAGR), defined as the average monthly enrollment growth of Medicaid over the last 3 fiscal years. This accounts for enrollment growth.
3. All alternative transports will be via ground level transport with costs calculated on a per mile basis (procedure code A0425).
4. 75% of the alternative transports will require Basic Life Support and 25% will require Advanced Life Support. Advance Life Support is necessary if the patient needs medication administration during the transport. Basic Life Support requires personnel with less training and has a lower fee.

The full fiscal impact is detailed in **Table 2**. However, based on these assumptions, it is estimated to cost $5,043,957 (federal and State dollars) for SFY2019 and $5,245,715 for SFY2020 for the reimbursement of ambulance transports to alternative locations.

Transporting to a more appropriate alternative location instead of the emergency department (ED) may also save money on the cost of care, as the alternative location is likely to be more cost effective. However, the actual savings would be based on the alternative facilities and the rates of the LME-MCOs who contract with those facilities. Furthermore, those savings would be reflected within the LME-MCO budgets, because DMA pays the LME-MCOs a capitated, per member per month rate for Medicaid beneficiaries who receive behavioral health services.

TABLE 2

Fiscal Impact:	SFY2019	SFY2020
# of Alternative Transports (11.8% of Total Transports)	45,527	47,349
Ground Mileage, Per Statute Mile (Procedure Code A0425):		
Mileage Per Transport	8.76	8.76
Total Mileage Projected	399,030	414,992
Cost Per Mile	$ 3.03	$ 3.03
Fiscal Impact - Subtotal	**1,209,062**	**1,257,425**
Basic Life Support, Emergency Transport (A0429):		
# of Transports (75% of Total)	34,146	35,511
Cost Per Transport	$ 70.75	$ 70.75
Fiscal Impact - Subtotal	**$ 2,415,802**	**$ 2,512,435**
Advanced Life Support, Emergency Transport (A0427):		
# of Transports (25% of Total)	11,382	11,837
Cost Per Transport	$ 124.68	$ 124.68
Fiscal Impact - Subtotal	**$ 1,419,092**	**$ 1,475,856**
Fiscal Impact - Total	$ 5,043,957	$ 5,245,715

C. Additional Considerations

While planning sustainable Medicaid coverage for ambulance transports to alternative care locations, DMA will ensure that Medicaid reimbursement is contingent upon an EMS System's ability to demonstrate that its EMS providers have received appropriate education and training in caring for beneficiaries experiencing a behavioral health crisis. Additionally, the EMS System has at least one partnership with a receiving facility that can provide care appropriate for those beneficiaries. There are currently fewer than ten behavioral health urgent care centers across the State that are open 24 hours a day, 7 days a week, and alternate care locations are not in place in each county, so this initiative will take time to implement. Appropriate training will include, at a minimum, Crisis Intervention Team (CIT) training and training on how to assess beneficiaries experiencing a behavioral health emergency, including mental health, intellectual/development disabilities, and substance use disorders. Each EMS System will also be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Service Regulation, Office of Emergency Medical Services.

D. Submission of a State Plan Amendment

If CMS determines that ambulance transport to alternative appropriate care locations is reimbursable as a Medicaid covered benefit, DHHS will need recurring appropriations to add this coverage. The timeliness of the response from CMS and legislative action to authorize appropriations for SFY 2019 will dictate the State Plan Amendment submission date.

V. Conclusion

DHHS agrees that the ability to reimburse for ambulance transportation to alternative appropriate care locations for behavioral health emergencies is good public policy because it allows beneficiaries to receive appropriate, timely and cost-effective care. DHHS looks forward to receiving additional guidance from CMS and moving forward with the preliminary plan outlined in this report.

VI. Appendices

Appendix A: Session Law 2017-57, SECTION 11H.14A.

PLAN TO ESTABLISH MEDICAID COVERAGE FOR AMBULANCE TRANSPORTS TO ALTERNATIVE APPROPRIATE CARE LOCATIONS

SECTION 11H.14A.(a) It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (Department) March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," the Department shall design a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The plan shall ensure the following:

(1) Medicaid reimbursement is contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that the EMS System has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals.

(2) An EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 11H.14A.(b) No later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall include the following:

(1) The proposed reimbursement methodology to be utilized.

(2) An analysis of the financial impact of adding the coverage, including any anticipated costs to the Medicaid program.

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

(4) If the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), a time line for submission of any State Plan amendments or any waivers necessary for implementation and expected implementation date.

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

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

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

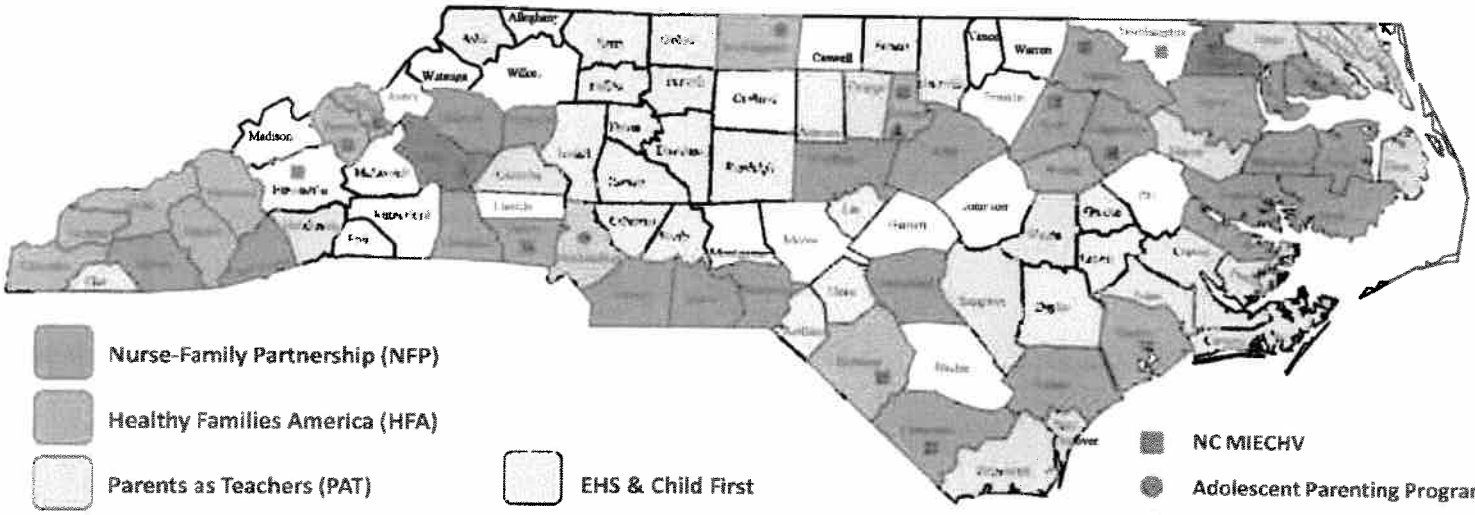
The Department shall develop a plan to implement changes necessary to provide Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program; however, consistent with G.S. 108A-54(e)(4), the Department is not authorized to make any changes to eligibility for the Medicaid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

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

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

(2) A detailed description of the coverage to be provided, including the proposed service definition, the home visit schedule, the scope of the covered service, and the anticipated reimbursement rate to be paid.
(3) An analysis of the total fiscal impact of adding Medicaid and NC Health Choice coverage for the home visits for pregnant women and families with young children. This shall include an outline of both costs and savings to the Medicaid and NC Health Choice programs, as well as any savings to other programs provided by the State.
(4) A description of how the Department intends to leverage any private funding that may be currently utilized to provide coverage for evidence-based home visits for pregnant women and families with young children.
(5) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e) or whether additional appropriations are required.
(6) Any plans to include pay-for-success initiatives as part of the Medicaid and NC Health Choice funding for the covered service.
(7) An anticipated time line for the implementation of the Department's plan and the submission of any necessary State Plan Amendments or waivers to the Centers for Medicare and Medicaid Services.

North Carolina Evidence-Based Home Visiting



- 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
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- NC MIECHV
- Adolescent Parenting Program
- Improving Community Outcomes for Maternal & Child Health
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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

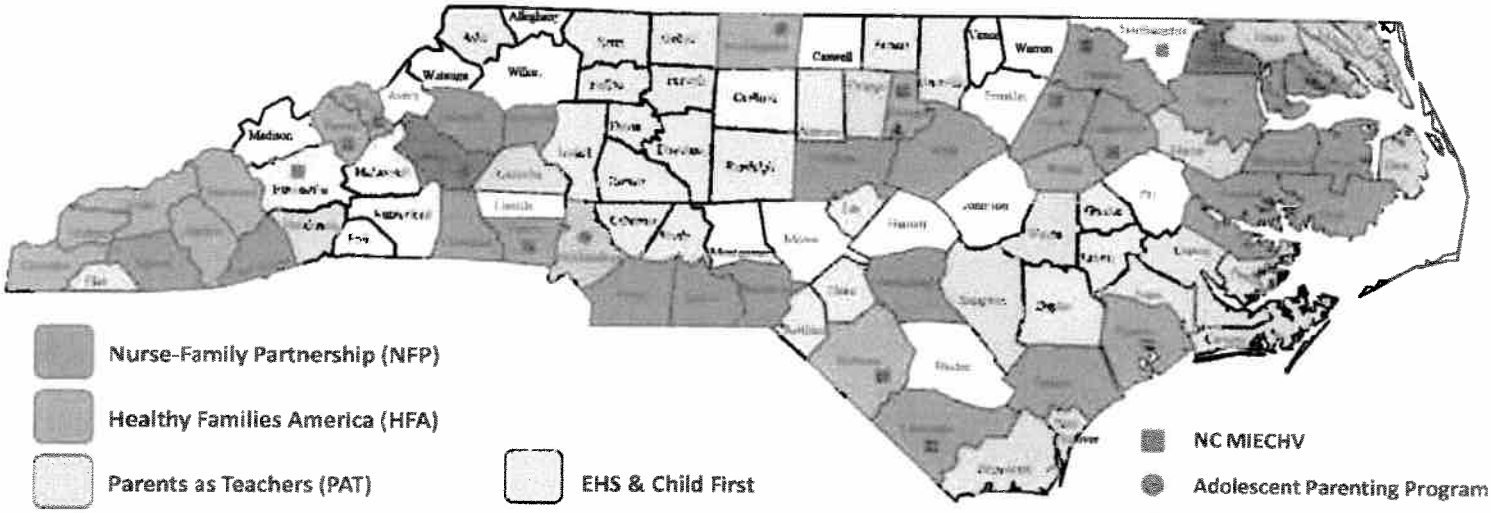
Early Head Start Home Visiting

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	

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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	

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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		

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	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.