GC-MOMS
Participant Assessments

Contents

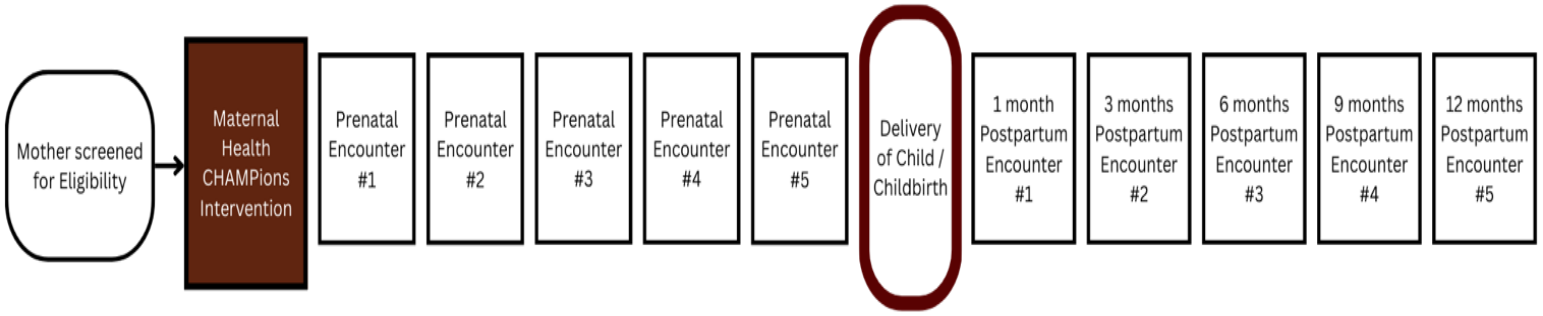
Milestones: Timeframes for Completing Forms and Assessments by the Navigator Team

Most forms and assessments will be completed during a specific timeframe, based on the perinatal time frame (*pre-pregnancy, perinatal period, postnatal period)*, child's age, milestone parameters after enrollment, or similar related parameters.

Some timeframes are determined by whether the family enrolls before or during pregnancy (prenatal enrollment) or after the birth of the youngest target child (postnatal enrollment).

The diagram here presents these general expected timeframes for carrying out the program of Navigator Home Visits.

IMAGE FROM CHAMPIONS GRANT PROPOSAL FOR REFERENCE



TAB ONE: Consent Forms & Communication & Appointment Logs

COMMUNICATIONS LOG

Date/Time	Method	Organization or Person	Purpose	Notes	Follow Up Needed
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No
__/__/____ ________	□ Phone □ Email/letter □ In Person □ Video call □ Other				□ Yes □ No

APPOINTMENT LOG (Home Visits)

APPOINTMENT LOG

Date / Time	WHO is the appointment with (Participant ... plus anyone else who joined the interaction)	Location of the appointment (home, park, coffee shop etc)	Notes

Release of information and consent forms can sometimes be confusing for both the Navigator and the Participants. Understanding what they are used for and what the participant's rights are is very important in helping decide which form(s) a participant may or may not want to sign.

In the case of the Program, the standard Consent form must be signed before a Participant will be enrolled and before any services or information other than about the Program may be offered.

The Media Consent form is encouraged but is not required. If a Participant does NOT agree to sign the Media Consent form, their chart needs to be starred as having NOT signed the Media Participant Consent Form. If they elect to participate in any public events, this needs to be discussed again. The Program will not use any form of media taken with any Participant who elects not to sign the Media Consent Form.

The following Frequently Asked Questions about Consent forms are written from the perspective of a Participant asking the Questions and the Navigator providing information.

What is a release of information form?

A standard Release of Information (ROI) / Consent Form is a form you sign to allow one provider to release information to another provider for yourself or your child(ren). Usually, there is a place on the form to indicate what information can and cannot be shared. For example, you may sign a release of information form allowing your prenatal care provider to share the results of your annual exam with your primary care provider.

What is a consent form?

A consent form is a form a doctor or community service provider might ask you to sign to give them permission to: collect information from you, use information you provide, provide a specific service to you, or explain the risks of a certain procedure. You may be asked to sign a consent form for yourself or your child(ren).

What does it mean if I sign a release of information or consent form?

Signing a release of information form gives a doctor or service provider permission to share specific information with another provider. The form should include the specific information to be shared. Signing a consent form gives a doctor or service provider permission to do something (a procedure, collect or share information, etc.), and/or indicates you understand the risk(s) involved in a procedure. Your signature on a consent form means you understand what is being asked and any possible risks to you or your child(ren).

When (or where) might I be asked to sign a release of information or consent form?

Your doctor or community service provider might ask you to sign one of these forms when you are a new Participant/client, a new service is offered, a new procedure needs to be done, or you ask them to share your information with someone for you.

Why would I want to sign a release of information or consent form?

Doctors and other providers usually cannot share your information without your permission. For example, if you change doctors you will need to sign a release of information form for your old doctor to share your records with your new doctor.

Do I have to sign a release of information or consent forms?

You do not have to sign a release of information or consent form if you do not want to. However, signing these forms can benefit you. If you don't understand the form, ask what it is for and why it is needed.

Can I change my mind after I sign a release of information or consent form?

Yes, you can let the provider know you want to remove or revoke your permission.

Can I ask questions?

YES! If you do not understand what information will be shared, who it will be shared with, or why it is needed—ASK these questions. You have every right to know before making a decision.

Dear Mother-to-Be,

Welcome to GC-MOMS!

Congratulations for taking a bold step for you and your baby's health and your family's future by enrolling in the GC-MOMS (Golden Crescent Management of Opioid Risk in Mothers) Program (hereinafter referred to as the Program). Once enrolled, your Maternal-Child Health Navigator (MCHN) will visit you every on a regular basis (approximately one time per month) until your baby is one years old. Your MCHN will link you with community resources and give you information and support at this important time in your life.

The GC-MOMS Program is an integrated part of the Program of Excellence for Mothers, Children & Families at the Texas A&M College of Nursing.

In order to have a successful relationship with our clients, we have some rules that guide our actions. To ensure a shared understanding, we would like you to know the following:

The MCHN will support you in every way we can that is reasonable and appropriate and within our scope as Nurses and within the parameters of the program and university.

The MCHN is <u>not allowed</u> to:

1. Give or accept gifts. This includes cash, gift certificates and items.
2. Drive you in their personal vehicle. However, they may refer you to a service available in the community.
3. Participate in a social network (i.e. Facebook, Twitter, Instagram) with clients.
4. Give out their personal phone numbers. The nurse will use their work phone which they will turn off after work hours (Monday – Friday, 8 AM – 5 PM). Text messaging will be used for the purpose of scheduling visits - no health teaching/nursing advice will be done through text.
5. Attend private events like baby showers, christenings or marriage ceremonies. If invited by you and their schedule allows, the MCHN may attend public events like graduation or school ceremonies.
6. Perform visits in the home when there are potential safety concerns for your MCHN (to be determined with Director/Nurse Supervisor). Visits can be scheduled in a different location.

The MCHN will work with your and their calendars to determine the best dates/times to meet. They will work with your calendar when they need to schedule or reschedule to meet with you (due to vacation, training, etc).

Other MCHNs may also work with you. Our Navigator Supervisor / Team Lead and an Administrative and Clinical Team will be closely involved.

We appreciate your choice to enroll in the GC-MOMS program. We look forward to partnering with you and helping you reach your goals for a healthy pregnancy, healthy child and increasing self-sufficiency for you and your family.

Communication is essential. Reach out to us if we can answer any questions or support you in any way.

Walter Page MS, BSN, RN Director of Maternal Child & Family Initiatives	Kat Hickl, MSW GC-MOMS Team Lead	TBD'd Maternal-Child Health Navigator	TBD'd Maternal-Child Health Navigator	TBD'd Maternal-Child Health Navigator	Susan Williams Sr. Admin. Coord.

ENROLLMENT FORM, STANDARD CONSENT, ELIGIBILITY, EMERGENCY CONTACT & RELEASE OF INFORMATION

GC-MOMS is a free community health care program. The Program provides pregnancy and parenting support to first-time mothers from nurses who visit their homes beginning in early pregnancy through the child's second birthday.

Please complete this form to enroll in the Program.

Program Eligibility

To participate in the Program, I understand that I must be a resident of the counties served by the program. The following rural counties in Texas are to be served: Lavaca, DeWitt, Jackson, and Calhoun.

I must be interested in having a child, pregnant or have a new baby in my household less than 1 year old. I can have more than one child in my family and be eligible for the program. There is no income requirement.

By signing below, I confirm that I meet the Program eligibility requirements, and I agree to provide the Program with any documents necessary to prove my eligibility if that is necessary.

Your Contact Information

First Name _____

Last Name _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Email _____

Date of birth _____

Emergency Contact Information

Please list the names and contact information of relatives or friends we may contact in case of emergency.

Name	Relationship	Telephone	Email

Permission to Share Health Information (Release of Information – ROI)

I allow the Program and Texas A&M University College of Nursing (TAMU-CON) to share health information about me, my child and my family collected during my participation in the GC-MOMS Program as described below. This health information may include names, contact information, birth dates, medical history, treatment records, information from surveys and during visits with my MCHN, and other information collected about me, my child and my family in the Program.

TAMU-CON may share health information about me, my child and my family to others for the following reasons:

- TAMU-CON will share health information to the GC-MOMS Program Service Office and the grant funding agency (Health Resources and Services Administration, HRSA) and others that fund or support the Program. They will monitor how the Program helps families and provide TAMU-SON with feedback and support about the Program.

- TAMU-CON may share health information with service providers in the community, such as health care and childcare providers, to help me get other services or resources I need.

  MCHNs in the Program will ask me questions and work with me to fill out forms on behalf of the state of Texas. This information will help them know how this Program is helping families.

- GC-MOMS welcomes nursing and other Texas A&M students engaged in an educational purpose, all of whom are under the direct supervision of a privileged staff member. By consenting to [care/treatment], you acknowledge that students may be involved in the care you receive. If you do not want students present during your care, please let an staff member know.

- We will keep the information we collect about you for potential use in research projects. We will remove identifying information before it is shared for research.

This permission will remain in effect until I cancel it. I can cancel this permission at any time by notifying the Program in writing at 8441 Riverside Parkway, Clinical Building 1, Rm 3539, Bryan, TX 77807. I understand that use or sharing of my information before I cancel this permission will not be affected.

I understand that this Program is voluntary, and I may refuse to sign this permission form. However, I will not be able to participate in the Program if I do not sign this permission form. I understand that my present or future health care outside of the Program, the payment of my health care or any other benefits to which I have a right will not be affected if I do not sign this permission form.

I understand that refusal to sign this permission form will not prevent sharing my health information as required or permitted by law. I also understand once health information about me, my child and my family has been shared outside TAMU-CON it may no longer be protected by federal or state privacy laws.

Signature Authorization

By signing below:

- I confirm that the information provided by me in this enrollment form is correct and that I will provide TAMU-CON with any updates to my information in writing during my participation in the Program.
- I agree to participate in the GC-MOMS Program at Texas A&M University College of Nursing.
- I have read and understand this enrollment form. I agree to the uses and sharing of health information described above.

Client's Signature	Client's Printed Name	Date
Parent/Legal Guardian Signature *(Required for participants under 18 years of age)*	Parent/Legal Guardian Printed Name	Date
GC-MOMS at Texas A&M University College of Nursing Representative Signature	GC-MOMS at Texas A&M University College of Nursing Representative Printed Name	Date

MEDIA APPEARANCE RELEASE

Participant: _____

Address: _____

1. The Participant consents to the use by Texas A&M University and assigns and grants to System Member the irrevocable and unconditional power, right, privilege and permission to make, record, produce, edit, modify, reproduce, exhibit, distribute, publish, publicly or privately display, publicly or privately perform, create derivative works, and transmit by the means of still photography, live or recorded broadcast, cablecast, webcast, or Internet streaming, broadband, wireless, mobile, film, videotape, or any other similar mechanical or electronic method (whether now known or invented later) the Participant's performance, contribution, appearance, name, voice, picture, likeness, poses, actions and any combination of any of these (the "Appearance") in connection with the Program of Excellence for Mothers, Children & Families production conducted by System Member (the "Project") which is generally for the purposes of education, instruction, research, publicity, advertising, and promotion in connection with the Project. Participant also waives any moral or similar rights Participant may have in the Project relating to the Appearance.

2. Participant understands that System Member shall have the absolute power and right to copyright the recorded production (and System Member shall be the owner of such copyright), in whole or in part, of the Project involving Participant and the Appearance and that such recorded production may be subsequently used, in whole or in part (including but not limited to any still recordings, images, or screen shots) for any purpose, including but not limited to the purposes described above at any time and from time to time hereafter throughout the world.

3. Participant also understands that there is no compensation or other consideration for appearance or participation in the Project, or for the grant of rights described in this document and that the opportunity to potentially appear in the recorded production related to the Project is sufficient consideration received for this Appearance Release.

4. Participant releases and discharges System Member, The Texas A&M University System and/or any affiliated organization, and their respective, regents, officers, employees, agents, and representatives from any and all claims, demands, causes of action, or liabilities arising out of or in connection with the Appearance or the making, producing, reproducing, processing, exhibiting, distributing, publishing, transmitting by any means described above or otherwise using the recorded production relating to the Project or the Appearance (e.g., violation of privacy rights; rights of publicity; false light; libel, slander, or disparagement; or copyright or trademark infringement).

5. Participant represents and warrants that Participant has not granted any similar rights to any third party that would conflict with the rights granted to System Member in this Appearance Release. Participant certifies and warrants that Participant is of legal age, has full power, right and authority to enter into this consent and release, has read same in its entirety, understands all of its terms and provisions, and voluntarily and knowingly executes this Appearance Release.

MEDIA APPEARANCE RELEASE

PARTICIPANT SIGNATURE:

Signature: _____

Printed Name: _____ Date: _____

IF PARTICIPANT IS *UNDER THE AGE OF 18 YEARS*, A PARENT OR LEGAL GUARDIAN MUST SIGN BELOW:

I agree to all the terms and conditions of this Appearance Release on behalf of myself and my child/ward.

Signature (Parent or Legal Guardian): _____

Printed Name: _____ Date: _____

TAB TWO: Demographics

TAB TWO: Demographics

Participant Demographics Record

Program Start Date* _____/_____/_____ Case ID*_____ Home Visitor Assigned* _____

Participant Enrollment Information		
Name*: _____ Date of Birth*: _____/_____/_____		
👍 Address: _____		
👍 Zip Code: _____	👍 Phone: _____	
Participant Demographics		
Gender*	☐ Female	☐ Male
Ethnicity	☐ Hispanic or Latino/a	☐ Not Hispanic or Latino/a
Race *(check all that apply)*	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander	☐ White ☐ More than one race – not specified ☐ Declined to identify
Primary Language *(check one)*	☐ English ☐ Spanish	☐ Other language: _____
Pregnancy Status at Enrollment*	☐ Pregnant ☐ Not Pregnant	☐ NA *(male Participant)*
👍 Marital Status *(check one)*	☐ Married ☐ Not married but living together	☐ Never married and not living with partner ☐ Separated or Divorced ☐ Widowed
LGBTQI+	☐ LGBTQI+	☐ Non- LGBTQI+
Insurance	☐ Employer insurance ☐ Self-pay ☐ Dual Eligible: Medicaid & Medicare ☐ Medicaid/CHIP only ☐ Medicare only	☐ Medicare plus supplemental ☐ TriCARE ☐ Other third party (privately insured) ☐ Uninsured

This section can be completed using information from other recent assessments or by asking the questions below. Home visitors may choose to re-word the questions as long as the data recorded meets the definitions in the guidance.

Priority Population Characteristics	Answer Options	"Yes" to any question = "Yes" Answer for that item
👍 Child abuse/ Child welfare system	☐ Yes ☐ No	Does Participant have a history of child abuse or neglect? Has Participant been involved with child welfare system?
👍 Substance Abuse	☐ Yes ☐ No	Does Participant have current or previous substance abuse problems?
👍 Tobacco Use in the Home	☐ Yes ☐ No	Are tobacco products used in the home?
👍 Low Student Achievement	☐ Yes ☐ No	Are you satisfied/dissatisfied with your level of achievement in school? Are you satisfied/dissatisfied with your child's level of achievement in school?"
👍 Developmental Delay or Disability	☐ Yes ☐ No	Does Participant have a child with a developmental delay or disability?

♲ U.S. Armed Forces	☐ Yes ☐ No	Is Participant an active/former member of the U.S. military? Is Participant or child a dependent of an active/former member of the U.S. military?

♲ *Denotes a field that should be updated periodically (review at least two times per year).*

Re-enrollment with gap in service: ☐ Yes ☐ No	(NFP Only) Transfer from another site: ☐ Yes ☐ No

Participant Record for others involved

For other people who may participate in the Program, Complete at initial intake and update as indicated.

Include anyone the client/Participant states is directly or importantly involved in the care of the family (to include, as indicated, father of the child, parents of the mother, grandparents, adult siblings, etc.)

Note: You do not have to complete all sections. If a question does not apply to you or you do not want to answer, feel free to cross it out or write "N/A" for non-applicable. You can also remove pages if they do not apply to your family.

PARENTAL / CHILD CAREGIVER / INVOLVED RELATIVE DEMOGRAPHICS (*Adult/Caregiver #2*)			
Name:		Date of Birth:	
Current Living Arrangement: ☐Rent/Own a Home ☐Homeless ☐Living with Relatives or Friends ☐Residential Treatment Center ☐Correctional Facility ☐Emergency Shelter ☐Other _____			
Street Address:			
City:	State:	Zip Code:	County:
Primary Phone Numbers:			
Emergency Contact:	Phone Number:		Relationship:
Marital Status/ Estado Civil: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated			
Insurance Plan:		Effective Date:	
Subscriber ID:		Group ID:	
PARENTAL MEDICAL HISTORY			
PRENATAL CARE (FOR CURRENT OR MOST RECENT PREGNANCY)			**Complete with: OB/GYN**
Gestational Age at Entry of Care:		Due Date:	Delivery Date:
Planned Mode of Delivery: ☐ Vaginal ☐Cesarean		Actual Mode of Delivery: ☐ Vaginal	☐Cesarean
Attended Postpartum Visit: ☐ Yes ☐ No If so, Location:		Date Completed:	
OBSTETRIC HISTORY		**Describe Any Complications During Prior Pregnancies:**	
Total Number of Pregnancies:			
Number of Live Births:			
Number of Children Currently Living with You:			
MEDICAL PROBLEMS REQUIRINGONGOING CARE			**Complete with: OB/GYN or Primary Care Provider**

Diagnoses/Conditions:

Note: You do not have to complete all sections. If a question does not apply to you or you do not want to answer, feel free to cross it out or write "N/A" for non-applicable. You can also remove pages if they do not apply to your family.

PARENTAL / CHILD CAREGIVER / INVOLVED RELATIVE DEMOGRAPHICS (*Adult/Caregiver #3*)			
Name:		Date of Birth:	
Current Living Arrangement: ☐Rent/Own a Home ☐Homeless ☐Living with Relatives or Friends ☐Residential Treatment Center ☐Correctional Facility ☐Emergency Shelter ☐Other _____			
Street Address:			
City:	State:	Zip Code:	County:
Primary Phone Numbers:			
Emergency Contact:	Phone Number:		Relationship:
Marital Status/ Estado Civil: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated			
Insurance Plan:		Effective Date:	
Subscriber ID:		Group ID:	

PARENTAL MEDICAL HISTORY			
PRENATAL CARE (FOR CURRENT OR MOST RECENT PREGNANCY)			**Complete with: OB/GYN**
Gestational Age at Entry of Care:		Due Date:	Delivery Date:
Planned Mode of Delivery: ☐ Vaginal ☐Cesarean		Actual Mode of Delivery: ☐ Vaginal	☐Cesarean
Attended Postpartum Visit: ☐ Yes ☐ No If so, Location:	Date Completed:		

OBSTETRIC HISTORY		**Describe Any Complications During Prior Pregnancies:**
Total Number of Pregnancies:		
Number of Live Births:		
Number of Children Currently Living with You:		

MEDICAL PROBLEMS REQUIRINGONGOING CARE	**Complete with: OB/GYN or Primary Care Provider**
Diagnoses/Conditions:	

CHILD DEMOGRAPHICS (Child enrolled in program, not siblings)		
Child's Name:		
Date of Birth:		Sex: ☐ Female ☐ Male
Who is the child currently living with? Select all that apply: ☐ Mother ☐Father ☐Grandparents ☐Sibling(s) ☐ Foster Family ☐ Other: _____		
Parent Name:		Involved in the child's life? ☐Yes ☐No
Parent Name:		Involved in the child's life? ☐Yes ☐No
Insurance Plan:		Effective Date:
Subscriber ID:		Group ID:
MEDICAL HISTORY		
Primary Care Provider:		Phone:
Birth Weight:	Gestational Age at Birth:	NICU stay? ☐No ☐Yes, # of days:
Prenatal Drug Exposure: ☐ No ☐ Yes, what drug:	Medical Complications at Birth:	
Ongoing Medical Issues and Diagnoses:		
Ongoing Medications:		
Do you have any concerns about this child's physical, mental, or behavioral health?		
RELATED HISTORY AND COMMUNITY LINKAGE		
List any difficulties or services this child has received (difficulties breastfeeding, failure to thrive, etc.)		
Does your child have a relationship with a lactation consultant or other provider? ☐Yes ☐No		
Is your child involved with the court/legal system? ☐Yes ☐No		
Has your child had any involvement with Child Protective Service (CPS) ☐ Yes, Currently Involved with CPS ☐ Yes, Previously Involved with CPS ☐ No, Never		
Caseworker:	Phone Number:	
Other important information about this child:		

Support Systems, Strengths, Areas for Improvement, Goals
Complete with Participant Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.

CURRENT SUPPORT SYSTEM (partner, family, friends, faith community, recovery, community, etc.)

YOUR STRENGTHS

YOUR AREAS FOR IMPROVEMENT AND NEEDS

YOUR GOALS (see the Goal Planning Tool in the Resources Tab)

CURRENT LIVING ARRANGEMENT		
List of People Living with You	Date of Birth	Relation
List of Children **NOT** Living with You	Date of Birth	Caregiver and Contact Number
Notes:		

CHILD(REN) NEEDS				
Item	**Yes**	**No**	**Pending**	**Notes**
Breast Pump	☐	☐	☐	
Breastfeeding Support	☐	☐	☐	
Car Seat	☐	☐	☐	
Childcare	☐	☐	☐	
Clothing	☐	☐	☐	
Crib or pack-n-play or bed	☐	☐	☐	
Diapers	☐	☐	☐	
Infant Formula	☐	☐	☐	
Infant Stroller	☐	☐	☐	
School Supplies	☐	☐	☐	
Specialized Medical Equipment	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	
Notes:				

REFERRALS AND SERVICES

Check box(es) for all applicable services currently engaged and new referrals needed for the family.

Complete with Participant

Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.

Service or Program	Discussed	Needed	Referred	Participating	Completed	N/A	Organization and Contact Information
SUPPORT SERVICES							
Parenting Classes							
Transportation Services							
SSI or Disability							
Temporary Assistance for Needy Families (TANF)							
Personal Safety							
Home Visitation Program							
Housing Assistance							
Healthy Start Program							
Employment services							
Other:							
FOOD & NUTRITION							
Breastfeeding Support							
Local Food Pantries							
SNAP							
Women, Infants, & Children (WIC)							
Other:							
Other:							
HEALTHCARE							
Health Insurance Enrollment							
Prenatal Healthcare							
Family Planning							
Primary Care							
Mental Health or Counseling (Trauma informed care)							
Smoking Cessation							
Other:							
Other:							
SUBSTANCE USE SERVICES							
Residential							
OutPatient							
Caring for Two Program							

The Cradles Project							
Recovery Support Services							
Naloxone (Narcan)							
Medication-Assisted Treatment (MAT)							
Transportation to Treatment							
Other:							

CHILD RELATED							
Early Childhood Intervention (ECI)							
Early Head Start							
NCI (Childcare Subsidy)							
Pediatrician or Primary Care							
Safe Sleep Education							
Other:							
Other:							

LEGAL ASSISTANCE							
Child Protective Service							
Legal Aid							
Specialty Court, specify:							
Other:							
Other:							

Notes

The Demographics forms are completed for the Participant at the time of enrollment. The first half of the form creates the core record for the family, so it should be completed on the first visit. Home visitors may need more than one visit to assess the Priority Population Characteristics, but it is important to have it complete within 30 days of enrollment.

Section/Item	Guidance
Initial Program & Staff Enrollment Information	
Program Start Date*	The date of enrollment in the home visiting program, according to the model's definition. *This is a required field.
Case ID*	This is the same as the case number used in the model data system. Enter the number carefully! It will be the family's main ID. *This is a required field.
Home Visitor Assigned*	The home visitor assigned to the family. This field is required because it makes many of the reports more user-friendly, allowing users to filter families by caseload. For a home visitor's name to appear in the list of home visitors, the home visitor must be added to the OLIVIA-NAVIGATOR LMS and the OLIVIA-NAVIGATOR data collection training must be completed prior to the new home visitor completing a home visit.
Participant Enrollment Information	
Name*	*First and last names are required fields in OLIVIA-NAVIGATOR. Middle initial is optional.
Address	Enter street address of Participant's residence.
Zip Code	Enter zip code. (When zip code is entered in Olivia-Navigator, city, county, and state will auto-populate.)
Phone	Enter main phone number for Participant. With consent, this may be used by the USF evaluation team to contact Participants directly.
Date of Birth*	Enter Participant's date of birth. *This is a required field in Olivia-Navigator.
Participant Demographics	
Gender*	Enter Participant's gender. *This is a required field in OLIVIA-NAVIGATOR.
Ethnicity	Allow Participant to identify Hispanic/Latino ethnicity.
Race	Allow Participant to self-identify Race. More than one option may be selected and will be reported as "more than one race". As of 10/1/18, a new option "More than one race – not specified" is available. This may be selected alone or with another race category. "Declined to identify" is an option, but it will be reported as missing data and should be avoided. "Declined to identify" should not be selected with another option.
Primary Language	Record only one language. If more than one language is spoken in the home, ask the Participant which language is spoken more often with the Target Child. If the primary language is not listed on the form, mark "other language" and write in the language.
Pregnancy Status at Enrollment*	Record the pregnancy status of the Participant at the time of enrollment in your agency's program. For a male Participant, mark "NA". *This is a required field in OLIVIA-NAVIGATOR. <u>Note for NFP</u>: If a Participant transfers from another NFP site after the birth of the target child, complete this field as "Not Pregnant. This a change from previous guidance.
✍ Marital Status	Enter Participant's marital status. If the Participant is divorced and living with another partner, record this as "Separated or Divorced". ✍ Update this field with changes.

Priority Population Characteristics	Update these fields with changes.
The funding authorizing Olivia-Navigator funding outlines populations for which Olivia-Navigator programs should provide priority enrollment. These populations are described by the risk factors or characteristics in the fields below. Priority enrollment should also be given to pregnant women under age 21 and to low income families. Data for those characteristics are recorded elsewhere. On the form, the name of the field used in Olivia-Navigator is in the left column, the yes/no answer options in the middle column, and questions to clarify the intent of each item or to suggest ways to phrase the question in the right column. The definitions below are the official definitions from HRSA's guidance.	
Child abuse/child welfare system	Participant has a history of abuse or neglect and has had involvement with child welfare services either as a child or as an adult (based on self-report).
Substance abuse	Participant has a history of substance abuse or has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment (based on self-report).
Tobacco Use in the Home	Participant or other household member uses tobacco products in the home (based on self-report). Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis) and non-combustibles (chew, dip, snuff, snus, dissolvables), and electronic nicotine delivery systems (ENDS).
Low Student Achievement	Participant perceives themselves or their child/children as having low student achievement (based on self-report).
Developmental Delay or Disability	Participant has a child or children suspected of having a developmental delay or disability (based on self-report or staff observation). If Participant does not have any children yet, mark "No".
U.S. Armed Forces	Participant is a current or former member of the Armed Forces or Participant/child is a dependent of an active/former member of the Armed Forces. Included in this definition are military members who are deployed outside of the United States. As such, the military member's dependent may be acquired through marriage, adoption, or other action during the course of a member's current tour of assigned duty. A pregnant woman whose child will or could be a dependent should be included (based on self-report).

Re-enrollment with gap in service:	If Participant was previously enrolled and dismissed from the program and you are re-enrolling the family again, mark Yes.
(NFP Only) Transfer from another site:	If Participant transferred from another NFP site, mark Yes.

TAB THREE: Medical & Nutrition History

TAB THREE: Medical & Nutrition History

PARENTAL MEDICAL HISTORY		
PRENATAL CARE (FOR CURRENT OR MOST RECENT PREGNANCY) Complete with Participant Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.		
Gestational Age at Entry of Care:		Due Date: Delivery Date:
Planned Mode of Delivery: ☐ Vaginal ☐ Cesarean		Actual Mode of Delivery: ☐ Vaginal ☐ Cesarean
Attended Postpartum Visit: ☐ Yes ☐ No If so, Location: Date Completed:		
OBSTETRIC HISTORY		**Describe Any Complications During Prior Pregnancies:**
Total Number of Pregnancies (see GTPAL below, these total numbers should match):		
Number of Children Currently Living with You:		
Dates of Prior Pregnancies		
Outcomes of Prior Pregnancies		
Gravida (total number of Pregnancies)		
Term (total number of Deliveries, @ 37 weeks or higher)		
Preterm (total number of Deliveries between 20 & 36 weeks)		
Abortions (total number of Miscarriages and/or Elective Abortions)		
Living (total number of Living Children)		
MEDICAL PROBLEMS REQUIRING ONGOING CARE Complete with: OB/GYN or Primary Care Provider		
Diagnoses/Conditions:		

Encounter Form / Home Visit Form - to Assess External Care Provider Encounters/Visits

Olivia-Navigator: Home Visit TouchPoint
(And edit Target Child Record TouchPoint for well-child visits)

Participant Name ____ Case ID ______________________ Month/Year ________________

Complete this form at every completed home visit.
Complete with Participant

Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.

Use one row for each competed visit.
All visits should be entered in OLIVIA-NAVIGATOR by 3 working days after the visit and be confirmed as entered.

At every visit			At every *postnatal* visit				
Date of Visit*	Staff	1. Health Insurance	2. Parent concerns about child	3. Care Visits	→ 4. Care Visit Dates and Reasons	5. Well-child visits	→ Visit(s) Completed (see list below)
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Did not ask	☐ Yes → ☐ No	Visit 1 Date: _________ Reason: ☐ Injury ☐ Other Visit 2 Date: _________ Reason: ☐ Injury ☐ Other Visit 3 Date: _________ Reason: ☐ Injury ☐ Other	☐ Yes → ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Did not ask	☐ Yes → ☐ No	Visit 1 Date: _________ Reason: ☐ Injury ☐ Other Visit 2 Date: _________ Reason: ☐ Injury ☐ Other Visit 3 Date: _________ Reason: ☐ Injury ☐ Other	☐ Yes → ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Did not ask	☐ Yes → ☐ No	Visit 1 Date: _________ Reason: ☐ Injury ☐ Other Visit 2 Date: _________ Reason: ☐ Injury ☐ Other Visit 3 Date: _________ Reason: ☐ Injury ☐ Other	☐ Yes → ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Did not ask	☐ Yes → ☐ No	Visit 1 Date: _________ Reason: ☐ Injury ☐ Other Visit 2 Date: _________ Reason: ☐ Injury ☐ Other Visit 3 Date: _________ Reason: ☐ Injury ☐ Other	☐ Yes → ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Did not ask	☐ Yes → ☐ No	Visit 1 Date: _________ Reason: ☐ Injury ☐ Other Visit 2 Date: _________ Reason: ☐ Injury ☐ Other Visit 3 Date: _________ Reason: ☐ Injury ☐ Other	☐ Yes → ☐ No	

Well-Child Visits (write in any new visits completed above)

Newborn	2-3 months old	9-10 months old	18-19 months old	4 - 4.5 years old
3-7 days old	4-5 months old	12-13 months old	2 - 2.5 years old	
2-4 weeks old	6-7 months old	15-16 months old	3 - 3.5 years old	

Guidance for Encounter Form / Home Visit External Care Provider Form

This form is to be completed at every completed home visit. The visit must be face-to-face for it to count as a Olivia-Navigator home visit; telephone or other electronic encounters are not Olivia-Navigator home visits. This guidance follows the Home Visit Form layout. Home visitors may instead choose to use the matrix layout to record all the visits completed in a month.

Section/Item	Guidance
Date of Visit*	The date of the completed visit. *In Olivia-Navigator, this is "Date Taken" and is a required field.
At Every Visit	
Do you have health insurance coverage?	In order to determine the Participant's health insurance coverage (or lack of) throughout the year, this must be asked/confirmed at each visit.
At Every Postnatal Visit (i.e. every visit once a Olivia-Navigator target child is enrolled)	
Do you have concerns about your child's development, behavior, or learning?	It is recommended that home visitors ask parents about developmental, behavioral, or learning concerns at every visit, even for newborns. HRSA requires that we report the number of postnatal visits where this question was asked. If the home visitor did not ask the question during a visit, mark "Did not ask".
Care / Emergency Room Visit (Y/N)	Ask this question at every visit to be sure that no visits are missed. If the answer is "Yes", then record the Care / ER Visit Date(s) and Reason(s). If the answer is "No", skip to well-child visits. If there is more than one target child and one child went to the ER and one did not, record "Yes". This question only applies to non-fatal ER visits. For the first home visit, it is acceptable to record No since any ER visit referenced would be prior to program enrollment.
→ ER Visit Date → ER Visit Reason	If the Participant answered "Yes" to taking a child to the ER, record the date and reason for the ER Visit. Be careful not to record a visit more than once. You may need to check the last Home Visit Form to confirm that the visit was not documented at the last visit. If there is more than one Olivia-Navigator target child and both went to the ER, record all the visit dates and reasons for the children separately. For example, if both children were in a car accident and were seen for their injuries at the ER on the same date, record two visits—one for each child. If the Participant is unsure of the exact date of the visit, record an estimated date. HRSA requires that we report the number of non-fatal ER visits due to injuries. Injuries refer to the following causes or mechanisms of injury: motor vehicle, suffocation, drowning, poisoning, fire/burns, falls, sports and recreation, and intentional injuries, such as child maltreatment. Note: If an ER Visit occurred, ER Visit Date and ER Visit Reason must be complete. If any one element is missing, ER Visit data are reported as missing.
Well-child visits (Y/N)	It is very important that each well-child visit is recorded at the home visit immediately following the well-child visit. For this reason, this question is included at every visit. If the question is not answered at every visit, there could be missing data for the performance measure for this child. If the answer is Yes, then the completed visits are recorded in the following question and then in the Child Record TouchPoint in OLIVIA-NAVIGATOR. For the first home visit, assuming that this information will have already been captured in the Target Child Record on the same day, it is acceptable to record No as the question will be redundant.
→ Well-child visits completed	If the Participant indicates that a well-child visit was completed, check the box of the age/visit. The age ranges are inclusive, meaning that 6-7 months old includes a two-month period of time, from when the child turned 6 months old until the last day the child was 7 months old. Visit dates and ages do not need to line up exactly; home visitors can use their judgment to determine if a visit a few days earlier or later than the designated age range should be recorded in one age range or another if the age ranges meet.

PREGNANT WOMAN'S HEALTH AND DIET QUESTIONS

Today's Date

Your Name	How many grades of school have you completed?	Are you currently? ☐ Married ☐ Unmarried

The following question is optional. Your answer will be used for group reporting purposes. If you do not answer, the staff will make a selection for you. This does not affect you receiving WIC or other benefits.

Are you Hispanic or Latino?	Race: Select one or more:	
☐ Yes ☐ No	☐ American Indian or Alaska Native Asian ☐ Black or African American ☐	☐ White European ☐ North African ☐ Middle Eastern ☐

Pregnancy Information

What was the date of your last menstrual period? Month/Day/Year_____	When is your baby due? Month/Day/Year_____
What was your weight just before you became pregnant with this baby? _____ pounds	

1. Number of pregnancies (including this pregnancy) _____

1a. Number of live babies (not including this pregnancy) _____

How many times have you been pregnant for 20 weeks or more before this pregnancy?

☐ None ☐ Number of pregnancies _____ ☐ Unknown

2. How many months were you pregnant when you had your first visit for prenatal care from a doctor or a certified nurse midwife for this current/most recent pregnancy?

☐ First month
☐ Second month
☐ Third month
☐ Fourth month
☐ Fifth month
☐ Sixth month
☐ Seventh month
☐ Eighth or Ninth month
☐ Unknown
☐ No Medical Care

3. For this pregnancy, check all that apply.

☐ Weight loss
☐ Nausea and vomiting
☐ Gestational Diabetes Mellitus
☐ Twins or more expected
☐ Fetal Growth Restriction
☐ High blood pressure
☐ None apply

4. How many times have you seen your health provider for this pregnancy? _____

5. Have you been offered a blood test for HIV? ☐ Yes ☐ No

6. For any **previous** pregnancies, please check all that occurred:

☐ History of GDM
☐ Preterm delivery (< 37 weeks)
☐ Early term delivery (37 to < 39 weeks)
☐ Infant 5 pounds, 8 ounces or less
☐ Infant died after 5 months of PG
☐ History of Preeclampsia
☐ Infant born alive, but died before 1 month
☐ Miscarriage
☐ Congenital/birth defects
☐ Infant 9 pounds or more at birth
☐ None apply

Medical Information

1. **Medical conditions/recent illnesses:** WIC staff will give you a list of medical conditions to review.
2. **Medications** (prescription or non-prescription)?
   ☐ Yes ☐ No
   If yes, what kind? _____
   Any side effects? ☐ Yes ☐ No
   If yes, what kind? _____
3. **Dental problems** affecting eating?
   ☐ Yes ☐ No
   If yes, what kind? _____
4. In the month before this pregnancy, how many times did you take a multivitamin? Less
   ☐ than once per week ☐ 8 or more times per week
   ☐ Number of times per week (1-7) _____ ☐ Unknown
5. Have you taken any vitamins or minerals in the past month? Yes
   ☐ ☐ No ☐ Unknown
6. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day? (20 cigarettes = 1 pack)
   ☐ Do not smoke ☐ Smoked, but quantity unknown
   ☐ Number of Cigarettes per day (1 - 96) _____ ☐ Unknown or refused
   ☐ 97 or more cigarettes per day
7. How many cigarettes do you smoke on an average day now?
   ☐ Do not smoke ☐ Smoked, but quantity unknown
   ☐ Number of Cigarettes per day (1 - 96) _____ ☐ Unknown or refused
   ☐ 97 or more cigarettes per day
8. Does anyone else living inside your household smoke inside the home? Yes,
   ☐ Someone else smokes inside the home
   ☐ No, no one else smokes inside the home
   ☐ Unknown
9. In the 3 months before you got pregnant, how many alcoholic drinks (beer, wine, liquor, wine coolers) did you have in an average week?
   ☐ Did not drink ☐ Drank, but quantity unknown
   ☐ Number of drinks per week (1 - 20) _____ ☐ Unknown or refused
   ☐ 21 or more drinks per week
10. Alcohol during pregnancy? ☐ Yes ☐ No
11. Are you currently (check all that apply)?
    ☐ Using any illegal substance ☐ Using marijuana in any form
    ☐ Abusing any prescription medications ☐ None
12. Any other physical disability, mental health condition or intellectual disability limiting ability to make appropriate feeding decisions and/or prepare food? ☐ Yes ☐ No

Breastfeeding Information

1. Have you ever breastfed or pumped breast milk to feed any of your children? ☐ Yes ☐ No

2. Are you currently breastfeeding or pumping breast milk? ☐ Yes ☐ No

   a. Is the baby less than one year old? Infant ID_____ ☐ Yes ☐ No

   b. Are you breastfeeding or pumping milk for more than one child? ☐ Yes ☐ No

   ☐ i. From same pregnancy (multiples)? ☐ ii. From different pregnancies?

3. Did you breastfeed as long as you desired? ☐ Yes ☐ No

   a. If no, Why?

- ☐ My baby had difficulty latching or nursing
- ☐ Breast milk alone did not satisfy my baby
- ☐ I thought my baby was not gaining enough weight
- ☐ My nipples were sore, cracked or bleeding or it was too painful
- ☐ I thought I was not producing enough milk, or my milk dried up
- ☐ I had too many other household duties
- ☐ I felt it was the right time to stop breastfeeding
- ☐ I got sick or I had to stop for medical reasons
- ☐ I went back to work
- ☐ I went back to school
- ☐ Lack of support
- ☐ My baby had an illness or medical condition
- ☐ Doctor recommended I supplement or wean
- ☐ Other _____

4. What have you heard about breastfeeding?

5. How are you thinking of feeding your baby?

- ☐ I want to nurse my baby from the breast
- ☐ I want to pump and nurse from the breast
- ☐ I want to pump only
- ☐ I want to provide both formula and breast milk
- ☐ I don't want to breastfeed
- ☐ I don't know
- ☐ Other

What is your breastfeeding goal?

_____ ☐ ☐

6. Are you interested in receiving more information about breastfeeding? Yes No

Breastfeeding Assessment

1. Are you worried about being able to breastfeed because of any medical conditions or medications: (if any of these boxes are checked, provide anticipatory guidance and referral to CLS/CLS/IBCLC)

- ☐ Breast Surgery/Trauma
- ☐ Hypothyroidism
- ☐ Diabetes
- ☐ Depression
- ☐ HIV (Do NOT ask. Only checked if voluntarily shared by client)
- ☐ No Concerns

Nutrition History

1. Number of meals per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
2. Number of snacks per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
3. Milk per day
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more
4. Appetite
☐ Good ☐ Fair ☐ Poor
5. A special diet
☐ Yes ☐ No
If yes, what kind? _____
6. Fast Food per week
☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 or more

7. Food allergies

Yes No

If yes, what kind? _____

8. Consume every day or most days?

Milk what kind? _____

Pop or other sweetened beverages

Sweets or salty snacks

Whole grains

Fruits and vegetables

9. Check all that apply

Unpasteurized juice or milk

Soft cheese

Raw/undercooked meat, fish, poultry or eggs

fish Raw sprouts

Refrigerated pate/meat spreads

Hot dogs/lunchmeats

Michigan

None apply

10. Check all that apply

Vegetarian diet

Low calorie/weight loss diet

Low-carbohydrate, high protein diet

Bariatric surgery

PICA

Vitamin/mineral/Iodine supplement daily

What kind? _____

Herbal supplement remedies/teas

What kind? _____

Fluoride

None apply

11. No

Staff Notes

TAB FOUR: Medications

TAB FOUR: Medications

CURRENT MEDICATION LIST Include prescription and Over the Counter & Supplements

Complete with Participant

Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.

Medication	Dose	Prescriber	Notes

Notes:

TAB FIVE: Substance Abuse Assessments & Related Treatment Plan

TAB FIVE: Substance Use Assessments

The ***Drug Abuse Screening Test (DAST-10***) is a 10-item brief screening tool that can be administered by a clinician or self-administered. Each question requires a yes or no response,

and the tool can be completed in less than 8 minutes. This tool assesses drug use, not including alcohol or tobacco use, in the past 12 months.

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse or (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Interpreting the DAST 10

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Participants receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

DAST-10 Score	Degrees of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior*, *7*(4),363–371.

Smoking / Tobacco Use before, during Pregnancy and at 1, 3, 6, 9, & 12 Months Postpartum

Tobacco Use Screening and Documentation Form

For clients who had a baby in the past year:

1.) Ask the Participant to choose the statement that best describes their smoking status:

- ☐ I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
- ☐ I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
- ☐ I stopped smoking AFTER I found out I was pregnant and I am not smoking now.
- ☐ I stopped smoking during pregnancy but I am smoking now.
- ☐ I smoked during pregnancy and I am smoking now.

Substance Use History

Update at each Encounter/Visit

Complete with Participant

Follow up as indicated with Provider, Social Worker, Case Manager, Recovery Coach, etc.

SUBSTANCE USE HISTORY Complete with Client / Family.

Follow up as needed with: Complete with Client / Family. Treatment Case Manager, Recovery Coach

	Ever Used	Used During Pregnancy	Date Last Used
Alcohol	☐Yes ☐No	☐Yes ☐No	
Amphetamines (ex. Adderall, "meth")	☐Yes ☐No	☐Yes ☐No	
Benzodiazepines (ex. Xanax)	☐Yes ☐No	☐Yes ☐No	
Cannabis ("marijuana")	☐Yes ☐No	☐Yes ☐No	
Cocaine	☐Yes ☐No	☐Yes ☐No	
Heroin	☐Yes ☐No	☐Yes ☐No	
Kush (synthetic marijuana)	☐Yes ☐No	☐Yes ☐No	
Prescription Drugs (ex. pain medications)	☐Yes ☐No	☐Yes ☐No	
Tobacco	☐Yes ☐No	☐Yes ☐No	
Other:	☐Yes ☐No	☐Yes ☐No	
Other:	☐Yes ☐No	☐Yes ☐No	

Notes:

MEDICAL SERVICES FOR SUBSTANCE USE Complete with Client / Family.

Follow up as needed with Physician, Nurse Practitioner, Medication Assisted Treatment (MAT) Provider

Medication Assisted Treatment (MAT) Engaged: ☐ Never ☐ Currently ☐ Prior MAT use Date of Last use:

Medication(s), Dose(s), and Date(s):	Name and Contact Information for MAT Clinic:

Addiction Medicine Services: ☐ Never ☐ Currently ☐ Prior, Date of Last Appointment:

Name and Contact Information for Addiction Medicine Clinic:

TAB SIX: Interpersonal Relations Assessments

TAB SIX: Interpersonal Relations Assessments

Intimate Partner Violence

Hurt, insulted, Threatened with Harm and Screamed (HiTS) Domestic violence Screening Tool

How often does your partner:	(1) Never	(2) Rarely	(3) Sometimes	(4) Fairly	(5) Often	(6) Frequently
1.) Physically hurt you:						
2.) Insult or talk down to you:						
3.) Threaten you with harm:						
4.) Scream or curse at you:						

Scoring: Each item is scored from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse, and should seek counseling or help from a domestic violence resource center.

Reminder that communication should

- Establish rapore with client
- Normalize the questions “we are asking all clients about partner violence”
- Explain reporting mandates

Intimate Partner Violence (IPV) Disclosure Screening Tool

OLIVIA-NAVIGATOR: IPV TouchPoint

Participant Name _____ Case ID _____

Date Completed* ____/____/_____ Staff Name _____

Complete this form when a screen for Intimate Partner Violence (IPV) is completed and/or when a Participant discloses IPV outside of an IPV screen.

IPV Screening		
1. IPV Screening Date	____/____/_____	
2. Screening Tool Used	☐ Clinical IPV Assessment/HITS	
3. Total Score	# _____	*If the score indicates a positive screen, offer the Participant a referral to the certified DV Center and record it in OLIVIA-NAVIGATOR, even if the Participant declines the referral.*
IPV Disclosure		
4. Participant was not screened but disclosed current IPV.	☐ Yes	*If Participant discloses IPV, offer the Participant a referral as stated above.*
5. IPV Disclosure Date	____/____/_____	
Notes		

GUIDANCE for IPV Disclosure Screening Tool:

This form is completed when a screen for Intimate Partner Violence (IPV) is completed and/or *when a Participant discloses IPV outside of an IPV screen.*

Section/Item	Guidance
Date Completed*	The date the form was completed. *In OLIVIA-NAVIGATOR, this is "Date Taken" and is a required field.
IPV Screening	
IPV Screening Date	The date the IPV screening was completed.
Screening Tool Used	Indicate which IPV screening tool was used. - HITS screening
Total Score	Record the total score from the screening tool. - If the HITS score is 9 or higher, the screen is positive and a referral to the certified domestic violence center should be made. Referrals for positive screens should be offered as soon as possible and always within 7 calendar days after the screen. (Of course, a late referral is better than no referral.)
IPV Disclosure	
Participant was not screened but disclosed current IPV.	The purpose of this field is to document that a Participant disclosed to the home visitor that she/he is currently experiencing intimate partner violence. We know that some people may not complete the IPV screen accurately, but that over time they may feel more comfortable/safe revealing these experiences to the home visitor. By documenting this disclosure, the program can more easily track those Participants who need continued follow-up. Additionally, if a Participant discloses IPV prior to completion of the IPV screen, the home visitor may not find it appropriate to complete the screen. Having the disclosure documented, we are better able to explain why some Participants were not screened. Note that this field would not be completed if the IPV screening data above were complete.
IPV Disclosure Date	The date that the Participant made the disclosure.
Notes	
This is an optional field for use by the Home Visitor, as needed.	

A Note on Referrals subsequent to concerning response

A referral should always be offered as soon as possible and always within seven days if the screen is positive or a disclosure is made. If the Participant declines the referral immediately, the home visitor should still record the OLIVIA-NAVIGATOR Referral Form for IPV, including the referral offered. At least one referral should be made to the local, certified Domestic Violence (DV) Center. If the Participant is hesitant to follow through with the referral, the home visitor may encourage her to start by just calling the local hotline number to speak with someone. They are the experts on assessing the complex needs and wishes of the survivor, can provide in-depth safety planning, and are knowledgeable on appropriate community providers to address the needs.

For families experiencing IPV, referrals for anger management, couples counseling, and batterers' intervention programs should never be made by a home visitor. They could cause more harm than good. A referral for individual counseling should only be made if there are specific mental health needs (such as depression) and is not a substitute for services provided by certified DV Centers.

The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) is a 12-item measure of perceived adequacy of social support from three sources: family, friends, & significant other; using a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree).

- 1. Zimet G.D., Powell, S.S., Farley, G.K., Werkman, S., Berkoff, K.A. (1990). Psychometric characteristics of the Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 55: 610-17.

- - 0 0 0 8	**ASSESSMENT DATE:** __ / __ / ____ *(mm/dd/yyyy)*
NODE: 0 7	**PHASE:** ○ Baseline ○ Post Randomization
SITE ID: 0 1 - 0 0	**SEGMENT:** **SEQUENCE:** 0 1
PARTICIPANT ID:	**FORM COMPLETED**
RELATION: -	**FORM COMPLETION LANGUAGE:** ○ English ○ Spanish ○ Both
FORM COMPLETION STATUS	1=Form completed as required 4=Not enough time at the visit 2=Participant refused 5=Participant did not attend visit

Rate the following statements using the following scale: 1=Very Strongly Disagree, 2=Strongly Disagree, 3=Disagree, 4=Neither agree nor disagree, 5=Agree, 6=Strongly Agree, 7=Very Strongly Agree

Evalué las siguientes declaraciones usando la siguiente escala: 1=Totalmente en desacuerdo, 2=Muy en desacuerdo, 3=En desacuerdo, 4=Ni de acuerdo ni en desacuerdo, 5=De acuerdo, 6=Muy de acuerdo, 7=Totalmente de acuerdo.

		Very Strongly Disagree *Totalmente en Desacuerdo* 1	Strongly Disagree *Muy en Desacuerdo* 2	Disagree *En Desacuerdo* 3	Neither Agree nor Disagree *Ni de Acuerdo ni en Desacuerdo* 4	Agree *De Acuerdo* 5	Strongly Agree *Muy de Acuerdo* 6	Very strongly Agree *Totalmente de Acuerdo* 7
1.	There is a special person who is around when I am in need. *Hay una persona en especial que esta cerca cuando yo estoy en necesidad.*	○	○	○	○	○	○	○

2.	There is a special person with whom I can share my joys and sorrows. *Hay una persona en especial con la cual yo puedo compartir mis alegrías y mis penas (lamentos).*	○	○	○	○	○	○	○
3.	My family really tries to help me. *Mi familia realmente trata de ayudarme.*	○	○	○	○	○	○	○
4.	I get the emotional help and support I need from my family. *Yo recibo la ayuda emocional y el apoyo que necesito de mi familia.*	○	○	○	○	○	○	○

SITE: 01 - 00 | PART ID: ____ | RELATION: __ - __ | ASSESS DATE: __ / __ / ____

		Very Strongly Disagree *Totalmente en Desacuerdo* 1	Strongly Disagree *Muy en Desacuerdo* 2	Disagree *En Desacuerdo* 3	Neither Agree nor Disagree *Ni de Acuerdo ni en Desacuerdo* 4	Agree *De Acuerdo* 5	Strongly Agree *Muy de Acuerdo* 6	Very strongly Agree *Totalmente de Acuerdo* 7
5.	I have a special person who is a real source of comfort to me. *Yo tengo una persona en especial la cual es verdaderamente una fuente de consuelo para mí.*	O	O	O	O	O	O	O
6.	My friends really try to help me. *Mis amistades realmente tratan de ayudarme.*	O	O	O	O	O	O	O
7.	I can count on my friends when things go wrong. *Yo puedo contar con mis amistades cuando las cosas salen mal.*	O	O	O	O	O	O	O
8.	I can talk about my problems with my family. *Yo puedo hablar de mis problemas con mi familia.*	O	O	O	O	O	O	O
9.	I have friends with whom I can share my joys and sorrows. *Yo tengo amistades con las cuales yo puedo compartir mis alegrías y mis penas (lamentos).*	O	O	O	O	O	O	O
10.	There is a special person in my life who cares about my feelings. *Hay una persona en especial en mi vida a quien le importa mis sentimientos.*	O	O	O	O	O	O	O
11.	My family is willing to help me make decisions. *Mi familia esta dispuesta a ayudarme ha hacer decisiones.*	O	O	O	O	O	O	O
12.	I can talk about my problems with my friends. *Yo puedo hablar de mis problemas con mis amistades.*	O	O	O	O	O	O	O

SITE: 01 - 00	PART ID:	RELATION: -	ASSESS DATE: __ / __ / ____

13. Please identify that "special person"

Por favor identifique esa "persona en especial"

Initials:

Iniciales: __.__

Relationship:

Relación:

- ○ Spouse/Partner

  Esposo(a)/pareja

- ○ Boyfriend/Girlfriend

  Novio/novia

- ○ Friend

  Amigo(a)

- ○ Professional (e.g., teacher, doctor, counselor, pastor)

  Profesional (e.g., maestro(a), doctor/médico, consejero(a), pastor)

- ○ Other family member

  Otro miembro de la familia

Comments: *Comentarios:*

TAB SEVEN: Physical Assessments

TAB SEVEN: Physical Assessments

10 B's: 1 month, 3/6/9/12 month postpartum appointment assessment

Checklist:
The 10 Bs:

- Baby
  - Physical Exam
  - Feeding
  - Growth and Weight Gain
    - WHO growth chart
- Breasts
  - Assess supply, latch, milk transfer, pain
  - Refer to lactation consultant/public health nursing services
  - Education on collection/storage of breast milk
  - Mastitis signs:
    - Fever, flu-like symptoms, erythema of breasts
- Bowels
  - Constipation treatment to reduce perineal pain
- Bladder
  - Urinary incontinence
- Belly
  - Pain
- Bottom
  - Perineal pain should resolve by now
  - Hemorrhoids
- Bleeding
  - Should be finished by now
- Baby blues/postpartum depression
  - Screen for both of these
  - EPDS tool
- Birth control
  - Discuss at this point
- Blood work
  - If needed, refer
    - Diabetes, anemia, hormones, etc.

https://www.mass.gov/doc/a-guide-for-your-6-week-postpartum-checkup/download
http://www.perinatalservicesbc.ca/Documents/Resources/Checklists/PSBC_Postpartum_Checklist.pdf

Pregnancy spacing Assessment

Ask the following questions regarding Pregnancy Spacing:

1. Have you had any pregnancies less than 12 months apart?
2. Are you interest in discussing family planning?

**NOTE to CSE TEAM: We do not yet have a detailed 'Pregnancy spacing Assessment' form.

**Please create the drop down for this form and we will add it once we find the assessment form we agree on or create one.

https://postpartumfp.srhr.org/ - link to an online World Health Organization tool to guide postpartum women through family planning options.

"It focuses on the initiation of family planning services within the first 12 months following childbirth to prevent closely spaced and unintended pregnancies."

TAB EIGHT: Mental Health Assessments

TAB EIGHT: Mental Health Assessments

Mental Health History / Brief Update form

MENTAL HEALTH HISTORY (Brief update)

Complete with client/Participant as part of each Encounter / Home Visit.

Follow up as needed with OB/GYN, Primary Care Provider, Nurse Practitioner or Mental Health Provider

Diagnosis	Date of Diagnosis	Provider	Provider Phone

Are you currently taking any medications for these diagnoses? ☐Yes ☐No
Please, explain:

Notes:

Duke University Religion Index (DUREL)

1. How often do you attend church, synagogue, or other religious meetings?
    a. Never
    b. Once a year or less
    c. A few times a year
    d. A few times a month
    e. Once a week
    f. More than once a week
2. How often do you spend time in private religious activities, such as prayer, meditation or Bible study?
    a. Rarely or never
    b. Once a month or less
    c. Once a week
    d. Few times a week
    e. Once a day
    f. More than once a day
3. In my life, I experience the presence of the Divine.
    a. Definitely not true
    b. Somewhat not true
    c. Neutral
    d. Somewhat true
    e. Definitely true
4. My religious beliefs are what really lie behind my whole approach to life.
    a. Definitely not true
    b. Somewhat not true
    c. Neutral
    d. Somewhat true
    e. Definitely true
5. I try hard to carry my religion over into other dealings in life.
    a. Definitely not true
    b. Somewhat not true
    c. Neutral
    d. Somewhat true
    e. Definitely true

Edinburg Postnatal Depression Scale (EPDS)

We would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all
2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all
3. *I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never
4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often
5. *I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all
6. *Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, have been coping as well as ever
7. *I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. *I have felt sad or miserable
    - Yes, most of the time
    - Yes, quite often
    - Not very often
    - No, not at all
9. *I have been so unhappy that I have been crying
    - Yes, most of the time
    - Yes, quite often
    - Only occasionally
    - No, never
10. *The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Scoring:
Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items.

Priority: Always look at item 10 (suicidal thoughts) and, if appropriate, assess safety of the mother and infant/family.
Maximum Score: 30
Depression Risk: 10 or greater
Scores greater than 13 indicate likelihood of depressive illness of varying severity; refer for further assessment and treatment as appropriate.

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J.M. Holden, R. Sagovsky

From: *British Journal of Psychiatry* (1987), 150, 782-786.

Guidance: OLIVIA-NAVIGATOR: Edinburgh (EPDS) Results TouchPoint

Participant Name _____ Case ID _____

Date Completed* ____/____/_____ Staff Name _____

Complete this form to record the results of the EPDS required for OLIVIA-NAVIGATOR.

EPDS Results		
Timeframe*	☐ Prenatal (not required for OLIVIA-NAVIGATOR) ☐ Postnatal	
Answer to #10	☐ Yes, quite often ☐ Sometimes ☐ Hardly ever ☐ Never	
Total Score	# _____	*If results indicate a positive screen, offer a referral to appropriate mental health services and record it in OLIVIA-NAVIGATOR.*
Notes		

==========

This form is completed ***when the Edinburgh Postnatal Depression Scale (EPDS) is completed***. Some program models require multiple administrations of depression screening tools. OLIVIA-NAVIGATOR measures completion of one administration and the timing coordinates with all program model requirements, i.e. if the model requirements are met, then the OLIVIA-NAVIGATOR requirement will be met. OLIVIA-NAVIGATOR requires that the screen be completed by 3 months postpartum for women enrolling during pregnancy and by 3 months post-enrollment for Participants enrolling postnatally.

Programs should also record follow-up administrations that occur after a positive screen.

Section/Item	Guidance
Date Completed*	The date the screening was completed. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Timeframe*	Indicate if the screen was completed during the prenatal or postnatal period. This field is essential for creating reports to assist programs in tracking EPDS screening data. It is not required to record prenatal screening in OLIVIA-NAVIGATOR.
Answer to #10	Record the Participant's answer to #10, which is an assessment of suicidal ideation or self-harm. Any answer other than "Never" indicates a positive screen for depression and should be referred for services immediately. The immediate safety of the Participant should also be assessed and an appropriate response completed.

Total Score	Record the total score from the EPDS screening results. - If the score is 10 or higher, the screen is positive and a referral to mental health services should be made. If the score is 10 or higher or if the answer to #10 is anything but "Never", a referral should be offered as soon as possible and always within 7 calendar days of the screen. (Of course, a late referral is better than no referral.) If the Participant declines the referral immediately, the home visitor should still record the OLIVIA-NAVIGATOR Referral Form for Depression with the referral offered. The home visitor is to continue encouraging the Participant to pursue that referral or offer another one.
Notes	
This is an optional field for use by the Home Visitor, as needed. If a Participant screens positive and is already receiving *recommended services* to address depression, the home visitor may determine that making another referral is not helpful. In this case, document this information here to include the name of Service Provider, the type of services provided, and when services began. See Olivia-Navigator Referral Form Guidance for more detail about *recommended services* for depression.	

Generalized Anxiety Disorder (GAD-7)

GAD-7 Anxiety Scale

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	○ 0	○ 1	○ 2	○ 3

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○ 0	○ 1	○ 2	○ 3

SCORING:

Each response from the GAD7 has a score ranging from 0 to 3. The score for each response is next to the check box. After a Participant has completed the GAD7, add up each column score, and then sum all four columns for the Participant's score. Below are the scoring guidelines for the GAD7.

Scoring Guidelines

Guidelines for Interpretation for GAD7

Score	Risk Level	Intervention
0	No to Low risk	None, rescreen annually
5	Mild	Provide general feedback, repeat GAD7 at follow up
10	Moderate	Further Evaluation Recommended and referral to mental health program
15+	Severe	Further Evaluation Recommended and referral to mental health program

Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7

If the total score is 10 or more, this could indicate a clinically significant problem and should trigger referral to a mental health program or enrollment in the Mental Health Integration Program.

Perceived Stress Scale (PSS)

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, please indicate your response by placing an "X" over the circle representing HOW OFTEN you felt or thought a certain way.

	Never	Almost Never	Sometimes	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	☐	☐	☐	☐	☐
In the last month, how often have you felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
In the last month, how often have you felt nervous and "stressed"?	☐	☐	☐	☐	☐
*In the last month, how often have you felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
*In the last month, how often have you felt that things were going your way?	☐	☐	☐	☐	☐
In the last month, how often have you found that you could not cope with all the things that you had to do?	☐	☐	☐	☐	☐
*In the last month, how often have you been able to control irritations in your life?	☐	☐	☐	☐	☐
*In the last month, how often have you felt that you were on top of things?	☐	☐	☐	☐	☐
In the last month, how often have you been angered because of things that were outside your control?	☐	☐	☐	☐	☐
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

Scoring: PSS scores are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 & 4 = 0) to the four positively stated items (*items 4, 5, 7, & 8) and then summing across all scale items. A short 4 item scale can be made from questions 2, 4, 5 and 10 of the PSS 10 item scale.

Scores ranging from 0-13 would be considered low stress. ► Scores ranging from 14-26 would be considered moderate stress. ► Scores ranging from 27-40 would be considered high perceived stress.

Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. Journal of Health and Social Behavior, 24, 386-396.

TAB NINE: Home Safety Assessments

TAB NINE: Home Safety Assessments

Housing Security Home Visit Form

Participant Name _____ Case ID _____

Date of Visit* _____/_____/_____ Staff Name _____

Complete this form at every completed home visit.

At Every Visit	
1. Do you have health insurance coverage?	☐ Yes ☐ No
At Every Postnatal Visit (i.e. every visit once a target child is enrolled)	
2. Do you have any concerns about your child's development, behavior, or learning?	☐ Yes ☐ No ☐ Did not ask
3. Since our last visit, have you taken your child to the hospital Emergency Room?	☐ Yes → *Answer #4* ☐ No *(Skip to #5)*
→ 4. If Yes, please note the date(s) and check the reason:	
ER Visit 1 Date: _____/_____/_____ ER Visit 1 Reason:	☐ Injury ☐ Other reason
ER Visit 2 Date: _____/_____/_____ ER Visit 2 Reason:	☐ Injury ☐ Other reason
ER Visit 3 Date: _____/_____/_____ ER Visit 3 Reason:	☐ Injury ☐ Other reason
5. Since our last visit, has your child had any well-child visits?	☐ Yes → *Record visit(s) below* ☐ No *(Stop here)*

→ *If Yes, complete the section below for the target child/children by marking the visit(s) completed.*

Child Name: _____ Child Name: _____

Well-child visits completed	Well-child visits completed
☐ Newborn	☐ Newborn
☐ 3-7 days old	☐ 3-7 days old
☐ 2-4 weeks old	☐ 2-4 weeks old
☐ 2-3 months old	☐ 2-3 months old
☐ 4-5 months old	☐ 4-5 months old
☐ 6-7 months old	☐ 6-7 months old
☐ 9-10 months old	☐ 9-10 months old
☐ 12-13 months old	☐ 12-13 months old
☐ 15-16 months old	☐ 15-16 months old
☐ 18-19 months old	☐ 18-19 months old
☐ 2 - 2.5 years old	☐ 2 - 2.5 years old
☐ 3 - 3.5 years old	☐ 3 - 3.5 years old
☐ 4 - 4.5 years old	☐ 4 - 4.5 years old

Household Housing Safety Profile

Olivia-Navigator: Household Profile TouchPoint and Child Wellness TouchPoint

Participant Name _____ Case ID _____

Date Completed* _____/_____/_____ Staff Name _____

Note: *Review the Participant Record and check any of the following fields that need to be updated. Update those fields in OLIVIA-NAVIGATOR by editing the Participant Record.*

- ☐ Address
- ☐ Zip code
- ☐ Marital Status
- ☐ Child abuse/child welfare
- ☐ Substance abuse
- ☐ Tobacco use in the home
- ☐ Low student achievement
- ☐ Developmental delay/disability
- ☐ U.S. Armed Forces

Timeframe*

☐ Enrollment ☐ Update

Participant Information

1. What kind of health insurance coverage do you have? *(check one)*	☐ Medicaid or Texas KidCare ☐ Private insurance ☐ Tri-Care	☐ No insurance ☐ Other insurance: _____
2. Do you have a high school diploma or GED?	☐ Yes → *Answer #3* ☐ No → *(Skip to #4)*	
→ 3. If Yes, what is the highest level of education completed? *(check one)*	☐ HS diploma/GED ☐ Some college/training ☐ Technical training/certification	☐ Associate's degree ☐ Bachelor's degree or higher
4. Are you currently enrolled in any type of school or training program?	☐ Yes → Mark here if middle/high school/GED prep → ☐ Yes ☐ No	
5. What is your employment status?	☐ Employed full-time ☐ Employed part-time	☐ Not employed currently
6. Do you use tobacco?	☐ Yes → *Answer #7*	☐ No → *(Skip to #8)*
→ 7. If Yes, are you currently receiving tobacco cessation services?	☐ Yes → Service Provider: - _____ ☐ No → *Offer referral and record a OLIVIA-NAVIGATOR Referral TouchPoint.*	
For Female Participants Only 8. Are you currently pregnant?	☐ Yes *(Skip to #10)* ☐ No → *Answer #9*	
→ 9. If No, would you like to become pregnant in the next year?	☐ Yes *(Discuss preconception health.)* ☐ No *(Discuss birth control.)*	
10. During the past 12 months, what was your yearly total household income before taxes? *(see guidance for clarification)*		$ _____
If income cannot be determined, indicate the primary reason:	☐ Key family member(s) would not share ☐ Participant is in foster care ☐ Other:	
11. How many people depend on this income?		# _____

Household Information (cont.)
12. Which of the following best describes the family's housing situation? *(choose only one answer from one column)* Not Homeless ☐ Owns or shares own home ☐ Rents or shares rented home ☐ Lives in public housing ☐ Lives with parent/family member ☐ Some other arrangement Homeless ☐ Sharing housing ☐ Lives in a shelter ☐ Some other arrangement

Food Security

Household Food Insecurity Access Scale (HIFAS) Measurement Tool

For more detailos on how to use this tool visit:
https://www.fantaproject.org/sites/default/files/resources/HFIAS_ENG_v3_Aug07.pdf

No	Question	Response Options	CODE
1.	In the past four weeks, did you worry that your household would not have enough food?	0 = No (skip to Q2) 1=Yes	….|__|
1.a	How often did this happen?	1 = Rarely (once or twice in the past four weeks) 2 = Sometimes (three to ten times in the past four weeks) 3 = Often (more than ten times in the past four weeks)	….|__|
2.	In the past four weeks, were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?	0 = No (skip to Q3) 1=Yes	….|__|
2.a	How often did this happen?	1 = Rarely (once or twice in the past four weeks) 2 = Sometimes (three to ten times in the past four weeks) 3 = Often (more than ten times in the past four weeks)	….|__|
3.	In the past four weeks, did you or any household member have to eat a limited variety of foods due to a lack of resources?	0 = No (skip to Q4) 1 = Yes	….|__|
3.a	How often did this happen?	1 = Rarely (once or twice in the past four weeks) 2 = Sometimes (three to ten times in the past four weeks) 3 = Often (more than ten times in the past four weeks)	….|__|
4.	In the past four weeks, did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?	0 = No (skip to Q5) 1 = Yes	….|__|
4.a	How often did this happen?	1 = Rarely (once or twice in the past four weeks) 2 = Sometimes (three to ten times in the past four weeks) 3 = Often (more than ten times in the past four weeks)	….|__|

TAB TEN: Prenatal Care

TAB TEN: Prenatal Care

Ask these questions:

1. If currently pregnant, do you attend regular visits with your OBcare provider?
2. When did you start your prenatal care?
3. Provide the contact information for your prenatal care in the Care Provider section.
4. How far do you have to drive to receive prenatal care?
5. Have you missed any prenatal appointments? If so, why?

TAB ELEVEN: Child Records

TAB ELEVEN: Child Records

ASQ-3

OLIVIA-NAVIGATOR: ASQ-3 Results TouchPoint (from Target Child Record TouchPoint Dashboard)

Participant Name _____ Case ID _____

Date Completed* ____/____/_____ Staff Name _____

Child Name* _____

Complete this form when an ASQ-3 Questionnaire required by OLIVIA-NAVIGATOR is administered .

ASQ-3 Administration and Results

Questionnaire Used*	☐ 2 month ☐ 4 month ☐ 6 month ☐ 8 month ☐ 9 month ☐ 10 month ☐ 12 month	☐ 14 month ☐ 16 month ☐ 18 month ☐ 20 month ☐ 22 month ☐ 24 month ☐ 27 month	☐ 30 month ☐ 33 month ☐ 36 month ☐ 42 month ☐ 48 month ☐ 54 month ☐ 60 month
Was age adjusted for prematurity?*	☐ Yes ☐ No	*If child is less than 24 months old and was born premature (less than 37 weeks gestation), the timing of ASQ-3 administration should be adjusted according to ASQ guidelines.*	
Communication Score: _____		☐ Score not recorded for this subscale because child is currently receiving services in this area	
Gross Motor Score: _____		☐ Score not recorded for this subscale because child is currently receiving services in this area	
Fine Motor: _____		☐ Score not recorded for this subscale because child is currently receiving services in this area	
Problem Solving: _____		☐ Score not recorded for this subscale because child is currently receiving services in this area	
Personal-Social: _____		☐ Score not recorded for this subscale because child is currently receiving services in this area	

Follow-Up

Follow-up Action Taken* *(check all that apply)*	☐ Provide developmental support activities → *Describe activities below (required)* ☐ Rescreen at next interval *(Record rescreen in OLIVIA-NAVIGATOR)* ☐ Refer to Early Steps or Child Find *(Record in OLIVIA-NAVIGATOR Referral)* ☐ Refer to other community agency/provider *(Record in OLIVIA-NAVIGATOR Referral)* ☐ No further action taken at this time

→ Describe activities provided (Include date delivered, name/description of activity, and area of concern addressed.)

Guidance for ASQ-3 Results & Follow-Up

This form is completed when the home visitor administers one of the ASQ-3 Questionnaires required by OLIVIA-NAVIGATOR.

Section/Item	Guidance
Date Completed*	The date the ASQ-3 was completed. *In Olivia-Navigator, this is "Date Taken" and is a required field.
ASQ-3 Administration & Results	
Questionnaire Used*	Indicate which questionnaire was used. OLIVIA-NAVIGATOR is only required to report on the 10-month, 18-month, and 30-month questionnaires so those are the only ones required in OLIVIA-NAVIGATOR. All questionnaires are included in the list and should be recorded in OLIVIA-NAVIGATOR for the following reasons, if applicable: • To track additional ASQ-3 screenings after a previous ASQ-3 score was below the cut-off or in the monitoring zone. A rescreen after a low score should be recorded in Olivia-Navigator. • To track ASQ-3 completion and follow-up for CQI purposes. • If the child was not screened during the required timeframe, home visitors should use the questionnaire for the next interval to screen the child.
Was age adjusted for prematurity?	If the child is less than 24 months old and was born premature (less than 37 weeks gestation), the ASQ-3 User's Guide provides guidance on how to adjust the age of the child so that the required Questionnaire is completed at the appropriate time. Be sure that you have entered the child's gestational age at birth in the Target Child Record and that you check this field "Was age adjusted for prematurity?" so that OLIVIA-NAVIGATOR can report timely screening accurately.
Subscale Scores Communication Gross Motor Fine Motor Problem Solving Personal-Social	Record the score for each subscale. If the child has already been identified as having a delay in one or more areas and is currently receiving services to address the area(s) of concern, do not complete the screen for that area/subscale and mark the box "Score not recorded for this subscale because child is currently receiving services in this area". You should still complete the screen for other areas, unless the child's service provider provides documentation they have screened in those areas at the required interval or that it is clinically inappropriate to screen in other areas. If the child is receiving services for all five areas, complete the form and TouchPoint and mark all five of the "Score not recorded…" boxes.
Follow-up Action Taken* *(check all that apply)*	This field is required in Olivia-Navigator. If the child scored in the white zone and there are no concerns about the child's development, mark "No further action taken at this time". If the child scored in the grey zone (monitoring), the home visitor should (at a minimum) provide developmental support activities that specifically address the area(s) of concern and then rescreen the child at the next ASQ-3 interval. If the activities option is marked, you will be required to describe the activities provided in order to save the TouchPoint in Olivia-Navigator. If the child scored below the cut-off (black zone) on one or more subscales, complete a Olivia-Navigator Referral Form. A referral to Early Steps (age 0-36 months) should always be offered to the parent as soon as possible and always within 7 calendar days. Referrals should always be recorded, even if the parent declines. Other referrals may also be made and should be recorded in the [Follow-up Action Taken] field as Refer to other community agency/provider. These referrals may include FDLRS Child Find for children older than 36 months, a private provider of speech and/or occupational therapy, or primary health care provider.

Follow-up Action Taken* *(continued)*	The home visitor should also provide developmental support activities, at least until the child receives an Early Steps evaluation, service from another community provider, or scores above the cutoff when re-screened. If a child is already receiving services from Early Steps and scores low on a new domain, the home visitor should notify Early Steps that the child scored low in a new domain. This notification should be recorded in OLIVIA-NAVIGATOR as a new referral, with service received the same day as the Date of Referral.
→ Describe activities provided	Briefly document the developmental support activities provided, which may include: • Activities from model curriculum: Program activities and resources from the home visiting model's curriculum or recommended approaches. • ASQ Learning Activities: An activity set from Brookes Publishing for use with parents and children to support any of the five developmental areas of the ASQ-3. • CDC materials and activities: The Centers for Disease Control (CDC) provide a multitude of resources on child development: www.cdc.gov/ncbddd/childdevelopment. The "Learn the signs. Act early." campaign focuses on children birth to age 5 and offers materials to help parents understand the importance of early intervention, age-specific milestones, and activities for supporting children's development. www.cdc.gov/ncbddd/actearly • Birth to 5 Watch Me Thrive: This campaign encourages healthy child development, universal screening, and support for the families and providers who care for them. For tips and resources for families to help promote their child's development: www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive/families • Other activities specifically designed to impact development in the area(s) of concern. According to HRSA, developmental support activities are defined as "a home visitor-delivered, specific developmental promotion to address the area of concern." In order for these requirements to be clearly met, we ask that the name of the activity/activities be listed in Olivia-Navigator, as well as the date(s) delivered and area(s) of concern being addressed. It is not enough to tell the parent about an activity. The home visitor must lead or support the parent in completing the activity with the child. Here are some examples of sufficient documentation: • 5/22 Sing a Song activity for communication • 6/29 Zip Top bag book (motor, language), 7/17 Drumming up Fun (motor, social emotional) • 2/18 Gross motor: Walking practice- Baby held on chair and pushed around room. Problem Solving: Scarf pull- put scarf into cardboard tub and baby pulled it out. Here are some examples of insufficient documentation and the reason why it's not sufficient: • Will complete scarf pull at next visit *(activity not completed yet, no area identified)* • 11/8 ASQ Activities – Fine Motor *(specific name of activity or description not provided)* • 12/2 Advised mom to try Cheerios pincer grab for fine motor *(advising is not enough; home visitor must lead or support parent in the activity)* Do not use this field to record other notes or information!

Brief Child Wellness Update

Olivia-Navigator: Child Wellness TouchPoint (from Target Child Record TouchPoint Dashboard)

Complete this form for each OLIVIA-NAVIGATOR target child at each required timeframe once the child is enrolled.

Target Child		
Child Name: _____	Date Completed*: _____/_____/_____	
Timeframe*:	☐ Enrollment	☐ Update
1. What kind of health insurance coverage does your child have? *(check one)*	☐ Medicaid or Texas KidCare ☐ Private health insurance ☐ Tri-Care	☐ No health insurance ☐ Other: _____
2. What is your child's usual source of medical care? *(check one)*	☐ Doctor's/Nurse Practitioner's Office ☐ Hospital Emergency Room ☐ Hospital Clinic ☐ Federally Qualified Health Center	☐ Retail Store or Minute Clinic ☐ No usual source of care ☐ Other: _____ _____
3. Does your child have a usual source of dental care?	☐ Yes	☐ No
4. In a typical week, how often do you or a family member read, tell stories, or sing songs to your child?	☐ Some days	☐ Every day

Guidance for Household Profile/Child Wellness Update

This form is to be completed for each family at Enrollment and twice per year throughout the family's time in the program. A lot of this information changes over time and HRSA requires that Olivia-Navigator collect this information at least once per year and for many items, at least twice per year.

Section/Item	Guidance
Date Completed*	The date that the data were collected. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Note on updating Demographics in Participant Record	Instead of requiring that the listed fields be recorded anew each time this form is completed, this note is a prompt to the home visitor to review the Participant Record and update any fields that have changed. These fields may also be updated at any time the home visitor learns of a change.
Timeframe*	Mark whether this is the Enrollment timeframe or one of the Updates: 1) Enrollment: The first time the form is completed. This should be at the enrollment visit or no later than 30 days after enrollment. Even if the first completion is more than 30 days after enrollment, the Timeframe should be marked Enrollment. 2) Update: Check this if the form is being completed during the Winter Update (Nov-Jan), Summer Update (Jun-Aug), or at Dismissal/Closure (if possible). Following are additional guidance around required timeframes for completing this form: - Winter Update: All fields are to be completed again sometime between Nov. 1 and Jan. 31 each year. Due to the possibility that families may leave the program unexpectedly, it is recommended that the Winter Update be completed in November. If the Enrollment timeframe of this form was completed between Oct. 1 and Jan. 31 and all fields were complete including the Child Wellness Update fields, then the Winter Update for that year may be skipped. - Summer Update: This update is to be completed sometime between June 1 and Aug. 31 each year. If the Enrollment timeframe of this form was completed between June 1 and Aug. 31 and all fields were complete including the Child Wellness Update fields, then the Summer Update for that year can be skipped. - Dismissal/Closure: This timeframe is to be completed, if possible, when the family leaves the program. This will not be possible for families who disengage and don't have a known last home visit. This timeframe is most important for families who have not had a completed form since the most recent Oct. 1. *This is a required field in OLIVIA-NAVIGATOR.
Participant Information	
What kind of health insurance coverage do you have?	Indicate what type of health insurance coverage, if any, the Participant has currently. - If Participant is covered by more than one type of insurance, record the primary insurance. - If Participant has no insurance but receives health care services at a safety net health care provider such as a Federally Qualified Health Center, mark "no insurance coverage". - Before recording "Other insurance", be sure that it does not fit in one of the other categories. Obamacare and COBRA are programs that facilitate access to insurance but are not insurance itself; the coverage obtained through these programs is usually private health insurance.
High school diploma or GED?	Indicate "Yes" or "No" at Enrollment. If the answer is Yes at Enrollment, the home visitor can continue to record Yes at each update without asking the question again. For Participants who answer "No" at Enrollment, it is important to provide support and resources to encourage completion of high school or GED.

→ Highest level of education completed	If the answer to "High school diploma or GED" is "Yes", complete this question. Select only one option—the highest level obtained. The answer options are arranged in order by level: 1) HS diploma/GED – Diploma or GED was earned in the past. 2) Some college/training – Currently enrolled or attended in the past. 3) Technical training/certification – Received technical training or certification in the past. 4) Associate's degree – Obtained an Associate's degree in the past. 5) Bachelor's degree or higher – Obtained a Bachelor's degree in the past.
Currently enrolled in school or a training program	A "Yes" answer indicates that the Participant is considered a full-time or part-time student by the institution he/she is attending.
→ Mark here if middle/high school/GED prep:	If the answer to "Currently enrolled in school" is "Yes", mark this response if the Participant is enrolled in middle school, high school, or a GED prep class. If the Participant has already obtained a high school diploma or GED, this question does not apply.
Employment status	"Employed" refers to whether the Participant is currently working for pay. Employed full-time: an employee who works an average of at least 30 hours per week. Employed part-time: an employee who works an average of less than 30 hours per week. Not employed: a Participant who is not working for pay. May include students, homemakers, and those actively seeking work but currently not employed.
Do you use tobacco?	Does the Participant use any type of tobacco? Tobacco use includes combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and ENDS.
If Yes, are you currently receiving tobacco cessation services?	If the answer to "Do you use tobacco?" is "Yes", the home visitor should determine if the Participant is currently receiving adequate cessation services. If the answer is "Yes", record the name of that Service Provider. If the Participant is not currently receiving adequate cessation services, mark "No" and offer a referral to tobacco cessation services as soon as possible and always within 7 days. (Of course, a late referral is better than no referral.) Record a OLIVIA-NAVIGATOR Referral Form and TouchPoint for Tobacco Cessation Services.
Are you currently pregnant?	This question is only for female Participants. It can be skipped for male Participants or for female Participants beyond reproductive age.
→ Would you like to become pregnant in the next year?	If the answer to "currently pregnant" is "No", ask this question. For more info about this question and follow-up resources, visit: https://powertodecide.org/one-key-question - If "Yes", discuss preconception health. www.cdc.gov/preconception/planning.html - If "No", discuss birth control options and provide support for accessing it. www.reproductiveaccess.org/resource/birth-control-choices-fact-sheet

Household Information	
Yearly total household income Unable to determine income	Refer to the "Guidance on Reporting Household Income" in the Appendix. To summarize: - Include "money income" that supports the family enrolled in home visiting services—before taxes. Do not include noncash benefits (such as public housing, Medicaid, and food stamps). Examples of "money income" are wages/earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, rents, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. If the yearly total household income question must be left blank, complete this question to explain why income could not be determined. Do not complete this question if both income questions are complete. * Note that if the question on yearly total household income is left blank, this family will be reported as having missing data for income and poverty level, even if the "unable to determine income" question has been completed.
How many people depend on this income?	Refer to the "Guidance on Reporting Household Income" in the Appendix. To summarize: - Include people in the household who are part of the family enrolled in home visiting services and who depend upon the income reported in Question 10. Non-relatives such as housemates should not be included. - The answer to this question must be at least 2 and no more than 14.
Which best describes the family's housing situation?	For families who are homeless or might be homeless, the home visitor may need to ask multiple questions to determine the housing status. Because this can be a sensitive topic, home visitors are encouraged to understand the definitions presented below and then to have an unscripted conversation with the Participant. Mark only one box. Notes about Not Homeless Categories: Housing choice vouchers (also known as section 8) are separate from public housing. Participants using these vouchers should be categorized as "Not Homeless – Rents or shares rented home". Public housing is managed by local housing agencies that receive federal aid from HUD. Definitions of Homeless Categories[1]: (according to McKinney-Vento Homeless Assistance Act) Homeless: individuals who lack a fixed, regular, and adequate nighttime residence - Fixed - stationary, permanent, and not subject to change - Regular - used on a predictable, routine, or consistent basis - Adequate - sufficient for meeting both the physical and psychological needs typically met in home environments Homeless - sharing housing: sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason Homeless - lives in a shelter: living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement Homeless - some other arrangement: living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings. [1] https://www.acf.hhs.gov/sites/default/files/ecd/homelessness_definition.pdf

Guidance for Child Wellness Update

This form is to be completed for each target child every time the Household Profile is completed. For families enrolled while pregnant with a target child, it is important to also complete this form at the first visit with the newborn. In Olivia-Navigator, record this as a Child Wellness Update TouchPoint from the Target Child Record TouchPoint Dashboard.

Target Child	
Date Completed*	The date that the data were collected. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Timeframe*	Mark whether this is the Enrollment timeframe or one of the Updates: **1)** Enrollment: The first time the form is completed. This should be at the enrollment visit or no later than 30 days after enrollment. **2)** Update: Check this if the form is being completed during the Winter Update (Nov-Jan), Summer Update (Jun-Aug), or at Dismissal/Closure (if possible). Following are additional guidance around required timeframes for completing this form: - Winter Update: Sometime between Nov. 1 and Jan. 31 each year. Due to the possibility that families will leave the program unexpectedly, it is recommended that the Winter Update is completed in November. If the Enrollment timeframe of this form was completed between Oct. 1 and Jan. 31 and all fields were complete, then the Winter Update for that year may be skipped. - Summer Update: Sometime between June 1 and Aug. 31 each year. If the Enrollment timeframe of this form was completed between June 1 and Aug. 31 and all fields were complete, then the Summer Update for that year can be skipped. - Dismissal/Closure: This timeframe is to be completed, if possible, when the family leaves the program. This will not be possible for families who disengage and don't have a known last home visit. This timeframe is most important for children who have not had a completed form since the most recent Oct. 1. *This is a required field in Olivia-Navigator.
Child health insurance	Indicate what type of health insurance coverage, if any, the child has at time of completion of the form. Choose one option. - If the child is covered by more than one type of insurance, record the primary insurance. - If the child has no insurance but receives health care services at a safety net health care provider such as a Federally Qualified Health Center, mark "no insurance coverage". - Before recording "Other insurance", be sure that it does not fit in one of the other categories. Obamacare and COBRA are programs that facilitate access to insurance, but are not insurance itself; coverage obtained through these programs is usually private health insurance. If you select "Other insurance", you must enter the name of the insurance in OLIVIA-NAVIGATOR.
What is your child's usual source of medical care?	While a child may receive medical care from different sources at different times, this question intends to identify the usual source of care, if there is one. Usual source of care: the particular medical professional, doctor's office, clinic, health center, or other place where a person would usually go if sick or in need of advice about his or her health. - How should urgent care be recorded? Urgent care does not necessarily describe a particular setting of care. Try to determine which category most closely aligns with the setting where urgent care was received and record it. - If the child has a usual source of care but no category closely aligns, record "Other" and describe the setting in the space provided.

Does your child have a usual source of dental care?	A usual source of dental care, or dental home, means that a child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a licensed dentist. It is recommended that a child has an established dental home no later than 12 months of age. www.aapd.org/research/oral-health-policies--recommendations/Dental-home-2/
In a typical week, how often do you or a family member read, tell stories, or sing songs to your child?	Participants should be asked to reflect on a typical week and determine how often their child was 1) read to, 2) told stories to, and/or 3) sang songs. Any combination of these activities over the week can be put together. These early language and literacy activities can be conducted by a combination of family members (mother, father, grandmother, etc.)

Additional questions for specific timeframes	
Postpartum check-up	Postpartum check-up/visit: visit between the woman and her medical provider to: - assess the mother's current physical health, including the status of pregnancy-related conditions like gestational diabetes - screen for postpartum depression - provide counseling on infant care and family planning - provide screening and referrals for the management of chronic conditions. A provider may also conduct a breast exam and discuss breastfeeding. The American College of Obstetricians and Gynecologists recommends that mothers receive a postpartum care visit 4-6 weeks after delivery. HRSA is looking for the visit to occur no later than 4 weeks postpartum. When asked at the Birth-1 month timeframe, there is usually still time for the home visitor to emphasize the importance of the visit and to address barriers if the mother has not had a visit and/or does not have plans to complete it. A note about twins: Because this form is completed for both children at the same time, this question on postpartum check-up may seem redundant. Please complete these fields the same way for both children.
→ Date of postpartum visit	Record the date of the completed postpartum visit.
Has your baby ever had breast milk?	This may include breastfeeding or the feeding of breast milk by pumping.
Breastfeeding at 2 months old	This may include breastfeeding or the feeding of breast milk by pumping.
Breastfeeding at 6 months old	This may include breastfeeding or the feeding of breast milk by pumping. This question cannot be completed until the child turns six months old, even if the answer is No and known before that time.
No breastfeeding due to medical conditions	Mothers with certain medical conditions are not recommended to breastfeed. Mark "Yes" if the mother did not initiate or continue breastfeeding due to one of the medical conditions listed here: www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/Contraindications-to-breastfeeding.html. Skip this question if it does not apply.

Child SSN Reminder	Most children will have received their Social Security Number by the time the home visitor completes the 2-3 months old timeframe. This is a good time to follow up and be sure the Child SSN is recorded in Olivia-Navigator. You may record it on this form for convenience and then enter it in Olivia-Navigator by editing the Target Child Record.

Delivery History Information Form

Olivia-Navigator: Delivery Information TouchPoint

Participant Name _____ Case ID _____

Date Completed* _____/_____/_____ Staff Name _____

Complete this form for each delivery that occurs after Participant enrollment, regardless of outcome or whether the child will be enrolled in the program. In the case of multiple births, complete a table for each delivery and enter a separate TouchPoint for each table.

Delivery #1	
1. Estimated Date of Delivery* _____/_____/_____	2. Actual Date of Delivery* _____/_____/_____
3. Did the delivery result in a live birth?*	☐ Yes → *Answer #4* ☐ No *(Stop here)*
→ 4. If yes, is the newborn enrolled as a OLIVIA-NAVIGATOR target child in the program?*	☐ Yes ☐ No

Delivery #2	
1. Estimated Date of Delivery* _____/_____/_____	2. Actual Date of Delivery* _____/_____/_____
3. Did the delivery result in a live birth?*	☐ Yes → *Answer #4* ☐ No *(Stop here)*
→ 4. If yes, is the newborn enrolled as a OLIVIA-NAVIGATOR target child in the program?*	☐ Yes ☐ No

Delivery #3	
1. Estimated Date of Delivery* _____/_____/_____	2. Actual Date of Delivery* _____/_____/_____
3. Did the delivery result in a live birth?*	☐ Yes → *Answer #4* ☐ No *(Stop here)*
→ 4. If yes, is the newborn enrolled as a OLIVIA-NAVIGATOR target child in the program?*	☐ Yes ☐ No

Delivery #4	
1. Estimated Date of Delivery* _____/_____/_____	2. Actual Date of Delivery* _____/_____/_____
3. Did the delivery result in a live birth?*	☐ Yes → *Answer #4* ☐ No *(Stop here)*

→ 4. If yes, is the newborn enrolled as a OLIVIA-NAVIGATOR target child in the program?*	☐ Yes ☐ No

Delivery #5	
1. Estimated Date of Delivery* _____/_____/_____	2. Actual Date of Delivery* _____/_____/_____
3. Did the delivery result in a live birth?*	☐ Yes → *Answer #4* ☐ No *(Stop here)*
→ 4. If yes, is the newborn enrolled as a OLIVIA-NAVIGATOR target child in the program?*	☐ Yes ☐ No

Guidance for Delivery Information Form

This form is completed for every delivery/birth that occurs after Participant enrollment, regardless of outcome or whether the child will be enrolled in the program. In the case of multiple births, complete a table for each delivery and record a separate TouchPoint for each table. This is recorded in Olivia-Navigator as a "Delivery Information TouchPoint". Please note that all fields are required to be complete in order to be able to save the TouchPoint in Olivia-Navigator.

This information is primarily used to report on pre-term birth rates among families while enrolled in the program.

Section/Item	Guidance
Date Completed*	The date that the data were collected. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Estimated Date of Delivery*	Record the estimated date of delivery (EDD). Home visitors may choose to record this field during pregnancy and then complete the form after the delivery. If so, the EDD should be confirmed at time of form completion. *This is a required field in Olivia-Navigator.
Actual Date of Delivery*	Record the actual date of delivery (or child's DOB). *This is a required field in OLIVIA-NAVIGATOR.
Did the delivery result in a live birth?*	Record live birth status. *This is a required field in Olivia-Navigator.
→ Is the newborn enrolled as a Olivia-Navigator target child in the program?*	Only newborns whose mothers were pregnant with them at the time of enrollment are eligible to be enrolled as Olivia-Navigator target children. Subsequent pregnancies and deliveries are important to capture on this form, but those children will not be enrolled as target children. *This is a required field in OLIVIA-NAVIGATOR.

How you and your nurse/midwife can recognise that your baby is feeding well							
What to look for/ask about	✓	✓	✓	✓	✓	✓	✓
Your baby: Is not interested, when offered breast, sleepy **(*A)**							
Is showing feeding cues but not attaching **(*B)**							
Attaches at the breast but quickly falls asleep **(*C)**							
Attaches for short bursts with long pauses **(*D)**							
Attaches well with long rhythmical sucking and swallowing for a short feed (requiring stimulation) **(*E)**							
Attaches well for a sustained period with long rhythmical sucking and swallowing **(*F)**							
Normal skin colour and tone							
Gaining weight appropriately							
Your baby's diapers: At least 5-6 heavy, wet diapers in 24 hours							
At least 2 dirty diapers in 24hrs, at least £2 coin size, yellow and runny							
Your breasts: Breasts and nipples are comfortable							
Nipples are the same shape at the end of the feed as at the start							
Referred for additional breastfeeding support							
Date:							
MCH Navigator initials:							
MCH Navigator: If any responses not ticked: watch a full breastfeed, develop a care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.							

***please see below for guidance on top-ups post-breastfeed**
Wet diapers: Day 1-2 = 1-2 or more in 24 hours Day 3-4 = 3-4 or more in 24 hours, heavier Day 6 plus = 6 or more in 24 hours, heavy

Stools/dirty diapers: Day 1-2 = 1 or more in 24 hours, meconium Day 3-4 = 2 (preferably more) in 24 hours changing stools By day 10-14 babies should pass frequent soft, runny stools everyday; 2 dirty diapers in 24 hours being the minimum you would expect. Exclusively breastfed babies should not have a day when they do not pass stool within the first 4-6 weeks. If they do then a full breastfeed should be observed to check for effective feeding. However, it is recognised that very preterm babies who transition to breastfeeding later may have developed their individual stooling pattern before beginning to breastfeed, and therefore this may be used as a guide to what is normal for each baby.
Feed frequency: Babies who are born preterm/sick may not be able to feed responsively in the way a term baby does. It is important that they have 8-10 feeds in 24 hours and they may need to be wakened if they don't show feeding cues after 3 hours. During this time it is important that you protect your milk supply by continuing to express. Being responsive to your baby's need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure, happy baby.

Breastfeeding assessment score to determine tube top ups

adapted from Imperial College Hospitals NHS Trust
To be used in conjunction with the assessment of maternal lactation, attachment and signs of effective milk transfer

Score	Definition	Action
A	Offered the breast, not showing feeding cues, sleepy	Full top up
B	Some interest in feeding (licking and mouth opening/head turning) but does not attach	Full top up
C	Attaches onto the breast but comes on and off or falls asleep	Full top up
D	Attaches only for a short burst of sucking, uncoordinated with breathing and swallowing and/or frequent long pauses	Half top up if the mother is available for next feed. The baby may wake early

E	Attaches well, long, slow, rhythmical sucking and swallowing – sustained for a short time with breasts not softened throughout	Half top up if mother is not available for next feed. If mother is available for next feed do not top up, and assess effectiveness of next feed.
F	Attaches well, long, slow, rhythmical sucking and swallowing – sustained for a longer time with breasts feeling soft following feed	No top up

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/03/breastfeeding_assessment_tool_neonatal.pdf

How you and your health visitor can recognize that your baby is feeding well			
What to look for/ask about	√	√	
Your baby: has at least 8 -12 feeds in 24 hours			
is generally calm and relaxed when feeding and content after most feeds			
will take deep rhythmic sucks and you will hear swallowing			
will generally feed for between 5 and 40 minutes and will come off the breast spontaneously			
has a normal skin colour and is alert and waking for feeds			
has regained birth weight			
Your baby's diapers: At least 6 heavy, wet diapers in 24 hours			
At least 2 dirty diapers in 24 hours, at least £2 coin size, yellow and runny and usually more			
Your breasts:			
Breasts and nipples are comfortable			
Nipples are the same shape at the end of the feed as the start			
How using a dummy/nipple shields/infant formula can impact on breastfeeding?			
Date			
Health visitor initials			
Health Visitor: if any responses not ticked: watch a full breastfeed, develop a care plan including revisiting positioning and attachment and/or refer for additional support. Consider specialist support if needed.			

This assessment tool was developed for use in or around day 10-14
Wet diapers: Diapers should feel heavy. To get an idea of how this feels take a nappy and add 2-4 tablespoons of water as this will help you know what to expect.
Stools/dirty diapers: By day 10-14 babies should pass frequent soft runny yellow stools every day with 2 stools being the minimum you would expect. After 4-6 weeks when breastfeeding is more established this may change with some babies going a few days or more without stooling. Breastfed babies are never constipated and when they do pass a stool it will still be soft, yellow and abundant.
Feed frequency: Young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to your baby's need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure happy baby.
Care plan commenced: Yes/No

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/07/breastfeeding_assessment_tool_hv.pdf

Infancy Questionnaire

Olivia-Navigator: Infancy Questionnaire TouchPoint (from Target Child Record TouchPoint Dashboard)

Participant Name _____ Case ID _____

Date Completed* _____/_____/_____ Staff Name _____

Child Name*: _____

Complete this form for each OLIVIA-NAVIGATOR target child when timeframe is reached. Skip timeframes prior to enrollment.

Timeframe*			
☐ Birth – 1 month old	☐ 2 – 3 months old	☐ 6 – 7 months old	☐ 10 – 11 months old

Questions for all timeframes		
1. Do you always place your baby to sleep on his or her back?	☐ Yes	☐ No
2. Do you always place your baby to sleep alone without bed sharing?	☐ Yes	☐ No
3. Do you always place your baby to sleep without soft bedding?	☐ Yes	☐ No
4. In a typical week, how often do you or a family member read, tell stories, or sing songs to your child?	☐ Some days ☐ Every day	
Is the Participant the biological mother of the child?*	☐ Yes *(Continue with additional questions)* ☐ No *(Stop here)*	

☐ Birth – 1 month old (Additional questions)		
5. Have you been to <u>your</u> medical provider for a postpartum check-up since the birth of your baby?	☐ Yes → *Answer #6* ☐ No *(Skip to #7)*	
→ 6. If Yes, date of postpartum visit	_____/_____/_____	
7. Has your baby ever had breast milk?	☐ Yes ☐ No	
(If mother could not initiate or continue breastfeeding due to medical conditions, mark Yes):	☐ Yes	

☐ 2 – 3 months old (Additional questions)		
5. Have you been to <u>your</u> medical provider for a postpartum check-up since the birth of your baby?	☐ Yes → *Answer #6* ☐ No *(Skip to #7)*	
→ 6. If Yes, date of postpartum visit	_____/_____/_____	
7. When your baby turned 2 months old, was he/she getting any breast milk?	☐ Yes ☐ No	
(If mother could not initiate or continue breastfeeding due to medical conditions, mark Yes):	☐ Yes	

☐ 6 – 7 months old (Additional questions)		
7. When your baby turned 6 months old, was he/she getting any breast milk?	☐ Yes ☐ No	

Is this child's Social Security Number recorded in OLIVIA-NAVIGATOR? If not, now may be a great time to ask for it!

(If mother could not initiate or continue breastfeeding due to medical conditions, mark Yes): ☐ Yes
☐ 10 – 11 months old (No additional Questions)

Guidance for Infancy Questionnaire

This form is to be completed for each Olivia-Navigator target child when the child reaches each timeframe. If the child is enrolled after a timeframe has passed, skip those timeframes and complete only the current and future timeframes.

Section/Item	Guidance
Date Completed*	The date that the data were collected. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Timeframe*	Each timeframe is two months long, but home visitors are encouraged to complete the form at the beginning of the timeframe as much as possible. Do not complete the forms early. Birth-1 month old: After the child is born – the last day the child is 1 month old. (Ideally, the child will be at least 2 weeks old when the form is completed.) 2-3 months old: From the day the child turns 2 mo. old – the last day the child is 3 mo. old 6-7 months old: From the day the child turns 6 mo. old – the last day the child is 7 mo. old 10-11 months old: From the day the child turns 10 mo. old – the last day the child is 11 mo. old. This is the only timeframe not requiring additional questions for biological mothers. *This is a required field in OLIVIA-NAVIGATOR.
Questions for all timeframes	
Safe sleep questions 1, 2, and 3	All three safe sleep questions should be asked at each timeframe. The American Academy of Pediatrics recommends that babies sleep on their backs, alone, and with no soft bedding throughout the first year of life. If a Participant answers "No" to any of the questions, the home visitor can use this as an opening to revisit safe sleep practices with the family. For resources on safe infant sleep, visit: www.ounce.org/safe_sleep.html Note: If the baby is still in the NICU when these questions are asked, you may record all three as "Yes". The intent of the questions is to determine if the Participant is aware of and practicing these safe sleep practices. Be sure to educate the Participant and re-visit the topic when the baby goes home.
In a typical week, how often do you or a family member read, tell stories, or sing songs to your child?	Participants should be asked to reflect on a typical week and determine how often their child was 1) read to, 2) told stories to, and/or 3) sang songs. Any combination of these activities over the week can be put together. These early language and literacy activities can be conducted by a combination of family members (mother, father, grandmother, etc.)
Is the Participant the biological mother of the child?*	This question identifies those OLIVIA-NAVIGATOR Participants who should be asked additional questions related to postpartum health and breastfeeding. If the answer is "No", then none of the additional questions apply to this Participant and child and the form is complete. If the answer is "Yes", continue to the additional questions for the appropriate timeframe. *This is a required field in OLIVIA-NAVIGATOR.

Target Child Enrollment & Summary Record

Olivia-Navigator: Target Child Record TouchPoint

Participant Name _____ Case ID _____

Date Completed* _____/_____/_____ Staff Name _____

Complete this form for each OLIVIA-NAVIGATOR Target Child during the first visit with the child.

Target Child Enrollment Information

1. Child Name* _____ 2. Child DOB* _____/_____/_____

3. Child Enrollment Date* _____/_____/_____ ➡ *If Participant enrolled while pregnant with child: Child DOB*
If Participant is enrolling with child: Program Start Date

4. Child SSN __ __ __-__ __-__ __ __ __ 5. Gestational Age at Birth _____ (# weeks)

Child Characteristics

6. Child Gender* *(check one)*	☐ Female ☐ Male		
7. Child Ethnicity *(check one)*	☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a		
8. Child Race *(check all that apply)*	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ More than one race – not specified		☐ Declined to identify
9. Is the Participant the child's biological mother?	☐ Yes ☐ No		
10. Well-child visits completed to date *(check all that apply)*	☐ Newborn ☐ 3-7 days old ☐ 2-4 weeks old ☐ 2-3 months old ☐ 4-5 months old	☐ 6-7 months old ☐ 9-10 months old ☐ 12-13 months old ☐ 15-16 months old	☐ 18-19 months old ☐ 2 - 2.5 years old ☐ 3 - 3.5 years old ☐ 4 - 4.5 years old

Complete this question if the Primary Caregiver was enrolled while pregnant with this child.

11. What kind of health insurance coverage does your child have? *(check one)*	☐ Medicaid or Texas KidCare ☐ Private health insurance ☐ Tri-Care ☐ No health insurance ☐ Other health insurance _____*

Guidance for Target Child Record

This form is completed for each target child during the first visit with the child. For children enrolling with their primary caregiver, this form is completed at the same time as the Participant Record. For children whose mothers were pregnant with them at time of enrollment, this form is completed at the first visit after the birth of the child. This is recorded in Olivia-Navigator as a "Target Child Record TouchPoint".

Section/Item	Guidance
Date Completed*	The date that the data were collected and the form was completed. *In Olivia-Navigator, this is "Date Taken" and is a required field.
Target Child Enrollment Information	
Child Name*	First and last names are required fields in Olivia-Navigator. Middle initial is optional.
Child DOB*	Child date of birth is a required field in Olivia-Navigator.
Child Enrollment Date*	This is one of two possible dates: 1) If the mother enrolled while pregnant with the child, enter the Child DOB. 2) If the child is already born and enrolling with the primary caregiver, enter the same date as the Participant's Program Start Date. Child Enrollment Date will always be one of the two above. For example: if the mother enrolled while pregnant with the child and the child is born but a home visit is not completed until the child is 3 weeks old, the form is completed on that visit, but the Child Enrollment Date is still the Child DOB. It is very important to record this date accurately. *This is a required field in Olivia-Navigator.
Child SSN	Social Security Numbers are needed for every Olivia-Navigator Target Child. They are used to link data sets required for program evaluation and continued funding of the program. - If the child has not yet been issued a SSN, leave this field blank. When you obtain the SSN, edit this the Target Child Record TouchPoint to record the field.
Gestational Age at Birth	Enter the gestational age of the child at birth in number of weeks. Children delivered at less than 37 weeks are considered pre-term; ASQ-3 screenings will be administered on an adjusted schedule until the child turns two years old.
Child Characteristics	
Child Gender*	Child Gender is a required field in Olivia-Navigator.
Child Ethnicity	Allow Participant to identify child's ethnicity.
Child Race	Allow Participant to identify child's race. More than one option may be selected and will be reported as "more than one race". As of 10/1/18, a new option "More than one race – not specified" is available. This may be selected alone or with another race category. "Declined to identify" is an option, but it will be reported as missing data and should be avoided. "Declined to identify" should not be selected with another option.
Participant/ biological mother	This helps to identify which Participants are the focus of postpartum health measures.

Well-child visits completed to date	Mark all well-child visits that have been completed in the child's life. Home visitors have flexibility in how they obtain this information. If caregiver isn't sure of exact timeframes, a discussion of general timeframes can lead the home visitor to estimate which visits were completed. This will be updated each time a new well-child visit is completed by editing the Target Child Record TouchPoint. If a newborn is in the NICU during the well-child visit timeframes, appropriate care is provided during this time and those timeframes can be marked as completed.
Child health insurance	Indicate what type of health insurance coverage, if any, the child has at time of enrollment. Choose one option. - If the child is covered by more than one type of insurance, record the primary insurance. - If the child has no insurance but receives health care services at a safety net health care provider such as a Federally Qualified Health Center, mark "no insurance coverage". - Before recording "Other insurance", be sure that it does not fit in one of the other categories. Obamacare and COBRA facilitate access to insurance, but are not insurance itself; insurance obtained through these programs is usually private health insurance. If you select "Other insurance", you must enter the name of the insurance in Olivia-Navigator.
Dismissal of Child Prior to Family Dismissal	If one target child in a family with multiple target children needs to be dismissed, this can be done at the end of the Target Child Record TouchPoint in Olivia-Navigator. The dismissal fields are not included on this form, but they are the following: Child Dismissal Date: ___/___/_____ Child Dismissal Reason: ☐ Child aged out (PAT only) ☐ Child no longer in Participant's custody ☐ Child deceased See FAQs on page 46 for more information.

Perceived Maternal Parenting Self-Efficacy (PMP S-E) tool

Please rate how strongly you agree with each of the following statements.

Strongly disagree (0) Disagree (1) Neutral (2) Agree (3) Strongly Agree (4)

1. I am good at keeping my baby occupied
2. I am good at feeding my baby
3. I am good at changing my baby
4. I am good at bathing my baby
5. I can make my baby happy
6. I can make my baby calm when he/she has been crying
7. I am good at soothing my baby when he/she becomes upset
8. I am good at soothing my baby when he/she becomes fussy
9. I am good at soothing my baby when he/she continually cries
10. I am good at soothing my baby when he/she becomes more restless
11. I am good at getting my babies attention
12. I believe that I can tell when my baby is tired and needs to sleep
13. I believe that I have control over my baby
14. I can tell when my baby is sick
15. I can read my baby's cues
16. I am good at understanding what my baby wants
17. I am good at knowing what activities my baby does not enjoy
18. I believe that my baby responds well to me
19. I believe that my baby and I have a good interaction with each other
20. I can show affection to my baby