Final Report and Evaluation
Pilot Public Health Nurse Home Visit

Use the following format to provide a summary of your project. Please include:

A. Amount of pilot funds used. Were additional funds used from other sources? If so, how much?
Funding for public health home visiting programs outside of maternal case management and targeted case management include state funding, general fund, Maternal Child Infant Early Home visiting grant, Oregon Center for Children and Youth with Special Health Needs, Early Learning Hub funds, and additional in-kind funds.

B. Final Measures and a brief narrative/summary of Goals, Activities, Measures, and Results.

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<tr>
<th>Goals</th>
<th>Activities</th>
<th>Outcome Measure(s)</th>
<th>Final Results</th>
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<td>1. Collect data on tobacco, alcohol and drug screening for pregnant and postpartum women.</td>
<td>Summary: • Staff were trained in knowledge, administration, and follow up of Prenatal SBIRTs or SBIRT like screenings. • Implemented Prenatal SBIRT or SBIRT like screenings in county home visiting programs.</td>
<td>Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women.</td>
<td>Summary: Counties were consistently 90% or higher on SBIRT or SBIRT like screenings.</td>
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<td>2. Public health nurses to learn about the prenatal SBIRT and plan to implement it with pregnant and postpartum women.</td>
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<td>3. Develop the process to implement and collect data on SBIRTS completed.</td>
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<td>4. Coordinate with community partners to support a referral system that is easily accessible and loops back to the referral source.</td>
<td>Summary: • On-going information and communication with hospital maternity case coordinators. • Strengthen relationship to referral agencies and connecting with new partners.</td>
<td>2. Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.</td>
<td>Summary: Counties continue to collaborate and maintain strong relationships with referring agencies in addition to exploring and developing new partnerships. Linn, Benton and Lincoln counties regularly meet to coordinate and evolve</td>
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- Developed a list of dental providers to support referral and promotion of oral health at 1 year of age.
- Working to integrate home visiting with OB clinic.
- Talk with Healthy Families.
- Created a brochure on marijuana and breastfeeding.
- Met with WIC staff regarding referrals to MCH.

**Benton**
- Continue to participate and engage with community partners.
- Developed a process to communicate to the referral source the outcome referrals.
- Hired new public health nurse in Jan 2016 after 9 months of recruitment.

**Lincoln**
- Developed a Joint Community Advisory Board, which includes partners and parents. One of their activities includes strengthening a referral system.
- Held a meet and greet with Centro de Ayuda, Lincoln County School District, Healthy Families and Nurse Home Visiting programs.
- Outreach to local Pediatric offices.
- Differential Response Training with DHS, building relationships.
- Radio talk show about home visiting programs and WIC.

| 5. Assess the percentage of children enrolled who receive at least one ASQ | Summary: Counties are working to better assess ASQ completion inside and outside of the home | 3. An ASQ is completed by the age of 6 months, at least 80% | Summary: Due to variation in data entry and reporting, it was difficult to compare maternal child health programming to form standardization in practice and metrics across jurisdictions. |
by the age of 6 months.

6. Create a process to inform providers of ASQ results.

visit. There is also more work to be done to better understand ASQ reporting and to identify areas of improvement.

Highlights of activities:

**Linn**
- MCH staff are encouraged to complete ASQs on routine timeframes: 2, 4, 6, 8 months etc. and always send results to the provider.

**Benton**
- Reminded staff to document ASQs when completed. However, there is not a way to document an ASQ is completed with another agency.
- Providers are not yet prepared to receive ASQs, though referrals are made to providers if indicated from results.
- Explored a health navigator position to expand caseloads and provide needed education and support for families.

**Lincoln**
- Experimented and finally settled on a way to pull this data in home visiting EHR system. May not be the same across region.
- The Early Learning Hub’s Health Care Integration work group conducted a survey for providers about their use of the ASQ. They are now making plans to train providers in ASQ use this spring.
- There is no system in place yet to coordinate everyone doing ASQs.

7. Connect families to their medical/oral health homes.

Summary: Counties refer multiple times to connect families to providers and community resources.

4. Coordination and referral processes for access to primary

Summary: More work needs to be done to consistently measure and compare results across the counties.

Lincoln completed an ASQ for their clients by 6 months of age an average of 96% of the time.

For Linn and Benton, the percentage of completion of the ASQ by 6 months of age varied greatly from quarter to quarter. More support is needed to reassess variables involved in a data pull for ASQs and identify contributing factors that can improve rates.

Counties do not have a way to document if an ASQ is completed elsewhere.
| Highlights of activities: | care and oral health are established.  
| Linn | a. 75% of clients will be encouraged to see their primary care provider and oral provider or referred to a PCP or dentist at least once. | provider and dental referrals across the counties.  
| • Developed a list of dental providers to support referral and promotion of oral health at 1 year of age. |  
| • Working to integrate home visiting with OB clinic. | The data bellows shows the total number of referrals made. This includes referrals to medical providers/specialties, community resources, state and local service programs, early learning, etc. |  
| Benton |  
| • Working on improving documentation to better capture referral rates. | Benton  
| 871 total referrals for 107 clients. |  
| Lincoln |  
| • Monthly triage meetings take place at Samaritan Pacific Communities Hospital, Samaritan North Lincoln Hospital and Peace Health Peace Harbor Hospital in Florence to coordinate with Health Care providers. This is a coordinated care opportunity to make sure no one slips thru the cracks. | Lincoln  
| 2210 total referrals for 407 clients. |  
| • Currently working to get access to Care Everywhere in Samaritan to ease the documentation burden of meeting with new parents in the hospital. |  
| 8. Childhood immunization rates will improve. |  
| Summary: Counties support childhood immunizations in many ways. Home visiting is one strategy use to improve community immunization rates among children. |  
| Highlights of county activities: |  
| Linn |  
| • Developed informational brochure to promote immunizations. |  
| Benton |  
| 79% of children in the home visiting program show up to date immunizations by 36 months of age. |  
| • 75% of children will receive their recommended vaccines before their second birthday*. |  
| 5. 75% of children will receive their recommended vaccines before their second birthday*. |  
| Provider engagement and accountability is needed to improve rates. Our role in public health is to assess, educate and refer. |  
| All counties have met or exceeded this measure. |  
| Benton |  
| 79% of children in the home visiting program show up to date immunizations by 36 months of age. |  
| 85% of clients will be encouraged to see their primary care provider and oral provider or referred to a PCP or dentist at least once. |  
| 75% of children in the home visiting program show up to date immunizations by 36 months of age. |
- Connected with Immunization Program to assess data and identified improvements needed in reconciling electronic medical records with ALERT data.
- Supported county clinics with vaccine management and reporting.

**Lincoln**
- LC Immunization Coordinator is setting all home visiting staff up with access to Alert II.
- Not absolutely sure we are all measuring the same thing across the region. Need to expand our measurement to age 24 mos.
- We feel that our process has improved however and we are getting better information to our parents.
- Still need to work with community pediatric providers to get data into ALERT quicker.

- **Linn** 87% of children in the home visiting program show up to date immunizations by 36 months of age.
- **Lincoln** We averaged 80% of home visiting clients by age 12 months were up to date on immunizations. This metric is higher statistically with families engaging in home visiting.

9. Coordinate maternal child health services.  

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<th>Summary: Benton and Lincoln coordinate WIC visits with maternity case management visits. Linn coordinates their maternity case management visits with Reproductive Health visits and WIC classes.</th>
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<td>6. Coordinate prenatal assessments with WIC appointments for pregnant women.</td>
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<td>Summary: Aligning prenatal assessments with WIC appointments has been a strength in providing prenatal services to pregnant women. Some counties have limited capacity hindering this coordination.</td>
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In Lincoln and Benton pregnant women receive a prenatal assessment along with their initial WIC appointment. In Linn County, prenatal assessments are incorporated with reproductive health appointments.

C. What were the most important outcomes of your Pilot?
- Coordinating data collection and comparing results across counties.
- Using strong county relationships to discuss alignment in practices, services, and metrics.
- Seeing how successful home visiting nurses are in connect families to resources.
D. How has your Pilot contributed to Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care?
Nurse home visiting programs support families to access care at the right time at the right place for the right reason. As evident from the number of referrals made, we coordinate care from the home to health partners, education partners, and social partner reducing waste and duplication. As public health, we focus on prevention using our strengths in building and maintaining quality relationships with clients and community partners for upstream intervention. We have engaged in Early Learning Hub efforts in completing ASQs across systems.

E. What has been most successful?
- Understanding our limitations in data collection and evaluation and aligning data across the three counties.
- Obtaining the capacity in nursing services and exploring other roles to expand services to more families.
- Showing success of the program to get families connected.
- Developing expanding referral systems.

F. Were there barriers to success? How were they addressed?
- Different data collection systems/electronic medical records and required use of multiple data systems.
- Mandated use of FamilyNet which means we are dependent on state to get us more specific, detailed data reports.
- Inequitable reimbursement for maternity case management.
- Recruiting and retaining public health nurses. Competitive wages from acute care settings.
- Different models of home visiting.
Much of these barriers are outside our control. We are focusing this year’s work on creating consistent practice standards and metrics across the counties and perhaps adopting an evidence based program as our model.

G. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)
The Home Visiting Pilot is entering a second phase of development that will include implementation across the counties. This requires:
- Adequate capacity in nursing
- Diversified team support
- Interoperability with the state data system
- Support in data reporting and interpretation
- Investment funds to standardizing home visiting programs across the counties.

H. Will the activities and their impact continue? If not, why?
Home visiting program development will continue as we assessing capacity and funding resources for a standard model.