MIECHV Performance Measures – Guidance for Screenings and Referrals

Updated September 2022

Overview

Each year, MDH is required to report on MIECHV Performance Measures (https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/Federal_Home_Visiting_Program_Performance_Indicators_and_Systems_Outcomes_Summary.pdf) to the federal Health Resources and Services Administration (HRSA) as a requirement for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant. HRSA outlines six benchmark areas which include Maternal and Newborn Health, Child Injuries, Maltreatment and Emergency Department Visits, School Readiness and Achievement, Crime or Domestic Violence, Family Economic Self-Sufficiency, and Coordination and Referrals. Within each of these benchmark areas, HRSA identifies performance measures. By October 30th of each year, Minnesota must demonstrate improvement in benchmark areas covered by the MIECHV Performance measures. This document provides guidance about the MIECHV Performance Measures related to screenings and referrals, including when screening and referrals should be provided to families to ensure Minnesota's MIECHV home visiting programs are meeting performance measure expectations.

The MIECHV performance measures related to screenings and referrals include:

- Depression Screening (Performance Measure 3)
- Developmental Screening (Performance Measure 12)
- Intimate Partner Violence (IPV) Screening (Performance Measure 14)
- Completed Depression Referrals (Performance Measure 17)
- Completed Developmental Referrals (Performance Measure 18)
- Tobacco Cessation Referrals (Performance Measure 6)
- IPV Referrals (Performance Measure 19)

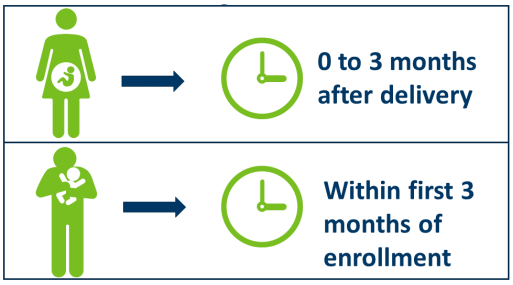
Questions?

The MIECHV Form 2 Performance Indicators and Systems Outcomes Toolkit (https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/form-2-performance-measurement-toolkit.pdf) has useful information as well as the Information for Home Visiting Evaluation Data Collection Manual (https://www.health.state.mn.us/docs/communities/fhv/ihvedatacollmanual.pdf). For further questions, contact the Family Home Visiting Evaluation Unit at Health.FHVData@state.mn.us.

Screening Measure Timeframes

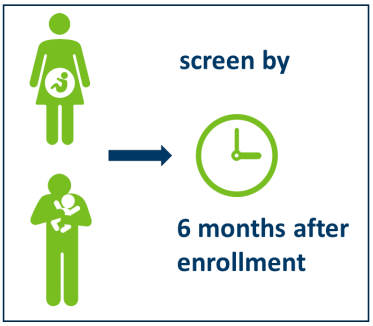
Depression Screening

Screen caregivers 0 to 3 months after delivery if they enrolled prenatally. Screen all other caregivers within first 3 months of enrollment in FHV.



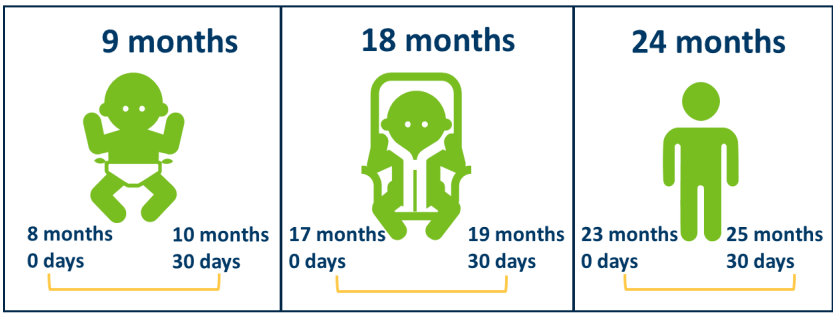
IPV Screening

Screen all caregivers (pregnant or not pregnant) within 6 months of enrollment in FHV.



Developmental Screening

Screen children at 9, 18, and 24 months of chronological age. See "Developmental Screening Measure" below for details on screening windows.



Depression Screening Measure

Measure Definition

Percentage of primary caregivers enrolled in home visiting who are screened for depression using a validated tool:

1. Between the date of delivery and 3 months after delivery (if primary caregiver was enrolled prenatally)
2. Within the first 3 months of enrollment in the home visiting program (if primary caregiver was NOT enrolled prenatally)

Who is included in the measure?

All primary caregivers who have been enrolled in home visiting at least 3 months. NOTE: this includes primary caregivers regardless of gender, age, or relationship to the target child.

When should screenings be completed?

1. If primary caregiver enrolled in home visiting prenatally (before the delivery of target child): complete at least one depression screening between delivery and 3 months post-delivery
2. All other primary caregivers: complete at least one depression screening within the first 3 months of enrollment in home visiting

What screening tools can be used?

A validated screening tool must be used. MIECHV grantees should use the Patient Health Questionnaire-9 (PHQ-9) or Edinburgh Postnatal Depression Scale (EPDS) (http:/med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) for depression screening. The PHQ-2 and PHQ-4 can be used as a first-step screen and must be followed-up with the PHQ-9 for positive screens. For more details, refer to the PHQ Website (http://www.phqscreeners.com).

How do I track screenings in IHVE?

Report completed screenings in your agency's IHVE-compatible data entry system. Answer the questions:

1. Were any screenings completed during this home visit, or as a follow-up to this home visit?
2. What was the screening date?
3. Which family member was screened?
4. What type of screening was given?
    a. Select 01 Mental Health Screening – Including Depression, Anxiety, Substance Use from the drop-down list.
5. What Mental Health Screening tool was used?

a. Select the tool that was used from the drop-down list:
    i. 01 Edinburgh Postnatal Depression Scale (EPDS)
    ii. 02 Patient Health Questionnaire-9 (PHQ-9)
    iii. 03 Patient Health Questionnaire-4 (PHQ-4)
    iv. 04 Patient Health Questionnaire-2 (PHQ-2)

6. What was the screening result?

Notes:

- Screenings can be over telephone or an online platform if the tool used allows that as valid.
- Screenings can be performed by someone other than home visitor if home visitor can see screening results and verify screening was performed correctly.

Developmental Screening Measure

Measure Definition

Percentage of index (target) children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool.

Who is included in the measure?

Target children aged 9 months to 30 months.

When should screenings be completed?

When the child reaches one of these age ranges (based on birth date – chronological age):

- **9 months** (8 months 0 days through 10 months 30 days)
- **18 months** (17 months 0 days through 19 months 30 days)
- **24 months** (23 months 0 days through 25 months 30 days)

What screening tools can be used?

MDH recommends the use of the Ages and Stages Questionnaire (ASQ-e) (https:/www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreen/asq3.pdf), although the Parents' Evaluation of Developmental Status (PEDS) (https:/www.health.state.mn.us/docs/people/childrenyouth/ctc/devscreen/peds.pdf) is also an acceptable validated parent-completed tool. Use the appropriate age screening tool to that child's adjusted age as instructed by the tool developer. For example, if you are screening a 9-month-old child who was born 4 weeks premature, administer the 8-month ASQ-3 questionnaire based on the child's adjusted age.

Additional developmental screenings can be performed at other time points according to guidance from the tool developer or requirements of other programs (e.g. Follow-Along Program (https://www.health.state.mn.us/people/childrenyouth/fap/index.html)).

How do I track screenings in IHVE?

Report completed screenings in your agency's IHVE-compatible data entry system. Answer the questions:

1. Were any screenings completed during this home visit, or as a follow-up to this home visit?
2. What was the screening date?
3. Which family member was screened?
4. What type of screening was given?
    a. Select 03 Developmental Screening from the drop-down list.
5. What Developmental Screening tool was used?
    a. Select the tool that was used from the drop-down list.
        i. 01 Ages and Stages Questionnaire-3 (ASQ-3)
        ii. 02 Parents' Evaluation of Developmental Status (PEDS)
6. What was the screening result?

Note: Screenings can be performed by someone other than home visitor if home visitor can see screening results and verify screening was performed correctly.

IPV Screening Measure

Measure Definition

Percentage of primary caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) using a validated tool.

Who is included in the measure?

Primary caregivers enrolled for at least 6 months. NOTE: this includes primary caregivers regardless of gender, age, or relationship to the target child.

When should screenings be completed?

Within 6 months of enrollment for all caregivers. All caregivers should be screened regardless of relationship status.

What screening tools can be used?

Use one of these validated tools:

- Humiliation, Afraid, Rape, Kick (HARK) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/table/T1/)
- (HITS Screening Tool for Domestic Violence) (http:/www.ncbi.nlm.nih.gov/pmc/articles/PMC4002190/figure/F4/)
- Relationship Assessment Tool (RAT) (https://www.dropbox.com/s/53yhktumby1nd9k/RAT%20English%20Spanish.pdf?dl=0)

How do I track screenings in IHVE?

Report completed screenings in your agency's IHVE-compatible data entry system. Answer these questions:

1. Were any screenings completed during this home visit, or as a follow-up to this home visit?
2. What was the screening date?
3. Which family member was screened?
4. What type of screening was given?
    a. Select 02 Intimate Partner Violence Screening from the drop-down list.
5. What Intimate Partner Violence screening tool was used?
    a. Select the tool that was used from the drop-down list:
        i. 01 Humiliation, Afraid, Rape, Kick (HARK)
        ii. 03 Hurt-Insult-Threaten-Scream (HITS)
        iii. 04 Relationship Assessment Tool (RAT)
6. What was the screening result?

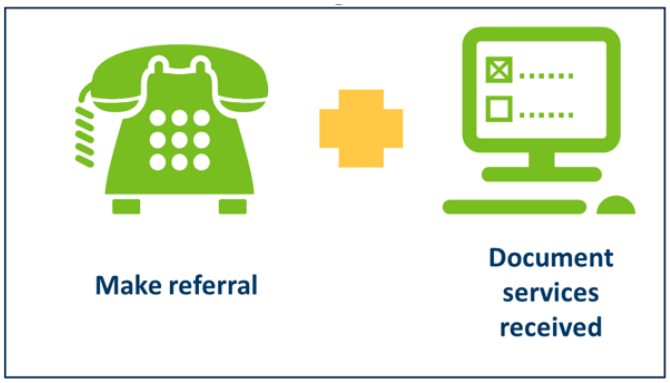
Notes:

- For Nurse-Family Partnership implementing agencies: the first four questions of the NFP Clinical IPV Assessment form comprise the HITS tool. Report this to IHVE as HITS; do not select "Other screening tool" and write-in "NFP Clinical IPV Assessment."
- For agencies that use the HARK-C, the first four questions comprise the HARK. Report this to IHVE as HARK; do not select "Other screening tool" and write-in "HARK-C."

Referral Measure Timeframes

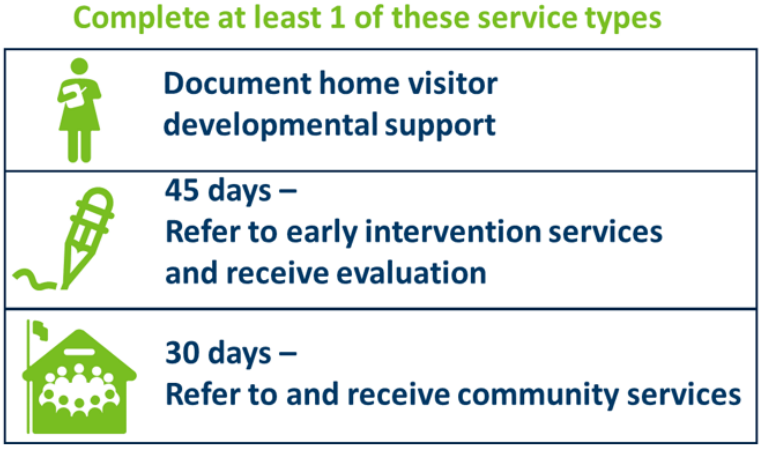
Completed Depression Referrals

Refer caregivers to services to address mental health after a positive screen for depression. Document that the caregiver received services by updating referral status and reporting referral service date to IHVE.



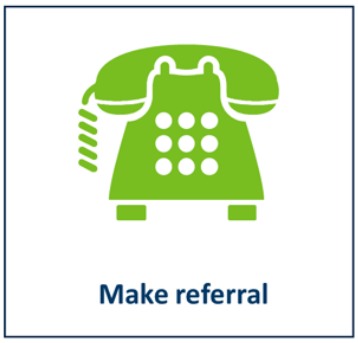
Completed Developmental Referrals

Refer children to at least one of these service types below after a developmental screening indicating potential developmental delays. Document receipt of services to IHVE. Receipt of services within 45 days for Early Intervention services and 30 days for other community services meets the timeframe requirements for the measure.



IPV Referrals

Refer caregivers to available service(s) after a positive screen for intimate partner violence using a validated tool. Document referral to IHVE. Offering a referral counts as giving the referral, even if the client declines.



Tobacco Cessation Referrals

Refer caregivers to services after they report using commercial tobacco or cigarettes at enrollment. Referral must be made within three months of enrollment. Document referral to IHVE. Offering a referral counts as giving the referral, even if the client declines.

Completed Depression Referrals Measure

Measure Definition

Percentage of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts.

Who is included in the measure?

Primary caregivers that screened positive for depressive symptoms with a validated tool (within the screening timeframes for the Depression Screening measure, above), AND who were referred for appropriate mental health services.

What counts as a completed referral?

Referrals where clients received at least one service contact count as a completed referral. This means where a client received at least one mental health service or appointment with a provider to address mental health. Receipt of services can take place at any time after the referral was made.

Note: Even if a referral is declined by the client, please add to IHVE that a referral was made.

How do I track referral status?

Home visitor should follow-up with caregiver to determine whether they received mental health services (received at least one mental health service or appointment with a provider to address mental health). When the referral has been completed, report "completed" referral status to IHVE with the initial date of service.

1. Were any referrals offered during this home visit, or as a follow-up to this home visit?
2. What was the referral date?
3. Which family member was referred?
4. What type of referral was offered?
    a. Select appropriate referral option from the drop-down list
        i. **Crisis Intervention:**
            1. 23 Mental Health Crisis Services
        ii. **Health Care Services:**
            1. 49 Mental Health Services. Choose this for referrals for traditional mental health services AND for referrals to a primary care provider for mental health medication/supports. *Do not choose Primary Care to ensure the referral data reflects accurate.*
        iii. **Other Services:**
            1. 99 Other Provider or Community Services. Choose this and write in Mothers & Babies or NFP Mental Health Intervention.
5. What is the current status of this referral?
    a. Select the appropriate status from the drop-down list.
6. If referral status = complete: What was the date of the first appointment or services from the referral provider?
7. If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible).

Note: Calling a mental health hotline does not qualify for this referral.

Completed Developmental Referrals Measure

Measure Definition

Percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner.

Who is included in the measure?

Number of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool).

What counts as a completed referral?

Any of these service types will qualify the child for the numerator but can refer child to more than one type of service as needed/according to best practice.

- **Received individualized developmental support from a home visitor;** This is a home visitor-delivered, specific developmental promotion to address the area of concern. This can include more frequent screenings, activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen. There is no time requirement for this service option.
- **Were referred to early intervention services and received an evaluation within 45 days: Referral to Early Intervention (EI) or Early Childhood Special Education (ECSE) services.** This includes referrals to Help Me Grow (http://helpmegrowmn.org/HMG/index.html). To count as a completed referral, an evaluation must be completed within 45 days of the date of referral. OR
- **Were referred to other community services and received services within 30 days.** This includes any services available that provide developmentally-enhancing support to children and families other than EI and ECSE. Examples include Early Childhood Family Education (ECFE), primary care, specialized health care providers (such as speech or occupational therapy), parent-child groups, early literacy supports, and parent training. This may also include early childhood mental health treatment. To count as a completed referral, services must be received within 30 days of the date of referral.

How do I track a referral status?

Home visitor should follow-up with family to determine whether the child received one of the three service types. When referral has been completed, report "completed" referral status to IHVE with the initial date of service.

1. Were any referrals offered during this home visit, or as a follow-up to this home visit?
2. What was the referral date?
3. Which family member was referred?
4. What type of referral was offered?

a. Select the appropriate service the family member was referred to from the drop-down list

   i. **Child Development and Parenting Support:**

      1. 61 Early Intervention/Part C
      2. 62 Early Childhood Family Education (ECFE)
      3. 63 Early Childhood Mental Health
      4. 64 Head Start/Early Head Start
      5. 65 School Readiness or Preschool program
      6. 66 Home Visitor Individualized Support for Child Development

   ii. **Health Care Services:**

      1. 41 Primary Care Provider
      2. 42 Health Care Specialist

5. What is the current status of this referral?
   a. Select the appropriate status from the drop-down list.
6. If referral status = complete: What was the date of the first appointment or services from the referral provider?
7. If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible)

IPV Referrals Measure

Measure Definition

Percent of primary caregivers enrolled in home visiting with positive screens for IPV (measured using a validated tool) who receive referral information to IPV resource.

Who is included in the measure?

Primary caregivers enrolled with positive screens for IPV within 6 months of enrollment.

What counts as a completed referral?

Referral information means the primary caregiver was provided information about IPV community resources by the home visitor. Offering a referral counts as giving the referral, even if the client declines. Referrals do not require receipt of services to be counted.

Although IPV screenings must occur within 6 months of enrollment, there is no specific time frame for when the referral should occur. The referral can occur in a different reporting period than the screening.

How do I track a referral?

Report completed screenings in your agency's IHVE-compatible data entry system. Answer these questions:

1. Were any referrals offered during this home visit, or as a follow-up to this home visit?
2. What was the referral date?
3. Which family member was referred?
4. What type of referral was offered?
    a. Under Crisis Intervention, select 23 Intimate Partner Violence/Domestic Violence Services/Women's Shelter from the drop-down list.
5. What is the current status of this referral?
    a. Select the appropriate status from the drop-down list.
6. If referral status = complete: What was the date of the first appointment or services from the referral provider?
7. If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible).

Tobacco Cessation Referrals Measure

Measure Definition

Percentage of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.

Who is included in the measure?

Primary caregivers enrolled for 3 months who used tobacco or cigarettes at enrollment.

Data is collected on the primary caregiver intake form about tobacco use, although may not be asked on the first home visit. These questions, however, should be asked within the first month of services. Home visitors should update the primary caregiver intake form or complete a demographics update form when the questions are asked and answered to clarify a caregivers' tobacco use status. The questions that need to be answered include:

1. Does the participant currently use tobacco, such as cigarettes, cigars, chewing tobacco, or electronic cigarettes (excluding religious or ceremonial use)?
2. Is the participant enrolled in a tobacco or smoking cessation program or receiving tobacco cessation counseling?

What counts as a referral?

Referrals include tobacco cessation counseling or services. This could include a home visitor providing information to the client about services available, providing a handout, etc.

Note: Even if a referral is declined by the client, this still counts as a referral and needs to be documented in IHVE. In the tracking status, check that it was declined.

How do I track a referral?

Report completed referrals in your agency's IHVE-compatible data entry system. Answer these questions:

1. Were any referrals offered during this home visit, or as a follow-up to this home visit?
2. What was the referral date?
3. Which family member was referred?
4. What type of referral was offered?
    a. Under Health Care Services, select 48 Tobacco/Smoking Cessation from the drop-down list.
5. What is the current status of this referral?
    a. Select the appropriate status from the drop-down list.
6. If referral status = complete: What was the date of the first appointment or services from the referral provider?
7. If referral status = declined, unavailable or ineligible: Specify reason why referral was not completed (e.g. declined, unavailable, or ineligible)