2023

Nurse Home Visiting Clinical Guidelines

Developed for Babies First!, Nurse-Family Partnership, CaCoon, and Family Connects Oregon

Oregon Health Authority

OCCYSHN
Oregon Center for Children and Youth with Special Health Needs

OHSU

Contact Us

Contact information:

Julie Plagenhoef, MPH, RN
MCH Nurse Consultant
Oregon Health Authority
Public Health Division
Julie.A.Plagenhoef@dhsoha.state.or.us

Kelcie Grace Germano MPH, BSN, RN (she/her)
Senior Research RN/Care Coordination Specialist
Oregon Center for Children and Youth with Special Health Needs
germano@ohsu.edu

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Introduction

The Nurse Home Visiting Clinical Guidelines have been developed for use by Babies First!, CaCoon, Nurse-Family Partnership and Family Connects Oregon programs. Participants in Nurse-Family Partnership and Family Connects Oregon should use their program-specific guidelines, where applicable.

The implementing agency is responsible for having appropriate guidelines and training in place to support nurse competency in any other clinical care expected by the local implementing agency and not addressed by these guidelines (e.g., wound care, fluoride varnish).

Nurse home visiting programs should use the assessment tools indicated in these guidelines or program models. If programs use assessment tools other than those delineated by the guidelines or program models, those tools should be evaluated for appropriateness (e.g., evidence-based, validated, equitable, etc.).

Acronym List

ASI: Addiction Severity Index

AUDIT: Alcohol Use Disorder Identification Test

BMI: Body Mass Index

BP: Blood Pressure

CAGE: Cut, Annoyed, Guilty, Eye-opener (Alcohol consumption questionnaire)

CAGE-AID: CAGE, Adapted to Include Drugs

CDC: Centers for Disease Control and Prevention

CRAFT: Car, Relax, Alone, Forget, Family/Friends, Trouble (Alcohol consumption questionnaire for teens)

DANCE: Dyadic Assessment of Naturalistic Caregiver Experiences

DBP: Diastolic Blood Pressure

EDD: Estimated Due Date

EI/ECSE: Early Intervention/ Early Childhood Special Education

FCO/FCI: Family Connects Oregon/ Family Connects International

HR: Heart Rate

HDL: High Density Lipoproteins

IADPSG: international association of diabetes in pregnancy study group

IBCLC/ CLC: International Board Certified Lactation Counselor/ Certified Lactation Counselor

IGT/IFG: Impaired Glucose Tolerance/ Impaired Fasting Glucose

IPV: Intimate Partner Violence

KIPS: Keys to Interactive Parenting Scale

MCH: Maternal and Child Health

MIECHV: Maternal, Infant, Early Childhood Home Visiting

NFP: Nurse-Family Partnership

NIDA: National Institute on Drug Abuse

OCCYSHN: Oregon Center for Children and Youth with Special Health Needs

PHN: Public Health Nurse

PCI: Parent-Child Interaction

SAB: Spontaneous Abortion

SBIRT: Screening, Brief Intervention and Referral to Treatment

SBP: Systolic Blood Pressure

SDOH: Social Determinants of Health

SOB: Shortness of Breath

STD: Sexually Transmitted Diseases

TAB: Therapeutic Abortion

T-ACE: Tolerance, Annoyed, Cut down, Eye-opener (Alcohol use questionnaire)

UTI: Urinary Tract Infection

WIC: Women, Infants and Children

Guideline 1: Prenatal History and Physical Assessment: Nursing

Guideline 1: Prenatal History and Physical Assessment: Nursing

Programs: Babies First!
Nurse-Family Partnership

Effective Date:1/2021
Reviewed Date: 1/2023
Revised Date: 1/2023
Next Review: TBD

Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup

Purpose

A thorough nursing assessment of the client's physical and emotional health will provide essential information to enable the nurse to develop a care plan that supports the most appropriate interventions to promote a healthy pregnancy and optimal birth outcomes.

Process

A comprehensive nursing assessment should be done at the initial prenatal visit. It may not be possible to complete the full assessment in one visit, and not all of these issues may be pertinent to every client. However, as an important component of the nursing process, the following systems delineated in Table 1 should be considered for assessment in a timely manner. Some more sensitive areas might require waiting until rapport is established to assess (e.g., IPVand substance use). Some of these areas may be assessed through therapeutic conversation, rather than hands-on assessment, per nurse's discretion. Any areas that require further assessment and follow up should be noted and explored in further visits as soon as possible. Physical and mental health concerns should have continued follow up at subsequent visits as needed.

The body systems to consider for the assessment are listed in Table 1. Blood pressure and weight should be monitored at each prenatal visit (see also Perinatal Blood Pressure Assessment Guideline). If implementing agencies expect nurses to perform clinical care skills not included within these guidelines, the implementing agency is responsible for ensuring that appropriate guidelines and training are in place to support the necessary nurse competency in those skills. (e.g., flouride varnish, prescription or over-the-counter medication administration, immunizations).

While clients with chronic health issues (e.g., asthma, renal disease, cardiac disease, orthopedic issues) may need some additional case management services, clinical care responsibilities lie with the medical care provider. Signs and symptoms of concern, or medical concerns raised by the client, should be referred to the appropriate medical care provider, and the referral should be documented (see Table 1 guidelines for when to refer). See the Pregnancy Warning Signs in the Prenatal Education Table of the Babies First! Manual for list of specific signs to report to provider immediately.

Prenatal Assessment Considerations	Considerations for referral to provider	
General Health Status	Vital Signs (blood pressure and weight per Guidelines; and temperature, heart rate, and respirations as needed if abnormality suspected); Cognitive state: mood, orientation; Pain; Medications. Medical hx (e.g., Gestational or Diabetes Type II, anemia, hypo/ hyperthyroidism, seizures) Immunizations, allergies)	*BP: SBP >130 mm Hg or DBP > 80 mm Hg Weight: increase or decrease not consistent with diet Temp: <96 or >101°F Pain not controlled with meds Progression of chronic disease Change in orientation status or level of consciousness
Reproductive	EDD; Gravida, term, preterm, SAB, TAB, Living; Obstetric history/complications of previous pregnancies; Pregnancy planned or not planned; Prenatal care; Birth plan; Childbirth class plan; Reproductive plan; Contraceptive plan; Vaginal or pelvic pain; Vaginal or pelvic infections/ Sexually Transmitted Infections/risk for infection	Abdominal Pain, dysuria Bloody discharge Discharge concerning for infection
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Skin pale, diaphoretic, cold; contusions, abrasions or other lesions not explained, or not healing properly
Head, Eyes, Ears, Nose, Throat (HEENT)	Vision; hearing; dental care; pain	Vision changes Persistent headache Tooth pain
Breasts	Breast surgery hx; breastfeeding plan	Signs of infection

Respiratory	Respiratory rate, effort, pattern; hx of disease, such as Asthma	RR <12 /min or >24/ min Shallow breaths, feeling short of breath, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	*BP: SBP >130 mm Hg or DBP > 80 mm Hg HR: <50, >100 at rest, with consideration of what is normal for client Detection of new murmur or abnormal rhythm. (See also Blood Pressure Assessment Guideline)
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/vomiting; indigestion	Abdomen tender/painful Bowel movement type/amount abnormal for patient Persistent nausea/vomiting
Diet and Exercise	Appetite; dietary intake; special dietary needs; food safety risks; folic acid use; weight; height; BMI; activity level	Loss of appetite affecting weight, inadequate weight gain (See also Prenatal Weight Assessment Guideline)
Urinary	Voiding characteristics (amount, color, odor, pain). History of UTIs.	Dysuria; Polyuria not associated with intake Oliguria or anuria (should void 0.5 to 1 ml/kg/hr) Blood or clots in urine
Peripheral Vascular	Edema; Varicosities; Leg pain	2+ edema not resolving, or in conjunction with other signs (BP, headache, blurred vision, HR changes, SOB). Persistent leg pain
Musculoskeletal	Extremity strength; extremity movement; Activity level; Limitations to activity; Pain	Unexpected weakness (<4/5 strength) in one or more limbs Unexpected change in mobility Persistent pain

Neurologic	Extremity sensation, seizure history; fatigue/ sleep	Numbness or tingling in extremities Seizures Extreme fatigue, especially in conjuction with anemia
Mental Health	History of treatment for mental illness; History of depression/anxiety; Suicide ideation/ attempts; History of abuse; Stress level; Self-esteem; Support system; Current affect	Within first 5 visits, conduct depression screening, suicide screening, intimate partner violence screening (see also IPV Screening Guideline, and Mood Disorders Screening Guidelines), make referral as appropriate
Behavioral	Tobacco use/exposure; Substance use/ exposure; Risky behaviors	As early as possible after establishing rapport, but within four weeks of enrollment, and at 36 weeks gestational age, use a validated tool to screen all clients for use of alcohol, illicit drugs, prescription drugs, and tobacco and make referral as appropriate (see also Substance Use Screening Guideline)

References:
1. Bates' Nursing Guide to Physical Exam and History Taking (2011).
2. NICE Clinical Guidelines, No. 62. National Collaborating Centre for Women's and Children's Health (UK). 2008 Mar. Accessed https://www.ncbi.nlm.nih.gov/books/NBK51890/

Guideline 2: Prenatal Weight Assessment

Guideline 2: Prenatal weight assessment	
Programs: Babies First! Nurse-Family Partnership	Effective Date:1/2021 Reviewed Date: 1/2023 Revised Date 1/2023 Next Review: TBD
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Group	

Purpose

Supporting healthy weight gain during pregnancy promotes healthy birth outcomes. Clients with either a rapid or slow weight gain during later pregnancy are at increased risk for preterm births. Those with high pre-pregnancy BMI have increased risk for gestational diabetes, hypertension, and preeclampsia, among other risks. Using the World Health Organization BMI calculations, the Institute of Medicine recommends total pregnancy weight gain based upon pre-pregnancy weight or weight at the first prenatal care appointment.

Process (Singleton Pregnancy)

- Calibrated scales are recommended: assure that scales are calibrated at least annually, if applicable.
- Document client self-report of pre-pregnancy weight.
- Measure height, without shoes, during initial assessment. If the home visitor has no means to measure height, use client self-report or obtain information from pregnancy care provider.
- If a scale is available, weigh client and document weight at every prenatal visit. If reliable scales are not available, work with pregnancy care provider to ensure weight is measured. A weight from the last provider visit or self-report is acceptable if noted in medical record. Weight gain should be slow:
  - 1 to 4 pounds total in first 3 months
  - 2 to 4 pounds each month from 4 months to delivery
- Using pre-pregnancy weight, compute BMI. There are several websites that will quickly provide the calculation: https://www.nhlbi.nih.gov/health/ educational/lose_wt/BMI/bmicalc.htm
- Plot weight gain using the following grids, by pre-pregnancy BMI: https:// www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WIC/Documents/611-612-613-weight-gain-grids.pdf
- Alert prenatal care provider if client is losing weight or gaining weight excessively.

Table 1. Pregnancy Weight Gain for Singleton Pregnancy		
Pre-pregnancy Weight	**Total Weight Gain**	**Weekly Weight Gain for 2nd and 3rd Trimesters**
Underweight (BMI < 18.5)	28-40 pounds	1 pound (range 1.0 to 1.3)
Normal weight (BMI 18.5 to 24.9)	25-35 pounds	1 pound (Range 0.8 to 1.0)
Overweight (BMI 25.0 to 29.9)	15-25 pounds*	0.6 pounds (Range 0.5 to 0.7)
Obese (BMI ≥ 30.0)	11-20 pounds*	0.5 pounds (0.4 to 0.6)

* IOM for overweight and obese people have raised concerns among physicians; ACOG statement is that the relationship between pregnancy weight gain, fetal weight gain and pregnancy outcomes is complex. It may be reasonable for clients who are overweight or obese to gain less weight than recommended, per their physician guidelines (3).

Process (Twin Pregnancy):

- If scales are available, assure that scales are calibrated at least annually.
- Document client or medical provider report of pre-pregnancy weight.
- Measure height, without shoes, during initial assessment. If the home visitor has no means to measure height, use client self-report or obtain information from pregnancy care provider.
- If a scale is available, weigh client and document weight at every visit. If scales are unavailable, obtain weight from primary care provider.
- Using pre-pregnancy weight, compute BMI. There are a number of websites that will quickly provide the calculation:
  https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm
- Alert prenatal care provider if client is losing weight or gaining weight excessively.
- Support clients in maintaining a healthy weight between pregnancies. Weight should be assessed via scale, self-report, or primary care office up to 12 weeks post-partum.

Table 2. Pregnancy Weight Gain for Twin Pregnancy		
Pre-pregnancy Weight	**Total Weight Gain - Twins**	**Weekly Weight Gain for 2nd and 3rd Trimesters – Twins**
Underweight women (BMI < 18.5)	Individualized – Speak to PN Care Provider	Individualized – Speak to PN Care Provider
Normal weight women (BMI 18.5 to 24.9)	37-54 pounds	1.1 to 1.7 pounds
Overweight women (BMI 25.0 to 29.9)	31-50 pounds	1.0 to 1.6 pounds
Obese women (BMI ≥ 30.0)	25-42 pounds	0.8 to 1.4 pounds

References:

1. Institute of Medicine and National Research Council. 2009. Weight Gain During Pregnancy: Reexamining the Guidelines. Washington, DC: The National Academies Press. https://doi.org/10.17226/12584
2. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-weight- gain.htm, accessed 12/19/2017.
3. Weight gain during pregnancy. Committee Opinion No. 548. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:210–2. (reaffirmed 2018).

Guideline 3: Perinatal Blood Pressure Assessment

Guideline 3: Perinatal Blood Pressure Assessment	
Programs: Babies First! Nurse-Family Partnership Family Connects Oregon	Effective Date:1/2021 Reviewed Date: 1/2023 Revised Date: 1/2023 Next Review: TBD
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Taking an initial blood pressure reading will establish a baseline for future evaluation; successive blood pressure readings will assist in evaluating alterations that may be detrimental to the client and/or the pregnancy.

Process

- Blood Pressure should be measured and recorded at each visit prenatally and at least until 6 weeks postpartum. **If** the first postpartum visit is later than 6 weeks, at least one blood pressure should be taken.
- In hypertensive clients, BP should be monitored at least 6 weeks postpartum and further until hypertension is resolved.
- Measure blood pressure after client has been sitting quietly for five minutes with arm resting at heart level. Back should be straight and legs should be uncrossed with feet flat on the floor. Attempt to take a blood pressure reading at least 30 minutes after the client has exercised, consumed caffeine, or used tobacco. Client should not be talking at the time of the reading.
- Assess size of cuff required. A cuff that is too large will give a falsely low reading, and a cuff that is too small will give a falsely high reading. The length of the cuff bladder should be at least 80% of the arm's circumference.
- Ideally, a reading should be taken on both arms and the higher reading should be recorded. **If** only one arm is measured, use the left arm unless contraindicated.
- The use of a wrist cuff for the measuring of blood pressure is not recommended at this time. **If** one is used, using a validated device and utilizing proper technique will contribute to more accurate readings. Wrist cuffs have potential as a reliable method, but further evaluation is needed.

- Per the 2017 American College of Cardiology/American Heart Association (ACC/AHA), blood pressure categories during pregnancy are: normal (< 120/< 80), elevated (120-129/ < 80 mmHg), stage 1 hypertension (130-139 and/or diastolic 80-89), and stage 2 hypertension (prior diagnosis of chronic hypertension or systolic ≥ 140 or diastolic ≥ 90 mmHg).
- A recent study (7) indicates the risk of preeclampsia increases with increasing BP at <20 weeks pregnant: even stage 1 hypertension (130-139/80-89) had a preeclampsia prevalence of 15.1% and a RR of 2.7 (95% CI 2.2-3.4), compared to normotensive with 4.5% prevalence.
- If the blood pressure is >129/79 for either systolic or diastolic measurement, reassess in 15 minutes. Ensure proper cuff and client positioning (see above). Prenatal or postnatal blood pressure readings greater than 130 mmHg systolic or 80 mmHg diastolic x2 15 minutes apart should be immediately reported to the prenatal care provider.
- Prenatal or postnatal acute onset of blood pressure readings of 160 mmHg systolic or 110 mmHg diastolic (sustained 15 minutes or more) constitutes a medical emergency and should be immediately reported to the provider. If the provider is not able to be reached, consider emergency department evaluation, per nursingjudgement.
- Take a blood pressure, and alert prenatal care provider if client reports any of these symptoms (may indicate preeclampsia**): Persistent severe headaches, changes in vision, right upper quadrant abdominal pain, or sudden weight gain of more than 2 pounds in a week.
- If blood pressure is <90/60 or significantly below baseline confirmed with at least two measurements or 15 minutes apart, evaluate for tachycardia, excessive vaginal bleeding, clots, fundal height and consistency, abdominal pain, hydration, dizziness or orthostasis. Notify primary care provider and determine if increasing fluid intake

*Note: the BP recommendation for adults was updated by the American College of Cardiology and the American Health Association in 2017. Many on-line resources still reference the BP of 140/90. (140/90 mmHg two times more than 4 hours apart, or 160/110 mmHg)

** Note: Preeclampsia is defined as gestational hypertension combined with proteinuria after 20 weeks gestation. A 24-hour urine specimen is necessary to reliably measure urine protein excretion for a diagnosis of proteinuria; a conventional urine dipstick test is not adequate. Severe headaches are the most common indicator of a postpartum eclamptic seizure. The development of HELLP Syndrome most commonly occurs within 72 hours postpartum. (see the ACOG Practice Bulletin for more detailed information on preeclampsia).

References:

1. Institute for Clinical Systems Improvement (07/2012), National Institutes of Health.
2. The American College of Obstetricians and Gynecologists. Hypertension in Pregnancy
3. (2013). https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and- Work-Group-Reports/Hypertension-in-Pregnancy.
4. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA. Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. Journal of the American College of Cardiology. Vol 71, no. 19, 2018.
5. Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. Committee Opinion No. 692. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017:129:e90–5.
6. Interpregnancy care. Obstetric Care Consensus No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e51-72. https:// www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus- Series/Interpregnancy-Care
7. Tesfalul MA, Sperling JD, Blat C, Parikh NI, Gonzalez-Velez JM, Zlatnik MG, Norton ME. Perinatal outcomes and 2017 ACC/AHA blood pressure categories. Pregnancy Hypertens. 2022 Jun;28:134-138. doi: 10.1016/j.preghy.2022.03.004. Epub 2022 Mar 16. PMID: 35381471.

Guideline 4: Perinatal Breastfeeding* Promotion and Support

*The term breastfeeding is used here and throughout this document to describe a baby feeding from a lactating person's chest.

Guideline 4: Perinatal Breastfeeding Promotion and Support	
Programs: Babies First! CaCoon Nurse-Family Partnership Family Connects Oregon	Effective Date:1/2021 Reviewed Date:**1/2023** Revised Date:**1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Breastfeeding is the biological norm for infant nutrition and the ideal method for feeding infants. Breast milk not only meets the specific nutritional needs of human babies, it also provides enzymes, growth factors, antibodies and hormones not found in formula. It is easy for babies to digest, supports optimal growth and development, and provides health benefits for parent, including lower risk of high blood pressure, diabetes Type II, ovarian cancer and breast cancer. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months, and then continued breastfeeding for one year and beyond, even as solid foods are introduced.

Process

All home visitors should:

- Understand a family's motivations and barriers to breastfeeding. During pregnancy, use open-ended questions to assess the client's breast health history (breast surgery may impact success with breastfeeding), desires around breastfeeding and plan for feeding their infant, and impact of previous experience and preconceptions about breastfeeding
- Be able to list local public health challenges impacting breastfeeding in their community (e.g. COVID19)
- Provide accurate and reliable breastfeeding education and resources (WIC, La Leche League, health care providers and lactation specialists)
- Advocate for breastfeeding families (key resources linked on the OHA website: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/BABIES/BREASTFEEDING/Pages/index.aspx
    - » Breastfeeding laws
    - » Breastmilk donating and sharing

- Understand local breastfeeding resources and the strengths/limitations of each role: https://massbreastfeeding.org/wp-content/uploads/2019/09/The-Landscape-of-Breastfeeding-Support-draft-1.pdf
- Know when and how to make referrals to the appropriate level of lactation care
- Postpartum, continue to monitor and support breastfeeding (see contraindications below), ensuring client has access to lactation consultation, as needed. Reinforce that breastfeeding takes practice, and that solutions are available for problems or concerns that arise.

Home visitors with training and competency* should

- Provide a physical assessment of breastfeeding client and baby (including oral assessment of infant)
- Observe an infant feeding (latch and positioning)
- Provide tips and tricks to increase milk supply and discuss and support pumping
- Discuss signs and symptoms of common problems, including mastitis, clogged ducts
- Monitor infant growth using growth charts
- Develop a breastfeeding plan
- Communicate and collaborate with other breastfeeding professionals

Resources for home visitors providing support

- Academy of Breastfeeding Medicine: https://www.bfmed.org/protocols
- Medications and Breastmilk: LactMed: https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Dr. Hale's Infant Risk Center at Texas Tech University www.infantrisk.com
- CDC contraindications to breastfeeding: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html
- WIC: https://www.oregon.gov/oha/ph/healthypeoplefamilies/wic/Pages/index.aspx
- LaLeche: https://www.llli.org/

*Training and competency may vary depending on implementing agency and International Board Certified Lactation Consultant, Certified Lactation Counselor (IBCLC, CLC certification)

Breastfeeding and Special Circumstances (From CDC):

- Opioids: The AAP supports breastfeeding by narcotic-dependent parent participating in a supervised maintenance program (e.g., methadone, buprenorphine) and who are negative for HIV and illicit drugs, especially PCP and cocaine Prescribed opioid use for limited duration are not contraindicated.
- Marijuana: While data on marijuana's effects on infants exposed through breastmilk is limited, tetrahydrocannabinol (THC) can pass from the breast milk to the infant and may harm the infant. Potential also exists for impairment in the parent's ability to care for the infant.

- Tobacco or e-cigarettes: It is always best for a client to NOT smoke or vape. However, for clients who are not prepared to quit, breastfeeding will decrease the baby's risk for respiratory problems, allergies, and Sudden Infant Death Syndrome. Clients who smoke are encouraged to breastfeed, and to keep secondhand smoke (or vaping cartridges or liquid nicotine) away from the baby – not smoking near baby, in the house or car, to change the client's shirt after smoking, etc. Clients who smoke may also have lower milk production.
- Alcohol: Not drinking alcohol is the safest option for a breastfeeding client. Generally, moderate alcohol consumption by a breastfeeding client (up to 1 standard drink per day) is not known to be harmful to the infant, especially if the client waits at least 2 hours after a single drink before nursing. However, exposure to alcohol above moderate levels through breast milk could be damaging to an infant's development, growth, and sleep patterns. Alcohol consumption above moderate levels may also impair a parent's judgment and ability to safely care for her child.
- Hepatitis B and C: Clients with Hepatitis B or C may breastfeed. If a client has an open sore on their breast, or a cracked and bleeding nipple, they can breastfeed from the side that is not affected, and express and discard any milk they collect from the affected side until the sore heals. Ensure the lesion is covered carefully so the baby has no risk of contact.
- HIV-AIDS: The AAP recommends no breast milk if the client is HIV-positive.
- Active, untreated Tuberculosis: May give expressed milk; may resume breastfeeding when client is treated for 2 weeks and is documented as no longer infectious.
- Active herpes simplex lesions on breast: Should NOT breastfeed and should NOT give expressed milk. May feed from breast with no lesion if lesion on other breast is covered so there is no risk of transmission.
- Varicella 5 days before through 2 days after birth: clients should be separated from infants but may give expressed milk.
- Infant metabolic disorder, such as galactosemia: No breast milk.
- Clients positive for human T-cell lymphotrophic virus type I or II or untreated Brucellosis may not breastfeed or give expressed milk.
- Vaccines: According to the ACIP's General Best Practice Guidelines for Immunization in Special Situations, except for smallpox and yellow fever vaccines, neither inactivated nor live-virus vaccines administered to a lactating person affect the safety of breastfeeding for the breastfeeding person or their infants.

References

1. Breastfeeding and the Use of Human Milk. SECTION ON BREASTFEEDING. Pediatrics Mar 2012, 129 (3) e827-e841.
2. Centers for Disease Control and Prevention. Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies. Atlanta: U.S. Department of Health and Human Services; 2013.
3. Jolley, Sandra. Breastfeeding Triage Tool. Public Health Seattle and King County. 2005, 5th ed.

Guideline 5: Home Environment and Environmental Exposures Assessment

Guideline 5: Home Environment and Environmental Exposures Assessment	
Programs: Programs: Babies First! CaCoon Nurse-Family Partnership Family Connects Oregon	Effective Date:**1/2021** Reviewed Date: **1/2023** Revised Date: **1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

PURPOSE

An evaluation of the home environment and potential environmental exposures will augment the History and Physical assessment of the client. This additional knowledge will inform the development of a nursing care plan that supports the most appropriate interventions to promote a healthy pregnancy, optimal birth outcomes, and child development.

PROCESS

It is strongly recommended to use a known tool to evaluate environmental factors that may affect the health and wellbeing of clients.

The Environmental Exposure Assessment should be used for an initial assessment. This was developed for the prenatal time period but may be used at any time during program enrollment. If problems are identified, the Pediatric Environmental Home Assessment Scenario may be used to further understand the problem and develop interventions.

It will be necessary to continue to reevaluate many of these issues throughout the management of the case.

If a different assessment tool will be used, it should cover:

Shelter Status	Toxin Exposure
Heating/Cooling	Pets
Cleanliness	Firearms
Water	Phones
Sewage/Garbage	Smoke and smoking
Carbon monoxide Alarms	Lead Exposure
Food Storage	Food Preparation

References:
1. https://www.marchofdimes.org/pregnancy/lead-poisoning.aspx accessed 4/25/2018
2. Based upon guidelines from OAR 410-130-0595

Guideline 6: Perinatal Gestational Diabetes Mellitus Assessment

Guideline 6: Perinatal Gestational Diabetes Mellitus Assessment	
Programs: Babies First! Nurse-Family Partnership Family Connects Oregon	Effective Date:1/2021 Reviewed Date: 1/2021 Revised Date: Next Review:1/2023
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Gestational diabetes mellitus (GDM) is a common disorder of pregnancy. Between 2% and 10% of pregnancies are impacted by GDM. Currently, there is discussion about lowering the threshold for diagnosis, especially in high-risk ethnic populations with a higher prevalence of GDM. The American Diabetes Association encourages providers to test women with risk factors for type 2 diabetes at the first prenatal appointment; a diagnosis of diabetes at this time is considered overt diabetes, not GDM. Untreated or poorly controlled GDM can lead to many complications including preeclampsia and/or preterm delivery.

Complications for the baby may include stillbirth, macrosomia (very large at birth), neonatal hypoglycemia, and risks for future development of obesity and diabetes. It is the severity of the hyperglycemia that is important to short and long term maternal and fetal outcomes. Fifty percent of women with GDM will develop type 2 diabetes later in life.

Process

- During the initial prenatal assessment, assess for diagnosis of GDM and any diagnosis of GDM with previous pregnancies, as applicable.
  - » Women with risk factors for Type 2 Diabetes (see Table 1) should be screened for diabetes at their first prenatal visit using standard diagnostic criteria.
  - » Clients should be tested for GDM at 24-28 weeks of gestation in women not previously known to have diabetes.
  - » Diagnostic criteria for GDM are based on a “One-step” 75 g oral glucose tolerance test (OGTT) derived from IADPSG criteria OR a (older) “Two-step” Glucose Challenge test (or glucose screening test). There is currently disagreement on the optimal strategy (American Academy of Diabetes).
- Provide education about diagnostic testing to clients, as applicable. Connect clients to resource for GDM testing if needed.
- Provide education about the risks associated with GDM (see Health Education Tables).

- Advise client of specific risk factors for development of GDM:
    - ✓ African American, American Indian/Alaska Native, Asian American, Hispanic, or Pacific Islander
    - ✓ Overweight (BMI ≥ 25 kg/m2 or ≥ 23 kg/m2 in Asian Americans)
    - ✓ Older than 25 years
    - ✓ Parent or sibling with diabetes
    - ✓ Previous pre-diabetes diagnosis
    - ✓ History of GDM in a previous pregnancy
    - ✓ History of delivery of a baby who weighed 9 pounds or more
- For clients with a diagnosis of GDM, review primary care provider plan with client and encourage them to adhere to the plan. This may include a healthy diet, physical activity, routine monitoring and testing (including urine ketone levels and daily blood glucose checks), referrals to specialists (e.g., dietician, diabetes educator), and possibly medication.
- Advise client with a GDM diagnosis that they will need to be tested 4-12 weeks postpartum using the 75-g oral glucose tolerance test and nonpregnancy diagnostic criteria to ensure her blood glucose levels have returned to normal, and screened at least every 3 years for life.
- Provide education on prevention or delay of type 2 diabetes later in life, including importance of breastfeeding.
- Clients with GDM that have prediabetes should receive intense lifestyle intervention

Table 1. Risk factors for Type 2 Diabetes
Physical inactivity
First-degree relative with diabetes
High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
Women who delivered a baby weighing >9 lb or were diagnosed with GDM (tested every 3 years for life)
Hypertension (≥140/90 mmHg or on therapy for hypertension)
HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
Women with polycystic ovary syndrome
A1C ≥5.7%, IGT, or IFG on previous testing
Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
History of CVD
For all other patients, testing should begin at 45 years of age

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3. https://www.cdc.gov/diabetes/basics/gestational.html, accessed on 12/19/2017

Guideline 7: Social Determinants of Health Screening

Guideline 7: Social Determinants of Health Screening	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:1/2021 Reviewed Date: **1/2023** Revised Date: **1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Scientific research has made it clear that access to good health care is not sufficient to produce a healthy society. The social determinants of health (e.g., income, education, transportation, housing, food, community safety) have a profound impact on child and adult physical and mental health. The research on adverse childhood experiences (ACEs) and early brain development has demonstrated that psychosocial stressors are "toxic" to the developing brain and metabolic systems of the young child, increasing risk of chronic disease, behavioral health conditions and developmental delay. Home visitors are uniquely positioned to address these challenges. By directly focusing on these needs, home visitors can buffer the impact of stressors on the brain through promoting responsive, nurturing relationships.

Process

Assess for the availability of resources to meet daily needs (e.g. safe, stable housing, transportation, food security, necessities including diapers, safety equipment), social network/support system and ability to access and/or utilize needed services. NFP and FC programs should use the program-specific SDOH assessments. Babies First! and CaCoon should see table below for areas to be assessed.

Note: Adverse Childhood Events (ACEs) screening may be done as part of the SDOH screening; however, it is recommended that an intentional process to work with families on this issue be employed, such as the Near at Home Toolkit.

SDOH assessment	Considerations for referral or follow up by home visitor
Food security	Worry about having enough food any days in past three months
Housing security	Worry about having a safe place to sleep any days in past three months; Multiple families living in one household; Having issues with landlord or with rental agreement
Childcare security	Worry about having good childcare any days in past three months; Never utilized child care
Transportation	Being limited in doing what they need to do because of lack of transportation any days in past three months; Missed a medical appointment due to lack of transportation.
Economic Stability	Trouble for paying for basic living expenses any days in past three months; Utility company threatening to shut off services any time in past 12 months
Employment	Client wants help keeping or finding a job; never had employment
Family and Community Support	Often or always feel isolated from those around them Need more help with day-to-day activities (shopping, finance management, activities of daily living)
Racism or Discrimination Experience	Identifies as a racial and ethnic minority (https://www.cdc.gov/minorityhealth/racism-disparities/index.html); Interested in information about how a hx of discrimination (e.g., due to race, skin color, immigration status, age, income, sex/gender, sexual orientation, religion or pregnancy status) might affect health or parenting.
Education	Not a high school graduate; gaps in education; literacy difficulties; English as a learned language; interest in career development

In collaboration with the client, the home visitor and client should develop goals and activities/ interventions to address the social determinants of health.
If you prefer to use a standardized screening tool there are several available (please see below). Many of these also include questions related to mental health, substance use, and partner violence; and many do not address racism.

- Oregon Primary Care Association: https://www.orpca.org/initiatives/social-determinants-of-health/251- sdoh-tools-resources
- Oregon Family Well Being Assessment
- The American Academy of Family Physicians. Social Needs Screening Tool
- The Centers for Medicare & Medicaid Services Accountable Health Communities'. Health-Related Social Needs Screening Tool(innovation.cms.gov)
- OHSU NICU Patient Support Survey (On Basecamp)

Resources

American Academy of Pediatrics:https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-resource-library/social-determinants-of-health/?page=1&sortDirection=1&sortField=Year

Guideline 8: Reproductive Life Planning

Guideline 8: Reproductive Life Planning	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:1/2021 Reviewed Date: **1/2023** Revised Date:**1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Reproductive life plans are intended to promote planned, healthy pregnancies, positive birth outcomes, and overall health and well-being for women, men, and infants.

Process

Reproductive life planning can be initiated at any time (e.g., prenatal, postpartum or interconception) and should be offered to everyone, irrespective of assumptions or biases about individual circumstances. Furthermore, reproductive life plans should be considered fluid, and updated regularly per changing goals, needs, and life circumstances (updated at least annually). Addressing reproductive life planning during the perinatal periods offers an opportunity to provide education, support, and resources to help.

Discuss client's reproductive life plan about becoming pregnant by asking questions like:

a. Do you want to have (more) children?
b. How many (more) children would you like to have and when?

Approach this conversation respectfully and with the intention to support the person in achieving their goals and patience in knowing that many people may find it difficult to answer these questions.

If pregnancy is planned in the near future, offer preconception health information. See CDC https://www.cdc.gov/preconception/women.html for suggested education. If the client desires pregnancy testing, then provide or refer for pregnancy testing and preconception counseling. All options counseling should be made available to all pregnant clients.

If client is not planning pregnancy at this time, offer evidence informed counseling about the full range of contraceptive methods, including emergency contraception. See www.bedsider.org or www.HealthyChildren.org for suggested education.

The OHA website has several one-pagers in English and Spanish on specific birth-control methods, as well as a YouTube video. Offer information about how to access reproductive health services and refer as needed. The OHA Reproductive Health Program has a list of clinics HERE

If client is unsure of their goals around pregnancy, using a client-centered approach, continue to explore clients' readiness for pregnancy, goals, needs and life circumstances.

Resources

- Before, Between and Beyond Pregnancy, Resource Guide for Clinicians https://beforeandbeyond.org/toolkit/reproductive-life-plan-assessment/
- Centers for Disease Control and Prevention Contraceptive Guidance for Health Care Providers https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm
- Centers for Disease Control and Prevention Preconception Health https://www.cdc.gov/preconception/overview.html
- Show Your Love Wellness Campaign https://showyourlovetoday.com/
- Power to Decide https://powertodecide.org/one-key-question

Guideline 9: Mood Disorder Screening

Guideline 9: Mood Disorder Screening	
Programs: Babies First! Nurse-Family Partnership Family Connects Oregon	Effective Date:1/2021 Reviewed Date: 1/2023 Revised Date: 1 /2023 Next Review: 6/2023
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Perinatal mood disorders, which include major and minor depressive episodes and anxiety that occur during pregnancy or in the first 12 months after delivery, are one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven mothers and one in ten fathers [(2)]. It is important to identify pregnant and postpartum clients with mood disorders because untreated perinatal mood disorders can have devastating effects on the parent, as well as their infants and families. Likewise, depression outside of the perinatal period can have a major impact on a child's life. Depressed caregivers may use less emotion or expression when communicating with infants and adversely impact bonding. Depressed parents are more likely to have challenges meeting the health and safety needs of their children [(3)].

Process

Use a validated tool to screen all clients for mood disorders.
Examples of validated tools are below.

- ☐ Patient Health Questionnaire-9 (PHQ-9) 9-item screener for DSM-IV depression criteria and other leading major depressive symptoms, especially valuable outside of the perinatal period. (Utilized by Nurse-Family Partnership program)
- ☐ Edinburgh Postnatal Depression Scale (EPDS) 10- item non-standardized self-report measure assessing maternal postnatal/postpartum depression. (Utilized by Family Connects Oregon program)

Both the EPDS and the PHQ-9 are validated for use in the perinatal population, and there is no fee. The benefits are that they are self-administered, translated into many languages, and easy to complete. The EPDS addresses the anxiety component of perinatal mood disorders as well as depressive symptoms and suicidal thoughts. The PHQ-9 does not have the anxiety component but includes suicidal ideation; it is also validated outside of the perinatal period. The screens should be administered at intervals according to the guidelines of the home visiting program and any time concerns arise. Communicate screening results to prenatal care provider if not within normal limits and document. Determine need for further assessment. If the screening results suggest a mood disorder, share concerns with the client and develop a plan of care to:

- ☐ Continue to establish a supportive relationship
- ☐ Recognize and reassure. They are not alone, it is not their fault, and with help they will get better
- ☐ Help the client reach out.
- ☐ Educate the client.
- ☐ Educate on possible treatment options;
- ☐ Plan interventions based on need (e.g., safety plans, Lines for Life)

Resources

- Oregon Maternal Mental Health Webpage https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALT H/pages/index.aspx
- Postpartum Support International http://www.postpartum.net/

References:
1. American College of Obstetricians and Gynecologists Committee Opinion https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression
2. Postpartum Support International. https://www.postpartum.net/ Accessed 11/20/2020.
3. Parental Depression: How it affects a Child. Yale Medicine. https://www.yalemedicine.org/conditions/how-parental-depression-affects-child

Guideline 10: Intimate Partner Violence Screening

Guideline 10: Intimate Partner Violence Screening	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:1/2021 Revised Date: 1/2023 Next Review: 6/2023
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Intimate Partner Violence (IPV) impacts people across all age groups, educational levels, races, ethnicities, socioeconomic backgrounds, and cultures; the number of individuals affected can only be estimated because many instances of IPV are never reported. The Centers for Disease Control and Prevention (CDC) suggests that nearly 3 in 10 women and 1 in 10 men in the U.S. have experienced rape, physical violence, and/or stalking by a partner; these numbers do not reflect people subjected to psychological abuse. Pregnancy and the postpartum period is a particularly dangerous time for people impacted by IPV. Home visiting professionals are in unique positions to assess, educate, and support families in learning about healthy relationships, connecting clients with resources, and creating IPV safety plans as needed.

Process

- Local implementing agencies should have written guidelines in place that delineate safety procedures for home visitors during IPV assessments.
- Guidelines should include, but are not limited to safety measures such as:
  - » Arrange time to screen client alone, never with partner, friends or family.
  - » Use professional interpreter if needed, never a family member.
  - » Never leave IPV information around without first finding out if it is safe to do so. A safer strategy is to include IPV resources in a full list of general resources, or to focus on information about healthy relationships (examples of general relationship cards can be found here).
- Attempt to normalize the screening process to promote comfort with the discussion and encourage candid responses: use a framing statement such as, "We've started talking to all of our clients about safe and healthy relationships, because these have such a large impact on your health."

- Note that non-structured discussions that focus on parenting, safety or healthy relationships are more likely to illicit disclosure of violence, so it is most helpful to establish a therapeutic relationship before using the IPV screening tool.

After establishing rapport and creating a safe environment, use a validated tool to screen for IPV according to the schedule in Chapter C. Examples of validated tools include:

- » Futures Without Violence Relationship Assessment Tool https://www.futureswithoutviolence.org/healthy-moms-happy-babies-using-the-relationship-assessment-tool-and-universal-education/

- » For NFP program, use the Clinical IPV Assessment form.

- Ensure clients also know that what they say is confidential unless what they tell you falls within the mandatory reporting guidelines. Among others, this includes child abuse or neglect: if you suspect a child with whom you have had contact is being abused or neglected, or that a person has abused a child, you must report it.
  - » For full mandatory reporting information, go to: http://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx

- When IPV is identified, support the client in making a safety plan.
  See the Futures Without Violence Safety Plan and Instructions
  The plan covers:
  Safety during a violent incident
  - ✓ Safety when preparing to leave
  - ✓ Safety in client's own home
  - ✓ Safety with a protection order
- Provide client with community resources for IPV advocacy support and services; remember to evaluate safety risks for client before leaving print IPV materials in the home.

*The Futures Without Violence Relationship Assessment tool currently uses the pronoun "he" when talking about partners. The current guidance is to simply change the language to "my partner" and continue using the tool.

References:

1. Healthy Moms, Happy Babies: Using the Relationship Assessment Tool and Universal Education. https://www.futureswithoutviolence.org/healthy-moms-happy-babies-using-the-relationship-assessment-tool-and-universal-education/
2. How to Screen for Intimate Partner Violence: Tools from ACOG. http:// www.obgyn.net/young-women/how-screen-intimate-partner-violence-tools-acog
3. Module 3 (Young Mom's Version). Assessment and Safety Planning for Domestic Violence in Home Visitation. https://www.futureswithoutviolence.org/youngmomsmodule/.
4. Tools for improving maternal health and safety in a multicultural context. https://www.futureswithoutviolence.org/tools-for-improving-maternal-health- safety-in-a-multicultural-context/, accessed 12/27/2017.

Guideline 11: Substance Use Screening

Guideline 11: Substance Use Screening	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:1/2021 Reviewed Date: 1/2023 Revised Date: 1/2023 Next Review: TBD
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Evidence directly links prenatal exposure to drugs, alcohol and tobacco with negative impacts on the developing fetus and/or the pregnancy outcome and child development. Clients are strongly discouraged from using these substances. The effects of alcohol, tobacco and opiate use are fairly well described. However, for many other substances, researchers frequently find an association between drug use and adverse pregnancy outcomes this does not mean there is a causal relationship. For instance, marijuana is composed of many different chemicals and can be mixed with other drugs; women may use multiple substances and may also exhibit other risky behaviors; and, it is difficult to effectively measure and monitor substance use.

Because we often cannot be certain what outcomes are related to which substances and behaviors, we are not able to determine the dose relationship; therefore, women are discouraged from using any quantity of anything not prescribed by the prenatal care provider.

Substance use in any parenting person, even outside of the prenatal period, may increase risk of developmental delays, child abuse or neglect and difficulty providing necessary household resources. It is important to provide caregiver screening during the perinatal period and beyond.

Process

Assessment, Diagnosis and Planning:

- As early as possible after establishing rapport, screen for substance use according to program guidelines.
- Use a validated tool to screen all clients for use of alcohol, drugs including prescription drugs, and tobacco. Examples of validated tools are below, but this is not an exhaustive list. Note: FCI uses CAGE and Nurse-Family Partnership uses a program-specific tool.

  - » Alcohol: SBIRT, AUDIT, Abbreviated AUDIT-C, or a single question such as "How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?"; others screening tools include the CAGE-AID, CAGE, T-ACE, and ASI.
  - » Alcohol and Drugs: 4 P's Plus; Screening to Brief Interventions (S2BI); CRAFT (age 26 or younger); Brief Screener for Alcohol, Tobacco and Drugs (BSTAD); and NIDA Quick Screen.

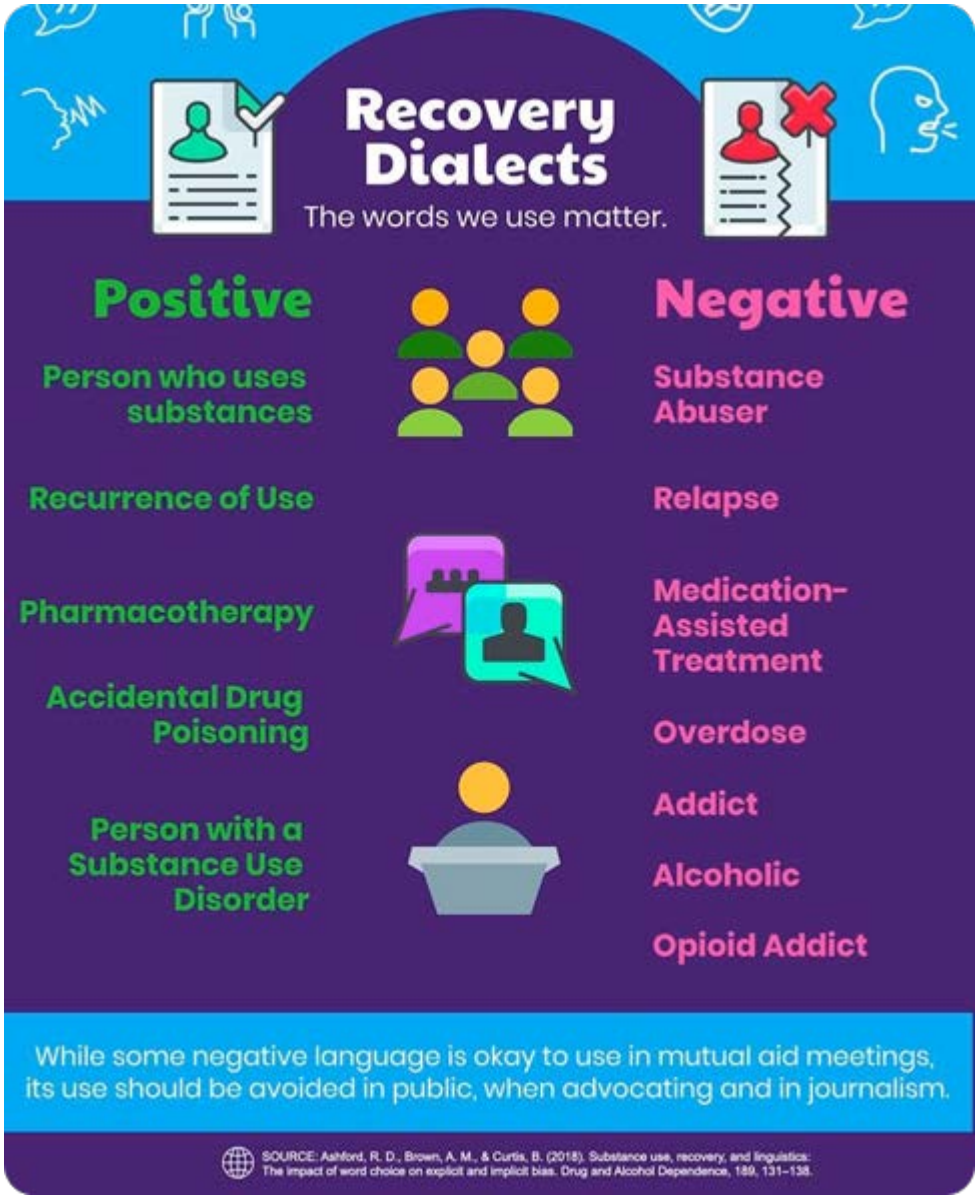
- Assess cognitive status, especially changes in mood that might be a sign of preexisting or coexisting conditions such as multi-substance use, depression, or mental health concerns. Just eliminating one substance may not solve the problem.
- Document any screening results, and communicate to pregnancy care provider if not within normal limits. Determine need for further assessment, and ensure access to care, by pregnancy care provider.
- Determine with provider need for screening of STIs, hepatitis B and C, and tuberculosis, especially if there are signs of co- existing conditions.
- If the screening results suggest substance use, share concerns with the client and develop a plan of care to:
  - » Continue to establish a supportive relationship.
  - » Educate the client on effects of substance use during pregnancy: Ask the client to describe her understanding of the situation, link substance use to any signs or symptoms client has (there may be none), describe importance of stopping, explain what could happen with continued use.
  - » Educate on possible treatment options such as pharmacotherapy and behavioral therapy like skill-building and problem-solving (medically supervised withdrawal is not recommended at this time due to association with high relapse rate).
  - » Plan interventions based on need (see below).

Interventions

- It is important to meet clients where they are at. Determine client goals related to substance use and consider harm reduction strategies. Per the Harm Reduction Coalition, harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself.

- Depending upon the substance, the level of use, and the outcome of the communication with the prenatal or primary care provider, assist the client in accessing drug and/or alcohol rehabilitation supports. Treatment with methadone or buprenorphine may be recommended by physician, as patients treated with opioid antagonists demonstrate significant reduction in relapse rate compared to only behavioral treatment.

- Engage all clients in a conversation providing education, feedback and guidance on the potential harmful effects of substance use. Some clients may need more intensive motivational interviewing, or Brief Interventions conversation (see the MIECHV Substance use risk Profile – Pregnancy Scale tool or the NFP Visit-to-Visit Guidelines, as allowed by program area). Refer to the recovery dialect handout below to understand appropriate language to use in discussions about substance use.
- For clients using tobacco or vaping liquid nicotine, implement the 5As framework for counseling (Ask, Advise, Assess, Assist, Arrange); provide education and refer as appropriate; continue to monitor and support the client in achieving cessation. The CDC website has education resources for this purpose: https://www.cdc.gov/reproductivehealth/MaternalInfantHealth/TobaccoUsePregnancy/index.htm
- Provide emotional support to clients who becomes abstinent during pregnancy, as they may struggle with strong feelings related to exposing the fetus to potentially harmful substances.
- Opiates, alcohol, and nicotine can be passed to infants through breast milk. Advise pregnant people of these risks and discourage breastfeeding people from using substances. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics supports breastfeeding by people who are prescribed opioids while enrolled in substance use treatment. Please review The Academy of Breastfeeding Medicine, Protocol 21 on substance use and breastfeeding. Encourage clients that meet the following criteria to breastfeed:
    - » Engaged in substance treatment; plans to continue postpartum
    - » Abstinence 90 days prior to delivery demonstrated in outpatient setting
    - » Toxicology testing of urine negative at delivery
    - » Engaged in prenatal care and following recommendations
    - » Methadone or Buprenorphine -maintained (regardless of dose) and closely monitored by physician
    - » Reduce nicotine intake; do not smoke or vape around infant; understand impact of 3rd hand smoke.
    - » Wait 90-120 minutes after drinking alcohol to breastfeed whenever possible
    - » Marijuana use: reduce use; not enough data support recommending against breast feeding, but urge caution.
- Oregon law does not consider substance use during pregnancy to be child abuse under child- welfare statutes, and there is not a requirement for health care professionals to report suspected prenatal drug use. Oregon's mandatory child abuse and neglect reporting law can be found here: https://oregon.public.law/statutes/ors_419b.005



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Guideline 12: Postpartum History and Physical Assessment

Guideline 12: Postpartum History and Physical Assessment	
Programs: Babies First! Nurse-Family Partnership Family Connects Oregon	Effective Date:**1/2021** Reviewed Date: **1/2023** Revised Date: **1/2023** Next Review: **TBD**
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

A thorough nursing assessment of the client's physical and emotional health after childbirth will provide essential information to enable the nurse to develop a care plan that supports the most appropriate interventions to promote health and the nurturing of a positive parent- infant relationship postpartum. The postpartum period is also a key time to monitor for pregnancy- associated problems and provide early interventions: the maternal mortality rate has been steadily increasing since 1999 and reached 21.5 deaths per 100,000 births in 2014. The top causes of pregnancy related deaths in the United States are due to heart conditions, infections, bleeding, blood clots and high blood pressure. The risk of pregnancy-related deaths in African-American and Native American women is two to four times higher than those of white women. Providing thorough nursing assessments in the post-partum period may be an essential part of reducing maternal morbidity and mortality.

Process

A nursing head to toe assessment should be done at the first visit post-partum. Areas that require further assessment and follow up (such as mental health status), should be noted and explored in further visits as soon as possible. Some of these areas may be assessed through therapeutic conversation, rather than hands-on assessment, per nurse's discretion. Physical and mental health not within normal limits may indicate the need for a care plan for continued follow up at subsequent visits. The body systems to consider for a head to toe assessment are listed in Table 1. Blood pressure should be monitored at each visit up to 6 weeks postpartum. In hypertensive clients, BP should be monitored at least 6 weeks postpartum and further until hypertension is resolved (see Perinatal Blood Pressure Assessment Guideline). Note that secondary postpartum hemorrhage can happen between 24 hours and 12 weeks after giving birth.

Clients with chronic health issues (e.g., asthma, renal disease, cardiac disease, orthopedic issues) may need some additional case management services; Signs and symptoms of concern or client concerns should be referred to the appropriate medical care provider, for clinical care, and the referral should be documented (see Table 1 guidelines for when to refer).

Postpartum assessment considerations		Considerations for referral to provider
General Health Status	Vital Signs (blood pressure per Guideline; and temperature, heart rate, and respirations as needed if abnormality suspected); Cognitive state: mood, orientation; Pain; Medications. Medical hx (e.g., Gestational or Diabetes Type II, anemia, hypo/hyperthyroidism, preeclampsia, placenta previa, abruptio placenta, prolonged rupture, pre-term delivery); Source of prenatal care; when prenatal care began.	*BP: SBP >130 mm Hg or DBP > 80 mm Hg Weight: increase or decrease not consistent with diet Temp: <96 or >101°F Pain not controlled with medication Progression of chronic disease Change in orientation or level of consciousness
Reproductive	Status of uterus and cramping; Contraceptive plan/ sexual activity; Vaginal or pelvic pain; Vaginal or pelvic infections/Sexually Transmitted Infections/HIV/risk for infection; vaginal discharge (lochia); episiotomy/perineum pain; Group B Strep status and treatment; Hepatitis B hx and immunization status; Parity/ Gravida; type of delivery; problems during delivery;	Dark red lochia more than 4 days after delivery; lochia serosa (pink/brown) > 2 weeks after delivery (can indicate hemorrhaging); foul odor Pain not controlled with medication, or experiencing pain for > 2 weeks; Bleeding outside expected per provider education; Bleeding after 6 weeks Uterus hard at umbilicus or not decreasing in size
Integumentary	Skin color, temperature, integrity; mucous membrane status; incisions (verify appt for staple removal, if applicable)	Skin pale, diaphoretic, cold; contusions not explained, or not healing properly; if cesarean: scar red, inflamed, warm, bleeding, foul order, extreme tenderness, unusual swelling, pus, dehiscence
HEENT	Vision; hearing; dental care; pain	Vision changes Persistent headache Tinnitus

Breasts	Chest/breastfeeding plan; breast tissue firm, venous pattern increased, areola color dark, nipple everted; pain; no signs infection or clogged duct. See Breastfeeding Guidelines If no concerns, assessment may be by verbal report	Engorged tender breasts; Inverted nipples, forceful or poor let down, pain with feeding may need referral to lactation specialist Redness, burning, itching, pus refer to physician
Respiratory	Respiratory rate, effort, pattern; hx of disease, such as asthma	RR <12 /min or >20/ min Shallow breaths, feeling short of breath, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	*BP: SBP >130 mm Hg or DBP > 80 mm Hg HR: <50, >100 at rest, with consideration of what is normal for client Detection of new murmur or abnormal rhythm
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/ vomiting; indigestion; presence of hemorrhoids	Abdomen unusually tender Bowel movement type/amount abnormal for patient Persistent nausea/vomiting Blood in stool; severe pain with hemorrhoid
Diet and Exercise	Food availability; appetite; special dietary needs/preferences; food safety risks; vitamin/mineral supplementation should be continued per provider's recommendation (especially calcium intake); adequate food supply; adequate fluid intake; weight;	Food insecurity Loss of appetite affecting weight Weight gain, especially in conjunction with changes in BP, edema, headache, or vision changes
Urinary	activity level; fatigue Voiding characteristics (amount, color, odor, pain). History of UTIs.	Pain with urination Increased frequency / urgency not associated with intake Oliguria or anuria (should void 0.5 to 1 ml/kg/hr) Blood or clots in urine (not associated with vaginal bleeding) Difficulty emptying bladder

Peripheral Vascular	Edema; Varicosities; Leg pain, redness, tenderness	2+ edema, redness, tender, or hot area (risk thrombophlebitis) not resolving, or in conjunction with other signs (BP, headache, blurred vision, HR changes, SOB) Persistent leg pain
Musculoskeletal	Extremity strength; extremity movement; Activity level; Limitations to activity; Pain	Unexpected weakness (<4/5 strength) in one or more limbs Unexpected change in mobility Persistent pain
Neurologic	Extremity sensation, seizure history; fatigue/sleep	Numbness or tingling in extremities Seizures Extreme fatigue, especially in conjunction with anemia
Mental Health	**History of treatment for mental illness; History of depression/anxiety; Suicide ideation/attempts; History of abuse; Stress level; Self-esteem; Support system; Current affect**	By 4 – 6 weeks post-partum and at 3-4 months, conduct depression screening, suicide screening, intimate partner violence screening, make referral as appropriate Persistent blues not resolving >2 weeks Thoughts of harming self or others Psychosis
Behavioral	**Sexual activity; tobacco use/ exposure; substance use/exposure; illicit drugs; prescription/over the counter drugs; risky behaviors**	As needed, conduct substance use screening and make referral (See Substance Use Screening Guideline)
Developmental	Education level; reading level; special needs	Hx of diagnoses of disability as a youth may indicate and qualify person for increased support through DD or another avenue.

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Guideline 13: Newborn, Infant, Toddler History and Physical Assessment

Guideline 13: Newborn, Infant, Toddler History and Physical Assessment	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:**1/2021** Reviewed Date: **1/2023** Revised Date: **1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Thorough assessments are an important component of the nursing process. Assessments provide information on the child's physical, emotional, and developmental health, which enables the nurse to develop a care plan that supports the most appropriate interventions to promote healthy growth and development.

Process

The newborn head to toe assessment should be completed at the first post-partum visit. It may not be possible to complete the full assessment in one visit, and not all of these issues may be pertinent to every client. However, as an important component of the nursing process, consider assessing the systems. Systems to assess are listed in Table 1 (Newborn and Infant) and Table 2 (Toddler). Newborn assessments should include clothing and diaper removal (with parent/caregiver permission) to assess all physical aspects; toddler assessments may be focused and does not have to include clothing removal unless necessary to assess a concern.

Blood pressure (BP) and temperature for infants and toddlers are not required; the local implementing agency may decide to take BP and temperatures on a case-by-case basis (e.g., if a client is on blood pressure medication, or for teaching parents how to take temperature). For that reason, considerations for referrals to the primary care provider are listed and include parameters for BP and temperature. Nurses should always make referrals based on concern and clinical judgement, even if the client does not fit criteria listed in tables.

Growth (weight, length and head circumference) should be recorded and plotted on appropriate growth grid. See recommended growth grids here: https://www.cdc.gov/growthcharts/index.htm.

If providing BP and temperature monitoring, pay special attention to Vital Sign (VS) abnormalities in infants < 1 month, as a single VS abnormality may be the only sign of serious illness.

Newborn and infant assessment considerations		Considerations for referral to provider
General Health Status	Vital Sign: weight (see reference at end of table), recumbent length, head circumference (recommended monthly up to three years of age); and temperature, heart rate (taken for full minute if crying), and respirations; blood pressure as needed if abnormality suspected; Medical hx (e.g., type of birth, gestational age, birth weight and length, newborn blood tests, immunizations, major or minor anomalies suggesting need for genetic evaluation)	*SBP: <50 mmHg or >100 mmHg (<3 months); <75 or >115 mmHg (3-11 months) Heart Rate: <80 or >190 (< 3 months); <80 or >160 (3-11 months) RR: <30 or >60 (< 3 months); <20 or >50 (3-11 months) Temp: Ear or temporal arterly temperature of 100.4 F (38 C) or higher; Oral temperature of 100 F (37.8 C) or higher; Axillary temperature of 99 F (37.2 C) or higher Weight loss of >10% birth weight for normal weight or >15% for preterm infants, failure to gain any weight after 72 hours Larger than expected increase in head circumference
Cognitive	Alertness Congenital anomalies	Lethargy, unresponsive or minimal responsiveness to touch; No tracking with eyes Minimal responsiveness to interactions
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Skin jaundice Lesions, bruising, rashes (not diaper rash) Mottled skin (especially in conjunction with fever or lethargy and not normal for infant)
HEENT	Head size/shape, sutures, fontanels Vision, fixate and follow response Ears Nose Hearing screen done by 1 mo Tongue and palate normal Oral health assessed	Enlarged or sunken fontanel, prematurely closed sutures (<2 mo for posterior; < 9 mo for anterior) Lack of tracking, scleral icterus after 7 days of age, purulent drainage, persistent drainage, redness/ swelling, or conjunctival erythema Ears with pits or tags Nose patency; Lingual frenulum affecting feeding; thrush; cleft palate/lip
Respiratory	Respiratory rate, effort, pattern	Tachypnea/ bradypnea Shallow breaths, significant changes in respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	Hyper/hypotension Tachy/bradycardia Detection of new murmur or abnormal rhythm.
Gastrointestinal	Abdominal appearance/tenderness; bowel tones via auscultation; and movement (4 or more stools after 4th day and until 3-4 weeks after birth, then decreases); nausea/vomiting; Indigestion	Abdomen tender Umbilical site drainage, presence of stump >14 days Bowel movement type/amount abnormal for patient Persistent or projectile vomiting Oozing from umbilical stump; redness/foul odor/ erythema of umbilical stump Non-reducible umbilical hernia, concern for hepatosplenomegaly

Diet	Appetite: Breastfeeding or bottle feeding success Weight (Normal: immediate after birth loss less than 95%ile according to https://www.newbornweight.org/ Birthweight regained within 14 days (see table below for average weight gains for month; - https://newbornweight.org/) Length -following curve on standard growth charts Head Circumference following curve on standard growth charts (https://www.cdc.gov/growthcharts/html_charts/hcageinf.htm)	Weight loss >= 8-10% by day 5 or later (if physical assessment is normal, indicates at least careful follow up warranted). Poor/inadequate weight gain (for pre-term infants, see https://www.oregon.gov/oha/ph/healthypeoplefamilies/wic/documents/preterm.pdf for indications for referral and promoting caloric requirements) Signs of dehydration- dry mucus membranes, capillary refill on thumb or great toenail > 2 seconds
Urinary	Voiding characteristics (amount, color, odor, pain)	Apparent pain with urination Oliguria or anuria (should void at least 6 soaked diapers days 5-28 or 1ml/kg/hr) Blood or clots in urine
Peripheral Vascular	Femoral pulses Temperature of extremities	Weak femoral pulse Cool extremities not related to room temperature or lack of clothing, especially with fever, mottling or lethargy.
Musculoskeletal	Spine formation Formation/movement of extremities	Torticollis Noted abnormalities of leg length or thigh-fold asymmetry
Neurologic	Reflexes: Suck, blink, gag, rooting, extrusion, Babinski, Moro, startle, plantar/palmar, stepping Tonic neck Symmetry of limbs/movement Muscle tone	Absence or change in reflexes not appropriate for post-natal age Asymmetry in movement Abnormal muscle tone- increased or decreased, symmetric or asymmetric
Developmental	Social/Verbal/Gross/Fine motor development Sleep habits	See Newborn, Infant, Toddler Developmental Screening Guideline

*Change in vital signs may be the first and only sign of an infection

Baby's age	Average Weight Gain
0-4 months	5.5-8.5 ounces per week
4-6 months	3.25-4.5 ounces per week
6-12 months	1.75-2.75 ounces per week

Sources:

World Health Organization Child Growth Standards, 2006.

Toddler assessment considerations		Considerations for referral to provider
General Health Status	Vital Signs (weight, recumbent length, head circumference (recommended up to three years of age); and axillary temperature, heart rate, and respirations; blood pressure (as needed if abnormality suspected); Medical hx (e.g., type of birth, newborn blood tests, major or minor anomalies suggesting need for genetic evaluation)	SBP: <75 mmHg or >125 Heart Rate: <80 or >125 RR: <20 or >40 Temp: <96 or >101°F Failure to gain weight/ head circumference: https://www.cdc.gov/growthcharts clinical_charts.htm
Cognitive	Alertness Congenital anomalies	Lethargy, diminished responsiveness to stimuli Absent/poor visual tracking
Integumentary	Skin color, temperature, integrity; capillary refill; mucous membrane status	Lesions, bruising, rashes Mottled skin (especially in conjunction with fever or lethargy and not normal for toddler)
HEENT	Head size/shape, sutures, fontanels Vision, fixate and follow response Ears, nose Oral care provided – fluoride given	Prematurely closed anterior fontanel (<9 mo), notable head shape abnormality Lack of tracking Ears with pits or tags, discharge Nose discharge
Respiratory	Respiratory rate, effort, pattern	Tachypnea/ bradypnea Shallow breaths Increased respiratory effort (nostril flaring, retractions)
Cardiovascular	Heart Rate, blood pressure, pulses, rhythm, hx heart disease	Hyper/hypotension Tachy/bradycardia New murmur or abnormal rhythm
Gastrointestinal	Abdominal appearance/tenderness; bowel tones and movement; nausea/ vomiting; indigestion	Abdomen tender Bowel movement type/amount abnormal for patient Vomiting/Diarrhea

Diet	Appetite Breastfeeding and solid foods Weight (Normal: 3-5 oz/week from 6-18 mo) and Height Head Circumference (up to 3 years: https://www.cdc.gov/growthcharts/clinical_charts.htm	Signs of dehydration Tracking along percentile lines for weight, length and head circumference
Urinary	Voiding characteristics (amount, color, odor, pain)	Apparent pain with urination Increased or decreased urine output Blood or clots in urine
Peripheral Vascular	Femoral pulses Temperature of extremities	Weak femoral pulse Cool extremities not related to room temperature or lack of clothing, esp with fever, mottling or lethargy
Musculoskeletal	Spine formation Formation/movement of extremities	Abnormal movements Parent/caregiver Developmental concerns
Neurologic	Reflexes: deep tendon Symmetry of limbs/movement Muscle tone	Absence, asymmetrical, or change in reflex Asymmetry in movement Decreased muscle tone
Developmental	Social/Verbal/Gross/Fine motor development Sleep habits Parent-Child Interaction; assess behaviors for positive attachment	See Guideline Newborn, Infant, Toddler Developmental Screening See Guideline Parent Child Interaction

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Guideline 14: Infant, Toddler Developmental Screening

Guideline 14: Infant, Toddler Developmental Screening	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date: 1/2021 Reviewed Date: 1/2023 Revised Date: 1/2023 Next Review: TBD
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Assessing child development from newborn through toddler stage helps identify developmental delays early. Early intervention is key to reducing the impact of delay on the child and their family. Parent-child interaction and attachment can be enhanced when parents understand the child's developmental status.

Process

Administration of a valid screening tool identifies children that are developing on schedule; identifies areas children would benefit from practice/support; and identifies children at risk for developmental delays. Results of screening will inform you that: most children are on-schedule and doing great; some children will benefit from practice in an area of development; and a few children will need referral for evaluation. Screening does not diagnose delays or disabilities. If a child has known developmental delays, do not continue with screening.

Home Visitors in the Babies First! and Nurse-Family Partnership programs are encouraged to use the Ages and Stages Questionnaires (ASQ)-3 and the Ages and Stages Questionnaires (ASQ): Social Emotional (SE)-2 for screening. The screens should be administered at intervals according to the guidelines of the home visiting program and anytime concerns arise. ASQ-3 and ASQ-SE results may be obtained from other providers rather than having the family repeat the screening for the same age.

The ASQ-3 is a series of questionnaires for children ages 1 month to 5 ½ years. These are valid tools that are known to accurately identify children at risk for developmental delays. There are 21 age-based ASQ-3 questionnaires but not all ages need to be administered for each child. The 9-month questionnaire was designed for use in health care settings and is not recommended for use in home visiting.
The ASQ:SE-2 is composed of nine questionnaires that can be used with all children from 1 month to 72 months of age.

1. Step one: Introduce the screening tool to families, explain the purpose of the screening, who will have access to the screening information and how the results will be used.

2. Step two: Home visitors should carefully calculate a child's age at administration in months and days. See ASQ-3 and/or ASQ:SE-2 User's Guides for detailed guidance. There is an age calculator that the publisher of the ASQ provides at the following website. https://agesandstages.com/free-resources/asq-calculator/. Age adjustments must be made when a child is born more than 3 weeks premature, up to, but not including 24 months.

3. Step three: The questionnaire is completed. Accuracy is improved when a familiar caregiver reports on observable behaviors in a familiar, comfortable environment over time. The child should be given some time to play with materials and the caregiver should try out the majority of the items. Studies suggest that parents are highly reliable reporters on developmental screening tools. The questionnaires are designed to encourage parent/caregiver involvement in the screening process. Home Visitors report that completing the ASQ-3/ASQ: SE-2 with parents offers an important opportunity to educate parents about whether their child's development and behavior is similar to that of same-age peers.

4. Step four: Score the questionnaire. Review responses. If there are any missing items, try to obtain answers. If an item is inappropriate, omit the item. Calculate area totals. If any items omitted, calculate new area total (See ASQ-3/ASQ:SE-2 User's Guide for detailed guidance). Review any parent comments.

5. Step five: Score interpretation and follow-up. Consider culture and family values when interpreting the results. Discuss results with family. If score is above the monitoring zone: Provide follow-up activities and rescreen according to program schedule. If the score is in the monitoring gray zone: Provide activities to practice skills in specific areas and rescreen in 2 months or sooner. Make community referrals as appropriate if the score is below cutoff in one of more areas.

In consultation with family, provide referral to Early Intervention and share results with the primary care provider. The summary sheet (score form) provides a complete summary of ASQ information, and can be used to share information with other providers. When sharing results with the summary sheet only, the optional individual item response section should be completed.

If a parent expresses concern, regardless of the ASQ result, re-screen and refer if necessary. Follow-up activities may include:

- ASQ Play activities found in the Appendix of the ASQ-3 User's Guide. They are in a chart format, and each age interval contains activities across developmental areas.
- ASQ Learning Activities are a separate publication. The learning activities contain actions by developmental area. An on-line guide to activities by developmental area may be found here.
- ASQ: SE-2 Learning Activities are found in Appendix E of the ASQ-SE2 User's Guide. The Learning Activities include age-by-age handouts and activities to support parents. On-line parent handout activity sheets may be found here.
- CDC's Learn the Signs. Act Early Initiative includes a number of resources for professionals (including home visitors) and parents. https://www.cdc.gov/ncbddd/actearly/index.html

Information about how to refer a child to EI/ECSE can be found here: https://www.oregon.gov/ode/students-and-family/specialeducation/earlyintervention/pages/ default.aspx

Guideline 15: Oral Health Screening for Infants and Children

Guideline 15: Oral Health Screening for Infants and Children	
Programs: Babies First! Nurse-Family Partnership CaCoon Family Connects Oregon	Effective Date:**1/2021** Reviewed Date: **1/2023** Revised Date: **1/2023** Next Review: **TBD**
Review Responsibility: MCH and OCCYSHN State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose

Having a healthy mouth plays a vital role in developing and maintaining the overall health and wellness of children, and good oral health starts with a child's baby teeth. Having healthy primary teeth allows a child to chew and eat properly; speak more clearly; guides adult teeth into place; helps to shape a child's face; and keeps future dental costs to a minimum. The purpose of a screening is to identify normal versus abnormal oral conditions and to make referrals for dental care.

Process

A basic oral assessment for newborns is important and should be done as part of the newborn history and physical assessment. Starting at age 4-6 months, and every 6 months ongoing, perform an oral health screening. Recommended screening tools include those endorsed by the Oregon Oral Health Coalition (e.g., The First Tooth Caries Risk Assessment), the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics.

An oral health screening is comprised of two parts:

1. Reviewing oral health history/risk assessment
2. Performing a physical examination of the child's teeth and gums

The oral health history review should cover a child's and his/her caregiver's past and current oral health practices and experiences to help discover risk for oral problems. This review can include the following:

- Previous oral problems
- Diet and nutrition
- Fluoride intake (recommended intake will depend on community, refer to provider for amount)

- Primary source of drinking water
- Past fluoride treatment
- Fluoride supplements (e.g. tablets or rinse)
- Dental visit history
- Medications that affect the mouth
- Baby bottle or sippy cup use

An oral health screening involves a physical examination of a child's mouth, including the lips, tongue, teeth, gums and tissues. For a child less than 3 year of age: the home visitor and the caregiver should sit facing each other with their knees touching. Lay the child on the home visitor's lap with his/her head securely nestled against the screener's abdomen. With gloved hands, the screener should lift the child's lips, feel the soft tissues, check the physical condition of the teeth and gum and look throughout the mouth. For a child 3 years of age or older, the child can be checked while sitting close and across from the screener. A tongue depressor can be used to move the lips to view the teeth and gums.

Interventions

- Provide age and culturally appropriate anticipatory guidance. See parent handout from the American Academy of Pediatric Dentistry for specifics birth to school age.
- If drinking non-fluoridated water, ensure family has supplemental fluoride and are administering.
- If local protocols are in place, apply fluoride varnish. This website provides a training on varnish application.
- Ensure parents are regularly brushing any and all teeth with a fluoride toothpaste.
- Refer children for regular dental care or immediate care if assessed to be at increased risk for oral disease. Every child should have a dental visit by age 1. OHP covers dental care from birth.

References
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https://www.mchoralhealth.org/pocket/
https://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=555&pagekey=101563&cbreceipt=0
https://mouthmonsters.mychildrensteeth.org/tips-for-parents/

Guideline 16: Parent Child Interaction Assessment

Guideline 16: Parent Child Interaction Assessment	
Programs: Babies First! Nurse-Family Partnership Family Connects Oregon	Effective Date:1/2021 Reviewed Date: 1/2023 Revised Date: 1/2023 Next Review: TBD
Review Responsibility: MCH State Nurse Consultants, PHN Home Visitor Workgroup, FCO Medical Director	

Purpose:

A healthy relationship between a caregiver and their infant is essential for ensuring optimal physical, cognitive, social and emotional development. Infants are born with innate biological behaviors that signal a caregiver to respond and aid. When a caregiver responds appropriately over and over, the infant learns trust and forms crucial attachments to the caregiver. These early relationship experiences form the basis for infant's understanding of how relationships work, and secure attachment requires warm, nurturing and consistent caregiving. Promoting positive parent/caregiver-child interaction is a key component of home visiting, as home visitors are in a unique position to assess, support and enhance those interactions during the first year of life.

Process

Assessment:

- Nurse home visitors with training in a validated parent-child interaction (PCI) assessment tool (e.g., DANCE, Parent Child Relationship Assessment/NCAST, KIPS) should use that assessment tool. Use the tool-specific scores to identify when parents would benefit from interventions (see Interventions section below).
- It is recommended that programs who are planning to provide parent education and attachment promotion seek training and certification in a validated PCI tool like the ones noted above; however, when a validated parent-child assessment tool is not in use by an agency, the Bright Futures Age Specific Observations of Parent-Child Interactions may be used: https://www.brightfutures.org/mentalhealth/pdf/professionals/in/observation.pdf. Although this is not a formal screening tool, it contains assessment criteria to help determine if concerns are present.
- It is not possible to determine a cutoff point for referral without using a validated tool; however, it is important to make sure that parent-child interactions are

positive and opportunities for improvement are not missed; nurses should have a low threshold for instituting strength-based interventions. MCH State Nurse Consultants trained in validated tools are available for consultation as needed.

- Parent-child interaction assessments should be culturally sensitive and completed per program guidelines or more often as needed based on assessment.
- Each parent-child assessment should have accompanying documentation that includes assessment results, nursing diagnosis, expected outcomes, planning and interventions.

Interventions:

When a concern is identified by the nurse or parent, provide follow-up. Follow-up may include:

1. Providing anticipatory guidance on infant cues, spoiling, child behaviors and responses
2. Interventions from evidenced based curriculums designed to strengthen attachment and overall parent-child interaction:
    i. Circle of security (parent education handouts and videos available online: https://www.circleofsecurityinternational.com/)
    ii. Partnering in Parenting Education (PIPE) curriculum (materials must be purchased)
    iii. Promoting First Relationships
    iv. Zero-3 (parent education handouts available under specific topics) https://www.zerotothree.org/resources/series/parent-favorites#social-emotional-development
3. Referral to a mental health provider trained to address parent child interaction (see a list of sites that provide Parent-Child Psychotherapy and Parent Child Interaction Therapy)
    i. Treatment of underlying conditions contributing to PCI interruption such as toxic stress, substance use disorder, or other mental health disorders.

Additional Training resources:

1. Oregon Infant Mental Health Association
2. Essentials of Home Visiting Trainings (contact the MCH Workforce Development team for access) include some courses that relate to this topic:
    i. Foundations of Infant Mental Health Practice in Home Visiting
    ii. Exploring Values and Beliefs around Parenting
    iii. Home Visiting with Families During Pregnancy
    iv. Promoting Effective Parenting with Motivational Interviewing

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