Ohio Infant Mortality Reduction Initiative Reference Materials

Materials for OIMRI are presented in this pdf in the following order:

Data Overview
Currently, data for the Ohio Infant Mortality Reduction Initiative (OIMRI) is collected on paper forms and entered into an access data base. The following files are the data collection forms for this data base:

1. OIMRI Birth Outcomes
2. OIMRI Intake
3. OIMRI Exit
4. OIMRI Caseload

Note: There is limited exit data is actually collected.

Future Data Collection Tool – Maternal Child Health IDS
OIMRI is moving into using the new MCHIDS system in the near future but there is no definite implementation date. Draft versions of the data fields definitions are:

1. Initial Prenatal Visit-Updated 02242016
2. Prenatal Visit-Updated 02052016
3. Initial Postpartum Visit-Updated 02052016
4. Postpartum Visit-Updated 02082016
5. Exit Visit-Updated 02082016

At this point in time, there is no draft for the demographics definitions document but the series of screen captures is available in OIMRI demographics.

Program Descriptive Information
The following reports and tables provide descriptive information about OIMRI:

1. Program Report 2009-2012
2. Data summary tables 2014 (attached Excel File “Copy of OIMRI FY2014”)
3. Local report example from Cuyahoga County ( “OIMRI Cuyahoga County Five year write up 2005 to 2010”)
4. Summary of OIMRI-related data/research submitted by a grantee (“Butler Co. Collab Research Projects IM”)
# OHIO DEPARTMENT OF HEALTH
## OIMRI CLIENT BIRTH OUTCOME REPORT

| County name: ______________________ |
| Completed by: _____________________ |
| Reporting Date: ___________________ |
| (MM/DD/YYYY) _____________________ |

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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Last Name</td>
<td>____________</td>
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<tr>
<td>2.</td>
<td>Social Security Number</td>
<td>______________________</td>
</tr>
<tr>
<td>3.</td>
<td>Child’s Name:</td>
<td>____________</td>
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<tr>
<td></td>
<td>Last Name</td>
<td>____________</td>
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<tr>
<td>4.</td>
<td>Child’s Date of Birth (MM/DD/YYYY)</td>
<td>____________</td>
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<tbody>
<tr>
<td>5.</td>
<td>Risk Factors</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Less than 18 or more than 35 years old</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Medical problems (STD, UTI, diabetes, etc.)</td>
<td></td>
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<tr>
<td>c.</td>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Previous pregnancy (complications/poor outcomes)</td>
<td></td>
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<tr>
<td>e.</td>
<td>2nd pregnancy within twelve months</td>
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<tr>
<td>f.</td>
<td>Tobacco use (smoking, snuff, etc.)</td>
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<tr>
<td>g.</td>
<td>Alcohol use suspected</td>
<td></td>
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<tr>
<td>h.</td>
<td>Drug use suspected</td>
<td></td>
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<tr>
<td>i.</td>
<td>Late entry into prenatal care (after 13 weeks)</td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Non-compliance with keeping appointments</td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Domestic violence</td>
<td></td>
</tr>
<tr>
<td>l.</td>
<td>Pregnancy unwanted</td>
<td></td>
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<tr>
<td>m.</td>
<td>Mental retardation / mental illness</td>
<td></td>
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<tr>
<td>n.</td>
<td>Homelessness/ poor living environment</td>
<td></td>
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<tr>
<td>o.</td>
<td>Language barriers</td>
<td></td>
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<tr>
<td>p.</td>
<td>Other ________________________________</td>
<td></td>
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<tr>
<td>6.</td>
<td>Is mother using family planning method all the time?</td>
<td></td>
</tr>
<tr>
<td>(Check one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>No: Seeking pregnancy</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>No: Missed appointment</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>No: Medical reasons</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>No: Undecided</td>
<td></td>
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<tbody>
<tr>
<td>7.</td>
<td>Weeks gestation when prenatal care began:</td>
<td></td>
</tr>
<tr>
<td>Number of weeks</td>
<td>_____</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td>8.</td>
<td>Number of prenatal visits throughout the pregnancy:</td>
<td></td>
</tr>
<tr>
<td>Scheduled</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Kept</td>
<td>_____</td>
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<tbody>
<tr>
<td>9.</td>
<td>Weeks gestation at time of delivery:</td>
<td></td>
</tr>
<tr>
<td>Number of weeks</td>
<td>_____</td>
<td></td>
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</tbody>
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<tr>
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<tbody>
<tr>
<td>10.</td>
<td>Birth weight of child:</td>
<td></td>
</tr>
<tr>
<td>Pounds</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Ounces</td>
<td>_____</td>
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<tr>
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<tbody>
<tr>
<td>11.</td>
<td>Source of data for birth information:</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>12.</td>
<td>Has the Child been referred to WIC with completed CPA form by outreach worker?</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If No, please explain why: ________________________________</td>
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</tbody>
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Rev. 5/6/2008
County name: ______________________

Completed by: ______________________

Date of Enrollment: __________________ (MM/DD/YYYY)

1. ______________________ __________________ ________
   Last Name         First Name         M.I.

2. Date of Birth (MM/DD/YYYY) ______________________

3. Social Security Number ______________________

4. County of Residence ______________________

5. Maiden Name ______________________

6. Race/Ethnicity (Check one)
   a. Asian or Pacific Islander
   b. Black (non-Hispanic)
   c. Hispanic
   d. Native American
   e. Other

7. Risk Factors
   a. Less than 18 or more than 35 years old
   b. Medical problems (STD, UTI, diabetes, etc.)
   c. Anemia
   d. Previous pregnancy (complications/poor outcomes)
   e. 2nd pregnancy within twelve months
   f. Tobacco use (smoking, snuff, etc.)
   g. Alcohol use suspected
   h. Drug use suspected
   i. Late entry into prenatal care (after 13 weeks)
   j. Non-compliance with keeping appointments
   k. Domestic violence
   l. Pregnancy unwanted
   m. Mental retardation / mental illness
   n. Homelessness/ poor living environment
   o. Language barriers
   p. Other ______________________

8. Has the client made a family planning method choice for after the delivery?
   □ Yes
   □ No

9. Client status when outreach worker first enrolled client (complete only one):
   a. _____ Weeks pregnant
   b. _____ Weeks postpartum

10. Barriers to care:
    a. No transportation
    b. No insurance
    c. Didn’t know was pregnant
    d. Personal Problems
    e. Other ______________________

11. Client enrolled in WIC prior to outreach contact?
    □ Yes
    □ No

    If No, complete question #12

12. Client has been referred to WIC with completed CPA form by outreach worker?
    □ Yes
    □ No

    If No, please explain why: ______________________

13. How was client recruited by the outreach worker?
    (Check only one)
    a. Door to door canvassing
    b. Neighborhood canvassing
    c. Home visit
    d. Self
    e. Friend, relative or neighbor
    f. Prenatal provider
    g. CFHS
    h. Agency other than CFHS

Rev. 5/6/2008
County name: ____________________
Completed by: ____________________
Reporting Date: ____________________
(MM/DD/YYYY)

1. ____________________ ____________________ ______
   Last Name   First Name   M.I.

2. Social Security Number ____________________

3. Child’s Name: ____________________ ____________________
   Last Name   First Name

4. Child’s Date of Birth (MM/DD/YYYY) ____________________

5. Risk Factors
   a. Less than 18 or more than 35 years old
   b. Medical problems (STD, UTI, diabetes, etc.)
   c. Anemia
   d. Previous pregnancy (complications/poor outcomes)
   e. 2nd pregnancy within twelve months
   f. Tobacco use (smoking, snuff, etc.)
   g. Alcohol use suspected
   h. Drug use suspected
   i. Late entry into prenatal care (after 13 weeks)
   j. Non-compliance with keeping appointments
   k. Domestic violence
   l. Pregnancy unwanted
   m. Mental retardation / mental illness
   n. Homelessness/ poor living environment
   o. Language barriers
   p. Other ____________________

6. Is mother using family planning method all the time?
   (Check one)
   a. Yes
   b. No: Seeking pregnancy
   c. No: Missed appointment
   d. No: Medical reasons
   e. No: Undecided

7. How many well child visits did child have?
   Scheduled _____   Kept _____

8. Is child’s immunization complete for age?
   ☐ Yes
   ☐ No
   If No, please explain why: ____________________
   __________________________________________

Rev. 5/6/2008
### OHIO DEPARTMENT OF HEALTH

**OIMRI CASELOAD ANALYSIS REPORT**

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**County name:** ________________________

**Completed by:** ________________________

**Reporting Date:** ________________________

(______/______/YYYY)

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1. **Outreach staff caseload**

<table>
<thead>
<tr>
<th>Name of outreach staff (Last Name, First Name)</th>
<th>% Time in project (100% FTE = 40hrs/week)</th>
<th>Total monthly clients (OIMRI clients = moms only)</th>
</tr>
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</tbody>
</table>

2. **Outreach staff contacts**

**Home visit contacts only:**

- Pregnant clients: _________
- Postpartum clients: _________

**Phone contacts only:**

- Pregnant clients: _________
- Postpartum clients: _________

3. **Total number of clients enrolled in WIC with completed CPA**

4. **Clients Terminated**

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Mother’s Social Security Number</th>
<th>Reason for Termination (Use code below)</th>
<th>Date of Termination (month/day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td></td>
</tr>
</tbody>
</table>

1 = Baby turned one year  
2 = Infant death  
3 = Pregnancy ended  
4 = Lost to follow up  
5 = Client not interested in participating  
6 = Client moved out of the service area  
7 = Client no longer needs assistance  
8 = 2nd pregnancy in 12 months  
9 = Unknown

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*Rev. 6/25/2008*
Initial Prenatal Visit - Definitions

**Facility** – Use the drop down menu to select the agency where the client was seen. If you do not see your agency listed in the drop down menu, please contact your technical support.

**County** – Use the drop down menu to select the county where the client was seen. If you do not see your county listed in the drop down menu, please contact your technical support.

**Date of Encounter** – Enter the date the client was seen. This is not necessarily the same date as the data entry date.

**Home Visitor** – Enter the name of the community health worker who completed the encounter.

**Contact Type** – Select the appropriate option of how the home visitor conducted the encounter with the client.

- Home Visit – Select this option if a face-to-face interaction was made between the community health worker and expectant parent, parent and/or family.
- Hospital – Select this option if the face-to-face interaction occurred in the hospital.
- Office – Select this option if the face-to-face interaction occurred in the physician’s office, healthcare center, agency or health department, etc.
- Phone – Select this option if contact occurred by phone.
- Email – Select this option if communication occurred by email.
- Text Message – Select this option if communication occurred by text.
- Other – Select this option if another location applies. If selected, explain in the **Notes/Follow-up section** at the bottom of the page.

**# Contact Attempts** – Enter the number of attempts made to contact the client prior to the encounter.

**Entered By** – The name of the staff member who entered the encounter into the OIMRI system. This may be a different person than the “Home Visitor.”

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**Encounter Reasons** – Check all of the reasons for this encounter

- General Follow up – Select this option if this encounter’s purpose is to check on client.
- Insurance – Select this option to document or initiate that the client has medical coverage.
- Medical/Dental – Select this option if medical or dental referral is required.
- Mental Health – Select this option if mental health referral is required.
- Food – Select this option if a referral was made for services, such as food pantry, WIC, or other local resources.
- Transportation – Select this option if a referral was made for transportation services, such as bus passes, taxi, car repair or other local resources.
- Housing – Select this option if a referral was made for housing services.
Initial Prenatal Visit - Definitions

- **Education** – Select this option if client indicates educational services are required, such as GED, financial aid, tutoring services, placement exams, etc.
- **Child Care** – Select this option if client requires child care services.
- **Utilities** – Select this option if client requires assistance with utility services, e.g., electricity.
- **Domestic Violence** – Select this option if client requests intervention or there is evidence of domestic violence.
- **Referral for Child** – Select this option if referral for child is needed for developmental screenings, evidence of abuse, educational services, etc.
- **Other** – Select this option if another reason applies.

**Specify Other** – Enter the ‘Other’ type of encounter reason.

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**Translator Needed** – Select ‘Yes’ if a translator was needed at this encounter.

**Mother in Foster Care?** – Select ‘Yes’ if the client was in foster care at the time of this encounter.

**How was Client Recruited?** – Select all of the options for how the client was recruited into the OIMRI program.

- **Door–to–door canvassing** – Select this option if the community health worker conducted door-to-door contact for client recruitment.
- **Neighborhood/community canvassing** – Select this option if the community health worker conducted neighborhood or community contact for client recruitment, i.e. health fairs, State fair, festivals, job fairs, community baby shower, laundry, beauty salon, etc.
- **Self** – Select this option if the client voluntarily contacted the agency for services.
- **Friend, relative or neighbor** – Select this option if client was recruited through a friend, relative or neighbor.
- **Prenatal provider** – Select this option if client was recruited through the prenatal provider, i.e. medical provider, nurse, midwife, nurse practitioner, social worker, nutritionist, etc.
- **Child and Family Health Services** – Select this option if client was recruited through the Child and Family Health Services program.
- **Social service/community organization/business** – Select this option if client was recruited through social services, community organizations, business, etc.
- **Faith–based organization** – Select this option if client was recruited through faith-based organization.
- **Printed materials** – Select this option if client was recruited through literature and billboards.
- **Social media** – Select this option if client was recruited through social media, i.e. Facebook, Instagram, Twitter, and text messaging.

**Mother’s Education** – Select the client’s reported level of education at the time of the encounter.
Initial Prenatal Visit - Definitions

- 8th Grade or Less
- 9th through 12th Grade; No Diploma
- High School Graduate or GED Completed
- Some College Credit, but No Degree
- Associate Degree
- Bachelor's Degree
- Master's Degree
- Doctorate Degree
- Unknown – Select this option if the client is unsure of her last level of education.

**Household Size** – Enter the number of individuals in a client’s family who are supported by the amount of income listed in the “Household Income” field. “Family” is defined as a social unit composed of one or more person(s) living together as a household including dependents away at school. If the client is a teenager requesting confidential services, she is considered to have a household size of two (2). If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), that child is not counted as part of the household size. A pregnant woman is counted as two (2). The minimum number in a household is two (2).

**Household Income** – Enter the weekly, monthly, or yearly total, combined income (before taxes or deductions) of all individuals in the client’s family (see definition of “family” in Household Size). If the weekly or monthly income varies during the year, use an average. If the client is a teenager requesting confidential services, use only her/his personal financial resources for determining the weekly income. If a family receives direct payments (cash in-hand) for child support, include as part of the household income; if a family receives child support payments (indirectly) through County Department of Job and Family Services (CDJFS), do not count the child support separately from the CDJFS payments. If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), the amount of child support paid is excluded from the gross amount of the family’s income. Do not include the total income for other families living at the same address. Do not include Metropolitan Housing allowance, Food Stamp vouchers, or the like.

**Income Verified** – Select ‘Yes’ if the client has shown income documentation (e.g. pay stub, employment record). This is required. A signed self-report can be an acceptable form of income verification.

**Household Annual Income** – This field is populated automatically in the OIMRI application. It does not appear on the Initial Prenatal Visit form.

**Housing Situation** – Select the appropriate status of the client’s housing information at the time of the encounter.

- Permanent – Select this option if client’s place of residence is stable.
- Temporary – Select this option if client’s place of residence is short-term or uncertain.
- Homeless – Select this option if client does not have affordable and suitable place of residence.
Initial Prenatal Visit - Definitions

**Insurance Status** – Select the appropriate state of the client’s insurance at the time of the encounter

- Medicaid – Select this option if the client is enrolled in Medicaid.
- Uninsured/Underinsured (Partial Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is between 100% and 250% of the federal poverty level.
- Private Insurance – Select this option if the client has any health insurance policy purchased by an employer, through the market place exchange, or by an individual from a private insurance company.
- Uninsured/Underinsured (No Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is below 100% of the federal poverty level.
- Uninsured/Underinsured (Full Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is above 250% of the federal poverty level.
- Other – Select this option if the client has a third-party payer for these services other than Medicaid or private insurance. This field should not be used to record more detailed information about one of the previous categories (i.e., name of Medicaid HMO or private insurance company).

**Specify Other** – Enter the ‘Other’ type of insurance the client reported at the time of the encounter.

**Uninsured / Underinsured Status** – Select the appropriate of the client’s Uninsured / Underinsured Status

- Medicaid Application Assistance - Combined Programs Application (CPA) has been completed and will be submitted to the County Department of Jobs and Family Services (CDJFS) for Medicaid enrollment. Refer to the CPA Policy in the CFHS Program Standards Administration Manual.
- Medicaid Eligibility Pending - CPA was previously submitted to CDJFS and notice of Medicaid enrollment has not been received.
- Medicaid Ineligible – Client previously applied for Medicaid but was found to be ineligible by CDJFS.
- Client Refused Medicaid - Client may be eligible but refuses Medicaid services at this time or does not follow through on the submission of required documents.

**Information on Father?** – Select ‘Yes’ if information is available about the father of the client’s child.

- Father’s First Name – Enter the first name of the father of the client’s child.
- Father’s Last Name – Enter the last name of the father of the client’s child.
- Father’s Phone – Enter the telephone number of the father of the client’s child.
- Is Father Employed? – Select ‘Yes’ if the father of the client’s child is employed at the time of the encounter.

**Prenatal Care Office Visits Started?** – Select ‘Yes’ if the client has started prenatal care office visits at the time of the encounter.
Initial Prenatal Visit - Definitions

If yes, Prenatal Care Begin Date – Enter the date the client’s prenatal care began.

Number of Prenatal Visits Scheduled – Enter a number for how many prenatal visits the client scheduled to date. This does not include future scheduled visits.

Number of Visits Kept – Enter a number for how many prenatal visits the client has kept to date at the time of the encounter.

Number of Weeks Gestation at Date of Encounter – Enter the number of weeks gestation at the time of the encounter.

Client Enrolled in WIC prior to Community Health Worker contact? – Select ‘Yes’ if the client was enrolled in the WIC program prior to the encounter.

If no, has client been referred to WIC by Community Health Worker? – Select ‘Yes’ if the client was referred to the WIC program by the community health worker at the time of the encounter. If no, explain reason.

Mother’s Health History

Medications, Prescriptions – Select ‘Yes’ if the client is currently taking prescribed medications at the time of the encounter.

If yes, type – Enter the name(s) of medications/prescriptions the client reports taking at the time of the encounter.

Over the Counter – Select ‘Yes’ if the client is currently taking over-the-counter medications at the time of the encounter.

If yes, type – Enter name of over the counter medications the client reports taking at the time of the encounter.

Herbs/Supplements – Select ‘Yes’ if the client is currently taking herbs and/or herbal supplements at the time of the encounter.

If yes, type – Enter the name of herbs/supplements the client reports taking at the time of the encounter.

Vitamin Use? – Select ‘Yes’ if the client is currently taking vitamins.

If yes, type – Enter the type of vitamins the client reports taking at the time of the encounter.
Initial Prenatal Visit - Definitions

Progesterone Administered? – Select ‘Yes’ if the client was administered Progesterone at the time of the encounter.

Conditions – Conditions at the time of the encounter. Check all that apply.

- Sickle Cell – Select this option if the client has been diagnosed as having Sickle Cell disease at the time of the encounter.
- RH Factor – Select this option if the client has Rh negative blood type and has developed antibodies.
- Placenta Issues – Select this option if the client has knowledge of having placenta issues.
- Obesity – Select this option if the client self-reports or is diagnosed being obese.
- Infections – Select this option if the client has been diagnosed as having sexually-transmitted infections (STI).
- Asthma – Select this option if the client has been diagnosed as having asthma.
- Hypertension – Select this option if the client has been diagnosed as having hypertension or has knowledge of family history of hypertension.
- Gum Disease – Select this option if the client has been diagnosed as having gum disease.
- Heart Disease – Select this option if the client has been diagnosed as having heart disease or has knowledge of having family history of heart disease.
- Hepatitis B – Select this option if the client has been diagnosed as having Hepatitis B.
- Diabetes – Select this option if the client has been diagnosed as having diabetes or has knowledge of having family history of diabetes.
- Other – Select this option if the client has other condition(s) not listed above. Specify other condition(s).
- None – Select this option if none of the above apply.

Outcome of Prior Pregnancies

Number of Prior Pregnancies – Enter the number of pregnancies the client has had prior to the date of the encounter.

Number of Live Births – Enter the number of live births the client has had prior to the date of the encounter.

Number of Miscarriages – Enter the number of miscarriages the client has had prior to the date of the encounter. Miscarriage is the spontaneous expulsion of a human fetus before it is viable.

Number of Stillbirths – Enter the number of stillbirths the client has had prior to the date of the encounter. Stillbirth is the birth of a dead fetus.

Number of Low Birth weights (less than 5 1/2 lbs) – Enter the number of low birth weight infants the client has had prior to the date of the encounter.
Initial Prenatal Visit - Definitions

**Number of Premature Births (Less than 37 weeks)** – Enter the number of premature births the client has had prior to the date of the encounter.

**Preterm Labor Experiences with Prior Pregnancies** – Select ‘Yes’ if the client has had experience with preterm labor.

**If yes, describe** – Enter a description explaining the specific preterm labor experience the client has had with her prior pregnancies.

**NICU with Last Pregnancy** – Select ‘Yes’ if the client’s last pregnancy resulted in the child being admitted into the Neonatal Intensive Care Unit (NICU).

**If yes, Length of Stay (days)** – Enter the number of days the client’s infant was in NICU.

**Date Last Pregnancy Ended** – Enter the date the client’s last pregnancy ended.

**Outcome of Last Pregnancy**

- **Live Birth** – Select this option if a fetus, whatever its gestational age, exited the maternal body and subsequently showed any sign of life, such as voluntary movement, heartbeat, or pulsation of the umbilical cord, for however brief a time and regardless of whether the umbilical cord or placenta are intact (World Health Organization, 1950).
- **Termination** – Select this option if pregnancy was terminated.
- **Miscarriage** – Select this option if there was a spontaneous loss of the pregnancy before the 20th week, most often occurring before the 12th week of pregnancy.
- **Stillbirth** – The death of a fetus occurring at any time after 20 weeks of pregnancy. Stillbirth is also known as Intrauterine Fetal Death.

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**Home Safety Environment**

**Working Smoke Detectors(s) in home?** – Select ‘Yes’ if the client has working smoke detectors in her place of residence at the date of the encounter.

**Working Carbon Monoxide Detector in home?** – Select ‘Yes’ if the client has working carbon monoxide detectors in her place of residence at the date of the encounter.

**Healthy Homes Environmental Assessment completed?** – Select ‘Yes’ if the client has had a Healthy Homes Environmental Assessment completed at her place of residence at the encounter.

If ‘Yes’, list the findings
Initial Prenatal Visit - Definitions

- Cigarette/Tobacco Smoke or Ash Tray
- Smell/Odor of Mold, Mildew, or Gas
- Fuel Burning Appliances
- Cockroaches, Frass, Bed bugs, Fleas
- Rats, Mice, Bats
- Food (Human or Pet) and Water Improperly Stored
- Mold/Mildew/Moisture on Surfaces/Walls
- Peeling Paint on Surfaces/Walls
- Carbon Monoxide Detector
- Cleaning Products, Pesticides Not Stored Properly
- Hobbies i.e., Make Jewelry or Glaze Pottery, Work with Stained Glass
- Garbage Improperly Stored
- Accumulation of Dust/Dirt Inside Home
- Clutter
- No Smoke Detectors/Batteries Installed/Operable
- Accessible Medicines/Cleaning Supplies
- Damaged Electrical Outlets or Frayed Wiring
- Fall/Trip Hazards Present (Rugs, Broken Steps)
- Inadequate Lighting
- Lack of Child Proofing of Home (Outlet Covers, Stair Gates, Shortened Window Blind Cords)
- Hand Railings Broken or Missing
- Any Other Concern
- Conducted Education On-Site
- Provided Educational Material(s)
- Mailed Educational Material(s)
- Recommended to a Referral Agency?
- Recommend Follow-Up Visit

Guns in the Home? – Select ‘Yes’ if the client states there are guns in her place of residence at the date of the encounter.

If Yes, are they locked? – Select ‘Yes’ if the client states there are guns in her place of residence at the date of the encounter and they are secured/locked.

Pets in Home? – Select ‘Yes’ if the client has pets in her place of residence at the date of the encounter.

Reproductive Life Plan
Initial Prenatal Visit - Definitions

Using contraception at time of current pregnancy? – Select ‘Yes’ if the client was using contraception at the time of current pregnancy. Select ‘No’ if the client was not using contraception at the time of current pregnancy.

If No, provide reasons

- Didn't mind if I got pregnant - Select this option if the client indicates that she didn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client was not using contraception because of previous birth control side effects.
- My husband or partner didn't want me to use birth control – Select this option if client’s husband or partner did not want her to use any form of birth control.
- Didn't think I could get pregnant – Select this option if the client did not think she could get pregnant.
- Problems getting birth control – Select this option if the client had difficulty obtaining birth control.
- Other – Select this option if another reason applies.

Specify Other – Enter other reason that the client was not using contraception at the time of current pregnancy.

If Yes, Contraception Use?

- No Method – Ignore this choice. If no contraceptive method was used at time of conception, select “No” to question above.
- Abstinence – Select this option if the client refrained from sexual activities.
- Condom – Select this option if condoms were used during sexual intercourse.
- Depo Provera – Select this option if Depo Provera injection was administered to the client.
- Diaphragm – Select this option if the client used a diaphragm during sexual intercourse.
- Hormone Implant – Select this option if the client had hormonal implants.
- IUD (hormone) – Select this option if the client used a hormone IUD (or intrauterine device).
- IUD (non–hormone) – Select this option if the client used an non–hormone IUD (or intrauterine device).
- Patch – Select this option if the patch was used.
- Pill – Select this option if the client used birth control pills.
- Ring – Select this option if the client used the birth control ring.
- Rhythm Method – Select this option if the client practiced the rhythm method.
- Sterilization – Select this option if the client had tubal ligation.
- Withdrawal – Select this option if the client self-reported that her husband or partner withdrew during sexual intercourse.
- Other – Select this option if another method was used.

Specify Other – Enter other type of contraception the client was using at the time of current pregnancy.

If Yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client was using contraception at the time of her current pregnancy and experienced problems.
Initial Prenatal Visit - Definitions

Specify Other – Specify what types of problems the client had with the contraception she was using at the time of the current pregnancy.

Pregnancy Intention – Select ‘Yes’ if the client intended to get pregnant at the time of her current pregnancy.

Plans for contraception after birth? – Select ‘Yes’ if the client has plans for contraception after her current pregnancy is concluded. Select ‘No’ if the client does not have plans for contraception after her current pregnancy is concluded.

If No, provide reasons

- Don’t mind if I get pregnant – Select this option if the client indicates that she doesn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client does not plan to use contraception because of previous birth control side effects.
- My husband or partner doesn’t want me to use birth control – Select this option if client’s husband or partner does not want her to use any form of birth control.
- Don’t think I can get pregnant – Select this option if the client did not think she could get pregnant.
- Problems getting birth control – Select this option if the client thinks she will have difficulty obtaining birth control.
- Other – Select this option if another reason applies.

Specify Other – Enter the other reason(s) that the client will not be using contraception after her current pregnancy.

If yes, Contraception Use?

- No Method – Ignore this choice. If client does not plan to use a contraceptive method after birth, select “No” to question above.
- Abstinence – Select this option if the client plans to refrain from having sexual intercourse.
- Condom – Select this option if client plans to use condoms during sexual intercourse.
- Depo Provera – Select this option if the client plans to use Depo Provera.
- Diaphragm – Select this option if the client plans to use a diaphragm during sexual intercourse.
- Hormone Implant – Select this option if the client plans to obtain a hormonal implant.
- IUD (hormone) – Select this option if the client plans to use a hormone IUD (or intrauterine device).
- IUD (non–hormone) – Select this option if the client plans to use a non-hormone IUD (or intrauterine device).
- Patch – Select this option if the client plans to use a patch.
- Pill – Select this option if the client plans to use birth control pills.
- Ring – Select this option if the client plans to use the birth control ring.
- Rhythm Method – Select this option if the client will practice the rhythm method.
- Sterilization – Select this option if the client plans to have a tubal ligation.
Initial Prenatal Visit - Definitions

- Withdrawal – Select this option if the client plans to practice the husband or partner withdrawal method during sexual intercourse.
- Other – Select this option if another method applies.

Specify Other – Enter other type of contraception the client will be using after the current pregnancy is completed.

If Yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client expects to have problems with contraception she plans to use after the current pregnancy.

Explain Issues/Problems with Contraception – Specify what types of problems the client expects to have with the contraception she plans to use after the current pregnancy.

Risk Assessment (Select all that apply)

- Less Than 18 Years Old or Greater Than 35 Years Old – Select this option if client is less than 18 years of age or the client is greater than 35 years of age.
- Previous Pregnancy Problems – Select this option if the client experienced any complications with previous pregnancies.
- 2nd Pregnancy Within 12 Months – Select this option if the client became pregnant within 12 months of previous pregnancy.
- Tobacco Use – Select this option if client reports tobacco use or there is an indication of tobacco use.
- Alcohol Use – Select this option if client reports alcohol use or there is indication of alcohol use.
- Drug Use – Select this option if client reports use of drugs or there is indication of drug use.
- Vitamin Use – Select this option if client reports use or there is indication of the use of prescribed, over-the-counter, and/or herbal supplements.
- Children in Protective Services – Select this option if client reports that she currently has or had a child/children in protective services.
- Late Entry into Prenatal Care (after 13 weeks) – Select this option if client is 14 weeks or beyond in her pregnancy before receiving prenatal care.
- Dental Care Needs – Select this option if client has current dental needs or expressed interest in obtaining dental care.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Diagnosis of Developmental Disability – Select this option only if client has been diagnosed with a developmental disability.
- Food Insecurity – Select this option if the client has a lack of access to a reliable and sufficient quantity of affordable and nutritious food.
- Mental Illness – Select this option if client has been diagnosed with a mental illness or expressed concern about mental illness.
- Poor Environment – Select this option if client resides in a home or area that is not safe, clean and/or may be hazardous (living conditions) to her health and well-being.
- Language Barriers – Select this option if there is difficulty in communicating.
Initial Prenatal Visit - Definitions

- Non–Compliance with Keeping Appointments – Select if the client has not kept scheduled appointments.
- Lack of Social Support for Mother – Select if the client indicates that she does not have any support, such as family, spouse/partner, friends, etc.
- Lack of Emotional Support of Father – Select if the client has self-reported lack of support from the father.
- Lack of Financial Support of Father – Select if the client reported no financial support from the father.
- Lack of Transportation – Select if the client does not have access to transportation.
- Did Not Know was Pregnant – Select if the client was unaware she was pregnant with her current pregnancy.
- Multiple Birth – Select if the client is currently pregnant with twins, triplets, etc.
- No Insurance – Select if the client does not have medical insurance.
- Low Income – Select if the client has reported her income is below poverty level.
- Less than High School Education – Select if the client did not receive a high school diploma or equivalent.
- Death of a Baby Before Age One – Select this option if the baby does not live to reach his/her first birthday.
- Other – Select this option if another risk applies.
- None – DO NOT SELECT THIS OPTION.

Specify Other – Enter any other types of risk the client indicates at the time of the encounter.

5 A's Smoking Cessation Program

ASK

Smoking Status - Select one from the following options regarding the client’s usage of tobacco products.

- Never
- Former
- Current

# Days Smoked in the Past 30 Days – The number of days the client smoked in the past 30 days.

# Cigarettes/Day – The number of cigarettes the client smokes per day.

Secondhand Smoke Exposure

Client – Select ‘Yes’ if the client is exposed to secondhand smoke in her place of residence or work. Select ‘No’ if the client is not exposed to secondhand smoke in her place of residence or work.

Child /Children – Select ‘Yes’ if the Child/Children are exposed to secondhand smoke. Select ‘No’ if the Child/Children are not exposed to secondhand smoke.
Initial Prenatal Visit - Definitions

ADVISE

- Strong Advice to Quit
- Benefits of Quitting
- Harms of Smoking
- Difficulty of Quitting
- Risks of Secondhand Smoke Exposure
- Client Refused

ASSESS

Willingness to Quit in 30 Days – Select ‘Yes’ if the client is willing to quit in 30 days. Select ‘No’ if the client is not willing to quit in 30 days.

Stages of Change – Select one of the following “Stages of Change” the client reported at the time of the encounter.

- Pre–contemplation
- Contemplation
- Preparation
- Action
- Maintenance

If ‘Yes’, set quit date.

If ‘No’, list reason(s) for not quitting.

ASSIST

- Follow-up from Last Visit
- Review Problem Solving Skills
- Provide Self-Help Materials
- Provide Social Support
- Identify Local Social Support
- Client Refused

ARRANGE

- Cessation Specialist
- Quit Line
Initial Prenatal Visit - Definitions

- Baby and Me Tobacco–Free Program
- Client Refused

Follow-up Appointment – Enter the date for the client’s next Follow-up Appointment.

Screenings/Assessments – (Select all that apply)

- Edinburgh Postnatal Depression Scale 1 (EPDS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Domestic Violence
- Ages and Stages Questionnaire
- None
- Other

Specify Other – Enter other type Screening/Assessment that was done at the time of the encounter.

Partners for a Healthy Baby Provided – Select ‘Yes’ if the ‘Partners for a Healthy Baby’ curriculum was used at the time of the encounter. Select ‘No’ if the ‘Partners for a Healthy Baby’ curriculum was not used at the time of the encounter.

If ‘Yes’ was selected above then select one or more of the following:

- Before Baby Arrives
- Baby’s First Six Months
- Baby’s Months 7–12
- Baby’s Months 13–18
- Toddler’s Months 19–36

If selected, check the specific materials provided.

Client Referred – Select ‘Yes’ if the client was referred to another program or agency at the time of the encounter. Select ‘No’ if the client was not referred to another program or agency at the time of the encounter.

Referrals – If ‘Yes’ was selected above then select all that apply:

Referral resources will be listed for each OIMRI project.

Time Spent for this Encounter (mins) – Enter the time in minutes that was spent on this encounter.

Notes/Follow up – Use this section to enter any additional notes about the client and/or the encounter.
Initial Prenatal Visit - Definitions

**Success Story** – Use this section to record client’s/CHW noteworthy accomplishments and/or overall successful program outcomes.

**Flag for Follow-up** – Check this box if the encounter should be flagged for additional follow-up.

**Follow-up Date** – Enter the date for additional follow-up.

**Follow-up Completed** – Check this box if the follow-up has been completed.

**Reason for Follow-up** - Select those that apply to the client.

- Transportation
- Addiction Treatment
- Housing
- Child Care
- Fatherhood Services
- Insurance
- Food
- Education
- Utilities
- Medical/Dental
- Clothing
- Employment
- Domestic Violence/Child Safety
- Mental Health
- Furniture
- Legal Assistance
- Referral for Child
Prenatal Visit - Definitions

Facility – Use the drop down menu to select the agency where the client was seen. If you do not see your agency listed in the drop down menu, please contact your technical support.

County – Use the drop down menu to select the county where the client was seen. If you do not see your county listed in the drop down menu, please contact your technical support.

Date of Encounter – Enter the date the client was seen. This is not necessarily the same date as the data entry date.

Home Visitor – Enter the name of the community health worker who completed the encounter.

Contact Type – Select the appropriate option of how the Home Visitor conducted the encounter with the client.

- Home Visit – Select this option if a face-to-face interaction was made between the community health worker and parent and/or family.
- Hospital – Select this option if the face-to-face interaction occurred in the hospital.
- Office – Select this option if the face-to-face interaction occurred in the physician’s office, healthcare center, agency or health department, etc.
- Phone – Select this option if contact occurred by phone.
- Email – Select this option if communication occurred by email.
- Text Message – Select this option if communication occurred by text.
- Other – Select this option if another location applies. If selected, explain in the Notes/Follow-up section at the bottom of the page.

# Contact Attempts – Enter the number of attempts made to contact the client prior to the encounter.

Entered By – The name of the staff member who entered the encounter into the OIMRI system. This may be a different person than the “Home Visitor.”

Encounter Reasons – Check all of the reasons for this encounter

Encounter Reasons – Check all of the reasons for this encounter

- General Follow up – Select this option if this encounter’s purpose is to check on client.
- Insurance – Select this option to document or initiate that the client has medical coverage.
- Medical/Dental – Select this option if medical or dental referral is required.
- Mental Health – Select this option if mental health referral is required.
- Food – Select this option if a referral was made for services, such as food pantry, WIC, or other local resources.
Prenatal Visit - Definitions

- Transportation – Select this option if a referral was made for transportation services, such as bus passes, taxi, car repair or other local resources.
- Housing – Select this option if a referral was made for housing services.
- Education – Select this option if client indicates educational services are required, such as GED, financial aid, tutoring services, placement exams, etc.
- Child Care – Select this option if client requires child care services.
- Utilities – Select this option if client requires assistance with utility services.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Referral for Child – Select this option if referral for child is needed for developmental screenings, evidence of abuse, or educational services.
- Other – Select this option if another reason applies.

Specify Other – Enter the ‘Other” type of encounter reason

Client Status

Weeks Pregnant – Enter the number for how many weeks pregnant the client was at the time of the encounter.

Expected Due Date – Enter the expected due date of the client at the time of the encounter.

Weeks gestation when prenatal care began – Enter the number of weeks gestation when the client’s prenatal care began.

Number of prenatal visits scheduled – Enter a number for how many prenatal visits the client has scheduled to date at the time of the encounter. This does not include future scheduled visits.

Number of visits kept – Enter a number for how many prenatal visits the client has kept to date at the time of the encounter.

Plans for contraception after birth – Select ‘Yes’ if the client has plans for contraception after her current pregnancy.

If No, provide reasons

- Don’t mind if I get pregnant – Select this option if the client indicates that she doesn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client does not plan to use contraception because of previous birth control side effects.
- My husband or partner doesn’t want me to use birth control – Select this option if client’s husband or partner does not want her to use any form of birth control.
- Don’t think I can get pregnant – Select this option if the client does not think she could get pregnant.
Prenatal Visit - Definitions

- Problems getting birth control – Select this option if the client thinks she will have difficulty obtaining birth control.
- Other – Select this option if another reason applies.

Specify Other – Enter other reason that the client does not plan to use contraception after the current pregnancy.

If Yes, Contraception Use?

- No Method – Select this option if the client will not, in the future, use contraceptives.
- Abstinence – Select this option if the client plans to refrain from having sexual intercourse.
- Condom – Select this option if client plans to use condoms during sexual intercourse.
- Depo Provera – Select this option if the client plans to use Depo Provera.
- Diaphragm – Select this option if the client plans to use a diaphragm during sexual intercourse.
- Hormone Implant – Select this option if the client plans to obtain a hormonal implant.
- IUD (hormone) – Select this option if the client plans to use a hormone IUD (or intrauterine device)
- IUD (non–hormone) – Select this option if the client plans to use a non-hormone IUD (or intrauterine device)
- Patch – Select this option if the client plans to use a patch.
- Pill – Select this option if the client plans to use birth control pill.
- Ring – Select this option if the client plans to use the birth control ring.
- Rhythm Method – Select this option if the client will practice the rhythm method.
- Sterilization – Select this option if the client plans to have a tubal ligation.
- Withdrawal – Select this option if the client plans to practice the husband or partner withdrawal method during sexual intercourse.
- Other – Select this option if none of the above apply.

Specify Other – Enter other type of contraception the client plans to use after the current pregnancy.

If yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client anticipates issues or problems with using contraception after her current pregnancy.

Specify Other – Specify what types of problems the client anticipates with using contraception after her current pregnancy.

Risk Assessment (Select all that apply)

- Less Than 18 Years Old or Greater Than 35 Years Old – Select this option if client is less than 18 years of age or the client is greater than 35 years of age.
- Previous Pregnancy Problems – Select this option if the client experienced any complications with previous pregnancies.
- 2nd Pregnancy Within 12 Months – Select this option if the client became pregnant within 12 months of previous pregnancy.
Prenatal Visit - Definitions

- Tobacco Use – Select this option if client reports tobacco use or there is an indication of tobacco use.
- Alcohol Use – Select this option if client reports alcohol use or there is indication of alcohol use.
- Drug Use – Select this option if client reports use of drugs or there is indication of drug use.
- Vitamin Use – Select this option if client reports use or there is indication of the use of prescribed, over-the-counter, and/or herbal supplements.
- Children in Protective Services – Select this option if client reports that she currently has or had a child in protective services.
- Late Entry into Prenatal Care (after 13 weeks) – Select this option if client is 14 weeks or beyond in her pregnancy before receiving prenatal care.
- Dental Care Needs – Select this option if client has current dental needs or expressed interest in obtaining dental care.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Diagnosis of Developmental Disability – Select this option only if client has been diagnosed with a developmental disability.
- Food Insecurity – Select this option if the client has a lack of access to a reliable and sufficient quantity of affordable and nutritious food.
- Mental Illness – Select this option if client has been diagnosed with a mental illness.
- Poor Environment – Select this option if client resides in a home or area that is not safe, clean and/or may be hazardous (living conditions) to her health and well-being.
- Language Barriers – Select this option if there is difficulty in communicating.
- Non–Compliance with Keeping Appointments – Select if the client has not kept scheduled appointments.
- Lack of Social Support for Mother – Select if the client indicates that she does not have any support, such as family, spouse/partner, friends, etc.
- Lack of Emotional Support of Father – Select if the client has self-reported non-support from the father.
- Lack of Financial Support of Father – Select if the client reported no financial support from the father.
- Lack of Transportation – Select if the client does not have access to transportation.
- Did Not Know was Pregnant – Select if the client was unaware she was pregnant.
- Multiple Birth – Select if the client is currently pregnant with twins, triplets, etc.
- No Insurance – Select if the client does not have medical insurance.
- Low Income – Select if the client has reported her income is below poverty level.
- Less than High School Education – Select if the client did not receive a high school diploma or equivalent.
- Death of a Baby Before Age One – Select this option if a baby from a previous pregnancy did not live to reach his/her first birthday.
- Other – Select this option if another risk applies.

Specify Other – Enter any other types of risk the client indicates at the time of the encounter.

5 A's Smoking Cessation Program
Prenatal Visit - Definitions

ASK

Smoking Status - Select one from the following options regarding the client’s usage of tobacco products.

- Never
- Former
- Current

# Days Smoked in the Past 30 Days – The number of days the client smoked in the past 30 days.

# Cigarettes/Day* – The number of cigarettes the client smokes per day.

Secondhand Smoke Exposure

Client – Select ‘Yes’ if the client is exposed to secondhand smoke in her place of residence or work. Select ‘No’ if the client is not exposed to secondhand smoke in her place of residence or work.

Child /Children – Select ‘Yes’ if the Child/Children are exposed to secondhand smoke. Select ‘No’ if the Child/Children are not exposed to secondhand smoke.

ADVISE

- Strong Advice to Quit
- Benefits of Quitting
- Harms of Smoking
- Difficulty of Quitting
- Risks of Secondhand Smoke Exposure
- Client Refused

ASSESS

Willingness to Quit in 30 Days – Select ‘Yes’ if the client is willing to quit in 30 days. Select ‘No’ if the client is not willing to quit in 30 days.

Stages of Change – Select one of the following “Stages of Change” the client reported at the time of the visit.

- Pre–contemplation
- Contemplation
- Preparation
- Action
- Maintenance
Prenatal Visit - Definitions

ASSIST

- Follow-up from Last Visit
- Review Problem Solving Skills
- Provide Self-help Materials
- Provide Social Support
- Identify Local Social Support
- Client Refused

ARRANGE

- Cessation Specialist
- Quit Line
- Baby and Me Tobacco–Free Program
- Client Refused
- Follow-up Appointment

Follow-up Appointment – Enter the date for the clients next Follow-up Appointment.

Screenings/Assessments – (Select all that apply)

- Edinburgh Postnatal Depression Scale 1 (EPDS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Domestic Violence
- None
- Other

Specify Other – Enter other type Screening/Assessment that was done at the time of the encounter.

Partners for a Healthy Baby Provided – Select ‘Yes’ if the ‘Partners for a Healthy Baby’ information was provided at the time of the encounter. Select ‘No’ if the ‘Partners for a Healthy Baby’ information was not provided at the time of the encounter.

If ‘Yes’ was selected above then select one or more of the following:

- Before Baby Arrives
- Baby's First Six Months
- Baby's Months 7–12
- Baby's Months 13–18
- Toddler's Months 19–39
Prenatal Visit - Definitions

**Client Referred** – Select ‘Yes’ if the client was referred to another program or agency at the time of the encounter. Select ‘No’ if the client was not referred to another program or agency at the time of the encounter.

**Referrals** – If ‘Yes’ was selected above then select all that apply:

Referral resources will be listed for each OIMRI project.

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**Time Spent for this Encounter (mins)** – Enter the time in minutes that was spent on this encounter.

**Notes/Follow up** – Use this section to enter any additional notes about the client and/or the encounter.

**Success Story** – Use this section to record client’s/CHW noteworthy accomplishments and/or overall successful program outcomes.

**Flag for Follow-up** – Check this box if the encounter should be flagged for additional follow-up.

**Follow-up Date** – Enter the date for additional follow-up.

**Follow-up Completed** – Check this box if the follow-up has been completed.

**Reason for Follow-up** - Select those that apply to the client.

- Addiction Treatment
- Child Care
- Clothing
- Domestic Violence/Child Safety
- Education
- Employment
- Fatherhood Services
- Food
- Furniture
- Housing
- Insurance
- Legal Assistance
- Medical/Dental
- Mental Health
- Referral for Child
- Transportation
- Utilities
Initial Postpartum Visit- Definitions

**Facility** – Use the drop down menu to select the agency where the client was seen. If you do not see your agency listed in the drop down menu, please contact your technical support.

**County** – Use the drop down menu to select the county where the client was seen. If you do not see your county listed in the drop down menu, please contact your technical support.

**Date of Encounter** – Enter the date the client was seen. This is not necessarily the same date as the data entry date.

**Home Visitor** – Enter the name of the community health worker who completed the encounter.

**Contact Type** – Select the appropriate option of how the Home Visitor conducted the encounter with the client.

- Home Visit – Select this option if a face-to-face interaction was made between the community health worker and parent and/or family.
- Hospital – Select this option if the face-to-face interaction occurred in the hospital.
- Office – Select this option if the face-to-face interaction occurred in the physician’s office, healthcare center, agency or health department, etc.
- Phone – Select this option if contact occurred by phone.
- Email – Select this option if communication occurred by email.
- Text Message – Select this option if communication occurred by text.
- Other – Select this option if another location applies. If selected, explain in the Notes/Follow-up section at the bottom of the page.

**# Contact Attempts** – Enter the number of attempts made to contact the client prior to the encounter.

**Entered By** – The name of the staff member who entered the encounter into the OIMRI system. This may be a different person than the “Home Visitor.”

**Encounter Reasons** – Check all of the reasons for this encounter

- General Follow up – Select this option if this encounter’s purpose is to check on client.
- Insurance – Select this option to document or initiate that the client has medical coverage.
- Medical/Dental – Select this option if medical or dental referral is required.
- Mental Health – Select this option if mental health referral is required.
- Food – Select this option if a referral was made for services, such as food pantry, WIC, or other local resources.
- Transportation – Select this option if a referral was made for transportation services, such as bus passes, taxi, car repair or other local resources.
- Housing – Select this option if a referral was made for housing services.
Initial Postpartum Visit- Definitions

- Education – Select this option if client indicates educational services are required, such as GED, financial aid, tutoring services, placement exams, etc.
- Child Care – Select this option if client requires child care services.
- Utilities – Select this option if client requires assistance with utility services.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Referral for Child – Select this option if referral for child is needed for developmental screenings, evidence of abuse, or educational services.
- Other – Select this option if another reason applies.

Specify Other – Enter the ‘Other’ type of encounter reason.

Initial Postpartum Information

Postpartum Visits Scheduled – Enter the number of postpartum visits the client has scheduled at the time of the encounter.

Postpartum Visits Kept – Enter the number of postpartum visits the client has kept at the time of the encounter.

Last Visit Date Kept – Enter date of the last visit the client kept at the time of the encounter.

Did Client Report Postpartum Depression – Select ‘Yes’ if the client reported postpartum depression at the time of the encounter.

Household Size – Enter the number of individuals in a client’s family who are supported by the amount of income listed in the “Household Income” field. “Family” is defined as a social unit composed of one or more person(s) living together as a household including dependents away at school. If the client is a teenager requesting confidential services, she is considered to have a household size of two (2). If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), that child is not counted as part of the household size. A pregnant woman is counted as two (2).

Household Income – Enter the weekly, monthly, or yearly total, combined income (before taxes or deductions) of all individuals in the client’s family (see definition of “family” in Household Size). If the weekly or monthly income varies during the year, use an average. If the client is a teenager requesting confidential services, use only her/his personal financial resources for determining the weekly income. If a family receives direct payments (cash in-hand) for child support, include as part of the household income; if a family receives child support payments (indirectly) through CDJFS, do not count the child support separately from the CDJFS payments. If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), the amount of child support paid is excluded from the gross amount of the family’s income. Do not include the total income
for other families living at the same address. Do not include SSI monies, which must be spent for a
designated family member. Do not include Metropolitan Housing allowance, Food Stamp vouchers, or
the like.

**Income Verified** – Select “Yes” if the client has shown income documentation (e.g. pay stub,
employment record). Documentation is a MANDATORY CFHS policy, per the CFHS Administrative
Program Standards. A signed self-report can be an acceptable form of income verification.

**Household Annual Income** – This field is populated automatically in the OIMRI application. It does not
appear on the Initial Prenatal Visit form.

**Housing Situation** – Select the appropriate status of the client’s housing information at the time of the
encounter.

- Permanent – Select this option if client’s place of residence is stable.
- Temporary – Select this option if client’s place of residence is short-term or uncertain.
- Homeless – Select this option if client does not have affordable and suitable place of residence.

**Insurance Status** – Select the appropriate state of the client’s insurance at the time of the encounter

- Medicaid – Select this option if the client is enrolled in Medicaid.
- Uninsured/Underinsured (Partial Pay) – Select this option if the client does not have a third-
  party payer for services received at this encounter and is between 100% and 250% of the federal
  poverty level.
- Private Insurance – Select this option if the client has any health insurance policy purchased by
  an employer, through the market place exchange, or by an individual from a private insurance
  company.
- Uninsured/Underinsured (No Pay) – Select this option if the client does not have a third-party
  payer for services received at this encounter and is below 100% of the federal poverty level.
- Uninsured/Underinsured (Full Pay) – Select this option if the client does not have a third-party
  payer for services received at this encounter and is above 250% of the federal poverty level.
- Other – Select this option if the client has a third-party payer for these services other than
  Medicaid or private insurance. This field should not be used to record more detailed information
  about one of the previous categories (i.e., name of Medicaid HMO or private insurance
  company).

**Specify Other** – Enter the “Other” type of insurance the client reported at the time of the encounter.

**Uninsured / Underinsured Status** – Select the appropriate of the client’s Uninsured / Underinsured
Status

- Medicaid Application Assistance - Combined Programs Application (CPA) has been completed
  and will be submitted to the County Department of Jobs and Family Services (CDJFS) for
Initial Postpartum Visit- Definitions

Medicaid enrollment. Refer to the CPA Policy in the CFHS Program Standards Administration Manual.

- Medicaid Eligibility Pending - CPA was previously submitted to CDJFS and notice of Medicaid enrollment has not been received.
- Medicaid Ineligible – Client previously applied for Medicaid but was found to be ineligible by CDJFS.
- Client Refused Medicaid - Client may be eligible but refuses Medicaid services at this time or does not follow through on the submission of required documents.

Mother’s Education – Select the client’s last known level of education at the time of the encounter.

- 8th Grade or Less
- 9th through 12th Grade; No Diploma
- High School Graduate or GED Completed
- Some College Credit, but No Degree
- Associate Degree
- Bachelor’s Degree
- Master’s Degree
- Doctorate Degree
- Unknown – Select this option if the client is unsure of her last level of education.

Birth Outcome

Plans for contraception after birth – Select ‘Yes’ if the client has plans for contraception after her most recent pregnancy.

If No, provide reasons

- Don’t mind if I get pregnant – Select this option if the client indicates that she doesn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client does not plan to use contraception because of previous birth control side effects.
- My husband or partner doesn’t want me to use birth control – Select this option if client’s husband or partner does not want her to use any form of birth control.
- Don’t think I can get pregnant – Select this option if the client does not think she could get pregnant.
- Problems getting birth control –Select this option if the client thinks she will have difficulty obtaining birth control.
- Other – Select this option if another reason applies.

Specify Other – Enter other reason that the client does not plan to use contraception after the most recent pregnancy.
Initial Postpartum Visit- Definitions

If Yes, Contraception Use?

- **No Method** – Select this option if the client will not, in the future, use contraceptives.
- **Abstinence** – Select this option if the client plans to refrain from having sexual intercourse.
- **Condom** – Select this option if client plans to use condoms during sexual intercourse.
- **Depo Provera** – Select this option if the client plans to use Depo Provera.
- **Diaphragm** – Select this option if the client plans to use a diaphragm during sexual intercourse.
- **Hormone Implant** – Select this option if the client plans to obtain a hormonal implant.
- **IUD (hormone)** – Select this option if the client plans to use a hormone IUD (or intrauterine device).
- **IUD (non–hormone)** – Select this option if the client plans to use a non–hormone IUD (or intrauterine device).
- **Patch** – Select this option if the client plans to use a patch.
- **Pill** – Select this option if the client plans to use birth control pills.
- **Ring** – Select this option if the client plans to use the birth control ring.
- **Rhythm Method** – Select this option if the client will practice the rhythm method.
- **Sterilization** – Select this option if the client plans to have a tubal ligation.
- **Withdrawal** – Select this option if the client plans to practice the husband or partner withdrawal method during sexual intercourse.
- **Other** – Select this option if another method applies.

**Specify Other** – Enter other type of contraception the client plans to use after the most recent pregnancy.

If Yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client anticipates with issues or problems with using contraception after her most recent pregnancy.

**Specify Other** – Specify what types of problems the client anticipates with using contraception after her current pregnancy.

**Child 1, 2, 3** – Select the name of the child(ren) for the client’s current pregnancy. *Please note, the child must exist in the MCHIDS system under the ‘Relationship’ tab before the child will become available as an option in the child drop down menu. If the child is not available in the drop down menu, it is recommended that you use the ‘Save as Draft’ button located at the bottom of the form. Once your record is saved in ‘Draft,’ you can then click on the ‘Relationships’ tab and enter the child information. Please note that if you do not click the “Save as Draft” button you will lose all of the data you entered for the encounter. Also note that when creating a relationship that for the child drop down menus in the “Initial Prenatal Report” that the child’s relationship status must be either “Son,” “Daughter,” or “Child.” Once you have successfully saved the child information you can return to the ‘Draft’ record by clicking on the ‘OIMRI VISITS/ENCOUNTERS’ tab and editing the record. The child will now become available as an option in ‘Child’ drop down menu.*

**Source of data for birth information** – Select the source of the birth information from the drop down menu.

- **Birth Certificate**
- **Client**
Initial Postpartum Visit - Definitions

- Other

**Specify Other** – If you selected ‘Other’ as an option for ‘Source of data for birth information,’ enter the other source of the birth information.

**Weeks gestation at time of delivery** – Enter the weeks gestation of the child at the time of the delivery.

**Birth Date** – Enter the date of birth for the child.

**Birth Weight** – Enter the weight for the child at the time of delivery.

**NICU Admission?** – Select ‘Yes’ if the child was admitted to the Neonatal Intensive Care Unit (NICU) after delivery.

If yes, length of stay (days) – If you selected ‘Yes’ that the child was admitted to the NICU, enter the length of stay in days at the time of the encounter.

**Sleep position of baby** – Select the sleeping position of the baby as reported by the mother at the time of the encounter.

- Back
- Stomach
- Side

**Mother Sleeping in Same Bed?** – Select ‘Yes’ if the mother sleeps in the same bed as the child at the time of the encounter. Select ‘No’ if the mother does not sleep in the same bed as the child at the time of the encounter.

**Breastfeeding Initiated?** – Select ‘Yes’ if the mother has initiated breastfeeding after birth of the child. Select ‘No’ if the mother has not initiated breastfeeding after birth of the child.

**Current feeding** – Select the current method the mother uses to feed the child at the time of the encounter.

- Breastmilk
- Formula
- Breastmilk and Formula

**Reason quit Breastfeeding** – Enter a reason the client stopped breastfeeding if the ‘Formula’ option was selected for ‘Current Feeding.’

**If not Currently Breastfeeding, Number of Weeks Breastfed** – Enter a number of weeks the child was breastfed prior to the mother stopping breastfeeding.

**Number of Cigarettes Smoked in 3 months prior to Pregnancy** – Enter the number of cigarettes the mother smoked per day in the three months preceding the pregnancy.
Initial Postpartum Visit- Definitions

**Number of Cigarettes Smoked in 1st 3 months** – Enter the number of cigarettes the mother smoked per day in the first three months of the pregnancy.

**Number of Cigarettes Smoked in 2nd 3 months** – Enter the number of cigarettes the mother smoked per day in the second three months of the pregnancy.

**Number of Cigarettes Smoked in 3rd trimester or last 3 months** – Enter the number of cigarettes the mother smoked per day in the third three months of the pregnancy.

**Has Child Been referred to WIC from staff?** – Select ‘Yes’ if the client has been referred to the WIC program.

**If No, Explain:** – If the client was not referred to the WIC program, type in an explanation why.

**Child’s Immunization Status** – Make a selection based upon the child’s current immunization status.

- Complete for Age – Select this option if the child received complete/full immunizations as recommended for age per the CDC schedule.
- In progress – Select this option if immunizations are not complete as recommended for age per the CDC schedule, but are in progress.
- Incomplete for age – Select this option if immunizations are not complete as recommended for age per the CDC schedule, and are not in progress.
- Unknown – Select this option if the immunization status is unknown at the time of the encounter.

**Well Child Visits Scheduled** – Enter the number of well child visits the child has scheduled at the time of the encounter.

**Well Child Visits Kept** – Enter the number of well child visits the child has kept at the time of the encounter.

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**Risk Assessment (Select all that apply)**

- Less Than 18 Years Old or Greater Than 35 Years Old – Select this option if client is less than 18 years of age or the client is greater than 35 years of age.
- Previous Pregnancy Problems – Select this option if the client experienced any complications with the most recent pregnancy.
- 2nd Pregnancy Within 12 Months – Select this option if the client became pregnant within 12 months of previous pregnancy.
- Tobacco Use – Select this option if client reports tobacco use or there is an indication of tobacco use.
- Alcohol Use – Select this option if client reports alcohol use or there is indication of alcohol use.
- Drug Use – Select this option if client reports use of drugs or there is indication of drug use.
- Vitamin Use – Select this option if client reports use or there is indication of the use of prescribed, over-the-counter, and/or herbal supplements.
Initial Postpartum Visit - Definitions

- Children in Protective Services – Select this option if client reports that she currently has or had a child in protective services.
- Late Entry into Prenatal Care (after 13 weeks) – Select this option if client is 14 weeks or beyond in her pregnancy before receiving prenatal care.
- Dental Care Needs – Select this option if client has current dental needs or expressed interest in obtaining dental care.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Diagnosis of Developmental Disability – Select this option only if client has been diagnosed with a developmental disability.
- Food Insecurity – Select this option if the client has a lack of access to a reliable and sufficient quantity of affordable and nutritious food.
- Mental Illness – Select this option if client has been diagnosed with a mental illness.
- Poor Environment – Select this option if client resides in a home or area that is not safe, clean and/or may be hazardous (living conditions) to her health and well-being.
- Language Barriers – Select this option if there is difficulty in communicating.
- Non-Compliance with Keeping Appointments – Select if the client has not kept scheduled appointments.
- Lack of Social Support for Mother – Select if the client indicates that she does not have any support, such as family, spouse/partner, friends, etc.
- Lack of Emotional Support of Father – Select if the client has self-reported non-support from the father.
- Lack of Financial Support of Father – Select if the client reported no financial support from the father.
- Lack of Transportation – Select if the client does not have access to transportation.
- Did Not Know was Pregnant – Select if the client was unaware she was pregnant with the most recent pregnancy.
- Multiple Birth – Select if the client had twins, triplets, etc. with the most recent pregnancy.
- No Insurance – Select if the client does not have medical insurance.
- Low Income – Select if the client has reported her income is below poverty level.
- Less than High School Education – Select if the client did not receive a high school diploma or equivalent.
- Death of a Baby Before Age One – Select this option if the baby does not live to reach his/her first birthday.
- Other – Select this option if another reason applies.

Specify Other – Enter any other types of risk the client indicates at the time of the encounter.

5 A’s Smoking Cessation Program

ASK

Smoking Status - Select one from the following options regarding the client’s usage of tobacco products

- Never
Initial Postpartum Visit - Definitions

- Former
- Current

# Days Smoked in the Past 30 Days – The number of days the client smoked in the past 30 days.

# Cigarettes/Day – The number of cigarettes the client smokes per day.

Secondhand Smoke Exposure

Client – Select ‘Yes’ if the client is exposed to secondhand smoke in her place of residence or work. Select ‘No’ if the client is not exposed to secondhand smoke in her place of residence or work.

Child /Children – Select ‘Yes’ if the Child/Children are exposed to secondhand smoke. Select ‘No’ if the Child/Children are not exposed to secondhand smoke.

ADVISE

- Strong Advice to Quit
- Benefits of Quitting
- Harms of Smoking
- Difficulty of Quitting
- Risks of Secondhand Smoke Exposure
- Client Refused

ASSESS

Willingness to Quit in 30 Days – Select ‘Yes’ if the client is willing to quit in 30 days. Select ‘No’ if the client is not willing to quit in 30 days.

Stages of Change – Select one of the following “Stages of Change” the client reported at the time of the encounter.

- Pre–contemplation
- Contemplation
- Preparation
- Action
- Maintenance

ASSIST

- Follow-up from Last Visit
Initial Postpartum Visit - Definitions

- Review Problem Solving Skills
- Provide Self-help Materials
- Provide Social Support
- Identify Local Social Support
- Client Refused

ARRANGE

- Cessation Specialist
- Quit Line
- Baby and Me Tobacco–Free Program
- Client Refused
- Follow-up Appointment

Follow-up Appointment – Enter the date for the client’s next Follow-up Appointment.

Screenings/Assessments – (Select all that apply)

- Edinburgh Postnatal Depression Scale 1 (EPDS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Domestic Violence
- None
- Other

Specify Other – Enter other type Screening/Assessment that was done at the time of the encounter.

Partners for a Healthy Baby Provided – Select ‘Yes’ if the ‘Partners for a Healthy Baby’ information was provided at the time of the encounter. Select ‘No’ if the ‘Partners for a Healthy Baby’ information was not provided at the time of the encounter.

If ‘Yes’ was selected above then select one or more of the following:

- Before Baby Arrives
- Baby’s First Six Months
- Baby’s Months 7–12
- Baby’s Months 13–18
- Toddler’s Months 19–39

Client Referred – Select ‘Yes’ if the client was referred to another program or agency at the time of the encounter. Select ‘No’ if the client was not referred to another program or agency at the time of the encounter.
Initial Postpartum Visit - Definitions

Referrals – If ‘Yes’ was selected above then select all that apply:
Referral resources will be listed for each OIMRI project.

Time Spent for this Encounter (mins) – Enter the time in minutes that was spent on this encounter.

Notes/Follow-up – Use this section to enter any additional notes about the client and/or the encounter.

Success Story – Use this section to record client’s/CHW noteworthy accomplishments and/or overall successful program outcomes.

Flag for Follow-up – Check this box if the encounter should be flagged for additional follow-up.

Follow-up Date – Enter the date for additional follow-up.

Follow-up Completed – Check this box if the follow-up has been completed.

Reason for Follow-up - Select those that apply to the client.

- Addiction Treatment
- Child Care
- Clothing
- Domestic Violence/Child Safety
- Education
- Employment
- Fatherhood Services
- Food
- Furniture
- Housing
- Insurance
- Legal Assistance
- Medical/Dental
- Mental Health
- Referral for Child
- Transportation
- Utilities
Postpartum Visit- Definitions

**Facility** – Use the drop down menu to select the agency where the client was seen. If you do not see your agency listed in the drop down menu, please contact your technical support.

**County** – Use the drop down menu to select the county where the client was seen. If you do not see your county listed in the drop down menu, please contact your technical support.

**Date of Encounter** – Enter the date the client was seen. This is not necessarily the same date as the data entry date.

**Home Visitor** – Enter the name of the community health worker who completed the encounter.

**Contact Type** – Select the appropriate option of how the Home Visitor conducted the encounter with the client.

- Home Visit – Select this option if a face-to-face interaction was made between the community health worker and parent and/or family.
- Hospital – Select this option if the face-to-face interaction occurred in the hospital.
- Office – Select this option if the face-to-face interaction occurred in the physician’s office, healthcare center, agency or health department, etc.
- Phone – Select this option if contact occurred by phone.
- Email – Select this option if communication occurred by email.
- Text Message – Select this option if communication occurred by text.
- Other – Select this option if another location applies. If selected, explain in the Notes/Follow-up section at the bottom of the page.

**# Contact Attempts** – Enter the number of attempts made to contact the client prior to the encounter.

**Entered By** – The name of the staff member who entered the encounter into the OIMRI system. This may be a different person than the “Home Visitor.”

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**Encounter Reasons** – Check all of the reasons for this encounter

- General Follow up – Select this option if this encounter’s purpose is to check on client.
- Insurance – Select this option to document or initiate that the client has medical coverage.
- Medical/Dental – Select this option if medical or dental referral is required.
- Mental Health – Select this option if mental health referral is required.
- Food – Select this option if a referral was made for services, such as food pantry, WIC, or other local resources.
- Transportation – Select this option if a referral was made for transportation services, such as bus passes, taxi, car repair or other local resources.
- Housing – Select this option if a referral was made for housing services.
Postpartum Visit - Definitions

- Education – Select this option if client indicates educational services are required, such as GED, financial aid, tutoring services, placement exams, etc.
- Child Care – Select this option if client requires child care services.
- Utilities – Select this option if client requires assistance with utility services.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Referral for Child – Select this option if referral for child is needed for developmental screenings, evidence of abuse, or educational services.
- Other – Select this option if another reason applies.

Specify Other – Enter the ‘Other’ type of encounter reason.

Postpartum Information

Postpartum Visits Scheduled – Enter the number of postpartum visits the client has scheduled at the time of the encounter.

Postpartum Visits Kept – Enter the number of postpartum visits the client has kept at the time of the encounter.

Last Visit Date Kept – Enter date of the last postpartum visit the client kept at the time of the encounter.

Did Client Report Postpartum Depression – Select ‘Yes’ if the client reported postpartum depression at the time of the encounter.

Plans for contraception after birth – Select ‘Yes’ if the client has plans for contraception after her most recent pregnancy.

If No, provide reasons

- Don’t mind if I get pregnant – Select this option if the client indicates that she doesn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client does not plan to use contraception because of previous birth control side effects.
- My husband or partner doesn’t want me to use birth control – Select this option if client’s husband or partner does not want her to use any form of birth control.
- Don’t think I can get pregnant – Select this option if the client does not think she could get pregnant.
- Problems getting birth control – Select this option if the client thinks she will have difficulty obtaining birth control.
- Other – Select this option if another reason applies.
Postpartum Visit - Definitions

Specify Other – Enter other reason that the client does not plan to use contraception after the most recent pregnancy.

If yes, Contraception Use?

- **No Method** – Select this option if the client will not, in the future, use contraceptives.
- Abstinence – Select this option if the client plans to refrain from having sexual intercourse.
- Condom – Select this option if client plans to use condoms during sexual intercourse.
- Depo Provera – Select this option if the client plans to use Depo Provera.
- Diaphragm – Select this option if the client plans to use a diaphragm during sexual intercourse.
- Hormone Implant – Select this option if the client plans to obtain a hormonal implant.
- IUD (hormone) – Select this option if the client plans to use a hormone IUD (or intrauterine device).
- IUD (non–hormone) – Select this option if the client plans to use a non-hormone IUD (or intrauterine device).
- Patch – Select this option if the client plans to use a patch.
- Pill – Select this option if the client plans to use birth control pills.
- Ring – Select this option if the client plans to use the birth control ring.
- Rhythm Method – Select this option if the client will practice the rhythm method.
- Sterilization – Select this option if the client plans to have a tubal ligation.
- Withdrawal – Select this option if the client plans to practice the husband or partner withdrawal method during sexual intercourse.
- Other – Select this option if another method applies.

Specify Other – Enter other type of contraception the client plans to use after the most recent pregnancy.

If yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client anticipates issues or problems with using contraception after her most recent pregnancy.

Specify Other – Specify what types of problems the client anticipates with using contraception after her most recent pregnancy.

Child 1, 2, 3 – Select the name of the child(ren) for the client’s current pregnancy. *Please note, the child must exist in the MCHIDS system under the ‘Relationship’ tab before the child will become available as an option in the child drop down menu. If the child is not available in the drop down menu, it is recommended that you use the ‘Save as Draft’ button located at the bottom of the form. Once your record is saved in ‘Draft,’ you can then click on the ‘Relationships’ tab and enter the child information. Please note that if you do not click the “Save as Draft” button you will lose all of the data you entered for the encounter. Also note that when creating a relationship that for the child drop down menus in the “Initial Prenatal Report” that the child’s relationship status must be either “Son,” “Daughter,” or “Child.” Once you have successfully saved the child information you can return to the ‘Draft’ record by clicking on the ‘OIMRI VISITS/ENCOUNTERS’ tab and editing the record. The child will now become available as an option in ‘Child’ drop down menu.
Postpartum Visit- Definitions

Source of data for birth information – Select the source of the birth information from the drop down menu.

- Hospital
- Client
- Other

Specify Other – If you selected ‘Other’ as an option for ‘Source of data for birth information,’ enter the other source of the birth information.

Weeks gestation at time of delivery – Enter the weeks gestation of the child at the time of the delivery.

Birth Date – Enter the date of birth for the child.

Birth Weight – Enter the weight for the child at the time of delivery.

NICU Admission? – Select ‘Yes’ if the child was admitted to the Neonatal Intensive Care Unit (NICU) after delivery.

If yes, length of stay (days) – If you selected ‘Yes’ that the child was admitted to the NICU, enter the length of stay in days at the time of the encounter.

Sleep position of baby – Select the sleeping position of the baby as reported by the mother at the time of the encounter.

- Back
- Stomach
- Side

Mother Sleeping in Same Bed? – Select ‘Yes’ if the mother sleeps in the same bed as the child at the time of the encounter. Select ‘No’ if the mother does not sleep in the same bed as the child at the time of the encounter.

Breastfeeding Initiated? – Select ‘Yes’ if the mother has initiated breastfeeding after birth of the child. Select ‘No’ if the mother has not initiated breastfeeding after birth of the child.

Current Feeding – Select the current method the mother uses to feed the child at the time of the encounter.

- Breastmilk
- Formula
- Breastmilk and Formula

Reason Quit Breastfeeding – Enter a reason the client stopped breastfeeding if the ‘Formula’ option was selected for ‘Current Feeding.’
Postpartum Visit- Definitions

If not Currently Breastfeeding, Number of Weeks Breastfed – Enter a number of weeks the child was breastfed prior to the mother stopping breastfeeding.

Number of Cigarettes Smoked in 3 months prior to Pregnancy – Enter the number of cigarettes the mother smoked per day in the three months preceding the pregnancy.

Number of Cigarettes Smoked in 1st 3 months – Enter the number of cigarettes the mother smoked per day in the first three months of the pregnancy.

Number of Cigarettes Smoked in 2nd 3 months – Enter the number of cigarettes the mother smoked per day in the second three months of the pregnancy.

Number of Cigarettes Smoked in 3rd trimester or last 3 months – Enter the number of cigarettes the mother smoked per day in the third three months of the pregnancy.

Has Child Been referred to WIC from staff? – Select ‘Yes’ if the client has been referred to the WIC program.

If No, Explain: – If the client was not referred to the WIC program, type in an explanation why.

Child’s Immunization Status – Make a selection based upon the child’s current immunization status.

- Complete for Age – Select this option if the child received complete/full immunizations as recommended for age per the CDC schedule.
- In progress – Select this option if immunizations are not complete as recommended for age per the CDC schedule, but are in progress.
- Incomplete for age – Select this option if immunizations are not complete as recommended for age per the CDC schedule, and are not in progress.
- Unknown – Select this option if the immunization status is unknown at the time of the encounter.

Well Child Visits Scheduled – Enter the number of well child visits the child has scheduled at the time of the encounter.

Well Child Visits Kept – Enter the number of well child visits the child has kept at the time of the encounter.

Risk Assessment (Select all that apply)

- Less Than 18 Years Old or Greater Than 35 Years Old – Select this option if client is less than 18 years of age or the client is greater than 35 years of age.
- Previous Pregnancy Problems – Select this option if the client experienced any complications with the most recent pregnancy.
- 2nd Pregnancy Within 12 Months – Select this option if the client became pregnant within 12 months of previous pregnancy.
Postpartum Visit- Definitions

- Tobacco Use – Select this option if client reports tobacco use or there is an indication of tobacco use.
- Alcohol Use – Select this option if client reports alcohol use or there is indication of alcohol use.
- Drug Use – Select this option if client reports use of drugs or there is indication of drug use.
- Vitamin Use – Select this option if client reports use or there is indication of the use of prescribed, over-the-counter, and/or herbal supplements.
- Children in Protective Services – Select this option if client reports that she currently has or had a child in protective services.
- Late Entry into Prenatal Care (after 13 weeks) – Select this option if client is 14 weeks or beyond in her pregnancy before receiving prenatal care.
- Dental Care Needs – Select this option if client has current dental needs or expressed interest in obtaining dental care.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Diagnosis of Developmental Disability – Select this option only if client has been diagnosed with a developmental disability.
- Food Insecurity – Select this option if the client has a lack of access to a reliable and sufficient quantity of affordable and nutritious food.
- Mental Illness – Select this option if client has been diagnosed with a mental illness.
- Poor Environment – Select this option if client resides in a home or area that is not safe, clean and/or may be hazardous (living conditions) to her health and well-being.
- Language Barriers – Select this option if there is difficulty in communicating.
- Non–Compliance with Keeping Appointments – Select if the client has not kept scheduled appointments.
- Lack of Social Support for Mother – Select if the client indicates that she does not have any support, such as family, spouse/partner, friends, etc.
- Lack of Emotional Support of Father – Select if the client has self-reported non-support from the father.
- Lack of Financial Support of Father – Select if the client reported no financial support from the father.
- Lack of Transportation – Select if the client does not have access to transportation.
- Did Not Know was Pregnant – Select if the client was unaware she was pregnant with the most recent pregnancy.
- Multiple Birth – Select if the client had twins, triplets, etc. with her most recent pregnancy.
- No Insurance – Select if the client does not have medical insurance.
- Low Income – Select if the client has reported her income is below poverty level.
- Less than High School Education – Select if the client did not receive a high school diploma or equivalent.
- Death of a Baby Before Age One – Select this option if the baby does not live to reach his/her first birthday.
- Other – Select this option if none of the above apply.

**Specify Other** – Enter any other types of risk the client indicates at the time of the encounter.

---

5 A’s Smoking Cessation Program
Postpartum Visit- Definitions

ASK

Smoking Status - Select one from the following options regarding the client’s usage of tobacco products

- Never
- Former
- Current

# Days Smoked in the Past 30 Days – The number of days the client smoked in the past 30 days.

# Cigarettes/Day – The number of cigarettes the client smokes per day.

Secondhand Smoke Exposure

Client – Select ‘Yes’ if the client is exposed to secondhand smoke in her place of residence or work. Select ‘No’ if the client is not exposed to secondhand smoke in her place of residence or work.

Child/Children – Select ‘Yes’ if the Child/Children are exposed to secondhand smoke. Select ‘No’ if the Child/Children are not exposed to secondhand smoke.

ADVISE

- Strong Advice to Quit
- Benefits of Quitting
- Harms of Smoking
- Difficulty of Quitting
- Risks of Secondhand Smoke Exposure
- Client Refused

ASSESS

Willingness to Quit in 30 Days – Select ‘Yes’ if the client is willing to quit in 30 days. Select ‘No’ if the client is not willing to quit in 30 days.

Stages of Change – Select one of the following “Stages of Change” the client reported at the time of the encounter.

- Pre–contemplation
- Contemplation
- Preparation
- Action
- Maintenance
Postpartum Visit- Definitions

ASSIST

- Follow-up from Last Visit
- Review Problem Solving Skills
- Provide Self-help Materials
- Provide Social Support
- Identify Local Social Support
- Client Refused

ARRANGE

- Cessation Specialist
- Quit Line
- Baby and Me Tobacco–Free Program
- Client Refused
- Follow–up Appointment

Follow-up Appointment – Enter the date for the client’s next Follow-up Appointment.

Screenings/Assessments – (Select all that apply)

- Edinburgh Postnatal Depression Scale 1 (EPDS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Domestic Violence
- None
- Other

Specify Other – Enter other type Screening/Assessment that was done at the time of the encounter.

Partners for a Healthy Baby Provided – Select ‘Yes’ if the ‘Partners for a Healthy Baby’ information was provided at the time of the encounter. Select ‘No’ if the ‘Partners for a Healthy Baby’ information was not provided at the time of the encounter.

If ‘Yes’ was selected above then select one or more of the following:

- Before Baby Arrives
- Baby's First Six Months
- Baby's Months 7–12
- Baby's Months 13–18
- Toddler's Months 19–39
**Postpartum Visit- Definitions**

**Client Referred** – Select ‘Yes’ if the client was referred to another program or agency at the time of the encounter. Select ‘No’ if the client was not referred to another program or agency at the time of the encounter.

**Referrals** – If ‘Yes’ was selected above then select all that apply:
Referral resources will be listed for each OIMRI project.

---

**Time Spent for this Encounter (mins)** – Enter the time in minutes that was spent on this encounter.

**Notes/Follow up** – Use this section to enter any additional notes about the client and/or the encounter.

**Success Story** – Use this section to record client’s/CHW noteworthy accomplishments and/or overall successful program outcomes.

**Flag for Follow-up** – Check this box of the encounter should be flagged for additional follow-up.

**Follow-up Date** – Enter the date for additional follow-up.

**Follow-up Completed** – Check this box if the follow-up has been completed.

**Reason for Follow-up** - Select those that apply to the client.

- Addiction Treatment
- Child Care
- Clothing
- Domestic Violence/Child Safety
- Education
- Employment
- Fatherhood Services
- Food
- Furniture
- Housing
- Insurance
- Legal Assistance
- Medical/Dental
- Mental Health
- Referral for Child
- Transportation
- Utilities
Exit Visit - Definitions

**Facility** – Use the drop down menu to select the agency where the client was seen. If you do not see your agency listed in the drop down menu, please contact your technical support.

**County** – Use the drop down menu to select the county where the client was seen. If you do not see your county listed in the drop down menu, please contact your technical support.

**Date of Encounter** – Enter the date the client was seen. This is not necessarily the same date as the data entry date.

**Home Visitor** – Enter the name of the community health worker who completed the encounter.

**Contact Type** – Select the appropriate option of how the Home Visitor conducted the encounter with the client.

- Home Visit – Select this option if a face-to-face interaction was made between the community health worker and parent and/or family.
- Hospital – Select this option if the face-to-face interaction occurred in the hospital.
- Office – Select this option if the face-to-face interaction occurred in the physician’s office, healthcare center, agency or health department, etc.
- Phone – Select this option if contact occurred by phone.
- Email – Select this option if communication occurred by email.
- Text Message – Select this option if communication occurred by text.
- Other – Select this option if another location applies. If selected, explain in the **Notes/Follow-up section** at the bottom of the page.

**# Contact Attempts** – Enter the number of attempts made to contact the client prior to the encounter.

**Entered By** – The name of the staff member who entered the encounter into the OIMRI system. This may be a different person than the “Home Visitor.”

**Exit Reason** – Select the reason the client is exiting the program.

- Baby turned 2 years old
- Infant Death
- Pregnancy Ended
- Lost to Follow-up
- Client not interested in participation
- Client moved out of the service area
- Client no longer needs assistance
- Client became pregnant
- Client died
Exit Visit - Definitions

**Encounter Reasons** – Check all of the reasons for this encounter

- General Follow up – Select this option if the purpose of the encounter is to check on client.
- Insurance – Select this option if health insurance coverage was assessed and/or insurance referrals were provided.
- Medical/Dental – Select this option if medical or dental referral is required.
- Mental Health – Select this option if mental health referral is required.
- Food – Select this option if a referral was made for services, such as food pantry, WIC, or other local resources.
- Transportation – Select this option if a referral was made for transportation services, such as bus passes, taxi, car repair or other local resources.
- Housing – Select this option if a referral was made for housing services.
- Education – Select this option if client indicates educational services are required, such as GED, financial aid, tutoring services, placement exams, etc.
- Child Care – Select this option if client requires child care services.
- Utilities – Select this option if client requires assistance with utility services.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Referral for Child – Select this option if referral for child is needed for developmental screenings, evidence of abuse, or educational services.
- Other – Select this option if another reason applies.

**Specify Other** – Enter the ‘Other’ type of encounter reason

---

**Mother’s Education** – Select the client’s last known level of education at the time of the encounter.

- 8th Grade or Less
- 9th through 12th Grade; No Diploma
- High School Graduate or GED Completed
- Some College Credit, but No Degree
- Associate Degree
- Bachelor’s Degree
- Master’s Degree
- Doctorate Degree
- Unknown – Select this option if the client is unsure of her last level of education.

**Household Size** – Enter the number of individuals in a client’s family who are supported by the amount of income listed in the “Household Income” field. “Family” is defined as a social unit composed of one or more person(s) living together as a household including dependents away at school. If the client is a
Exit Visit - Definitions

teenager requesting confidential services, she is considered to have a household size of two (2). If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), that child is not counted as part of the household size. A pregnant woman is counted as two (2). The minimum number in a household is two (2).

**Household Income** – Enter the weekly, monthly, or yearly total of combined income (before taxes or deductions) of all individuals in the client’s family (see definition of “family” in Household Size). If the weekly or monthly income varies during the year, use an average. If the client is a teenager requesting confidential services, use only her/his personal financial resources for determining the weekly income. If a family receives direct payments (cash in-hand) for child support, include as part of the household income; if a family receives child support payments (indirectly) through CDJFS, do not count the child support separately from the CDJFS payments. If an individual in the household is paying child support for a child that does not live in the household (e.g., child lives with another relative), the amount of child support paid is excluded from the gross amount of the family’s income. Do not include the total income for other families living at the same address. Do not include SSI monies, which must be spent for a designated family member. Do not include Metropolitan Housing allowance, Food Stamp vouchers, or the like.

**Income Verified** – Select “Yes” if the client has shown income documentation (e.g. pay stub, employment record). Documentation is a MANDATORY CFHS policy, per the CFHS Administrative Program Standards. A signed self-report can be an acceptable form of income verification.

**Household Annual Income** – This field is populated automatically in the OIMRI application. It does not appear on the Initial Prenatal Visit form.

**Housing Situation** – Select the appropriate status of the client’s housing information at the time of the encounter.

- Permanent – Select this option if client’s place of residence is stable.
- Temporary – Select this option if client’s place of residence is short-term or uncertain.
- Homeless – Select this option if client does not have affordable and suitable place of residence.

**Insurance Status** – Select the appropriate state of the client’s insurance at the time of the encounter

- Medicaid – Select this option if the client is enrolled in Medicaid, Healthy Start, and Healthy Families.
- Uninsured/Underinsured (Partial Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is between 100% and 250% of the federal poverty level.
- Private Insurance – Select this option if the client has any health insurance policy purchased by an employer, through the market place exchange, or by an individual from a private insurance company.
Exit Visit - Definitions

- Uninsured/Underinsured (No Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is below 100% of the federal poverty level.
- Uninsured/Underinsured (Full Pay) – Select this option if the client does not have a third-party payer for services received at this encounter and is above 250% of the federal poverty level.
- Other – Select this option if the client has a third-party payer for these services other than Medicaid or private insurance. This field should not be used to record more detailed information about one of the previous categories (i.e., name of Medicaid HMO or private insurance company).

Specify Other – Enter the ‘Other’ type of insurance the client reported at the time of the encounter.

Uninsured / Underinsured Status – Select the appropriate of the client’s Uninsured / Underinsured Status

- Medicaid Application Assistance - Combined Programs Application (CPA) has been completed and will be submitted to the County Department of Jobs and Family Services (CDJFS) for Medicaid enrollment. Refer to the CPA Policy in the CFHS Program Standards Administration Manual.
- Medicaid Eligibility Pending - CPA was previously submitted to CDJFS and notice of Medicaid enrollment has not been received.
- Medicaid Ineligible – Client previously applied for Medicaid but was found to be ineligible by CDJFS for the program.
- Client Refused Medicaid - Client may be eligible but refuses Medicaid services at this time or does not follow through on the submission of required documents.

Number of postpartum visits scheduled – Enter a number for how many postpartum visits the client has scheduled to date at the time of the encounter. This does not include future scheduled visits.

Number of visits kept – Enter a number for how many postpartum visits the client has kept to date at the time of the encounter.

Plans for contraception after birth – Select ‘Yes’ if the client is currently using contraception.

If No, provide reasons

- Don’t mind if I get pregnant – Select this option if the client indicates that she doesn’t mind becoming pregnant.
- Side effects of birth control – Select this option if the client is not using contraception because of previous birth control side effects.
- My husband or partner doesn’t want me to use birth control – Select this option if client’s husband or partner does not want her to use any form of birth control.
- Don’t think I can get pregnant – Select this option if the client does not think she could get pregnant.
- Problems getting birth control – Select this option if the client is having difficulty obtaining birth control.
Exit Visit - Definitions

- Other – Select this option if another reason applies.

Specify Other – Enter other reason that the client is not using contraception.

If yes, Contraception Use?

- No Method – Select this option if the client will not, in the future, use contraceptives.
- Abstinence – Select this option if the client is refraining from having sexual intercourse.
- Condom – Select this option if client is using condoms during sexual intercourse.
- Depo Provera – Select this option if the client is using Depo Provera.
- Diaphragm – Select this option if the client is using a diaphragm during sexual intercourse.
- Hormone Implant – Select this option if the client uses a hormonal implant.
- IUD (hormone) – Select this option if the client uses a hormone IUD (or intrauterine device).
- IUD (non–hormone) – Select this option if the client uses a non–hormone IUD (or intrauterine device).
- Patch – Select this option if the client is using a patch.
- Pill – Select this option if the client is using birth control pills.
- Ring – Select this option if the client is using the birth control ring.
- Rhythm Method – Select this option if the client is practicing the rhythm method.
- Sterilization – Select this option if the client has had a tubal ligation.
- Withdrawal – Select this option if the client practices the husband or partner withdrawal method during sexual intercourse.
- Other – Select this option if another method applies.

Specify Other – Enter other type of contraception the client plans to use after the current pregnancy.

If yes, Issues/Problems with Contraception? – Select ‘Yes’ if the client is having issues or problems with using contraception.

Specify Other – Specify what types of problems the client is having with using contraception.

Child 1, 2, 3 – Select the name of the child(ren) for the client’s current pregnancy. *Please note, the child must exist in the MCHIDS system under the ‘Relationship’ tab before the child will become available as an option in the child drop down menu. If the child is not available in the drop down menu, it is recommended that you use the ‘Save as Draft’ button located at the bottom of the form. Once your record is saved in ‘Draft,’ you can then click on the ‘Relationships’ tab and enter the child information. Please note that if you do not click the “Save as Draft” button you will lose all of the data you entered for the encounter. Also note that when creating a relationship that for the child drop down menus in the “Initial Prenatal Report” that the child’s relationship status must be either “Son,” “Daughter,” or “Child.” Once you have successfully saved the child information you can return to the ‘Draft’ record by clicking on the ‘OIMRI VISITS/ENCOUNTERS’ tab and editing the record. The child will now become available as an option in ‘Child’ drop down menu.

Child’s Immunization Status – Make a selection based upon the child’s current immunization status.

- Complete for Age – Select this option if the child received complete/full immunizations as recommended for age per the CDC schedule.
Exit Visit - Definitions

- In progress – Select this option if immunizations are not complete as recommended for age per the CDC schedule, but are in progress.
- Incomplete for age – Select this option if immunizations are not complete as recommended for age per the CDC schedule, and are not in progress.
- Unknown – Select this option if the immunization status is unknown at the time of the encounter.

Well Child Visits Scheduled – Enter the number of well child visits the child has scheduled at the time of the encounter.

Well Child Visits Kept – Enter the number of well child visits the child has kept at the time of the encounter.

Was Lead Screening done for the Child?

- Yes
- No
- Don’t know

Was the level high?

- Yes
- No
- Don’t know

Developmental Screenings

Ages and Stages Questionnaire – Select ‘Yes” if the “Ages and Stages Questionnaire” was conducted.

Other – Select this option if screenings other than the “Ages and Stages Questionnaire” were conducted.

Risk Assessment (Select all apply)

- Less Than 18 Years Old or Greater Than 35 Years Old –Select this option if client is less than 18 years of age or the client is greater than 35 years of age.
- Previous Pregnancy Problems – Select this option if the client experienced any pregnancy complications.
- 2nd Pregnancy Within 12 Months – Select this option if the client became pregnant within 12 months since previous pregnancy.
- Tobacco Use – Select this option if client reports tobacco use or there is an indication of tobacco use.
- Alcohol Use – Select this option if client reports alcohol use or there is indication of alcohol use.
- Drug Use – Select this option if client reports use of drugs or there is indication of drug use.
Exit Visit - Definitions

- Vitamin Use – Select this option if client reports use or there is indication of the use of prescribed, over-the-counter, and/or herbal supplements.
- Children in Protective Services – Select this option if client reports that she currently has or had a child in protective services.
- Late Entry into Prenatal Care (after 13 weeks) – Select this option if client is 14 weeks or beyond in her pregnancy.
- Dental Care Needs – Select this option if client has current dental needs or expressed interest in obtaining dental care.
- Domestic Violence – Select this option if client requests intervention or if there is evidence of domestic violence.
- Diagnosis of Developmental Disability – Select this option only if client has been diagnosed with a developmental disability.
- Food Insecurity – Select this option if the client has a lack of access to a reliable and sufficient quantity of affordable and nutritious food.
- Mental Illness – Select this option if client has been diagnosed with a mental illness.
- Poor Environment – Select this option if client resides in a home or area that is not safe, clean and/or may be hazardous (living conditions) to her health and well-being.
- Language Barriers – Select this option if there is difficulty in communicating.
- Non–Compliance with Keeping Appointments – Select if the client has not kept scheduled appointments.
- Lack of Social Support for Mother – Select if the client indicates that she does not have any support, such as family, spouse/partner, friends, etc.
- Lack of Emotional Support of Father – Select if the client has self-reported non-support from the father.
- Lack of Financial Support of Father – Select if the client reported no financial support from the father.
- Lack of Transportation – Select if the client does not have access to transportation.
- Did Not Know was Pregnant – Select if the client was unaware she was pregnant.
- Multiple Birth – Select if the client had twins, triplets, etc.
- No Insurance – Select if the client does not have medical insurance.
- Low Income – Select if the client has reported her income is below poverty level.
- Less than High School Education – Select if the client did not receive a high school diploma or equivalent.
- Death of a Baby Before Age One – Select this option if the baby does not live to reach his/her first birthday.
- Other – Select this option if another risk applies.

Specify Other – Enter any other types of risk the client indicates at the time of the encounter.

5 A’s Smoking Cessation Program

ASK

Smoking Status - Select one from the following options regarding the client’s usage of tobacco products
Exit Visit - Definitions

- **Never**
- **Former**
- **Current**

### # Days Smoked in the Past 30 Days
The number of days the client smoked in the past 30 days.

### # Cigarettes/Day
The number of cigarettes the client smokes per day.

### Secondhand Smoke Exposure

**Client** – Select ‘Yes’ if the client is exposed to secondhand smoke in her place of residence or work. Select ‘No’ if the client is not exposed to secondhand smoke in her place of residence or work.

**Child/Children** – Select ‘Yes’ if the Child/Children are exposed to secondhand smoke. Select ‘No’ if the Child/Children are not exposed to secondhand smoke.

### ADVISE

- Strong Advice to Quit
- Benefits of Quitting
- Harms of Smoking
- Difficulty of Quitting
- Risks of Secondhand Smoke Exposure
- Client Refused

### ASSESS

**Willingness to Quit in 30 Days** – Select ‘Yes’ if the client is willing to quit in 30 days. Select ‘No’ if the client is not willing to quit in 30 days.

**Stages of Change** – Select one of the following “Stages of Change” the client reported at the time of the encounter.

- Pre–contemplation
- Contemplation
- Preparation
- Action
- Maintenance

### ASSIST
Exit Visit - Definitions

- Follow-up from Last Visit
- Review Problem Solving Skills
- Provide Self-help Materials
- Provide Social Support
- Identify Local Social Support
- Client Refused

ARRANGE

- Cessation Specialist
- Quit Line
- Baby and Me Tobacco–Free Program
- Client Refused
- Follow–up Appointment

Follow-up Appointment – Enter the date for the client’s next Follow-up Appointment.

Screenings/Assessments – (Select all that apply)

- Edinburgh Postnatal Depression Scale 1 (EPDS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Domestic Violence
- None
- Other

Specify Other – Enter other type Screening/Assessment that was done at the time of the encounter.

Partners for a Healthy Baby Provided – Select ‘Yes’ if the ‘Partners for a Healthy Baby’ information was provided at the time of the encounter. Select ‘No’ if the ‘Partners for a Healthy Baby’ information was not provided at the time of the encounter.

If ‘Yes’ was selected above then select one or more of the following:

- Before Baby Arrives
- Baby's First Six Months
- Baby's Months 7–12
- Baby's Months 13–18
- Toddler's Months 19–39
Exit Visit - Definitions

**Client Referred** – Select ‘Yes’ if the client was referred to another program or agency at the time of the encounter. Select ‘No’ if the client was not referred to another program or agency at the time of the encounter.

**Referrals** – If ‘Yes’ was selected above then select all that apply:

Referral resources will be listed for each OIMRI project.

---

**Time Spent for this Encounter (mins)** – Enter the time in minutes that was spent on this encounter.

**Notes/Follow up** – Use this section to enter any additional notes about the client and/or the encounter.

**Success Story** – Use this section to record client’s/CHW noteworthy accomplishments and/or overall successful program outcomes.

**Flag for Follow-up** – Check this box of the encounter should be flagged for additional follow-up.

**Follow-up Date** – Enter the date for additional follow-up.

**Follow-up Completed** – Check this box if the follow-up has been completed.

**Reason for Follow-up** - Select those that apply to the client.

  - Addiction Treatment
  - Child Care
  - Clothing
  - Domestic Violence/Child Safety
  - Education
  - Employment
  - Fatherhood Services
  - Food
  - Furniture
  - Housing
  - Insurance
  - Legal assistance
  - Medical/Dental
  - Mental Health
  - Referral for Child
  - Transportation
  - Utilities
Ohio Infant Mortality Reduction Initiative Cuyahoga County 2005-2010

Infant mortality is one of the significant health issues globally. The rate of infant mortality informs us how a nation and community is doing not just with the health care of the newborn but how it is fairing when addressing the health issues related to the parents of the newborn and the communities in which the family lives. The level of infant mortality also informs us of how a nation’s health is fairing longitudinally.

Here in the United States the leading causes of infant mortality are as follows: 1) Congenital Birth Defects, 2) Preterm Birth and Low Birth Weight, 3) Sudden Infant Death Syndrome, 4) Maternal Complications of Pregnancy, and 5) Complications of the Umbilical Cord, Placenta and Membranes.

The Kaiser Family Foundation records that among nations The United States of America ranks approximately 39th with an infant mortality rate of 6.26. The U.S. rate is higher than most industrialized nations. According to this information some smaller and less financially stable nations have a lower infant mortality rate than the U.S.A., i.e. Republic of Korea ranks 19 with a rate of 4.26 and Cuba ranks 37 with a rate of 5.82. The Center For Disease Control informs us that the African American population has an infant mortality rate is even higher than the U.S. general population, i.e. 13.4 for Non-Hispanic Blacks, 7.0 for all races in U.S. and 5.6 for Non-Hispanic Whites. Within the African American community premature birth and low birth weight are the leading causes of infant mortality.

The goal of the Ohio Infant Mortality Reduction Initiative (OIMRI) is to improve birth outcomes in at-risk African American communities through the work of Community Health Workers. In 2010 OIMRI in Cuyahoga County completed five years of service to the Warrensville and East Cleveland communities. A five year tally indicates that the women served by the OIMRI program of Cuyahoga County had better outcomes in the areas of weeks gestation at delivery, birth weight and infant mortality. The only exception is that the general population of pregnant women in Warrenville had a low birth weight percentage of 8.4 versus the low birth weight percentage of OIMRI participants of 9.04.

<table>
<thead>
<tr>
<th></th>
<th>OIMRI Information</th>
<th>Cuyahoga</th>
<th>Cleveland</th>
<th>East Cleveland</th>
<th>Warrensville</th>
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<tbody>
<tr>
<td>OIMRI Women Served</td>
<td>219</td>
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<td>OIMRI Babies Born</td>
<td>188</td>
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<tr>
<td>Full Term Births</td>
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<td>82.4%</td>
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<td>87.4%</td>
<td>86.7%</td>
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<td>Pre-Term Births</td>
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<td>17.6%</td>
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<td>Very Low Birth Weight</td>
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<td>9.8</td>
<td>15.3</td>
<td>23.5</td>
<td>14.6</td>
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</tbody>
</table>

Numbers are important, but we also want you to meet some of the lives families whose lives have been impacted the OIMRI program in Cuyahoga County.
Project 1

Butler County is among the ten worse urban areas in Ohio for infant mortality, with a Black, non-Hispanic infant mortality rate of 16.06, twice that of the 8.26 rate for White, non-Hispanic infants (Ohio Department of Health, 2012). Both these rates exceed the Healthy People 2020 goal of 6.0 signaling significant health disparities, very poor health of the African American community, and poor health in the county overall.

Excellent projects designed to address infant mortality are already underway, particularly the PRIM-Butler County Health Department initiative. However these projects are not designed to gain a broader understanding of the underlying social determinants of these health disparities, and vitally, have not focused on gaining women’s perspectives. In particular, African American pregnant and new mothers traditionally have not had a voice in planning interventions to prevent infant mortality. Recent efforts to draw the highest risk women to agency planning meetings using formal institutional formats (e.g. powerpoint presentations, panel sessions) have thus far been unsuccessful.

The Butler County Health Department and Miami University propose to conduct ethnographic person-centered interviews to better understand the contexts, resources, supports, and daily routines of African American pregnant women and new mothers. A quantitative survey administered at the time of the interviews will enable us to describe the participating population in comparison to the published literature on risk factors in pregnancy and infant mortality.

We have designed a multiple facetted project to develop in partnership with community members a nuanced understanding of the factors and processes that facilitate healthy mothers and infants in a high risk community.

The AIM of this proposal is to conduct ethnographic, person-centered interviews with African American pregnant women and new mothers to better understand the contexts, resources, supports, and daily routines of their everyday lives. The findings from this study will be de-identified, analyzed, and explored for rich, narrative insight into pregnancy and early motherhood from the points of view of women at greatest risk for infant mortality. These findings will stand alone as publishable research, but they will also be used as a descriptive context for a Community-Based Partnership Research (CBPR) project which is being submitted to ODH IRB for consideration under separate over. The deidentified and published or amalgamated findings of the interview study may be presented to the CBPR group as evidence and for further elaboration as deemed necessary by the community for the purposes of the CBPR project. Ultimately we will integrate and triangulate these two sets of data to develop a more holistic understanding of the factors contributing to high infant mortality, with the goal of then developing solutions in partnership with the mothers most affected by those factors.
Project 2

Butler County is among the ten worst urban areas in Ohio for infant mortality, with a Black, non-Hispanic infant mortality rate of 16.06, twice that of the 8.26 rate for White, non-Hispanic infants (Ohio Department of Health, 2012). Both these rates exceed the Healthy People 2020 goal of 6.0 signaling significant health disparities, very poor health of the African American community, and poor health in the county overall.

Excellent projects designed to address infant mortality are already underway, particularly the PRIM-Butler County Health Department initiative. However these projects are not designed to gain a broader understanding of the underlying social determinants of these health disparities. In particular, African American pregnant and new mothers traditionally have not had a voice in planning and implementing interventions to prevent infant mortality. Recent efforts to draw the highest risk women to agency planning meetings using formal institutional formats (e.g. PowerPoint presentations, panel sessions) have thus far been unsuccessful.

The Butler County Health Department and Miami University propose to use a Community Based Participatory Research (CBPR) model joining our various types of expertise and use innovative methods such as participatory theater and digital story telling to build a partnership with the African American mothers in Butler county and ensure that the voices of those most at risk of experiencing an infant death are heard and have a place at the table.

The hallmark of Community-Based Participatory Research (CBPR) is an equitable partnership among stakeholders who stand to benefit from the results or outcomes of research. CBPR is a model of Participatory Action Research (PAR) that aims to create equal partnerships with community partners, gain and develop knowledge, and create action to improve the health and well-being of the community, while emphasizing empowerment and learning for all those involved. The current proposal focuses on building trusting and collaborative relationships with all participants, and learning each other’s stories and concerns.

We have designed a multiple facetted project to develop a partnership with community members and build a nuanced understanding of the factors and processes that facilitate healthy mothers and infants in a high risk community.

1. Host small focus groups with African American women to better understand their concerns, resources, supports, and recommendations
2. Host Community Circles to facilitate active community member engagement in building a partnership with African American mothers and ensure that their voices are heard in the ways they want them heard.

Ultimately we will integrate and triangulate the insights we learn from the community circles to develop a more holistic understanding of the factors contributing to high infant mortality, with the ultimate goal of then developing solutions in partnership with the mothers most affected by those factors.