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Evaluation of FAMILY Inc.'s Home Visitation Program

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Project Title

Evaluation of FAMILY Inc.'s Home-Visitation Program

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Abstract

FAMILY, Inc. is a nonprofit that provides public health and family support services to women, children, and families in Pottawattamie and Mills counties. Its home visitation program provides health education information to families in the communities that are expecting a child or have a child less than five years of age. This project looked at FAMILY, Inc.'s database regarding the health of children enrolled in their home visitation program and use that information to help develop health education tools as they prepare to expand their programming to include Early Head Start (EHS). Currently FAMILY uses the Parents as Teachers curriculum, which requires that a health questionnaire be completed for each family at least every six months. The de-identified data taken from the health questionnaire was analyzed and compared with the performance standards for the EHS program to determine areas of improvement that FAMILY's home visitors can focus on to improve their programming to align with EHS guidelines.

This project helped FAMILY learn about the health of children enrolled in their program and help understand how it is completing the performance standards.

Introduction

The FAMILY, Inc. home visitation program began in 1991 under the umbrella of the Green Hills Area Education Agency and eventually transitioned this work to its own nonprofit in 2009. FAMILY provides public health and family support services to women, children, and families in Pottawattamie and Mills counties in Iowa (FAMILY, n.d). FAMILY, Inc. is funded by donations and grants. Its home visitation program provides home visits to families that are expecting a child or have a child less than five years of age using Parents as Teachers curriculum (FAMILY, n.d.). The Parent as Teachers is an internationally known evidence-based home visiting model that helps build thriving families and children that are healthy, safe and ready to learn by matching parents and caregivers with trained professionals who make regular personal home visits during a child's earliest years in life (Parents as Teachers, 2019). It was first developed and funded by Missouri educators and has expanded to become a national program (Parents as Teachers, 2019). This home visiting model is backed by 35 years of research-proven outcomes for children and families and currently serves nearly 200,000 families in all 50 states (Parents as Teachers, 2019). FAMILY's home visitation program currently provides parent education and modeling for child development to assist parents in their role as their child's first and most influential teacher (FAMILY, n.d.). Topics of education include parenting skill development, home safety checks, and developmentally appropriate activities for children, developmentally appropriate

discipline techniques, and child health and nutrition information (FAMILY, n.d.). Currently, FAMILY, Inc. has eight home visitors.

Problem Statement

FAMILY, Inc. received a grant with Early Head Start (EHS) that will expand FAMILY's home visitation program; research on EHS performance standards is needed to help FAMILY prepare before becoming a funded EHS program. This project used FAMILY's data to assess three indicators of health as well and compare this to different benchmarks. The findings should help to develop educational resources for parent educators to use with their families.

Importance of Proposed Project

After completing this project FAMILY will know EHS programs performance standards as well as know what areas in FAMILY's curriculum could use improving. FAMILY will also know how their program is performing for three different indicators of health.

Literature Review

Home visitation programs are a widespread early intervention strategy that began in the United States in the late 19th century (Council on Children and Adolescent Health, 1998). These programs involve a professional going to the parent's home and providing social, health-related, or educational materials (Avellar & Supplee, 2013; Council on Children and Adolescent Health, 1998). Home visitation programs have had

short term and long term impacts on both the mother and the child (Council on Children and Adolescent Health, 1998; Kemp et al., 2011; Raikes et al., 2006).

Home visitation programs that are targeted at low-income families who are facing stress and difficulty have shown the most success (Fergusson, Grant, Horwood, & Ridder, 2005; Olds et al., 1999). These home visitation programs benefit both the mother and child. Programs have shown positive impacts on child health, reducing childhood injuries and ingestions, reducing child abuse and neglect, improved behavioral adjustment, improved preschool education and service utilization, and increased positive parenting (Fergusson et al., 2005; Olds et al., 1999). Long term impacts of these programs include reduced subsequent pregnancies, reduced antisocial behavior in adolescents, reduced use of substances, reduced maternal and adolescent criminal behavior, and decrease in use of welfare (Jones Harden, 2012; Olds et al., 1997; Olds et al., 1998).

Alternatively, some home visitation programs have yet to show an impact. The Hawaii Healthy Start and the Healthy Families America home visitation programs did not show a significant difference between families enrolled in the programs and those not enrolled (Daro & Harding, 1999; Duggan et al., 2004). Both of these programs looked at parent-child interactions and the prevention of child abuse (Daro & Harding, 1999; Duggan et al., 2004). There is a need for further research to be conducted on the effectiveness of home visitation programs (Council on Child and Adolescent Health, 1998).

Goals and Objectives

The goal of this project was to help FAMILY's home-visitation program understand the expectations and performance standards to be a funded EHS program. Objectives of this study were to:

1. Research EHS materials and identify performance standards.
2. Identify areas of weakness in FAMILY's home visitation program.
3. Develop suggestions on improving FAMILY's health education curriculum.

Research Method

- Defined Research Question

  What are EHS programs performance standards? How are children enrolled in FAMILY's home-visitation program performing on three different health indicators in comparison with the state average?

- Study Population/study sample:

  The study population is all children enrolled in FAMILY's home visitation program from 2012-2018. Individuals enrolled in this program are families that are expecting or have children under the age of five. The database is updated every six months with the Health Record Review & Questionnaire. The study sample is children enrolled in the program over the past five years.

- Data sources:

The data was gathered using FAMILY, Inc.'s home visitation database. All data was de-identified by FAMILY personnel to be analyzed en masse from an excel spreadsheet. Data was transferred from FAMILY servers to me via a secure USB drive. Throughout the analysis, the data was stored on UNMC's protected server, One Drive. The data analysis identified areas that needed improving and found health education resources using the Early Head Start standards and their online website. Other sources utilized were the Centers for Disease Control and Prevention, CDC, for other educational materials.

- Data collection methods

  FAMILY, Inc. provides home visits to families that are expecting a child or have a child aged 0-5 years in Pottawattamie County, Iowa. Degreed parent educators conduct the home visits around the community utilizing the Parent as Teachers curriculum. When a new child enrolls in the program the home visitors completes a Health Record Review Questionnaire. The questionnaire includes questions about prenatal history, medical history, hearing, dental, safety, vision, and family medical history. This questionnaire is entered into the home visitation database within 30 days of completion with each family. The analysis used the questionnaire's data to look at health outcomes of the children enrolled in FAMILY's home visitation program and compared the outcomes to the performance standards from Early Head Start.

- Statistical and/or analytical methods

SPSS Statistics was used to conduct a descriptive analysis on three important health indicators; child carried full term, average birth weight, and number of children up-to-date on immunizations. These indicators will be compared against Iowa's state average.

- Limitations

  This study has limitations that impacted analysis. A limitation is if the parent or guardian completing the questionnaire doesn't know the answer to some of the questions. Other limitations are recall bias and self-reporting. Another limitation is human errors. Information can be entered into the database incorrectly or accidentally deleted from the database. Another limitation related to this specific population in Pottawattamie County related to generalizations to other geographic regions and home visitation programs.

- Policy analysis, interventions and program development recommendations as appropriate

  After analyzing the data, it showed areas of health education that needed improving. Then using outside sources adequate health education resources were found to help improve the program. The recommendations will allow FAMILY's home-visitation program to better educate enrolled families.

Ethics

Throughout this capstone project the data was de-identified and there wasn't any identifiable information about the families used. The project looked at different health

outcomes of children enrolled in the program but did not share any personal information with others. There was no conflict of interest that would impact the capstone project. All information viewed was kept confidential

EHS Performance standards

EHS programs serve infants and toddlers under the age of three, and pregnant women (Head Start, n.d.). EHS performance standards require that a program provide high-quality health, oral health, mental health, and nutrition services that are developmentally, culturally, and linguistically appropriate and that will support each child's growth and readiness (Head Start, n.d.). EHS performance standards have seven different areas of importance that programs must address. They are: *collaboration and communication with parents*; c*hild health status and care*; *oral health practices*; *child nutrition*; *child mental health and social and emotional well-being*; *family support services for health, nutrition, and mental health;* and *safety practices*.

Collaboration and Communication with Parents. Programs must collaborate and communicate with parents as partners in the health and well-being of their children in a linguistically and culturally appropriate manner and communicate with parents about their child's health needs and development concerns in a timely and effective manner (Head Start, n.d.). Programs must obtain in advance authorization from the parent or another person with legal authority for all health and developmental procedures administered through the program or by contract or agreement, and written documentation if they refuse to give authorization for health services. Home-visitation

programs must share with parents the policies for health emergencies that require a rapid response on the part of immediate medical attention (Head Start, n.d.).

EHS performance standards for *child health status and care* requires a source of health care, ensuring up to date child health status, ongoing care, extended follow-up care, and use of funds. For sources of health care “A program, within 30 calendar days after the first home visit, must consult with parents to determine whether each child has ongoing sources of continuous, accessible health care- provided by a health care professional that maintains the child’s ongoing health record and is not primarily a source of urgent care- and health insurance coverage” (Head Start, n.d.).

Ensuring up to date child health status requires that programs (1) within 90 days of the first home visit programs must obtain determinations from health care professionals as to whether the child is up-to-date on a schedule of age-appropriate preventative and primary medical and oral health care (Head Start, n.d.). (2) Within 45 days after the first home visit, a program must either obtain or perform evidence-based vision and hearing screenings (Head Start, n.d.). (3) A program must identify each child's nutritional health needs (Head Start, n.d.).

For ongoing care programs must 1) help parents continue to follow recommended schedules of well-child and oral health care (Head Start, n.d.). (2) A program must implement periodic observations or other appropriate strategies for program staff and parents to identify any new or recurring developmental, medical, oral, or mental health concerns (Head Start, n.d.). (3) A program must facilitate and monitor necessary oral health preventative care, treatment, and follow-up, including topical fluoride treatments (Head Start, n.d.).

Extended follow-up care requires a program to (1) facilitate further diagnostic testing, evaluation, treatment, and follow-up plan, as appropriate, by a licensed professional for each child with a health problem or developmental delay. (2) A program must develop a system to track referrals and services provided and monitor the implementation of a follow-up plan to meet any treatment needs associated with health, oral health, social and emotional, or developmental problem. (3) A program must assist parents in obtaining any prescribed medications, aids, or equipment for medical and oral health conditions (Head Start, n.d.).

The last part of *child health status and care* is the use of funds. Programs must use program funds for the provision of diapers and formula for enrolled children during the program day. A program may use funds for professional medical and oral health services when no other source of funding is available (Head Start, n.d.).

EHS's *Oral Health Practices* require a program to promote effective oral health hygiene by ensuring all children with teeth are assisted by appropriate staff, or volunteers, if available, in brushing their teeth with toothpaste containing fluoride one daily (Head Start, n.d.).

EHS's *child nutrition* requires that a program must design and implement nutrition services that are culturally and developmentally appropriate, meet the nutritional needs of and accommodate the feeding requirements of each child, including children with special dietary needs and children with disabilities (Head Start, n.d.). Programs should encourage family-style meals and promote breastfeeding. Programs must use funds from USDA Food, Nutrition, and Consumer Services child nutrition programs as the primary source of payment for meal services (Head Start, n.d.).

EHS's *child mental health and social and emotional well-being* have two different sections, wellness promotion, and mental health consultants. For wellness promotion, a program must (1) provide support for effective classroom management and positive learning environments (2) secure mental health consultation services on a schedule of sufficient and consistent frequency to ensure a mental health consultant is available to partner with staff and families in a timely and effective manner. (3) Obtain parental consent for mental health consultation services at enrollment and (4) build community partnerships to facilitate access to additional mental health resources and services (Head Start, n.d.). A program must ensure mental health consultants assist: (1) the program to implement strategies to identify and support children with mental health and social and emotional concerns. (2) Teachers to improve classroom management and teacher practices through strategies that include using classroom observations and consultations to address teacher and individual child needs and creating physical and cultural environments that promote positive mental and social and emotional functioning. (3) Other staff, including home visitors, to meet children's mental health and social and emotional needs through strategies that include observation and consultation. (4) Staff to address prevalent child mental health concerns, including internalizing problems such as appearing withdrawn and externalizing problems such as challenging behaviors. (5) In helping both parents and staff to understand mental health and access metal health. (6) In the implementation of the policies to limit suspension and prohibit expulsion (Head Start, n.d.).

EHS's standards for *Family support services for health, nutrition, and mental health* include both parent participation and collaboration. "Programs must collaborate

with parents to promote children's health and well-being by providing medical, oral, nutrition, and mental health education support services that are understandable to individuals, including individuals with low health literacy" (Head Start, n.d.). Collaboration must include specific opportunities for parents to learn about preventative medical and oral health care, discuss their child's nutritional status with staff, learn about healthy pregnancy and postpartum care, discuss with staff and identify issues related to child mental health and social and emotional well-being, and learn about appropriate vehicle and pedestrian safety for keeping children safe (Head Start, n.d.). EHS also requires programs to provide ongoing support to assist parents' navigation through health systems to meet the general health and specifically identified needs of their children. This includes an understanding on how to access health insurance for themselves and their families, understanding the results of diagnostic and treatment procedures, and in familiarizing their children with services they will receive while enrolled in the program (Head Start, n.d).

The last requirement of EHS's performance standards is *Safety Practices.* A program is required to train staff on, implement, and enforce a system of health and safety practices that ensure children are kept safe at all times (Head Start, n.d.). The program must develop and implement a system of management, including ongoing training, oversight, correction, and continuous improvement to ensure all facilities, equipment and materials, background checks, safety training, safety, and hygiene practices and administrative safety procedures are adequate to ensure child safety (Head Start, n.d.).

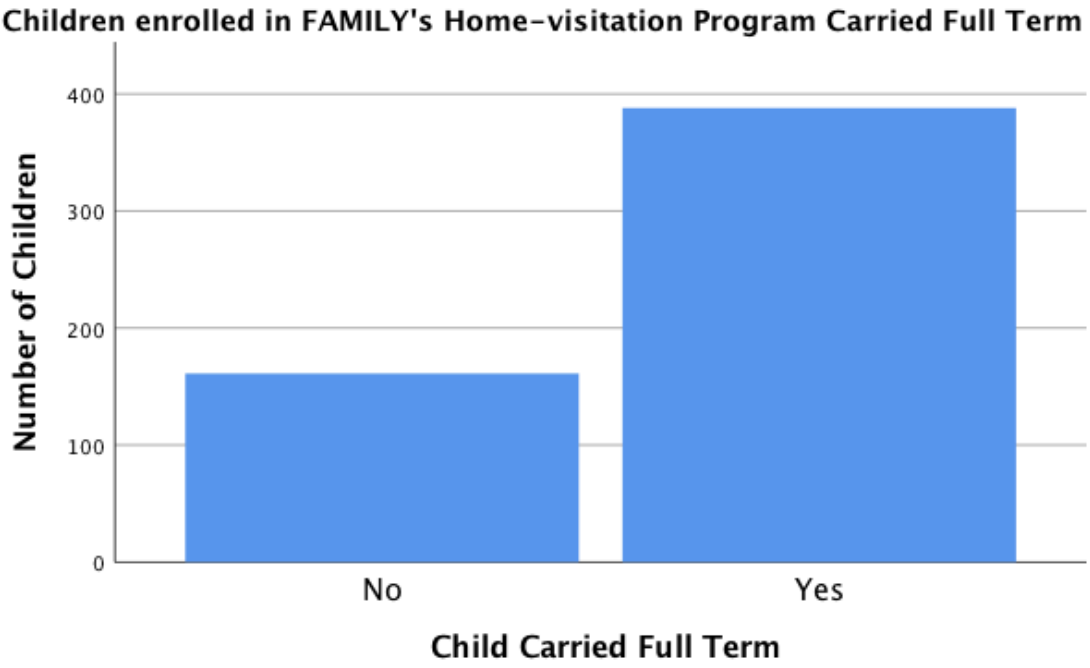
Results

In total there were 549 children enrolled in FAMILY from January 2012 to December 2018.

Children Carried to Full Term

Of the 549 participating children 388 were carried full term. This means that babies are born after 37 weeks of pregnancy. A child needs to be carried full term because the brain, lungs, and liver need the final weeks of pregnancy to fully develop (Centers for Disease Control and Prevention, CDC, 2019). Babies who are born before 37 weeks may experience breathing problems, feeding difficulties, cerebral palsy, developmental delay, vision problems, and hearing problems (CDC, 2019). EHS emphasizes educating pregnant mothers as well as families on the importance of being healthy. FAMILY's home visitation program shows that 70.6 percent of enrolled children were born full term. Iowa's average number of children carried full term is about 93 percent (Iowa.gov, 2019).

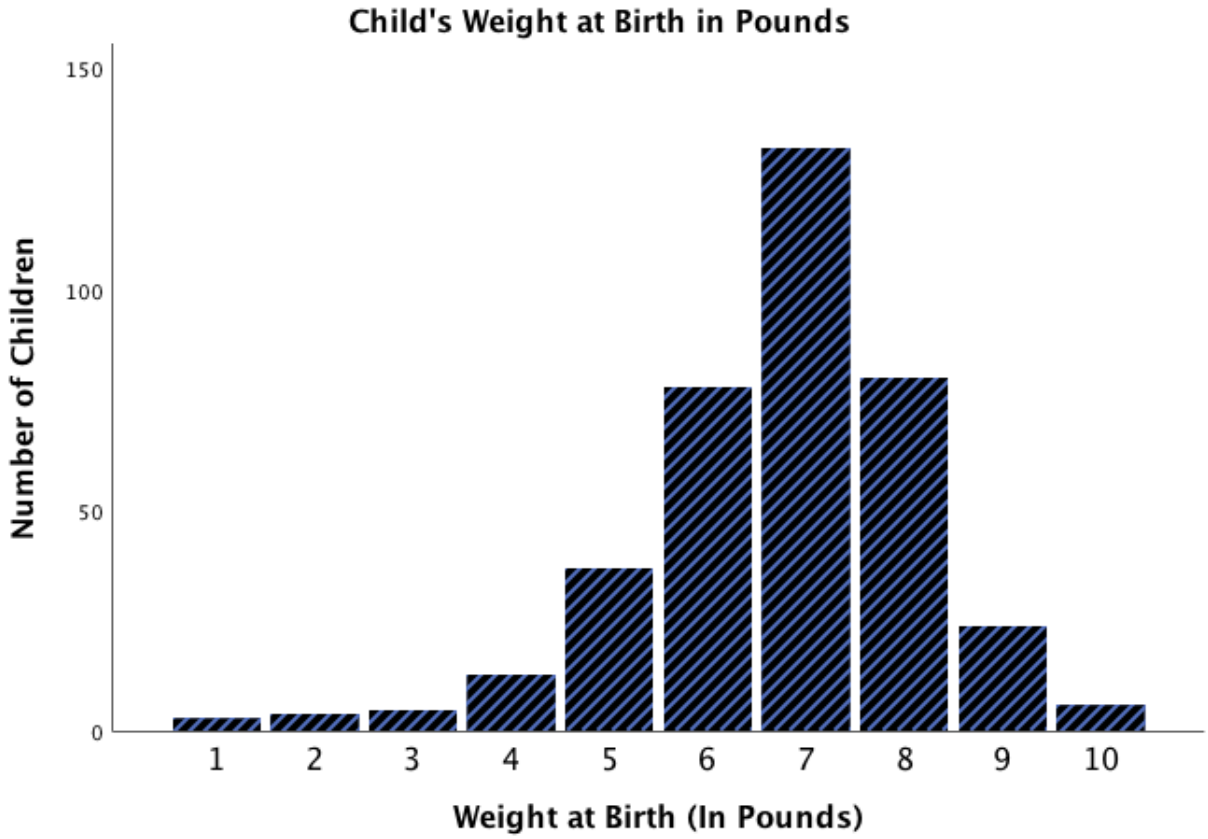
Graph 1: Child Carried Full Term



Children's Birth Weight

Of the 549 participating children 382 (69.6%) had information about their birth weight. The average birth weight of children enrolled in the program was 6.73 pounds. The smallest child weighed in at one pound and the heaviest child weighed in at ten pounds. There were 166 entries missing birth weight information due to not knowing or leaving the question blank. FAMILY and EHS need to know a child's birth weight because low birth weight can contribute to possible health issues in the future. Low birth weight is classified as a baby weighing less than 5 pounds, 8 ounces (Children's Hospital of Philadelphia, 2018). A baby's weight at birth is strongly associated with mortality risk during the first year and with developmental problems in childhood and the risk of various diseases in adulthood (Wilcox, 2001). FAMILY's average number of children born with low birth weight is about 6.1 percent compared to Iowa's average, which is 6.6 percent (Iowa Department of Public Health, 2018).

Graph 2: Children's Birth Weight

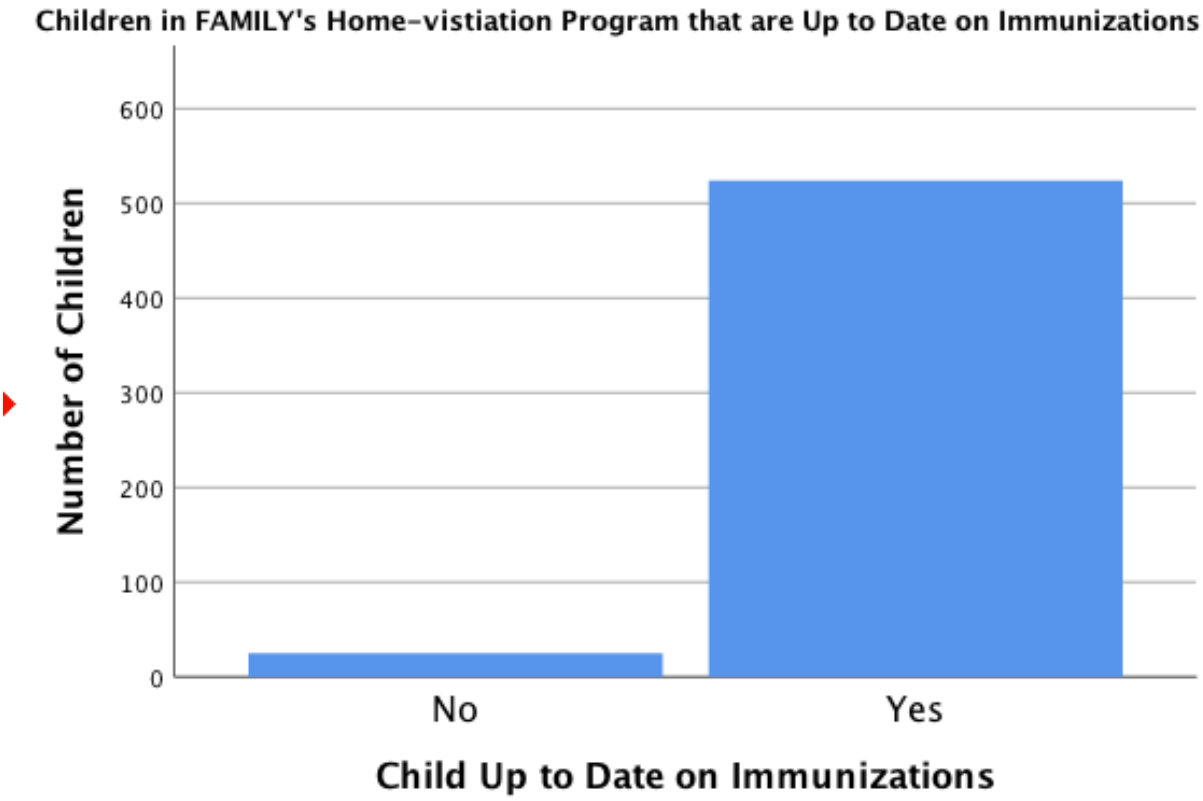


Immunizations

On-time immunizations throughout a child's lifespan are essential because it helps provide immunity before children are exposed to potentially life-threatening diseases (CDC, 2019). FAMILY's home-visitation program has an immunization rate of 95.4 percent meaning that of the 549 children enrolled in the program 524 children are up to date on all age-appropriate immunizations. This is higher than Iowa's average rate

of immunization, which is 74.9 percent (Iowa.gov, 2019). This includes the MMR (measles, mumps, and rubella), polio, hepatitis, and DTap vaccinations. EHS requires that all children enrolled in their program are up to date with all age-appropriate primary and preventative health care including immunizations. This shows that FAMILY's home-visitation program is already meeting one of EHS child health status standards.

Graph 3: Up To Date on Immunizations



Discussion

The project researched and identified EHS performance standards as well as recognized areas where FAMILY's home-visitation program is meeting EHS performance standards and areas where they could improve. FAMILY is meeting EHS performance standards for *child health status and care* specifically by encouraging staff

members to collect important health information on enrolled children. *Child health status and care* requires a source of health care, ensuring up to date child health status, ongoing care, and extended follow-up. EHS programs serve toddlers, infants, and pregnant women. Emphasizing the importance of maintaining a healthy lifestyle while pregnant is imperative. Children that are carried full-term are fully developed and less likely to develop certain medical issues. EHS emphasizes the importance of having ongoing care for any health problem a child has. If the child has a low birth weight this could lead to ongoing medical issues that the home-visitors need to be aware of. Another one of EHS performance standards is requiring and encouraging EHS staff members to assess if children are up to date on a schedule of age-appropriate preventative and primary medical health care including but not limited to immunizations. FAMILY's home-visitation program is meeting this requirement with over 90 percent of children up to date on all immunizations. From the data, it looks as though FAMILY is meeting EHS standard by providing quality health and oral health services.

Areas, where no information was found on, were child nutrition and mental health. EHS requires that each program promote a healthy diet with foods that are high in nutrients and low in fat, sugar, and salt. It is required that programs promote and encourage mothers to breastfeed their child (Head Start, n.d.). Gathering information on child nutrition and dietary habits will help FAMILY meet EHS standards and be useful in the future. In the data analyzed for this project, there wasn't any data on the mental health status of the child either. EHS requires that programs can address prevalent child mental health concerns. It would be useful for FAMILY to add mental health topics into their home-visitors curriculum if not already there.

This analysis had its limitations and those need to be taken into concern. Due to issues with receiving the data hindered the analysis to not be as comprehensive as it needed to be. The project only analyzed three variables but the data offers more information that needs to be analyzed. The data has important information about children's medical history like primary care physicians, hearing, vision and developmental screenings completed, and ongoing medical issues. For these areas to be utilized an individual with more biostatics background would have to go through and organize the data in a way that accounts for multiple entries entered under one child's ID number.

Synthesis of Competencies

The foundational competency learned throughout this experience was learning to interpret the results of data analysis for public health research, policy, or practice. Completing a data analysis of FAMILY's home visitation program and using that analysis to interpret any areas that may need to be improved upon accomplished this competency.

There were two concentration competencies learned throughout this capstone experience. The first was analyzing and addressing contexts and key factors relevant to the implementation of evidence-based health promotion strategies. Researching and organizing EHS's program standards so FAMILY could become a funded EHS program accomplished this competency. The second concentration competency was to demonstrate skills needed to coordinate and facilitate community partnerships to prioritize community needs, identify community assets, and create action to improve

public health outcomes and reduce health disparities. Analyzing the data and looking at areas where FAMILY could improve as well as identifying areas where FAMILY is meeting EHS performance standards accomplished this competency.

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Appendix A

Health Record Review & Questionnaire

Child Name: _____ Date: _____

Prenatal History:

Doctors who provide care during pregnancy

Name	Specialty

Please check any condition the biological mother experienced during the pregnancy with this child.

Excessive vomiting	☐	RH incompatibility	☐
Medications	☐	Drug use	☐
Diabetes	☐	Need for hospitalization	☐
Premature rupture of membranes	☐	Hemorrhaging	☐
Illnesses (i.e. measles)	☐	High blood pressure	☐
Trauma or injuries	☐	Alcohol use	☐
Tobacco use	☐	Other	☐

Any difficulty during: Pregnancy ☐ Yes ☐ No Labor ☐ Yes ☐ No
Delivery ☐ Yes ☐ No

Hospital: _____ Weight at Birth: _____ pounds, _____ ounces Height at Birth: _____ ins

Was the child carried full term?	☐ Yes	☐ No
Was your baby delivered breech?	☐ Yes	☐ No
Was your baby delivered by C-section?	☐ Yes	☐ No
Did your baby breathe on his/her own?	☐ Yes	☐ No

Was your baby discharged to home with mother? ☐ Yes ☐ No

Please describe any concerns you or your physician had at the time of delivery (born early, jaundice, medical diagnosis, etc.): _____

_____

Comments: _____

_____

_____

_____

_____

Medical History:
Does your child have a current medical condition? ☐ Yes ☐ No
Explain: _____

Has your child been hospitalized since birth for any reason? ☐Yes ☐ No
If Yes, state reason: _____

Has your child been in the emergency room since birth for any reason? ☐Yes ☐ No
If Yes, state reason: _____

Does your child take medication regularly? ☐ Yes ☐ No
If Yes, What medication? _____

Does your child have allergies? ☐ Yes ☐ No
If yes, to what:

Has your child had any illness with high fever? (104 degrees for longer than 2 days) ☐ Yes ☐ No

Doctors who provide care for this child

Name	Specialty

Does family currently have access to regular health care for?

1. Children and well baby? ☐ Yes ☐ No
   If yes, from whom? (include provider name) _____ Date of last visit: _____
2. Adults in family when they are sick? ☐ Yes ☐ No
3. Children when they are sick? ☐ Yes ☐ No

Is your child currently up to date on all recommended immunizations? ☐ Yes ☐ No
If No, state reason: _____

Comments: _____

Has your child been screened for lead level? ☐ Yes ☐ No

Child Age	Due Date	Date Received	Lead Risk Reported
12 Months			
2 Years			
3 Years			
4 Years			

Has your child been screened for anemia? ☐ Yes ☐ No
Explain: _____

Has your child ever been treated for reflux? ☐ Yes ☐ No
Does your child gag, cough, or choke more than usual when eating? ☐ Yes ☐ No

Has your healthcare provider ever expressed an concerns about your child's size and weight? ☐ Yes ☐ No
Do you feel your child eats a variety of nutritious foods? ☐ Yes ☐ No
Describe any concerns you have about your child's eating.

Was there ever any reason for concern about your child's general growth or development? ☐Yes ☐No
Please describe

Comments:

Hearing:
Did your child have a newborn hearing screen in the hospital? ☐ Yes ☐ No
If yes, what were the results?

Has your child had ear infections? ☐ Yes ☐ No
If yes, how many times has he/she been to the doctor for the ear infection and what was the treatment?

Has your child ever had a hearing examination or treatment? ☐ Yes ☐ No
If yes, when? _____
By whom? _____
Results _____

Hearing review

> Date completed: Initial: _____ Second: _____ Third: _____

Did your child have a newborn screening? Y N If yes, what were the results? _____
Newborn screening record provided or accessed? Y N

Has your child had ear infections? If so, how many times per year and what was the treatment?
Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child's hearing been checked by a healthcare provider? What were the results?
Initial: Y N _____
Second: Y N _____
Third: Y N _____

Has your child had an audiology exam?
Initial: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Second: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Third: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Hearing review (cont.)

Directions: Answer questions 1 to 8 for children under 2 years; answer questions 6 to 12 for children 2 years and older. A no answer for items 1 through 7 indicates the need for discussion and follow-up. A yes answer for items 8 through 12 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
1. Reacts to sudden loud noises.	Y N	Y N	Y N
2. Turns head toward interesting sounds or when his name is called.	Y N	Y N	Y N
3. Coos to himself and makes noise when he is alone.	Y N	Y N	Y N
4. Uses voice to get attention.	Y N	Y N	Y N
5. Tries to imitate you if you make his own sounds.	Y N	Y N	Y N
6. Seems to hear you if you talk in a whisper.	Y N	Y N	Y N
7. Seems to speak as well as other children the same age.	Y N	Y N	Y N
8. Has a family history of hearing problems.	Y N	Y N	Y N
9. Seems to have difficulty hearing.	Y N	Y N	Y N
10. Needs the television louder than other members of the family.	Y N	Y N	Y N
11. Seems to favor one ear over the other.	Y N	Y N	Y N
12. Makes you talk loudly or repeat frequently.	Y N	Y N	Y N

Hearing screening (if applicable)

Directions: Record any hearing screening completed. Indicate P for pass or R for refer.

	Initial		Second		Third	
	Right	Left	Right	Left	Right	Left
Hearing screening/OAE						
Tympanogram						
Audiometry						

Follow-up needed or actions taken:

Initial:

Second:

Third:

Dental:

Does your child have routine check-ups with a dental provider? ☐ Yes ☐ No

If yes, from whom? (include provider name) _____ Date of last visit:___

Dental review

> Date completed: Initial: _____ Second: _____ Third: _____

Does anything appear abnormal (swelling, redness, apparent decay) on the child's teeth or gums?

If yes, please describe.

Initial: Y N _____

Second: Y N _____

Third: Y N _____

Is brushing teeth or cleaning gums part of your child's daily routine?

Initial: Y N Second: Y N Third: Y N

Does your child fall asleep with a bottle? Initial: Y N Second: Y N Third: Y N

Don't forget to remind parent of the importance of visiting a dentist by the child's first birthday!

Safety:

Was family exposed to any of the following types of violent situations? (Check all that apply)

- ☐ Incidence of founded child abuse using DHS criteria
- ☐ Incident of domestic violence
- ☐ Due to natural disaster or other major disaster (e.g.: flood, tornado, accident)
- ☐ Neighborhood violence (e.g.: shooting, bombing, knifing)
- ☐ Peer violence

Safety review

Has your child been screened for lead levels? If yes, please describe the results.

Initial: Y N _____

Second: Y N _____

Third: Y N _____

Does your child ride in an approved car seat according to the state laws?

Rear-facing safety seat in the back seat? Initial: Y N Second: Y N Third: Y N

Forward-facing safety seat in the back seat? Initial: Y N Second: Y N Third: Y N

If your child is involved in biking or skating, is a helmet used?

Initial 1: Y N Second: Y N Third: Y N

Is your child exposed to second-hand smoke sometimes? If yes, please describe.

Initial: Y N _____

Second: Y N _____

Third: Y N _____

Is your home childproofed (for example, to prevent accidental poisoning, choking, and other injuries)?

Initial 1: Y N Second: Y N Third: Y N

Vision:

Is there a history of lazy eye or vision problems in the family? ☐ Yes ☐ No

Do you have concerns about your child's vision ☐ Yes ☐ No

If yes, please describe _____

_____

_____

_____

Vision review

> Date completed: Initial: _____ Second: _____ Third: _____

Has your child ever had a vision check by a doctor?

Initial: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Second: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Third: Y N _____
If yes, when? _____ By whom? _____
What were the results? _____

Directions: A yes answer for any item 1 through 12 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
1. Has eyes crossed – turning in or out – at any time, or eyes that do not appear straight, especially when the child is tired.	Y N	Y N	Y N
2. Has reddened eyes or eyelids.	Y N	Y N	Y N
3. Has encrusted eyelids.	Y N	Y N	Y N
4. Has frequent sties (pimple on the eyelid).	Y N	Y N	Y N
5. Has eyes that appear to move more than other people's eyes do.	Y N	Y N	Y N
6. Has eyelids that droop.	Y N	Y N	Y N
7. Has white spots or cloudiness covering some or all of the center of the eye.	Y N	Y N	Y N
8. Complains of burning, itching, or pain in eyes.	Y N	Y N	Y N
9. Stares at bright lights frequently or repeatedly flicks objects in front of face.	Y N	Y N	Y N
10. Is bothered by light more than you are.	Y N	Y N	Y N
11. Exhibits a pupil, the dark center part of the eye, that seems larger or smaller than the pupil in other children's eyes.	Y N	Y N	Y N
12. Complains of headache or nausea.	Y N	Y N	Y N

Follow-up needed or actions taken:

Initial:

Second:

Third:

Vision review (cont.)

A yes answer for three or more items on 13 through 23 indicates the need for discussion and follow-up.

The child:	Initial	Second	Third
13. Has watery eyes.	Y N	Y N	Y N
14. Complains of tired eyes; rubs eye often.	Y N	Y N	Y N
15. Moves the head forward or backward while looking at distant objects.	Y N	Y N	Y N
16. Turns the head to use one eye only (closes or covers one eye).	Y N	Y N	Y N
17. Tilts the head to one side often or all the time.	Y N	Y N	Y N
18. Places an object close to the eyes to look at it.	Y N	Y N	Y N
19. Squints while looking at objects.	Y N	Y N	Y N
20. Blinks more than you do.	Y N	Y N	Y N
21. Has difficulty walking or running; trips over objects more often than others do.	Y N	Y N	Y N
22. Is unable to see distant objects.	Y N	Y N	Y N
23. Has a family history of lazy eye or vision problems.	Y N	Y N	Y N

Functional assessment

Directions: To be completed by screener. Indicate P for present or A for absent.

	Initial		Second		Third	
	Right	Left	Right	Left	Right	Left
Blink Reflex						
Pupillary Response						
Corneal Light Reflex						
Tracking						
Reaching						

Other screenings (such as acuity screening for children over 2½ years of age):

Initial: _____

Second: _____

Third: _____

Follow-up needed or actions taken:

Initial:

Second:

Third:

Family Medical History:
Utilize this chart to identify any significant health concerns experienced by members of the family.

	Health Problems in Family														
	Alive	Cancer	Depression	Diabetes	Genetic Disorder	Hearing Impairment	Heart Disease	Hypertension	Learning Disability	Mental Illness	Obesity	Seizures	Stroke	Vision Impairment	Other:_____
Mother	☐ Yes ☐ No														
Father	☐ Yes ☐ No														
Sibling	☐ Yes ☐ No														
Grandparent	☐ Yes ☐ No														

Comments regarding Family Medical History:

Appendix B

Capstone Project - Determined as Not Human Subject Research

KD

Kotulak, Gail D

Reply

Fri 1/11, 1:22 PM
Linnenbrink, Brooke
Inbox

#1.8 Investigational Activities Requiring IRB Review & Approval.doc
100 KB
Show all 1 attachments (100 KB) Download
Save to OneDrive - University of Nebraska Medical Center
Brooke

Per the information provided in the emails below in which you are doing a class project for your Capstone (working with a non-profit and reviewing secondary data that is de-identified), the UNMC IRB determined it does not constitute human subject research as defined at 45CFR46.102. Therefore, it is not subject to the federal regulations. No further action is required. No Application needs to be submitted. See attached policy, section 5.6.

Please be advised that should anything change which would result in the project meeting the definition of human subject research, the IRB must be notified before any further research activity continues.

Should you have any questions please do not hesitate to contact the Office of Regulatory Affairs at 559-6463.

Sincerely,

Gail Kotulak, BS
IRB Administrator III
UNMC IRB

From: Linnenbrink, Brooke <brooke.linnenbrink@unmc.edu>
Sent: Friday, January 11, 2019 11:02 AM
To: Kotulak, Gail D <gkotulak@unmc.edu>
Subject: Re: Capstone Project IRB Question

Hi Professor Kotulak,

I talked to my preceptor and she said the data will be de-identified before I analyze it. I will only be providing my analysis back to the non-profit. I am not planning on presenting my findings outside of the university or publishing my findings either.

Thank you,

Brooke Linnenbrink
UNMC Master's of Public Health

Get Outlook for iOS

From: Kotulak, Gail D
Sent: Friday, January 11, 2019 10:39:34 AM
To: Linnenbrink, Brooke
Subject: RE: Capstone Project IRB Question

Good Morning Brooke:

Does the data have any identifiers?
Will you only be providing the analysis back to the non-profit.
Do you plan present outside the university or prepare for publication?

Thanks
Gail

From: Linnenbrink, Brooke <brooke.linnenbrink@unmc.edu>
Sent: Thursday, January 10, 2019 10:10 AM
To: Kotulak, Gail D <gkotulak@unmc.edu>
Subject: Capstone Project IRB Question

Hello Professor Kotulak

I am emailing you regarding my capstone project and whether I need IRB approval. For my project, I am working with a non-profit in Council Bluffs and will be analyzing data that they have collected over the past 5 years regarding their home visitation program. I will be looking at the data and analyzing how they are faring in regards to health education requirements. The data I am looking at is secondary data and is focused on quality improvement. I am just emailing you to see if I need to complete an IRB application.

Thank you for all your help,

Brooke Linnenbrink
UNMC Master's of Public Health
Health Promotion