

DOH - Benchmarks

Benchmark 1: Improved Maternal and Newborn Health	
Construct	1. Prenatal Care
Performance Measure	Percent of pregnant women who received prenatal care
Operational Definition	Target Population: Women who are pregnant when they enroll
	Numerator: Women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester
	Denominator: Women who were pregnant at enrollment
Definition of improvement and calculation	Definition of improvement: Increase the number of pregnant women who receive prenatal care
	Calculation: The number of women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester divided by the number of women who were pregnant at enrollment in year 2 compared to the number of women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester divided by the number of women who were pregnant at enrollment in year 1
*Cohort comparison:	
Data Source	HV program records, pregnant woman-self report
Measurement Tool	PAT: LSP #17 Prenatal care scores do not capture 2 nd trimester threshold, therefore we will ask PAT to use the HV record, "When did you receive prenatal care?" EHS: PIR #C15a,b Trimester of pregnancy in which the pregnant women served were enrolled or use internal program data HFA: HV record "When did you receive prenatal care?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question or administer the tool and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at enrollment within first 2 home visits and every 6 months of program enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	PAT data collection is not specific to the second trimester.

*Cohort

Year One = May 1, 2012 to April 31, 2013

Year Two = May 1, 2013 to April 31, 2014

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Benchmark 1: Improved Maternal and Newborn Health	
Construct	2. Parental use of alcohol, tobacco, or illicit drugs
Performance Measure	Percent of smokers at intake who decrease smoking by 1 year post enrollment.
Operational Definition	Target Population: Enrolled pregnant women and mothers who report current use of tobacco at enrollment
	Numerator: Number of enrolled smokers at intake, who reported decreased smoking by one year post enrollment
	Denominator: Number of enrolled smokers at intake who remain in the program for at least one year
Definition of improvement and calculation	Definition of improvement: Increase percent of smokers at intake who reported smoking fewer cigarettes by one year post enrollment Calculation: Number of smokers at intake who reported reduced smoking by one year post enrollment divided by the number of participants who reported smoking at intake
Individual	
Data Source	Collected during home visit using the 3 client/caregiver questions from PRAMS, "Prenatal Use of Tobacco"
Measurement Tool	HFA & EHS: PRAMS: "Prenatal Use of Tobacco" "In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day?" "In the last 3 months of your pregnancy how many cigarettes did you smoke on an average day?" "How many cigarettes do you smoke on an average day now?" 41 cigarettes or more 21 to 40 cigarettes 11 to 20 cigarettes 6 to 10 cigarettes Less than 2 cigarette I don't smoke now PAT: LSP#25: Do you currently smoke or use other tobacco products? How much do you use per day?
Reliability/Validity	Pregnancy Risk Assessment Monitoring System; A Survey for Healthier Babies in New Jersey (cited 2011 May). Available from: http://www.nj.gov/health/fhs/documents/methods_summary.pdf

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	LSP: #25 – N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will administer the questionnaire and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at intake and one year post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

DOH - Benchmarks

Benchmark 1: Improved Maternal and Newborn Health	
Construct	3. Preconception Care
Performance Measure	Percent of enrolled post partum women who receive a post partum examination within the first three months following enrollment
Operational Definition	Target Population: Post partum women enrolled in program
	Numerator: Number of post partum women who reported a post partum examination
	Denominator: Total number of enrolled post partum women who remain in the program for 3 months
Definition of improvement and calculation Cohort	Definition of improvement: Increase or maintain the percent of enrolled post partum women that received a post partum exam within the first three months following enrollment in year 1 as compared to the percent of enrolled post partum women that received a post partum exam within the first three months following enrollment in year 2 Calculation: Number of post partum women who report a post partum examination divided by the total number of post partum women in year 2 compared to the number of post partum women who report a post partum examination divided by the total number of post partum women in year 1.
Data Source	Collected during home visit interview
Measurement Tool	Question: "When was your last post-partum examination?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected or within the first 3 months following enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	All models will use same measurement tool

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Benchmark 1: Improved Maternal and Newborn Health	
Construct	4. Inter Birth Intervals
Performance Measure	Percent of enrolled mothers and pregnant women who received birth spacing education within 6 months of enrollment
Operational Definition	Target Population: Enrolled mothers and pregnant women
	Numerator: Total number of enrolled mothers and pregnant women who received birth spacing education within six months of enrollment
	Denominator: Total number of mothers and pregnant women enrolled during the program year for at least 6 months
Definition of improvement and calculation Cohort	<p>Definition of improvement: Increase or maintain the percent of mothers and pregnant women who enrolled during year 2 who received birth spacing education within six months of enrollment as compared to the percent of mothers and pregnant women who enrolled during year 1 who received birth spacing education within six months of enrollment</p> <p>Calculation: Total number of mothers and pregnant women who enrolled during year 2 who received birth spacing education within six months of enrollment divided by the total number of mothers and pregnant women who enrolled during year 2 compared to total number of mothers and pregnant women who enrolled during year 1 who received birth spacing education within six months of enrollment divided by the total number of mothers and pregnant women who enrolled during year 1.</p>
Data Source	Collected during home visit interview
Measurement Tool	HFA and EHS: Question: "Did the mother or pregnant woman receive birth spacing education?" PAT: LSP #1 " Do you have information about the different ways to prevent pregnancies?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at six months post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

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Benchmark 1: Improved Maternal and Newborn Health	
Construct	5. Screening for maternal depressive symptoms
Performance Measure	Percent of mothers who screened for depression by 6 months post enrollment
Operational Definition	Target Population: Enrolled mothers in the program
	Numerator: Number of enrolled mothers who were screened for depressive symptoms using the Edinburgh Postnatal Depression Scale between enrollment and 6 months post enrollment
	Denominator: Total number of enrolled mothers for at least 6 months
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 2, as compared to the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 1.
Cohort	Calculation: Number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 2 divided by the total number of enrolled mothers in year 2 compared to the number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 1 divided by the total number of enrolled mothers
Data Source	Collected during home visit interview
Measurement Tool	Edinburgh Postnatal Depression Scale Question: "Was the EPDS administered?"
Reliability/Validity	The EPDS has been found to have good reliability and validity, with a sensitivity of 86%, a specificity of 78% and a split-half reliability of .99 with a standardized α coefficient of .87 ¹
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected by six months post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

¹ The origins and development of the Edinburgh Postnatal Depression Scale. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf. Accessed July 11, 2011.

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Benchmark 1: Improved Maternal and Newborn Health	
Construct	6. Breastfeeding
Performance Measure	The number of weeks that index women who enrolled prenatally spent breastfeeding up until the child is 6 months of age.
Operational Definition	Target Population: Index women who enrolled prenatally
	Numerator: Total number of weeks that index women who enrolled prenatally spent breastfeeding
	Denominator: Number of index women who enrolled prenatally
Definition of improvement and calculation Cohort	<p>Definition of improvement: Increase in the average number of weeks that a mother who enrolled prenatally in year 2 spent breastfeeding compared to the average number of weeks that a mother who enrolled prenatally in year 1 spent breastfeeding.</p> <p>Calculation: Total number of weeks that mothers enrolled prenatally in year 2 spent breastfeeding divided by the total number of mothers who enrolled prenatally in year 2 compared to the total number of weeks that mothers enrolled prenatally in year 1 spent breastfeeding divided by the total number of mothers who enrolled prenatally in year 1.</p>
Data Source	Collected during home visit interview
Measurement Tool	HFA and EHS: PRAMS Breastfeeding questionnaire : “ How many weeks or months did you breastfeed or pump milk to feed your baby?” PAT: LSP #43 “How long did you breast feed your baby?”
Reliability/Validity	Pregnancy Risk Assessment Monitoring System; A Survey for Healthier Babies in New Jersey (cited 2011 May). Available from: http://www.nj.gov/health/fhs/documents/methods_summary.pdf
Data Collection & Analysis Plan	Person Responsible: The home visitor will administer the questionnaire and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected quarterly for CQI
	Analysis: Annually

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Comments/Anticipated Challenges	
Benchmark 1: Improved Maternal and Newborn Health	
Construct	7. Well Child Visits
Performance Measure	Percent of index children who received the recommended schedule of immunization according to the AAP/CHDP well child schedule at birth, 1, 2, 4 and 6 months of age.
Operational Definition	Target Population: Index children enrolled for at least 6 months
	Numerator: Number of index children enrolled for at least 6 months who received the recommended schedule of immunizations
	Denominator: Total number of index children in program who have been enrolled for at least 6 months.
Definition of improvement and calculation	Definition of improvement: Increase or maintain percent of index children who have been enrolled for at least 6 months who have received all recommended schedule of well child visits according to AAP/CHDP schedule in year 2 as compared to index children who have been enrolled for at least 6 months who have received all recommended well child visits according to AAP/CHDP schedule in year 1.
Cohort	Calculation: Number of index children enrolled for at least 6 months who received the recommended schedule of well child visits divided by the total number of index children in the program who have been enrolled for at least 6 months in year 2 compared to number of index children enrolled for at least 6 months who received the recommended schedule of well child visits divided by the total number of index children in the program who have been enrolled for at least 6 months in year 1.
Data Source	Program records and self report
Measurement Tool	PAT: LSP#20 "How often did you take your child for a well-child doctor's visit?" /LSP score of 5 on #20 EHS: Internal program data HFA: Program records and self report for immunization and well child visits
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask for well child visit/immunization report/record and the data entry personnel will enter the response into the database.
	Data collection schedule: collected at 6 months enrollment
	Analysis: Every 6 months for CQI and reported annually

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Comments/Anticipated Challenges	
Benchmark 1: Improved Maternal and Newborn Health	
Construct	8. Maternal and Child Health Insurance Status
Performance Measure	Percent of mothers and index children with health insurance by 6 months post enrollment
Operational Definition	Target Population: Enrolled mothers and children
	Numerator: Number of mothers with health insurance plus the number of index children with health insurance by 6 months post enrollment
	Denominator: Total number of enrolled mothers and children who remain enrolled for at least 6 months
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percentage of enrolled mothers and index children with health insurance by 6 months post enrollment in year 2 compared to the percentage of enrolled mothers and index children with health insurance by 6 months post enrollment in year 1.
Cohort	Calculation: The number of enrolled mothers and index children with insurance by 6 months post enrollment in year 2 divided by the total number of enrolled mothers and index children in year 2 compared to the enrolled mothers and index children with health insurance by 6 months post enrollment in year 1 divided by the total number of enrolled mothers and index children in year 1.
Data Source	Collected by home visitor
Measurement Tool	Question: "Do you currently have health insurance?" "Does your child currently have health insurance?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the questions and the data entry personnel will enter the response into the database.
	Data collection schedule: Quarterly
	Analysis: Every 6 months for CQI and reported annually

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Comments/Anticipated Challenges	
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Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	1. Visits for children to the ED from all causes
Performance Measure	Rate of emergency department visits per index child in the program enrolled for at least one year
Operational Definition	Target: All index children enrolled in the program
	Numerator : Total number of emergency department visits by index children in the program
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the rate of emergency department visits per index child in the program in year 2 compared to emergency department visits per index child in the program in year 1
Cohort	Calculation: Number of ED visits by all children in the program in year 2 divided by the total number of children in the program in year 2 compared to number of ED visits by all children in the program in year 1 divided by the total number of children in the program in year 1.
Data Source	Collected by home visitor
Measurement Tool	HV will ask question, "How many times has your child been to the emergency dept. for any reason?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the question and data entry personnel will enter data in database
	Data collection schedule: Quarterly
	Analysis: Annually for reporting

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Comments/Anticipated Challenges	In addition to reporting this as a whole, it will also be reported by the child’s age when the incident occurred (0-12 months, 13-36 months, and 37-60 months).
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Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	2. Visits of mothers to the ED from all causes
Performance Measure	Rate of emergency department visits per mother in the program enrolled for at least one year
Operational Definition	Target: Mothers enrolled in the program
	Numerator : Total number of emergency department visits by enrolled mothers in the program
	Denominator: Total number of enrolled mothers in the program
Definition of improvement and calculation	Definition of improvement: Decrease the rate of emergency department visits by enrolled mothers in the program in year 2 compared to emergency department visits by enrolled mothers in the program in year 1
Cohort	Calculation: Number of emergency department visits by enrolled mothers in the program in year 2 divided by the total number of enrolled mothers in the program in year 2 compared to the number of emergency department visits by enrolled mothers in the program in year 1 divided by the total number of enrolled mothers in the program in year 1.
Data Source	Collected by home visitor
Measurement Tool	Home visitor will ask the question, “How many times have you visited the emergency department for any reason?”
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the question and data entry personnel will enter the data
	Data collection schedule: Quarterly for CQI

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	Analysis: Annually reported
Comments/Anticipated Challenges	
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	3. Information provided or training of participants on prevention of child injuries including safe sleep, shaken baby, TBI, child passenger safety, poisonings, fire safety, water safety, playground safety
Performance Measure	Percentage of enrolled families who received information or training on the prevention of child injuries during the cohort year
Operational Definition	Target population: Enrolled families
	Numerator : Number of enrolled families who have received information or training on the prevention of child injuries
	Denominator: Total number of enrolled families
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percentage of enrolled families who enrolled during year 2 who received information or training on the prevention of child injuries compared to the percentage of enrolled families who enrolled during year 1 who received information or training on the prevention of child injuries .
Cohort	Calculation: Number of enrolled families who have received information or training on the prevention of child injuries divided by the total number of enrolled families in year 2 compared to the number of enrolled families who have received information or training on the prevention of child injuries divided by the total number of enrolled families in year 1
Data Source	Program administrative records
Measurement Tool	HFA Program’s policies and procedures: P & P contain procedures for providing information and training for the prevention of child injuries. Early Head Start - Internal program data PAT -Personal Visit Record
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the policies and procedures and will record completion of information

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	and training.
	Data collection schedule: Quarterly for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	4. Child injuries requiring medical treatment
Performance Measure	Rate of injuries index children receive that require medical treatment (ambulatory care, ED visits, and hospitalization, injury or ingestions)
Operational Definition	Target population: Index children enrolled in the program
	Numerator : Total number of injuries index children receive requiring medical treatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decreased rate in the injuries index children receive requiring medical treatment in year 2 compared to the injuries index children receive requiring medical treatment in year 1
Cohort	Calculation: Number of injuries index children receive requiring medical treatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of injuries index children receive requiring medical treatment in year 1 divided by the total number of index children in the program in year 1
Data Source	Adult enrolled index participant self report, collected by home visitor
Measurement Tool	HFA and EHS: Self report question administered by home visitor, "In the past 3 months, how many times did your child receive medical treatment for an injury? " (also inquire reason for the visit, kind of injury, type of treatment) PAT: score of 1 or 2 on LSP #8-Safety "Has your child ever had an accident that caused injury?" "Have you ever taken your child to the ER for accidental injury?" "Has he/she been hospitalized?" "Sustain permanent damage?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the questionnaire to the adult enrolled index participant
	Data collection schedule: Quarterly for CQI

Attachment "E"

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	Analysis: Annually reported
Comments/Anticipated Challenges	In addition to reporting this as a whole, it will also be reported by the child's age when the incident occurred (0-12 months, 13-36 months, and 37-60 months) Will require raw data from PAT

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	5. Reported suspected maltreatment (allegations)
Performance Measure	Percent of suspected maltreatment cases among index children in the program enrolled during the cohort year
Operational Definition	Target population: Index children in the program
	Numerator : Number of index children in the program who are reported to Child Welfare Services for suspected maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the percentage of suspected maltreatment cases among index children in the program in year 2 compared to suspected maltreatment cases among index children in the program in year 1.
Cohort	Calculation: Number of index children in the program who are reported to Child Welfare Services for suspected maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are reported to Child Welfare Services for suspected maltreatment in year 1 divided by the total number of index children in the program in year 1
Data Source	Hawaii Dept. of Human Services, Child Welfare Services
Measurement Tool	CWS report, report will contain aggregate data on unidentified index children in the program that are involved in cases of suspected maltreatment.
Reliability/Validity	N/A

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Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months)
	The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	6. Reported substantiated maltreatment
Performance Measure	Percent of substantiated maltreatment cases among index children in the program enrolled during the cohort year
Operational Definition	Target Population: Index children in the program
	Numerator : Number of index children in the program who are substantiated by Child Welfare Services for maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the percent of substantiated maltreatment cases among index children in the program in year 2 compared to substantiated maltreatment cases among index children in the program in year 1
Cohort	Calculation: Number of index children in the program who are substantiated by Child Welfare Services for maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are substantiated by Child Welfare Services for maltreatment in year 1 divided by the total number of index children in the program in year 1.
Data Source	Dept. of Human Services – Child Welfare Services
Measurement Tool	CWS report, report will contain unidentified index children in the program that are involved in cases of substantiated maltreatment

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Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: annually reported
Comments/Anticipated Challenges	We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months)
	The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	7. First time victims of maltreatment for index children in the program
Performance Measure	Percentage of index children in the program who are first time victims of maltreatment enrolled during the cohort year
Operational Definition	Target population: All index children in the program
	Numerator: Number of index children in the program who are first time victims of maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease percentage of first time victims of maltreatment of index children in the program in year 2 compared to first time victims of maltreatment of index children in the program in year 1
	Calculation: Number of index children in the program who are first time victims of maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are first time victims of maltreatment in year 1 divided by the total number of index children in the program in year 1
Cohort	1
Data Source	Dept. of Human Services – Child Welfare Services
Measurement Tool	CWS report, report will contain unidentified number of index children in the program that are involved in cases of first time victimization.

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Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: annually reported
Comments/Anticipated Challenges	We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months) The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS First time victim is defined as a child who had a maltreatment disposition of “victim” and never had prior disposition of victim.

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	1. Parent’s support for children’s learning and development (toys, talking, reading to)
Performance Measure	Percentage of adult enrolled index participants who demonstrate support of index child’s learning and development
Operational Definition	Target Population: Adult enrolled index participants who score below 7 on the Learning Materials subscale of the HOME
	Numerator : Adult enrolled index participants whose Learning Materials subscale score is above 7 at one year post enrollment
	Denominator: The total number of adult enrolled index participants who scored below 7 at one year post enrollment
Definition of improvement and calculation	Definition of improvement: Decrease the percent of adult enrolled index participants who score below 7 on the Learning Materials subscale of the Infant Toddler HOME
Individual	Calculation: Number of adult enrolled index participants whose Learning Materials subscale HOME scores are above 7 on the Infant Toddler HOME at one year post enrollment divided by the total number of adult enrolled index participants whose Learning Materials subscale HOME scores are below 7 on the Infant Toddler HOME

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Data Source	Infant Toddler HOME administered by home visitor
Measurement Tool	Infant Toddler HOME Sub scale 4- Learning Materials, #26-34; cut off threshold below 7
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the HOME and the data personnel will enter results into database.
	Data collection schedule: 1 year post enrollment
	Analysis: Annually
Comments/Anticipated Challenges	HOME will be used across all models Adult enrolled index participant is one primary caregiver

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	2. Parent knowledge of child development and of their child’s developmental progress
Performance Measure	Percentage of ASQ results that adult enrolled index participant reviewed with the home visitor
Operational Definition	Target population: Adult enrolled index participants
	Numerator : Number of ASQ results reviewed with the adult enrolled index participants
	Denominator: Total number of ASQ s administered at target age (8 months or 36 months)
Definition of improvement and calculation	Definition of improvement: Increase or maintain percentage of ASQ results that were reviewed with the adult enrolled index participant in year 2 as compared to percentage of ASQ results that were reviewed with the adult enrolled index participant in year 1
Cohort	Calculation: Number of ASQ results reviewed with the adult enrolled index participants in year 2 divided by the total number of ASQs administered in year 2 compared to the number of ASQ results reviewed with the adult enrolled index participants in year 1 divided by the total number of ASQs administered in year 1
Data Source	Administrative record review

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Measurement Tool	“What was the date the ASQ test result was reviewed with the adult enrolled index participant?”
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will record the date the ASQ was reviewed with the adult enrolled index participant and the data personnel will enter the data into the database.
	Data collection schedule: EHS, HFA, PAT: 8 month ASQ HIPPIY: 36 months
	Analysis: At target age and annually
Comments/Anticipated Challenges	Process measure
	Check program policy and procedures to ensure that the ASQ is reviewed w/parent
Benchmark 3: Improvements in School Readiness and Achievement	
Construct	3. Parenting behaviors and parent-child relationship (discipline strategy, play interaction)
Performance Measure	The percentage of adult enrolled index participants that score above the median for the Infant Toddler HOME at one year post enrollment
Operational Definition	Target population: Adult enrolled index participants who score below the median at enrollment
	Numerator: Number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at one year post enrollment
	Denominator: Total number of adult enrolled index participants with a HOME score below 32 at enrollment
Definition of improvement and calculation	Definition of improvement: Decrease the percentage of adult enrolled index participants who score below 32 on the Infant Toddler HOME at one year post enrollment in year 2 as compared to percentage of adult enrolled index participants who score below 32 on the Infant Toddler HOME at one year post enrollment in year 1
Cohort	Calculation: Number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at year one post enrollment divided by the total number of adult enrolled index participants in year one with a HOME score below 32 at enrollment compared to number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at year two post enrollment divided by the total number of adult enrolled index participants in year two with a HOME score below 32 on the Infant Toddler HOME at year two post enrollment.

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Data Source	HOME administered by home visitor
Measurement Tool	HOME
Reliability/Validity	HOME Observation for Measurement of the Environment (HOME) Inventory Administration Manual, Third Edition, 2001 (cited 2011 May). Available from: http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phio.html
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the HOME and the data entry personnel will enter results into the database
	Data collection schedule: At enrollment (within 90 days) and 1 year post enrollment
	Analysis: Annually
Comments/Anticipated Challenges	HOME will be used across all models
Benchmark 3: Improvements in School Readiness and Achievement	
Construct	4. Parent emotional well-being or parenting stress
Performance Measure	Percent of mothers who screened for depression by 6 months post enrollment
Operational Definition	Target population: Enrolled mothers in the program
	Numerator: Number of enrolled mothers who were screened for depressive symptoms using the Edinburgh Postnatal Depression Scale between enrollment and 6 months post enrollment
	Denominator: Total number of enrolled mothers
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 2, as compared to the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 1.
Cohort	Calculation: Number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 2 divided by the total number of enrolled mothers in year 2 compared to the number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 1 divided by the total number of enrolled mothers in year 1.
Data Source	Collected by home visitor

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Measurement Tool	Edinburgh Postnatal Depression Scale Question: "Was the EPDS administered?"
Reliability/Validity	The EPDS has been found to have good reliability and validity, with a sensitivity of 86%, a specificity of 78% and a split-half reliability of .99 with a standardized α coefficient of .87 ²
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected by six months post enrollment
	Analysis: Six months for CQI and report annually
Comments/Anticipated Challenges	
Benchmark 3: Improvements in School Readiness and Achievement	
Construct	5. Child's communication, language, and emergent literacy
Performance Measure	Percentage of index children who are screened for developmentally appropriate Communication skills at the target age
Operational Definition	Target population: enrolled index children at target age
	Numerator: Number of enrolled index children screened for developmentally appropriate communication skills at target age
	Denominator: Total number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who are screened for developmentally appropriate skills at target age
Process Individual comparison	Calculation: Number of enrolled index children screened for developmentally appropriate communication skills at target age divided by the total number of enrolled index children at target age.

² The origins and development of the Edinburgh Postnatal Depression Scale. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf. Accessed July 11, 2011.

DOH - Benchmarks

Data Source	Administered by home visitor at index child's target age
Measurement Tool	Age relevant ASQ 3
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User's Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: At target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months HIPYP target age: 36 months EHS target age: 8 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	6. Child's general cognitive skills
Performance Measure	Percentage of index children who are screened for general cognitive skills at the target age
Operational Definition	Target population: enrolled index children at target age
	Numerator: Number of enrolled index children screened for general cognitive skills at target age
	Denominator: Total number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who are screened for general cognitive skills at target age Calculation: Number of enrolled index children screened for general cognitive skills at target age divided by the total number of enrolled index children at target age
Process Individual comparison	

DOH - Benchmarks

Data Source	Administered by home visitor at index child's target age
Measurement Tool	Age relevant ASQ 3
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User's Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months HIPYP target age: 36 months EHS target age: 8months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	7. Child's positive approaches to learning including attention
Performance Measure	Percentage of index children who score above the cut off on the target age ASQ SE
Operational Definition	Target population: Index children at target age
	Numerator: Number of index children at target age that score above the cut off on the target age ASQ- SE
	Denominator: Number of index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who scored above the cut off at the target age
Process Individual comparison	Calculation: Number of index children at target age that score above the cut off on the target age ASQ-SE divided by the total number of index children at the target age.

DOH - Benchmarks

Data Source	Administered by home visitor at index child's target age
Measurement Tool	age specific ASQ SE
Reliability/Validity	Minnesota Department of Health; Developmental and Social-Emotional Screening of Young children (0-6 years of age) in Minnesota (cited 2011 May). Available from: http://www.health.state.mn.us/divs/fh/mch/devscrn/instr/asqse.html
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ SE and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 6 months PAT target age: 6 months EHS target age: 6 months HIPPI target age: 36 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	8. Child's social behavior, emotional regulation and emotional well-being
Performance Measure	Percentage of index children who score above the cut off on the target age ASQ SE
Operational Definition	Target population: Index children at target age
	Numerator: Number of index children at target age that score above the cut off on the target age ASQ- SE
	Denominator: Number of index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who scored above the cut off at the target age.
Process Individual comparison	Calculation: Number of index children at target age that score above the cut off on the target age ASQ-SE divided by the total number of index children at the target age.

DOH - Benchmarks

Data Source	Administered by home visitor at index child's target age
Measurement Tool	age specific ASQ SE
Reliability/Validity	Minnesota Department of Health; Developmental and Social-Emotional Screening of Young children (0-6 years of age) in Minnesota (cited 2011 May). Available from: http://www.health.state.mn.us/divs/fh/mch/devscrn/instr/asqse.html
Data Collection & Analysis Plan	Person Responsible: : Home visitor will administer the ASQ SE and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 6 months PAT target age: 6 months EHS target age: 6 months HIPPY target age: 36 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	9. Child's physical health and development
Performance Measure	Percentage of index children who score above the cut off on the Gross Motor section of the ASQ 3
Operational Definition	Target population: enrolled index children at target age
	Numerator: number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ3 at target age
	Denominator: number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% the percentage of enrolled index children who scored above the cut off at the target age at year 2 compared to index children who scored above the cut off at the target age at year 1

DOH - Benchmarks

Cohort	Calculation: Number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ 3 at target age in year 2 divided by the total number of enrolled index children at target age in year 2 compared to the number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ 3 at target age in year 1 divided by the total number of enrolled index children at target age in year 1
Data Source	Administered by home visitor at index child’s target age
Measurement Tool	age specific ASQ 3 Gross Motor section
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User’s Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months EHS target age: 8 months HIPPY target age: 36 months
Benchmark 4: Domestic Violence	
Construct	1. Screening for Domestic Violence
Performance Measure	The percentage of adult enrolled index parents who are screened for Domestic Violence within 6 months post enrollment
Operational Definition	Target population: Adult enrolled index mothers
	Numerator: Number of enrolled index mothers who are screened for Domestic Violence within 6 months post enrollment
	Denominator: Total number of enrolled index mothers who remain in the program for at least 6 months
Definition of improvement and	Definition of improvement: Increase or maintain at 90% of adult enrolled mothers who were screened for Domestic

DOH - Benchmarks

calculation	Violence within 6 months post enrollment.
Process Individual comparison	Calculation: Number of enrolled index mothers who are screened for Domestic Violence within 6 months post enrollment divided by the total number of enrolled index mothers.
Data Source	Questionnaire administered by home visitor
Measurement Tool	Women’s Experience with Battering Scale All models will use the Women’s Experience with Battering Scale
Reliability/Validity	Women’s Experience with Battering Scale – Reliability/Validity = Cronbach’s alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard).Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the questionnaire to the adult enrolled index mother and the data entry personnel will enter the data in the database Data collection schedule: within 6 months post enrollment Analysis: annually
Comments/Anticipated Challenges	It may be difficult for us to reach 90% during year 1 due to the need to train staff.

Benchmark 4: Domestic Violence	
Construct	2. Of families identified for DV, no. of referrals made to DV services
Performance Measure	The percentage of enrolled index parents who received referrals to domestic violence services.
Operational Definition	Target population: Enrolled index mothers who scored above 20 on the Women’s Experience with Battering Scale Numerator: Number of enrolled index mothers who received a referral to domestic violence services Denominator: Total number of enrolled index mothers who scored above 20 on the Women’s Experience with Battering Scale.
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% the number of enrolled index mothers who received referrals to domestic violence services.

DOH - Benchmarks

Process Individual comparison	Calculation: Number of enrolled index mothers who received a referral to domestic violence services divided by the total number of enrolled index mothers who scored above 20 on the Women’s Experience with Battering Scale
Data Source	Data will be recorded by data personnel when the home visitor refers an enrolled index mother to relevant domestic violence services
Measurement Tool	N/A
Reliability/Validity	Women’s Experience with Battering Scale – Reliability/Validity = Cronbach’s alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard).Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home Visitor will make the referral to relevant domestic violence services and data personnel will enter the data in the database
	Data collection schedule: Within 30 days of administration of Women’s Experience with Battering Scale
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Many rural areas have very limited relevant domestic violence resources

Benchmark 4: Domestic Violence	
Construct	3. Of families identified for Dv, no. of families with a completed safety plan
Performance Measure	The percentage of adult enrolled index parents who scored above 20 on the Women’s Experience with Battering Scale who complete a safety plan
Operational Definition	Target population: Enrolled index mothers who scored above 20 on the Women’s Experience with Battering Scale.
	Numerator: Number of enrolled index mothers who completed a safety plan
	Denominator: Total number of enrolled index mothers who scored above 20 on the Experience with Battering Scale.
Definition of improvement and	Definition of improvement: Increase or maintain at 90% the number of enrolled index mothers who completed a safety plan.

DOH - Benchmarks

calculation	Calculation: Number of enrolled index mothers who completed a safety plan divided by the total number of enrolled index mothers who scored above 20 on the Women’s Experience with Battering Scale.
Process Individual comparison	
Data Source	Data will be recorded by data personnel when the home visitor develops a safety plan
Measurement Tool	Completed Safety Plan
Reliability/Validity	Women’s Experience with Battering Scale – Reliability/Validity = Cronbach’s alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard).Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home Visitor will develop the safety plan and data personnel will enter the data in the database
	Data collection schedule: Within 30 days of administration of the Women’s Experience with Battering Scale
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 5: Family Economic Self Sufficiency	
Construct	1. Household income and benefits
Performance Measure	Total income of the adult enrolled index participants
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Total income for adult enrolled index participants
	Denominator: Total number of adult enrolled index participants
Definition of improvement and	Definition of improvement: Increase in the average total income of the adult enrolled index participants at enrollment

DOH - Benchmarks

calculation	and one year post enrollment
Individual	Calculation: Average income of adult enrolled index participants one year post enrollment minus the average income of adult enrolled index participants at month of enrollment
Data Source	Collected by home visitor
Measurement Tool	Question: Please estimate your annual total household income
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	<p>We are only collecting income, rather than ask the home visitor to estimate in-kind benefits.</p> <p>Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private, e.g., rent from tenants/borders, cash assistance from friends or relatives, or they may be linked to public assistance, i.e., child support payments, TANF, Social Security (SSI/SSDI/OAI), and unemployment insurance.</p>

Benchmark 5: Family Economic Self Sufficiency	
Construct	2. Employment of adult members of household
Performance Measure	Number of monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Total number of monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household

DOH - Benchmarks

	Denominator: Total number of adult enrolled index participants
Definition of improvement and calculation	Definition of improvement: Increase in the average number of monthly paid hours plus unpaid hours devoted to infant care (30 hours max) by all adult enrolled index participant members of the household at enrollment and one year post enrollment
Individual	Calculation: Number of average monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household one year post enrollment minus average monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household in month of enrollment
Data Source	Collected by home visitor in month of enrollment and one year post enrollment
Measurement Tool	Question: Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max)
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	

Benchmark 5: Family Economic Self Sufficiency	
Construct	3. Education of adult members of household
Performance Measure	Number of hours per month spent by adult enrolled index participants in education programs
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Number of hours per month spent by adult enrolled index participants in education programs

DOH - Benchmarks

	Denominator: Total number of adult enrolled index participants
Definition of improvement and calculation	Definition of improvement: Increase in the average hours per month spent by adult enrolled index participants in education programs at enrollment and one year post enrollment
Individual	Calculation: Number of average hours per month spent by adult enrolled index participants in education programs one year post enrollment minus the average hours per month spent by adult enrolled index participants in education programs in month of enrollment
Data Source	Collected by home visitor in month of enrollment and one year post enrollment
Measurement Tool	Question: Estimate your total monthly hours spent in education programs
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database Home
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	Education programs are defined as secondary, post secondary, trade school.

Benchmark 5: Family Economic Self Sufficiency	
Construct	4. Health Insurance status
Performance Measure	Percent of mothers and index children with health insurance
Operational Definition	Target population: Enrolled mothers and children
	Numerator: Number of mothers with health insurance plus the number of index children with health insurance.

DOH - Benchmarks

	Denominator: Total number of enrolled mothers and children
Definition of improvement and calculation	<p>Definition of improvement: Increase or maintain the percentage of enrolled mothers and index children with health insurance at enrollment and one year post enrollment</p> <p>Calculation: The number of enrolled mothers and index children with insurance at enrollment divided by the total number of enrolled mothers and index children compared to the total number of enrolled mothers and index children with insurance at one year post enrollment divided by the total number of enrolled mothers and index children one year post enrollment</p>
Individual	
Data Source	Collected by home visitor
Measurement Tool	“Do you currently have health insurance?” “Does your child currently have health insurance?”
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the questions and the data entry personnel will enter the response into the database.
	Data collection schedule: Quarterly
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	1. Number of families identified for necessary services
Performance Measure	Percentage of enrolled index families screened for necessary services
Operational Definition	Target population: Enrolled families
	Numerator: Number of enrolled families screened for necessary services

DOH - Benchmarks

	Denominator: Total number of enrolled families
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% of enrolled families screened for necessary services.
Process Individual comparison	Calculation: Number of enrolled families screened for necessary services divided by the total number of enrolled families.
Data Source	Collected by home visitor
Measurement Tool	Question: What services do you think your family needs?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: annually
Comments/Anticipated Challenges	Services: Financial, Women’s Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family Planning, Clinical Specialist, Nutrition other, Respite, Child Care, Emp/Adult school, Housing, MH/Fam Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence services, Other

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	2. Number of families that required services and received a referral to available community resources
Performance Measure	Percentage of enrolled families that were screened and received a referral to available community resources
Operational Definition	Target population: Enrolled families

DOH - Benchmarks

	Numerator: Number of enrolled families screened for necessary services and received a referral
	Denominator: Total number of enrolled families
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled families screened for necessary services and who received a referral.
Process	Calculation: Number of enrolled families screened for necessary services and received a referral divided by the total number of enrolled families.
Individual comparison	
Data Source	Collected by home visitor
Measurement Tool	Question: What services has the family been referred to?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Services: Financial, Women’s Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family Planning, Clinical Specialist, Nutrition other, Respite, Child Care, Emp/Adult school, Housing, MH/Fam Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence services, Other

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	3. MOUs: Number of formal agreements with other social service agencies in the community
Performance Measure	Total number of MOUs or other formal agreements home visiting implementing agencies have with other social service agencies in the community
Operational Definition	Target population: Documented MOUs or other formal agreements

DOH - Benchmarks

	Numerator: The number of documented MOUs or other formal agreements
	Denominator: The number of social service agencies in the community
Definition of improvement and calculation	Definition of improvement: Increase or maintain the number of formal agreements with social service agencies from year 1 compared to year 2
Cohort	Calculation: Number of formal agreements
Data Source	Home visiting implementing agency's record of documented MOUs or other formal agreements
Measurement Tool	How many MOUs or other formal agreements does your agency have with other social service agencies in the community?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visiting implementing agency
	Data collection schedule: Quarterly
	Analysis: annually
Comments/Anticipated Challenges	

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	4. Information sharing: Number of agencies which home visiting provider has a clear point of contact in collaborating, including sharing information between agencies
Performance Measure	The total number of collaborating community agencies with which the home visiting implementing agencies has a clear

DOH - Benchmarks

	point of contact
Operational Definition	Target population: Collaborating community agencies
	Numerator: N/A
	Denominator: N/A
Definition of improvement and calculation	Definition of improvement: Increase or maintain the number of collaborating community agencies with which the home visiting implementing agency has a clear point of contact at year 1 compared to year 2 Calculation: Number of collaborating community agencies.
Cohort	
Data Source	Home visiting implementing agency's record
Measurement Tool	How many collaborating community agencies does your home visiting implementing agency have a clear point of contact with?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visiting implementing agency
	Data collection schedule: Quarterly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Clear point of contact is defined as having: name, phone number, email address

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	5. Number of completed referrals – received report of the services provided
Performance Measure	Total enrolled families that were screened and received a referral for whom receipt of services was confirmed

DOH - Benchmarks

Operational Definition	Target population: Enrolled families who were screened and received a referral for necessary services
	Numerator: N/A
	Denominator: N/A
Definition of improvement and calculation	Definition of improvement: Increase or maintain the total number of referrals completed by families at year 1 compared to year 2.
Cohort	Calculation: Number of completed referrals that receive a report that the service was provided.
Data Source	Home visiting implementing agency administrative record
Measurement Tool	Did you receive the service for which you were referred?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Confirmation is defined as family's self report

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Hawaii Data Toolkit Guide



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Network Coordinator

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8/22/2012

Hawaii Data Toolkit Guide

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MIECHV benchmarks and constructs

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- 3.4 Parent emotional well-being or parenting stress
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- 3.7 Child's positive approaches to learning including attention
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Benchmark 4 Crime or Domestic Violence

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Benchmark 5 Family Economic Self Sufficiency

- 5.1 Household income and benefits
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Benchmark 6 Coordination and referrals for other community resources and supports

- 6.1 Number of families identified for necessary services
- 6.2 Number of families that required services and received a referral to available community resources
- 6.3 Number of formal agreements with other social service agencies in the community
- 6.4 Number of agencies which home visiting provider has a clear point of contact in collaborating, including sharing information between agencies
- 6.5 No. of completed referrals - received report of the services provided.

As part of the grant funded by Health Resources and Services Administration (HRSA) through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, information about families enrolled in these programs will be collected through record review, administering standardized measures, and questions asked during home visits. While a majority of the information is already being collected within the current home visiting programs, a few additional standardized measures and questions are being added. Therefore, this instrument toolkit will provide basic information about each instrument and guidance on how to best administer the instrument or question to obtain the most consistent information across multiple home visiting programs.

Information will be collected from the following standardized measures:

1. Pregnancy Risk Assessment Monitoring System (PRAMS) – Tobacco questionnaire
2. Pregnancy Risk Assessment Monitoring System (PRAMS) – Breastfeeding questionnaire
3. Reported suspected maltreatment (allegations)
4. Reported substantiated maltreatment
5. First time victim of maltreatment
6. Infant Toddler Home Observation for Measurement of the Environment (HOME)
7. Ages and Stages Questionnaire 3rd Edition (ASQ-3)
8. Ages and Stages Questionnaire Social-Emotional (ASQ-SE)
9. Edinburgh Postnatal Depression Scale (EPDS)
10. Women's Experience with Battering Scale (WEBS) aka Relationship Assessment Tool
11. Head Start Program Information Report (PIR)

Additional information will be collected through questions asked by the home visitor during specific home visits. An administration schedule showing when to administer these standardized measures and additional in-home questions is provided on page 35 of this toolkit.

Please note, that for training, guidance and questions regarding the HOME and ASQ, please refer to your user manual and site supervisor.

General Guidance

When collecting information from families through a questionnaire or in-person interview, it is important to ensure that information is collected in a consistent way across the different sites. Therefore, it is important that the interviewer ask questions in the most objective way possible. General guidance on how to administer a questionnaire and asking questions during an in-person interview are provided in the following two sections. Specific guidance for each questionnaire is provided after this section.

Administering a questionnaire:

- Remember, only 1 answer per question.
- Do not select an answer for the client.

If the respondent expresses uncertainty:

- Read the question to the client and assist them with honing their answer only if needed, otherwise, allow the client to complete the instrument on their own.
 - You may say things like, “how about thinking of it like percentages, which one do you feel more than half the time or 50% of the time? Which answer feels more accurate to you? Follow your gut / na’au, this is the best answer.
- If client has difficulty with completing the instrument due to limited English proficiency, please write “LEP” at top of the completed instrument before submitting to your Site Coordinator
 - If a family member assists client with completing the instrument, due to difficulties with reading English, write a note on the instrument prior to submitting to your Site Coordinator (e.g. “assisted by family member”)
 - If you read the instrument out loud to the client, please write a note on the instrument “read aloud to client”, before submitting to your Site Coordinator.

If the client refuses to complete the instrument, please document their reason for not completing the instrument on the form. Write their name on the form and write “Refused” on the form and include the reason for refusal.

If a client refuses to answer a specific item, the home visitor should write their initials next to the item that the client refused to answer. This will show that the client intentionally left the response/answer blank.

All completed forms, including “refusals” should be submitted to your site coordinator:

Healthy Families America

YWCA: Kellyn Coughlan

Child and Family Services, Ewa: Leilani Kutterer

Child and Family Services, Kaua’i: Margaret Smith

Maui Family Support Services: Glenna Okamura

Family Support Hawaii: Heather Takaki

Catholic Charities Hawaii: Jenny Tagalog

Early Head Start

Parents And Children Together (PACT): Ben Naki

Family Support Hawaii: Ellen O’Kelly

Maui Family Support Services: Edeluisa Baguio-Larena

HIPPY

Family Support Hawaii: Shannon Ramirez

Keiki ‘O Ka ‘Aina: Angela Lopes

PAT

Na Kamalei: Puanani Spencer

Keiki O Ka ‘Aina: Donnalei Gaison

Promising Practices:

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In-Person Interview Questions:

These interview questions are consolidated into separate forms by time point (e.g. enrollment, monthly, quarterly, etc.) depending on when the questions need to be asked. Sample forms labeled by time point are provided in the Appendices of the Toolkit.

When administering in-person interview questions, it is important to keep in mind a few guidelines to help ensure consistent and accurate data collection. These tips are important, because unlike questionnaires, the home visitors asking these questions play a big part in determining the quality of the information gathered from families.

Here are a few guidelines:

- Read the questions in the most neutral way possible
- Remain objective, do not attempt to interpret or lead the client's response/answer
- Write any notes on the form if there were any special circumstances or issues that arose.

If you have any questions about administering the instrument, please contact your site coordinator (see page 4) or the JHU team at (808) 949-0057.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health department that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Its main goal is to improve the health of mothers and infants by reducing adverse outcomes (i.e. Low birth weight, infant mortality and morbidity). The data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. Topics addressed in the questionnaire include barriers to and content of prenatal care, obstetric history, maternal use of alcohol and cigarettes, physical abuse, contraception, economic status, maternal stress, and early infant development and health status. Two important sub-sections of the PRAMS will be used as part of this project to measure outcomes, PRAMS: Prenatal Use of Tobacco and PRAMS: Breastfeeding Survey each containing no more than 7 items each.

PRENATAL USE OF TOBACCO SURVEY

When is the PRAMS: Prenatal Use of Tobacco Survey administered?

The Prenatal Use of Tobacco Survey will be administered at the time of Enrollment and at one year post-enrollment.

How to administer the PRAMS: Prenatal Use of Tobacco Survey?

When asking a client to complete the Prenatal Use of Tobacco Survey, be sure to provide a brief description of the survey. Explain why they are being asked to complete the form and how long it will take. Here is an example of what you might say:

Sample script (prenatal clients): “To help us better understand and improve the services we provide to our families that promote family health and well-being, we are asking all parents to complete a survey about their use of tobacco. This is a brief 7-item survey and takes only a couple minutes to complete. Your answers are kept completely confidential and will not be shared with anyone outside of our service team. If there are some questions you do not wish to answer, you may skip them. Please let me know if you have any questions.” (Hand the survey to MOB).

REMINDER: Follow all the general guidance provided on p. 3 of this Toolkit.

After completing the Prenatal Use of Tobacco Survey and BEFORE leaving the home

1. Thank the client for completing the form
2. Review the form for completeness. Please check the following:
 - ✓ Name
 - ✓ Date
3. Each item should have only 1 answer:
 - ✓ If a question is not answered, please ask the client to complete the missing item.
 - ✓ If a client chooses not to answer the question, the home visitor should write their initials next to the question indicating that it was left blank intentionally by the client.
 - ✓ If the client circles two numbers or places a circle between two numbers, please ask the client to select only one answer.
 - ✓ Do not select the best response for the client. You may say to them, “Please select the answer that you feel is the best answer for you.”

If the client currently smokes, engage them in a conversation to determine their readiness to quit and provide a referral to the Tobacco Quitline:

Note: Do we want to include standard language for making an immediate referral to the tobacco quit line or smoking cessation program? What steps should the toolkit provide for the home visitor? Include a brochure and handout from DOH or other agency?

- Hawaii Tobacco Quitline in English: 1-800-784-8669
- Hawaii Tobacco Quitline in Korean: 1-800-556-5564
- Hawaii Tobacco Quitline in Mandarin & Cantonese: 1-800-838-8917
- Hawaii Tobacco Quitline in Vietnamese: 1-800-778-8440

“Thank you for taking the time to complete this form. (after reviewing the survey, read one of the following scripts).

Sample Script: Currently smoking: “Since you are currently smoking, I would like to provide you with some information about the health risks of smoking (handout/brochure to provide participant?). Is this a habit you wish to quit? (continue to engage and provide referral). As part of our program’s continuous process of tracking family health, we will ask you to complete this survey again at a later date and can provide additional resources and a referral at any time, if you wish. Do you have any questions?”

Sample Script - Not smoking: “As part of our program’s continuous process of tracking family health, we will ask you to complete this survey again at a later date and can provide additional resources and a referral at any time, if you wish. Do you have any questions?”

SUBMIT COMPLETED FORM TO SUPERVISOR FOR DATA ENTRY

MIECHV Construct:

1.2 Parental use of alcohol, tobacco, or illicit drugs

Prenatal Use of Tobacco Survey (from PRAMS)

The following questions are about smoking cigarettes around the time of pregnancy (before, during, and after).

1. Have you smoked any cigarettes in the *past 2 years*?
 - a. No **If you answer No, this ends the survey**
 - b. Yes

2. In the *3 months before* you got pregnant, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)
 - a. 41 cigarettes or more
 - b. 21 to 40 cigarettes
 - c. 11 to 20 cigarettes
 - d. 6 to 10 cigarettes
 - e. 1 to 5 cigarettes
 - f. Less than 1 cigarette
 - g. I didn't smoke then

3. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)
 - a. 41 cigarettes or more
 - b. 21 to 40 cigarettes
 - c. 11 to 20 cigarettes
 - d. 6 to 10 cigarettes
 - e. 1 to 5 cigarettes
 - f. Less than 1 cigarette
 - g. I didn't smoke then

4. *During any of your prenatal care visits*, did a doctor, nurse, or other health care worker advise you to quit smoking?
 - a. No
 - b. Yes
 - c. I had quit smoking before my first prenatal care visit
 - d. I didn't go for prenatal care

5. How many cigarettes did you smoke on an average day *now*? (A pack has 20 cigarettes.)
 - a. 41 cigarettes or more
 - b. 21 to 40 cigarettes
 - c. 11 to 20 cigarettes
 - d. 6 to 10 cigarettes
 - e. 1 to 5 cigarettes
 - f. Less than 1 cigarette
 - g. I didn't smoke then

6. Which of the following statements best describes the rules about smoking *inside* your home *now*?

- a. No one is allowed to smoke anywhere inside my home.
- b. Smoking is allowed in some rooms or at some times.
- c. Smoking is permitted anywhere inside my home.

7. Listed below are some things about quitting smoking. For each thing, circle **Y** (Yes) if it applied to you *during your most recent* pregnancy or circle **N** (No) if it did not.

During your most recent pregnancy, did you-

- a. Set a specific date to stop smoking N Y
- b. Use booklets, videos, or other materials to help you quit N Y
- c. Call a national or state quit line or go to a website N Y
- d. Attend a class or program to stop smoking..... N Y
- e. Go to counseling for help with quitting N Y
- f. Use a nicotine patch, gum, lozenge, nasal spray or inhaler N Y
- g. Prescribe a pill like Zyban (also known as Wellbutrin or Bupropion)
or Chantix (also known as Varenicline) to help you quit N Y
- h. Try to quit on your own (e.g., cold turkey) N Y
- i. Other N Y

Please tell us:

Thanks for answering our questions!

BREASTFEEDING SURVEY

When is the PRAMS: Breastfeeding Survey administered?

The Breastfeeding Survey will be administered at the time of enrollment and every 3 months (quarterly) while in the program.

How to administer the PRAMS: Breastfeeding Survey?

When asking a client to complete the Breastfeeding Survey, be sure to provide a brief description of the survey. Explain why they are being asked to complete the form and how long it will take. Here is an example of what you might say:

Sample script (prenatal clients): “To help us better understand and improve the services we provide to our families that promote family health and well-being, we are asking all parents to complete a survey asking them about their feeding practices with their baby. This is a brief 6-item survey and takes only a couple minutes to complete. Your answers are kept completely confidential and will not be shared with anyone outside of our service team. If there are some questions you do not wish to answer, you may skip them. Please let me know if you have any questions.” (Hand the survey to MOB).

REMINDER: Follow all the general guidance provided on p. 3 of this Toolkit.

After completing the Breastfeeding Survey and BEFORE leaving the home

1. Thank the client for completing the form
2. Review the form for completeness. Please check the following:
 - ✓ Name
 - ✓ Date
3. Each item should have only 1 answer:
 - ✓ If a question is not answered, please ask the client to complete the missing item.
 - ✓ If a client chooses not to answer the question, the home visitor should write their initials next to the question indicating that it was left blank intentionally by the client.
 - ✓ If the client circles two numbers or places a circle between two numbers, please ask the client to select only one answer.
 - ✓ Do not select the best response for the client. You may say to them, “Please select the answer that you feel is the best answer for you.”

Note: If a mother reports difficulty with breastfeeding will a referral be made (item #4)? What steps should the toolkit provide for the home visitor? Is there a brochure/resource from DOH?

Wrap-up Sample Script: “Thank you for taking the time to complete this form. As part of our program’s continuous process of tracking family health, we will ask you to complete this survey every few months and can provide additional resources and a referral at any time, if you wish. Do you have any questions?”

SUBMIT COMPLETED FORM TO SUPERVISOR FOR DATA ENTRY

MIECHV Construct:

1.6 Breastfeeding

Breastfeeding Survey (from PRAMS)

The following questions are about breastfeeding since your new baby was born.

1. Did you ever breastfeed or pump breast milk to feed your new baby after delivery, even for a short period of time?

- a. No
- b. Yes

Go to question 6

2. Are you currently breastfeeding or feeding pumped milk to your new baby?

- a. No
- b. Yes

Go to question 5

3. How many weeks or months did you breastfeed or pump milk to feed your baby?

- a. Less than 1 week
- b. _____ Weeks **OR** _____ Months

4. What were your reasons for stopping breastfeeding? Check all that apply

- a. My baby had difficulty latching or nursing
- b. Breast milk alone did not satisfy my baby
- c. I thought my baby was not gaining enough weight
- d. My nipples were sore, cracked, or bleeding
- e. It was too hard, painful, or too time consuming
- f. I thought I was not producing enough milk
- g. I had too many other household duties
- h. I felt it was the right time to stop breastfeeding
- i. I got sick and was not able to breastfeed
- j. I went back to work or school
- k. My baby was jaundice (yellowing of the skin or whites of the eyes)
- l. Other

Please tell us:

5. How old was your new baby the first time he or she drank liquids other than breast milk (such as formula, water, juice, tea, or cow's milk)?

- a. My baby was less than 1 week
- b. _____ Weeks **OR** _____ Months
- c. My baby has not had any liquids other than breast milk

6. How old was your new baby the first time he or she ate food (such as baby cereal, baby food, or any other food)?

- a. My baby was less than 1 week
- b. _____ Weeks **OR** _____ Months
- c. My baby has not eaten any foods

Thanks for answering our questions!

Department of Health and Human Services: Consent Form

What is the DHS Consent?

In order to fulfill the requirements for Benchmark 2 (Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits), constructs 2.5, 2.6, and 2.7, all clients are being asked to sign a consent form allowing communication between the Department of Health (DOH) and the Department of Human Services (DHS). This signed consent will allow DOH to submit the mother's name, mother's date of birth, child's name, child's gender and child's date of birth to DHS. DHS will review this list and provide a report of the total number and percentage of suspected maltreatment cases, substantiated maltreatment, and first time victims. No names will be linked to this information. DOH will only receive aggregate data.

When is the DHS Consent administered?

The DHS consent form should be completed by the client within 6 months of enrollment along with any other program consent forms.

How to administer the DHHS Consent?

Sample Script: As part of our ongoing improvement to the program and being able to adequately provide needed services for families enrolled in our program, we are asking all families to provide their consent to the Department of Health to communicate with the Department of Human Services. This communication will allow us to understand what percentage of our families are experiencing challenges such as reports of child abuse and neglect. We need each person's permission to gather the records, but, the report we receive from DHS will not have any names listed. We will only see the total number of reports of families currently enrolled in services. It is not a requirement for you to sign this consent form to be enrolled in the program, but, by allowing us to collect this information our agency will have a better understanding of evaluating how well we are doing as far as providing support to our families. Do you have any questions or concerns?

After completing the DHS Consent form and BEFORE leaving the home

1. Thank the client for completing the form
2. Review the form for completeness. Please make sure the parent's signature is on the correct line and with the correct date.

Wrap-up Sample Script: "Thank you for providing your consent for this process. Do you have any questions?"

MIECHV Construct:

2.5 Reported suspected maltreatment (allegations)

2.6 Reported substantiated maltreatment

2.7 First time victim of maltreatment



State of Hawaii Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Individual/Organization Disclosing Protected Health Information	
Name : Dept. of Health Maternal and Child Health Branch	Address: 741 A Sunset Ave; Honolulu, HI 96816
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Dept. of Human Services: Social Services Division	Address: 810 Richards Street, Suite 400, Honolulu, HI 96813
Name of Individual/Organization Disclosing Protected Health Information	
Name : Dept. of Human Services: Social Services Division	Address: 810 Richards Street, Suite 400, Honolulu, HI 96813
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Dept. of Health Maternal and Child Health Branch	Address: 741 A Sunset Ave, Honolulu, HI 96816
Client/Patient Whose Protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):
I authorize that the Following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information)	
Mother's name, Mother's Date of Birth, Child's name, Child's gender and Child's Date of Birth	
_____Mental Health	_____Substance Abuse Treatment
	_____HIV/AIDS
The Protected Health Information is Being Used or Disclosed for the Following Purposes (<i>At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.</i>):	
To conduct a comparison of <u>enter program name</u> Program participants and Child Welfare data by Department of Health. Information shared between the Department of Health and the Department of Human Services will be used to determine the effectiveness of the <u>enter program name</u> program. No personal information will be shared publicly.	
Authorization Duration (This authorization will be in force and effect until the date or event specified below. At that time, this authorization to use or disclose this protected health information expires)	
Authorization Expiration Date:	Expiration Event That Relates to the Individual or the Purpose of the Use or Disclosure Until end of Department of Health comparison.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.	
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.	
The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.	
<input type="checkbox"/> The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.	
Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative	Description of Personal Representative's Authority

Home Observation for Measurement of the Environment (HOME)

The HOME Inventory is a screening tool designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings. There are various versions of the inventory that can be used for children of different age groups. The infant/toddler inventory which covers birth to 3 year olds address six subscales: responsivity, acceptance (avoidance of restriction and punishment), organization of the environment, appropriate learning and play materials, parental involvement, and variety in daily stimulation.

Administration: The HOME should be administered by a trained paraprofessional who goes to the home when the child is awake and can be observed interacting with the mother or primary caregiver. About one third of the inventory should be based on parent/guardian report where important “transactions” are not likely to occur during a home visit. It is recommended limiting measurement to one child in the family at a time. It should take one hour for the entire procedure. This tool is administered at enrollment and one year post enrollment.

Follow the protocol as describe in your HOME training manual. Discuss questions or concerns with your supervisor. Data collection questions can be directed to the Johns Hopkins University Evaluation Team (808) 949-0057.

[Note: Programs please review the Infant/Toddler HOME Summary Sheet on the next page and determine if all information on the form is needed or if it should be revised in some way.](#)

MIECHV Construct:

3.1 Parent’s support for children’s learning and development

3.3 Parenting behaviors and parent-child relationship

Infant/Toddler HOME
Bettye M. Caldwell and Robert H. Bradley
Summary Sheet

Family name _____ Date _____ Visitor _____

Address _____ Phone _____

Child's name _____ Birth date _____ Age _____ Sex _____

Interviewee _____ If other than parent, relationship to child _____

Family composition _____
(persons living in household, including sex and age of children)

Family ethnicity _____ Language spoken _____ Maternal education _____ Paternal education _____

Is mother employed? _____ Type of work when employed? _____ Hrs/Wk _____

Is father employed? _____ Type of work when employed? _____ Hrs/Wk _____

Current child care arrangements _____

Summarize past year's arrangements _____

Other person(s) present during visit _____

Notes _____

SUMMARY

Subscale	Possible Score	Median	Actual Score	Comments
I. RESPONSIVITY	11	9		
II. ACCEPTANCE	8	6		
III. ORGANIZATION	6	5		
IV. LEARNING MATERIALS	9	7		
V. INVOLVEMENT	6	4		
VI. VARIETY	5	3		
TOTAL SCORE	45	32		

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Infant/Toddler HOME Record Form

Place a plus (+) or minus (-) in the box alongside each item depending on whether the behavior is observed during the visit, or if the parent reports that the conditions or events are characteristic of the home environment. Enter the subtotals and the total on the Summary Sheet. **Observation (O), Either (E), or Interview (I) is indicated for each item.**

I. RESPONSIVITY	24. Child has a special place for toys and treasures. E	
1. Parent permits child to engage in "messy" play. I	25. Child's play environment is safe. O	
2. Parent spontaneously vocalizes to child at least twice. O	IV. LEARNING MATERIALS	
3. Parent responds verbally to child's vocalizations or verbalizations. O	26. Muscle activity toys or equipment. E	
4. Parent tells child name of object or person during visit. O	27. Push or pull toy. E	
5. Parent's speech is distinct, clear, and audible. O	28. Stroller or walker, kiddie car, scooter, or tricycle. E	
6. Parent initiates verbal interchanges with Visitor. O	29. Cuddly toy or role-playing toys. E	
7. Parent converses freely and easily. O	30. Learning facilitators—mobile, table and chair, high chair, play pen. E	
8. Parent spontaneously praises child at least twice. O	31. Simple eye-hand coordination toys. E	
9. Parent's voice conveys positive feelings toward child. O	32. Complex eye-hand coordination toys. E	
10. Parent caresses or kisses child at least once. O	33. Toys for literature and music. E	
11. Parent responds positively to praise of child offered by Visitor. O	34. Parent provides toys for child to play with during visit. O	
II. ACCEPTANCE	V. INVOLVEMENT	
12. No more than 1 instance of physical punishment during past week. I	35. Parent talks to child while doing household work. I	
13. Family has a pet. E	36. Parent consciously encourages developmental advance. I	
14. Parent does not shout at child. O	37. Parent invests maturing toys with value via personal attention. I	
15. Parent does not express overt annoyance with or hostility to child. O	38. Parent structures child's play periods. I	
16. Parent neither slaps nor spansks child during visit. O	39. Parent provides toys that challenge child to develop new skills. I	
17. Parent does not scold or criticize child during visit. O	40. Parent keeps child in visual range, looks at often. O	
18. Parent does not interfere with or restrict child more than 3 times during visit. O	VI. VARIETY	
19. At least 10 books are present and visible. E	41. Father provides some care daily. I	
III. ORGANIZATION	42. Parent reads stories to child at least 3 times weekly. I	
20. Child care, if used, is provided by one of 3 regular substitutes. I	43. Child eats at least one meal a day with mother and father. I	
21. Child is taken to grocery store at least once a week. I	44. Family visits relatives or receives visits once a month or so. I	
22. Child gets out of house at least 4 times a week. I	45. Child has 3 or more books of his/her own. E	
23. Child is taken regularly to doctor's office or clinic. I		
TOTALS I _____ II _____ III _____ IV _____ V _____ VI _____ TOTAL _____		

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Ages and Stages Questionnaire (ASQ)

The ASQ is a tool designed to help parents check their child's development, and screen for developmental delay. The core of ASQ is a series of questionnaires that correspond to age intervals from birth to 5 years. It contains simple questions for parents to answer about activities their child is (or is not) able to do. The questionnaires covers five domains that include communication, gross motor, fine motor, problem solving, and personal/social development. The answers are scored and help to determine whether the child's development is on schedule or whether the child should be referred for a developmental checkup with a professional.

Administration: The questions of the ASQ are intended for the parent to complete but can be assisted by a trained paraprofessional. It usually takes 10-15 minutes to complete. The scoring which usually takes 2-3 minutes is done either by a trained clerk or paraprofessional. It is administered at the child's age appropriate interval. Follow the protocol as provided by your supervisor and discuss questions or concerns with your supervisor. Data collection questions can be directed to the Johns Hopkins University Evaluation Team (808) 949-0057.

MIECHV Construct:

- 3.2 Parent knowledge of child development and of their child's developmental progress,
- 3.5 Child's communication, language, and emergent literacy,
- 3.6 Child's general cognitive skills
- 3.9 Child's physical health and development

Ages and Stages Questionnaire Social – Emotional (ASQ-SE)

The ASQ SE is a screening tool that identifies infants and young children (6 months to 5 years) whose social and emotional development requires further evaluation to determine if referral for intervention services is necessary. It is comprised of a questionnaire that addresses seven behavioral areas that include self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interactions with people.

Administration: The questions of the ASQ-SE are intended for the parent/caregiver to complete but can be assisted by a trained paraprofessional. It usually takes 10-15 minutes to complete. The scoring which usually takes 1-3 minutes is done either by a trained clerk or paraprofessional. It is administered at the child's age appropriate interval. Follow the protocol as provided by your supervisor and discuss questions or concerns with your supervisor. Data collection questions can be directed to the Johns Hopkins University Evaluation Team (808) 949-0057.

MIECHV Construct:

3.7 Child's positive approaches to learning including attention

3.8 Child's social behavior, emotional regulation and emotional well-being

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) is a brief 10-question scale that efficiently identifies individuals at-risk for perinatal depression. This scale focuses on how the mother has felt ***during the previous week***. This scale will not detect mothers with anxiety neuroses, phobias or personality disorders. Higher scores indicate a greater experience of depression with a maximum score of 30. Postnatal women scoring a 10 or greater on the EPDS may be experiencing depression, while non-postnatal women scoring 13 or greater may be experiencing depression. This scale may also be administered and used as a screening tool with non-postnatal women (Cox et al., 1996).

When is the EPDS Administered? The EPDS will be administered by the home visitor at the time of enrollment. If the EPDS cannot be completed at the time of enrollment, it must be completed within 6 months following enrollment.

How to Administer the EPDS: It is usually self-administered, requiring about five minutes to complete. When asking a client to complete the EPDS, be sure to provide a brief description of the EPDS. Explain why they are being asked to complete the form and how long it will take. Here is an example of what you might say:

Sample script (prenatal clients): “It is common to experience many changes after the arrival of a new baby into the family. To help us understand how these changes are affecting you, and to better assist you, we would like to ask you to complete a short survey, which takes about 5-minutes to complete and asks about how you have been feeling in the past 7 days. Your answers are kept completely confidential and will not be shared with anyone outside of our service team. If there are some questions you do not wish to answer, you may skip them. Please let me know if you have any questions.”
(Hand the survey to MOB).

Sample script (non-prenatal clients): “We are asking all parents to complete a brief survey, which take about 5-minutes to complete and asks you about how you have been feeling in the past 7 days. This survey will help us understand the experiences of parents enrolling in our program and provide any additional support services, as needed. Your answers are kept completely confidential and will not be shared with anyone outside of our direct service team. This is completely voluntary, so, if there are any questions you do not wish to answer, you may skip them. Please let me know if you have any questions.” (Hand the survey to MOB).

REMINDER: Follow all the general guidance provided on p. 3 of this Toolkit in addition to the reminders below.

- Ask mothers to check the response that comes closest to how she has been feeling in the previous 7 days
- Care should be taken to avoid the possibility of the mother discussing her answers with others. Answers should come from the mother / pregnant woman
- The mother should complete the scale herself, unless she has limited English or has difficulty reading.

After completing the EPDS and BEFORE leaving the home

1. Thank the client for completing the form
2. Review the form for completeness. Please check the following:
 - ✓ Name
 - ✓ Date

Note: We may want to revise the top portion of the form, which asks for address and DOB, as it does not seem relevant. Recommend to remove this from the form.

- ✓ All 10-items have a single response:
 - If a question is not answered, please ask the client to complete the missing item.
 - If a client chooses not to answer the question, the home visitor should write their initials next to the question indicating that it was left blank intentionally by the client.

✓ Each item should have only 1 answer:

- If the client circles two numbers or places a circle between two numbers, please ask the client to select only one answer.
- Do not select the best response for the client. You may say to them, “Please select the answer that you feel is the best answer for you.” Or use an example from the previous page.

3. **IMPORTANT:** Always look at item 10 (suicidal thoughts). If the response is “sometimes” or “yes, quite often” contact your supervisor **immediately** and follow your program’s response protocol.
4. Turn in completed forms within **24 hours** to your supervisor.

Note: Do we want to include scoring information for the home visitor in this toolkit? What steps should the toolkit provide for the home visitor? Do you want scoring to be completed only by supervisors or by home visitors as well?

If the client scores above a 13 on the EPDS it is likely that they are suffering from a depressive illness of varying severity. This score should not override clinical judgment. Please follow your agency’s policies and procedures and training provided by your direct supervisor to determine your next steps.

Scoring the EPDS

Questions 1, 2, & 4 are scored 0, 1, 2, or 3 with the top box scored as 0 and the bottom box as 3.

Questions 3, 5, and 10 are reversed scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible depression: 10 or greater (for post natal women) 13 or greater (for non-postnatal women)

Always look at item 10 (suicidal thoughts)

Here are some resources you may want to provide after discussion with your supervisor:

24hr Local Hotline Resource: Access Line, Suicide and Crisis line for State of Hawaii

- Local, Island of O`ahu: 808-832-3100
- Islands of Kaua`i, Lana`i, Moloka`i, Maui, & Hawai`i: 1-800-753-6879

24hr National Hotline Resources

- National Hopeline Network: 1-800-SUICIDE (1-800-784-2433)
- National Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255)
- Depression after Delivery (www.depressionafterdelivery.com)

Note: Are there any additional resources you would like to provide/list here?

5. If no follow-up on item 10 is needed, here is an example of what you might say:
“Thank you for taking the time to complete this form. It’s very helpful for our programs to get a sense of how families in our community are feeling. This will help us plan for possible additions to our program to better support families. Do you have any questions?”

What to do if severe depression or suicidal ideation is reported?

Sample Script: Thank you for taking the time to complete this form. After reviewing your answers, it seems like you are going through some difficult experiences. As part of being with our program, we want to provide you with the best support and resources possible. In order to do this, I would like to call my supervisor at this time to talk with them about some options that may be available for you within our program and with other agencies. Is this ok with you?

Contact your supervisor immediately and follow your agency’s response protocol.

SUBMIT COMPLETED FORM TO SUPERVISOR FOR DATA ENTRY WITHIN 24 HOURS

MIECHV Construct:

- 1.5 Screening for maternal depressive symptoms
- 3.4 Parent emotional well-being or parenting stress

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Relationship Assessment Tool (adapted from Women's Experience with Battering Scale)

It is an effective tool for the identification of chronic mental and physical health problems as a result of constant physical and moral abuse. It is a 12-item scale (originally 10 but added 2 more items to cover physical and sexual which measures battering by characterizing women 's perception of their vulnerability to physical and psychological danger or loss of power and control in relationships.

When is the Relationship Assessment Tool administered?

The Relationship Assessment Tool should be administered by the Home Visitor at enrollment or within 6 months of enrollment.

How to administer the Relationship Assessment Tool?

When administering the Relationship Assessment Tool, there are a few important factors to consider, as to ensure safety for the home visitor and the participant.

- The Relationship Assessment Tool should be administered only to the mother of the index child.
- This instrument should only be administered when the partner is not home, and the mother has privacy when answering these questions.
- Explain why you are administering the Relationship Assessment Tool before handing it to the participant.

Issues to consider: In general, how this tool is administered may also differ by agency depending on their current policy or a policy the agency chooses to develop as a result of administering this tool. What standard information shall we include in this section?

Some things to think about.... If a person is a victim of domestic violence it is important that the perpetrator not know that these kinds of questions are being asked. Therefore, it is not recommended that both partners be automatically assessed or administered the tool. DV advocates have suggested that if a perpetrator found out that the partner answered these type of questions, it may result in further abuse of the victim.

When it comes to administering the Relationship Assessment Tool to same-sex couples, this tool may be used, but, the concern remains that we may in fact be administering the tool to the perpetrator. Staff will need to be clear about taking precautions during administration of the instrument to ensure safety of any potential victims in the home.

Sample Script (if administered on its own): An important part of supporting the needs of you and your child consists of having a healthy relationship with your partner/spouse/significant other. We have a short 12-item survey that asks about this relationship. Your answers are completely confidential, which means that this information will only be shared between you and I, and only program staff that have a need to know this information. Please take a moment to review and read through the questions, if there are any questions you do not feel comfortable answering, you may skip them. Do you have any questions? (If there are no questions, hand Relationship Assessment Tool to the client).

Sample Script (if administered with other instruments):

In order to better understand which programs and services we can provide to support you and your baby/child, we have a few questions and surveys we would like for you to complete. Please take a moment to review and read through the questions, if there are any questions you do not feel comfortable answering, you may skip them. Do you have any questions?

INSERT INFORMATION ON HOW TO SCORE AND SCREEN FOR DOMESTIC VIOLENCE AND NEXT STEPS

What to do if current Domestic Violence is reported?

Please follow your agency's protocol and complete your agency's safety plan.

MIECHV Construct:

4.1 Screening for Domestic Violence

RELATIONSHIP ASSESSMENT TOOL

Date: _____

This is a self-administered tool for clients to fill out. If the client was unable to complete this tool today, was it because other people were present in the home? Circle one: **Yes/No**

Other reason for not using tool today: _____

(Note to home visitor: Please modify this script based on your state laws. This is just a sample script.)

“Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (Homeland Security) or law enforcement. There are just two things that I would have to report- if you are suicidal, or your children are being harmed. The rest stays between us and helps me better understand how I can help you and the baby.”

We ask all our clients to complete this form. For every question below, please look at the scale and select the number (1-6) that best reflects how you feel.

1	2	3	4	5	6
Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly

- 1) He makes me feel unsafe even in my own home..... _____
- 2) I feel ashamed of the things he does to me..... _____
- 3) I try not to rock the boat because I am afraid of what he might do _____
- 4) I feel like I am programmed to react a certain way to him _____
- 5) I feel like he keeps me prisoner _____
- 6) He makes me feel like I have no control over my life, no power, no protection..... _____
- 7) I hide the truth from others because I am afraid not to _____
- 8) I feel owned and controlled by him _____
- 9) He can scare me without laying a hand on me _____
- 10) He has a look that goes straight through me and terrifies me..... _____

Please turn the page and continue the survey. Thank you.

Adapted from: Smith, P.H., Earp, J.A., & DeVellis, R. (1995), Development and validation of the Women’s Experience with Battering (WEB)Scale. Women’s Health, 1, 273-288.

Relationship Assessment Tool (page 2)

1	2	3	4	5	6
Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly

- 1) Has my partner ever physically hurt me? _____
- 2) Has my partner ever forced me to do something sexual I didn't want to? _____

Thank you for completing this survey. Please give it back to your home visitor so they can complete the bottom portion.

Home visitors complete the next section:

- 1) What referrals and information were given to the client this session? (Please note, ALL clients should have been given the *Healthy Moms, Happy Babies* safety card).

(Circle all that apply)

- Social Worker/Counselor
- Domestic Violence Hotline
- Local Domestic Violence Advocate/Program
- *Healthy Moms, Happy Babies* Safety Card
- Other (please specify): _____

- 2) Did you offer safety planning? (This should happen for any score higher than 20 for pages one and two)

(Circle all that apply)

- Reviewed **Safety Planning** panel on *Healthy Moms, Happy Babies* card.
- Provided the *Safety Plan and Instructions* tool to my client.
- Provided domestic violence hotline numbers.
- Referred to domestic violence advocate for additional safety planning.
- Other (please specify): _____

IN-PERSON INTERVIEW QUESTIONS DURING HOME VISITS

In addition to administering standardized measures, there are specific in-person interview questions that need to be asked and are grouped by the following time points:

- Enrollment
- Monthly
- Quarterly
- 6 months (post-enrollment)
- 1 year (post-enrollment)

When administering these individual in-person questions, remember to follow the general guidance provided on p. 5.

Each time point has a form (pgs. 38 – 43), which contains a checklist of all formal instruments/questionnaires to be administered and in-person questions to be asked by the home visitor. This form may also be used as a checklist to ensure that all data for that specific time point is collected. For each visit listed above, a home visitor should take the appropriate form with them to the home visit. Fill out the top of the form with the client's name, home visitor's name, date of visit, enrollment date, and model name. The last section of the form contains a list of questions to be asked by the home visitor at some point during the home visit.

The next section (p. 35) is a checklist of all formal instruments to be completed during this visit. Home visitors should verify that they have all the instruments listed to take on the home visit. This is just another way you may wish to track data collection.

Data Quality Assurance and Quality Control (QA/QC)

To help ensure that the data being collected is of the highest integrity, a QA/QC procedure for reviewing data and data entry should occur at each agency before submitting data to the Department of Health. Each agency's QA/QC process will be different, but, in general it should include the following:

1. Supervisor review of all administered standardized measures and in-person questions for completeness, quality of data collected (i.e. if the form asks for the participant's DOB did they write their DOB or their child's DOB, which is a common mistake), and clinical concerns.
2. Method for tracking data collection by participant and time point
3. A method for reviewing that the data entered accurately reflects the data collected
4. Consistency in administration of standardized questionnaires across the home visiting team.
5. A method for tracking and logging notes that affect data collection process, procedure or quality.

References

J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.

Cox, J.L., Chapman, G., Murray, D., & Jones, P. (1996). Validation of the Edinburgh postnatal depression (EPDS) in non-postnatal women. *Journal of Affective Disorders*, 39, 185 – 189.

Smith, P.S., Earp, J.A., & DeVellis, R. (1995). Development and validation of the Women's Experience with Battering (WEB) Scale). *Women's Health*, 1, 273-288.

**DATA COLLECTION CHECKLIST
BY TIMEPOINT – FOR HVs**

Enrollment

Formal Instruments

- Life Skills Progression (LSP: 17, 25)
- PRAMS: Prenatal Use of Tobacco Survey
- Relationship Assessment Tool (within 6 months post-enrollment)
- Edinburgh Postnatal Depression Scale (within 6 months post enrollment)
- HOME (within 90 days)

Interview Questions

- When did you receive prenatal care? When was your last post-partum examination?
- Please estimate your annual total household income
- Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max)
- Estimate your total monthly hours spent in education programs

Monthly

Interview Questions

- What services do you think your family needs?
- What services has your family been referred to? Did you receive the service for which you were referred?

Quarterly

Formal Instruments

- PRAMS: Breastfeeding questionnaire (PAT: LSP #43 “How long did you breastfeed your baby?”)
- Life Skills Progression (item 43, 8)

Interview Questions

- Do you currently have health insurance?
- Does your child currently have health insurance?
- How many times has your child been to the emergency department for any reason?
- How many times have you visited the emergency department for any reason?
- HFA & EHS: In the past 3 months, how many times did your child received medical treatment for an injury? (also inquire reason for visit, kind of injury, type of treatment) - PAT will use LSP #8

6 months

Formal Instruments

- Life Skills Progression (item 17)
- PAT LSP #1 “Do you have information about the different ways to prevent pregnancies?”; EHS and HFA will have HVs ask this question of MOB as listed below
- PAT LSP #20 “How often did you take your child for a well-child doctor’s visit?”; EHS & HFA will use internal program or record data as listed below.
- Edinburgh Postnatal Depression Scale (If not yet completed, complete at this visit)
- Relationship Assessment Tool (If not yet completed, complete at this visit)

Interview Questions

- When did you receive prenatal care?
- Did the mother or pregnant woman receive birth spacing education? (PAT obtain data from LSP #1: see above)
- Was the Edinburgh Postnatal Depression Scale (EPDS) administered?

Every 6 months

Interview Questions

- When did you receive prenatal care?

1 year

Formal Instruments

- PRAMS: Prenatal Use of Tobacco; PAT will collect information by administering LSP #25: Do you currently smoke or use other tobacco products? How much do you use per day?
- HOME (Annually)

Interview Questions

- Please estimate your annual total household income
- Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max)
- Estimate your total monthly hours spent in education programs

*Create a reminder checklist for HVs to reference after completing each data collection time point. Review questionnaire for completeness, single item responses, initialing item/instrument refusals, who to give completed data form to, etc.....

*How to incorporate ASQ schedule reminders to complete based on target-age by program

Assessment Schedule (based on enrollment date)

	Projected Date	Date Completed	Time Calculation	Notes
Time 1: Monthly			Enrollment + 30 days	
Time 2: Monthly			Enrollment + 60 days	
Time 3: Quarterly 1			Enrollment + 90 days	Includes Monthly
Time 4: Monthly			Q1 + 30 days	
Time 5: Monthly			Q1 + 60 days	
Time 6: 6 Month			Q1 + 90 days	Includes Quarterly
Time 7: Monthly			6M + 30 days	
Time 8: Monthly			6M + 60 days	
Time 9: Quarterly 2			6M + 90 days	Includes Monthly
Time 10: Monthly			Q2 + 30 days	
Time 11: Monthly			Q2 + 60 days	
Time 12: Annual			Q2 + 90 days	Includes Monthly & Quarterly

ENROLLMENT

First Name: _____ Today's Date: _____
Last Name: _____ Enrollment Date: _____
Home Visitor's Name: _____ Specific-Model (e.g. HFA, EHS, PAT): _____

Formal Instruments

- Life Skills Progression (LSP: 17, 25)
- PRAMS: Prenatal Use of Tobacco Survey
- Relationship Assessment Tool (within 6 months post-enrollment)
- Edinburgh Postnatal Depression Scale (within 6 months post enrollment)
- HOME (within 90 days)

Interview Questions

1. When did you receive prenatal care? _____
2. When was your last post-partum examination? _____
3. Please estimate your annual total household income: _____ / year

Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private (e.g., rent from tenants/borders, cash assistance from friends or relatives) or they may be linked to public assistance (i.e. child support payments, TANF, Social security – SSI/SSDI/OAI), and unemployment insurance.

4. Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max):
_____ hrs / month
5. Estimate your total monthly hours spent in education programs: _____ hrs / month

Education programs are defined as secondary, post-secondary, trade school.

Monthly

First Name: _____ Today's Date: _____
Last Name: _____ Enrollment Date: _____
Home Visitor's Name: _____ Specific-Model (e.g. HFA, EHS, PAT): _____
Time point # (based on assessment schedule): _____

Interview Questions

1. What services do you think your family needs?

2. What services has your family been referred to?

3. Did you receive the service for which you were referred? (confirmation is defined as family's self-report)? ___ Yes or ___ No

**Services: Financial, Women's Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family planning, Clinical Specialist, Nutrition Other, Respite, Child Care, Emp/Adult School, Housing, MH/Family Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence Services, Other.*

Quarterly

First Name: _____ Today's Date: _____

Last Name: _____ Enrollment Date: _____

Home Visitor's Name: _____ Specific-Model (e.g. HFA, EHS, PAT): _____

Time point # (based on assessment schedule): _____

Formal Instruments

- PRAMS: Breastfeeding questionnaire (PAT: LSP #43 "How long did you breastfeed your baby?")
- Life Skills Progression (item 43, 8)

Interview Questions

1. Do **you** currently have health insurance? _____ Yes or _____ No
2. Does **your child** currently have health insurance? _____ Yes or _____ No
3. How many times has **your child** been to the emergency department for any reason? _____
4. How many times have **you** visited the emergency department for any reason? _____
5. **HFA & EHS (ONLY)**: In the past 3 months, how many times did **your child** receive medical treatment for an injury? _____
6. **INSERT SPECIFIC QUESTIONS** (also inquire reason for visit, kind of injury, type of treatment) -
PAT will use LSP #8
7. What services do you think your family needs?

8. What services has your family been referred to?

9. Did you receive the service for which you were referred? _____ Yes or _____ No

**Services: Financial, Women's Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family planning, Clinical Specialist, Nutrition Other, Respite, Child Care, Emp/Adult School, Housing, MH/Family Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence Services, Other.*

6 months

First Name: _____ Today's Date: _____
Last Name: _____ Enrollment Date: _____
Home Visitor's Name: _____ Specific-Model (e.g. HFA, EHS, PAT): _____
Time point # (based on assessment schedule): _____

Formal Instruments

- Life Skills Progression (item 17)
- PAT LSP #1 "Do you have information about the different ways to prevent pregnancies?"; EHS and HFA will have HVs ask this question of MOB as listed below
- PAT LSP #20 "How often did you take your child for a well-child doctor's visit?"; EHS & HFA will use internal program or record data as listed below.
- PRAMS: Breastfeeding questionnaire (PAT: LSP #43 "How long did you breastfeed your baby?")
- Life Skills Progression (item 43, 8)
- Edinburgh Postnatal Depression Scale (If not yet completed, complete at this visit)
- Relationship Assessment Tool (If not yet completed, complete at this visit)

Interview Questions

1. When did you receive prenatal care?
2. **HFA & EHS (ONLY):** Did the mother or pregnant woman receive birth spacing education?
3. Was the Edinburgh Postnatal Depression Scale (EPDS) administered? ___ Yes or ___ No
4. Do you currently have health insurance? ___ Yes or ___ No
5. Does your child currently have health insurance? ___ Yes or ___ No
6. How many times has your child been to the emergency department for any reason? _____
7. How many times have you visited the emergency department for any reason? _____
8. **HFA & EHS (ONLY):** In the past 3 months, how many times did your child received medical treatment for an injury? _____
9. **INSERT SPECIFIC QUESTIONS** (also inquire reason for visit, kind of injury, type of treatment) - PAT will use LSP #8
10. What services do you think your family needs?

11. What services has your family been referred to?

12. Did you receive the service for which you were referred? ___ Yes or ___ No

Annual

First Name: _____ Today's Date: _____
Last Name: _____ Enrollment Date: _____
Home Visitor's Name: _____ Specific-Model (e.g. HFA, EHS, PAT): _____
Time point # (based on assessment schedule): _____

Formal Instruments

- PRAMS: Prenatal Use of Tobacco; PAT will collect information by administering LSP #25: Do you currently smoke or use other tobacco products? How much do you use per day?
- HOME (Annually)
- PRAMS: Breastfeeding questionnaire (PAT: LSP #43 "How long did you breastfeed your baby?")
- Life Skills Progression (item 43, 8)

Interview Questions

1. Please estimate your annual total household income: _____ / year
Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private (e.g., rent from tenants/borders, cash assistance from friends or relatives) or they may be linked to public assistance (i.e. child support payments, TANF, Social security – SSI/SSDI/OAI), and unemployment insurance.
2. Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max):
_____ hrs / month
3. Estimate your total monthly hours spent in education programs: _____ hrs / month
Education programs are defined as secondary, post-secondary, trade school.
4. Do you currently have health insurance? _____ Yes or _____ No
5. Does your child currently have health insurance? _____ Yes or _____ No
6. How many times has your child been to the emergency department for any reason? _____
7. How many times have you visited the emergency department for any reason? _____
8. **HFA & EHS (ONLY):** In the past 3 months, how many times did your child received medical treatment for an injury? _____
9. **INSERT SPECIFIC QUESTIONS** (also inquire reason for visit, kind of injury, type of treatment) -
PAT will use LSP #8
10. What services do you think your family needs? _____
11. What services has your family been referred to?

12. Did you receive the service for which you were referred? _____ Yes or _____ No

ASQ Administration Schedule by Program & Target Age

	Target-Age		
	6 months	8 months	36 months
Age-Specific ASQ SE			
HFA	X		
PAT	X		
EHS	X		
HIPPY			X
Age-Relevant ASQ 3			
HFA		X	
PAT		X	
EHS		X	
HIPPY			X
Age-Specific ASQ 3 Gross Motor Section			
HFA		X	
PAT		X	
EHS		X	
HIPPY			X

MIECHV Calendar

Construct	Enrollment																		2 Years	3 Years
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18				
Client self report of pre-natal care	At enrollment						Every 6 mo. Of enroll.						Every 6 mo. Of enroll.							
Parental use of tobacco	Tobacco Use Survey at enrollment to 36 weeks of pregnancy												One year post enrollment							
Preconception Care	At enrollment						Every 6 mo. Of enroll.						Every 6 mo. Of enroll.							
Inter-birth intervals	At enrollment													notification of subsequent birth						
Maternal depressive symptoms							Edinburgh Postnatal Depression Screen -6 months post enrollment						Every 6 months (CQI)							
Breastfeeding	Breastfeeding Survey Question at prenatal enrollment			Quarterly			Quarterly			Quarterly			Quarterly							
Well-child visits	1-2 weeks & 1 mo. of age	2 mo. of age		4 mo. of age		6 mo. of age			9 mo. of age			12 mo. of age			15 mo. of age	18 mo. of age	2 years	3 years		
Maternal, child & household member health insurance status	At enrollment						Every 6 months (CQI)						annually							

Construct	Enrollment																	
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years
Visits for children to the ED	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
Visits of mother to the ED	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
Information/training on prevention of child injuries	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
Child injuries requiring medical treatment	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
Reported suspected maltreatment (allegations)	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
Reported substantiated maltreatment	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly
First time victim of maltreatment	Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly to program exit			Quarterly	Quarterly	Quarterly

Construct	Enrollment																	
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years
Parent's support for children's learning and development	HOME Inventory Scale score from assessment at enrollment												Scale score from assessment one year after enrollment					
Parent knowledge of child development								ASQ -Test Result Reviewed?										
Parenting behaviors and parent-child relationship	HOME Inventory Scale score from assessment at enrollment												HOME Inventory Scale score one year after enrollment					
Parent emotional well-being or parenting stress						Edinburgh Postnatal Depression Screen -6 months post enrollment							Edinburgh Postnatal Depression Screen one year after enrollment (CQI)					
Child's communication, language and emergent literacy	Ages and Stages Questionnaire Scale Score from assessment	ASQ Scale Score (CQI)		ASQ Scale Score (CQI)				ASQ Scale Score				ASQ Scale Score (CQI)						
Child's general cognitive skills	Ages and Stages Questionnaire Scale Score from assessment	ASQ Scale Score (CQI)		ASQ Scale Score (CQI)				ASQ Scale Score				ASQ Scale Score (CQI)						

Construct	Enrollment																	
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years
Child's positive approaches to learning	Ages and Stages Questionnaire SE Scale Score from assessment					ASQ:SE Scale Score						ASQ:SE Scale Score (CQI)				ASQ:SE Scale Score (CQI)		
Child's social behavior, emotional regulation	Ages and Stages Questionnaire SE Scale Score from assessment					ASQ:SE Scale Score						ASQ:SE Scale Score (CQI)				ASQ:SE Scale Score (CQI)		
Child's physical health and development- Well-child visits	Ages and Stages Questionnaire Scale Score from assessment	ASQ Scale Score (CQI)		ASQ Scale Score (CQI)		ASQ Scale Score (CQI)		ASQ Scale Score				ASQ Scale Score (CQI)						

Construct	Enrollment																		
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years	
Screening for Domestic Violence	Women's Experience with Battering Scale within 6 months post enrollment											One year post enrollment (CQI)							
Families identified for DV, no. of referrals made to DV services	Quarterly			Quarterly			Quarterly			Quarterly			Quarterly			Quarterly	Quarterly	Quarterly	
families identified for DV, no. of families with a completed safety plan	Quarterly			Quarterly			Quarterly			Quarterly			Quarterly			Quarterly	Quarterly	Quarterly	

Construct	Enrollment																	
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years
Household income and benefits	Source of income or benefits and the amount month of enrollment												Source of income or benefits and the amount one year post enrollment					
Employment of adult household members	# of adult household members employed and average hour/month worked by each adult household member month of enrollment												# of adult household members employed and average hour/month worked by each adult household member one year post enrollment					
Education of adult household members	# of adult household members in educational activities and hours/month spent by each adult household member in education program month of enrollment												# of adult household members in educational activities and hours/month spent by each adult household member in education program one year post enrollment					
Health Insurance Status	At enrollment												annually					

Construct	Enrollment																	
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15	Month 18	2 Years	3 Years
Number of families identified for necessary services	Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)
Number of families that required services and received a referral	Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)
Number of formal agreements with other social service agencies	Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)
Number of agencies which home visiting provider has a clear point of contact	Quarterly			Quarterly			Quarterly			Quarterly			Quarterly			Quarterly	Quarterly	Quarterly
No. of completed referrals – received report of the services provided	Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)			Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)	Monthly and Quarterly (CQI)

Immunization Calendar

Vaccine	AGE								
	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months
Hepatitis B	Date	Date			Date				
		Hearing			Hearing				
		Vision			Vision				
		Height			Height				
		Weight			Weight				
		Gen. Health			Gen. Health				
Rotavirus			Date	Date	Date				
			Hearing	Hearing	Hearing				
			Vision	Vision	Vision				
			Height	Height	Height				
			Weight	Weight	Weight				
			Gen. Health	Gen. Health	Gen. Health				

Vaccine	AGE								
	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months
Diphtheria, Tetanus, Pertussis			Date	Date	Date		Date		
			Hearing	Hearing	Hearing		Hearing		
			Vision	Vision	Vision		Vision		
			Height	Height	Height		Height		
			Weight	Weight	Weight		Weight		
			Gen. Health	Gen. Health	Gen. Health		Gen. Health		
Haemophilus Influenzae type b			Date	Date	Date	Date			
			Hearing	Hearing	Hearing	Hearing			
			Vision	Vision	Vision	Vision			
			Height	Height	Height	Height			
			Weight	Weight	Weight	Weight			
			Gen. Health	Gen. Health	Gen. Health	Gen. Health			

Vaccine	AGE								
	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months
Pneumococcal			Date	Date	Date	Date			
			Hearing	Hearing	Hearing	Hearing			
			Vision	Vision	Vision	Vision			
			Height	Height	Height	Height			
			Weight	Weight	Weight	Weight			
			Gen. Health	Gen. Health	Gen. Health	Gen. Health			
Inactivated Poliovirus			Date	Date	Date				
			Hearing	Hearing	Hearing				
			Vision	Vision	Vision				
			Height	Height	Height				
			Weight	Weight	Weight				
			Gen. Health	Gen. Health	Gen. Health				
Vaccine	AGE								

	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months
Influenza (annually)					Date				
					Hearing				
					Vision				
					Height				
					Weight				
					Gen. Health				
Measles, Mumps, Rubella						Date			
						Hearing			
						Vision			
						Height			
						Weight			
						Gen. Health			

Vaccine	AGE								
	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months
Varicella						Date			
						Hearing			
						Vision			
						Height			
						Weight			
						Gen. Health			
Hepatitis A (2 doses)						Date			
						Hearing			
						Vision			
						Height			
						Weight			
						Gen. Health			

MIECHV Benchmark Table

Benchmark 1: Improved Maternal and Newborn Health	
Construct	1. Prenatal Care
Performance Measure	Percent of pregnant women who received prenatal care
Operational Definition	Target Population: Women who are pregnant when they enroll
	Numerator: Women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester
	Denominator: Women who were pregnant at enrollment
Definition of improvement and calculation	<p>Definition of improvement: Increase the number of pregnant women who receive prenatal care</p> <p>Calculation: The number of women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester divided by the number of women who were pregnant at enrollment in year 2 compared to the number of women who were pregnant at enrollment who received their first prenatal care visit before the end of the second trimester divided by the number of women who were pregnant at enrollment in year 1</p>
*Cohort comparison:	
Data Source	HV program records, pregnant woman-self report
Measurement Tool	<p>PAT: LSP #17 Prenatal care scores do not capture 2nd trimester threshold, therefore we will ask PAT to use the HV record, "When did you receive prenatal care?"</p> <p>EHS: PIR #C15a,b Trimester of pregnancy in which the pregnant women served were enrolled or use internal program data</p> <p>HFA: HV record "When did you receive prenatal care?"</p>
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question or administer the tool and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at enrollment within first 2 home visits and every 6 months of program enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	PAT data collection is not specific to the second trimester.

*Cohort

Year One = May 1, 2012 to April 31, 2013

Year Two = May 1, 2013 to April 31, 2014

Benchmark 1: Improved Maternal and Newborn Health	
Construct	2. Parental use of alcohol, tobacco, or illicit drugs
Performance Measure	Percent of smokers at intake who decrease smoking by 1 year post enrollment.
Operational Definition	Target Population: Enrolled pregnant women and mothers who report current use of tobacco at enrollment
	Numerator: Number of enrolled smokers at intake, who reported decreased smoking by one year post enrollment
	Denominator: Number of enrolled smokers at intake who remain in the program for at least one year
Definition of improvement and calculation	Definition of improvement: Increase percent of smokers at intake who reported smoking fewer cigarettes by one year post enrollment
Individual	Calculation: Number of smokers at intake who reported reduced smoking by one year post enrollment divided by the number of participants who reported smoking at intake
Data Source	Collected during home visit using the 3 client/caregiver questions from PRAMS, "Prenatal Use of Tobacco"
Measurement Tool	HFA & EHS: PRAMS: "Prenatal Use of Tobacco" "In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day?" "In the last 3 months of your pregnancy how many cigarettes did you smoke on an average day?" "How many cigarettes do you smoke on an average day now?" 41 cigarettes or more 21 to 40 cigarettes 11 to 20 cigarettes 6 to 10 cigarettes Less than 2 cigarette I don't smoke now PAT: LSP#25: Do you currently smoke or use other tobacco products? How much do you use per day?
Reliability/Validity	Pregnancy Risk Assessment Monitoring System; A Survey for Healthier Babies in New Jersey (cited 2011 May). Available from: http://www.nj.gov/health/fhs/documents/methods_summary.pdf

Benchmark 1: Improved Maternal and Newborn Health	
Construct	2. Parental use of alcohol, tobacco, or illicit drugs
Reliability/Validity	LSP: #25 – N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will administer the questionnaire and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at intake and one year post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenge	

Benchmark 1: Improved Maternal and Newborn Health	
Construct	3. Preconception Care
Performance Measure	Percent of enrolled post partum women who receive a post partum examination within the first three months following enrollment
Operational Definition	Target Population: Post partum women enrolled in program
	Numerator: Number of post partum women who reported a post partum examination
	Denominator: Total number of enrolled post partum women who remain in the program for 3 months
Definition of improvement and calculation Cohort	Definition of improvement: Increase or maintain the percent of enrolled post partum women that received a post partum exam within the first three months following enrollment in year 1 as compared to the percent of enrolled post partum women that received a post partum exam within the first three months following enrollment in year 2 Calculation: Number of post partum women who report a post partum examination divided by the total number of post partum women in year 2 compared to the number of post partum women who report a post partum examination divided by the total number of post partum women in year 1.
Data Source	Collected during home visit interview
Measurement Tool	Question: "When was your last post-partum examination?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected or within the first 3 months following enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	All models will use same measurement tool

Benchmark 1: Improved Maternal and Newborn Health	
Construct	4. Inter Birth Intervals
Performance Measure	Percent of enrolled mothers and pregnant women who received birth spacing education within 6 months of enrollment
Operational Definition	Target Population: Enrolled mothers and pregnant women
	Numerator: Total number of enrolled mothers and pregnant women who received birth spacing education within six months of enrollment
	Denominator: Total number of mothers and pregnant women enrolled during the program year for at least 6 months
Definition of improvement and calculation Cohort	<p>Definition of improvement: Increase or maintain the percent of mothers and pregnant women who enrolled during year 2 who received birth spacing education within six months of enrollment as compared to the percent of mothers and pregnant women who enrolled during year 1 who received birth spacing education within six months of enrollment</p> <p>Calculation: Total number of mothers and pregnant women who enrolled during year 2 who received birth spacing education within six months of enrollment divided by the total number of mothers and pregnant women who enrolled during year 2 compared to total number of mothers and pregnant women who enrolled during year 1 who received birth spacing education within six months of enrollment divided by the total number of mothers and pregnant women who enrolled during year 1.</p>
Data Source	Collected during home visit interview
Measurement Tool	HFA and EHS: Question: "Did the mother or pregnant woman receive birth spacing education?" PAT: LSP #1. "Do you have information about the different ways to prevent pregnancies?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected at six months post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 1: Improved Maternal and Newborn Health	
Construct	5. Screening for maternal depressive symptoms
Performance Measure	Percent of mothers who screened for depression by 6 months post enrollment
Operational Definition	Target Population: Enrolled mothers in the program
	Numerator: Number of enrolled mothers who were screened for depressive symptoms using the Edinburgh Postnatal Depression Scale between enrollment and 6 months post enrollment
	Denominator: Total number of enrolled mothers for at least 6 months
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 2, as compared to the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 1.
Cohort	Calculation: Number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 2 divided by the total number of enrolled mothers in year 2 compared to the number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 1 divided by the total number of enrolled mothers
Data Source	Collected during home visit interview
Measurement Tool	Edinburgh Postnatal Depression Scale Question: "Was the EPDS administered?"
Reliability/Validity	The EPDS has been found to have good reliability and validity, with a sensitivity of 86%, a specificity of 78% and a split-half reliability of .99 with a standardized α coefficient of .87 ¹
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected by six months post enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

¹ The origins and development of the Edinburgh Postnatal Depression Scale. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf. Accessed July 11, 2011.

Benchmark 1: Improved Maternal and Newborn Health	
Construct	6. Breastfeeding
Performance Measure	The number of weeks that index women who enrolled prenatally spent breastfeeding up until the child is 6 months of age.
Operational Definition	Target Population: Index women who enrolled prenatally
	Numerator: Total number of weeks that index women who enrolled prenatally spent breastfeeding
	Denominator: Number of index women who enrolled prenatally
Definition of improvement and calculation Cohort	<p>Definition of improvement: Increase in the average number of weeks that a mother who enrolled prenatally in year 2 spent breastfeeding compared to the average number of weeks that a mother who enrolled prenatally in year 1 spent breastfeeding.</p> <p>Calculation: Total number of weeks that mothers enrolled prenatally in year 2 spent breastfeeding divided by the total number of mothers who enrolled prenatally in year 2 compared to the total number of weeks that mothers enrolled prenatally in year 1 spent breastfeeding divided by the total number of mothers who enrolled prenatally in year 1.</p>
Data Source	Collected during home visit interview
Measurement Tool	HFA and EHS: PRAMS Breastfeeding questionnaire : " How many weeks or months did you breastfeed or pump milk to feed your baby?" PAT: LSP #43 "How long did you breast feed your baby?"
Reliability/Validity	Pregnancy Risk Assessment Monitoring System; A Survey for Healthier Babies in New Jersey (cited 2011 May). Available from: http://www.nj.gov/health/fhs/documents/methods_summary.pdf
Data Collection & Analysis Plan	Person Responsible: The home visitor will administer the questionnaire and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected quarterly for CQI
	Analysis: Annually
Comments/Anticipated Challenges	

Benchmark 1: Improved Maternal and Newborn Health	
Construct	7. Well Child Visits
Performance Measure	Percent of index children who received the recommended schedule of immunization according to the AAP/CHDP well child schedule at birth, 1, 2, 4 and 6 months of age.
Operational Definition	Target Population: Index children enrolled for at least 6 months
	Numerator: Number of index children enrolled for at least 6 months who received the recommended schedule of immunizations
	Denominator: Total number of index children in program who have been enrolled for at least 6 months.
Definition of improvement and calculation	Definition of improvement: Increase or maintain percent of index children who have been enrolled for at least 6 months who have received all recommended schedule of well child visits according to AAP/CHDP schedule in year 2 as compared to index children who have been enrolled for at least 6 months who have received all recommended well child visits according to AAP/CHDP schedule in year 1.
Cohort	Calculation: Number of index children enrolled for at least 6 months who received the recommended schedule of well child visits divided by the total number of index children in the program who have been enrolled for at least 6 months in year 2 compared to number of index children enrolled for at least 6 months who received the recommended schedule of well child visits divided by the total number of index children in the program who have been enrolled for at least 6 months in year 1.
Data Source	Program records and self report
Measurement Tool	PAT: LSP#20 "How often did you take your child for a well-child doctor's visit?" /LSP score of 5 on #20 EHS: Internal program data HFA: Program records and self report for immunization and well child visits
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask for well child visit/immunization report/record and the data entry personnel will enter the response into the database.
	Data collection schedule: collected at 6 months enrollment
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 1: Improved Maternal and Newborn Health	
Construct	8. Maternal and Child Health Insurance Status
Performance Measure	Percent of mothers and index children with health insurance by 6 months post enrollment
Operational Definition	Target Population: Enrolled mothers and children
	Numerator: Number of mothers with health insurance plus the number of index children with health insurance by 6 months post enrollment
	Denominator: Total number of enrolled mothers and children who remain enrolled for at least 6 months
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percentage of enrolled mothers and index children with health insurance by 6 months post enrollment in year 2 compared to the percentage of enrolled mothers and index children with health insurance by 6 months post enrollment in year 1.
Cohort	Calculation: The number of enrolled mothers and index children with insurance by 6 months post enrollment in year 2 divided by the total number of enrolled mothers and index children in year 2 compared to the enrolled mothers and index children with health insurance by 6 months post enrollment in year 1 divided by the total number of enrolled mothers and index children in year 1.
Data Source	Collected by home visitor
Measurement Tool	Question: "Do you currently have health insurance?" "Does your child currently have health insurance?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the questions and the data entry personnel will enter the response into the database.
	Data collection schedule: Quarterly
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	1. Visits for children to the ED from all causes
Performance Measure	Rate of emergency department visits per index child in the program enrolled for at least one year
Operational Definition	Target: All index children enrolled in the program
	Numerator : Total number of emergency department visits by index children in the program
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the rate of emergency department visits per index child in the program in year 2 compared to emergency department visits per index child in the program in year 1
Cohort	Calculation: Number of ED visits by all children in the program in year 2 divided by the total number of children in the program in year 2 compared to number of ED visits by all children in the program in year 1 divided by the total number of children in the program in year 1.
Data Source	Collected by home visitor
Measurement Tool	HV will ask question, "How many times has your child been to the emergency dept. for any reason?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the question and data entry personnel will enter data in database
	Data collection schedule: Quarterly
	Analysis: Annually for reporting
Comments/Anticipated Challenges	In addition to reporting this as a whole, it will also be reported by the child's age when the incident occurred (0-12 months, 13-36 months, and 37-60 months).

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	2. Visits of mothers to the ED from all causes
Performance Measure	Rate of emergency department visits per mother in the program enrolled for at least one year
Operational Definition	Target: Mothers enrolled in the program
	Numerator : Total number of emergency department visits by enrolled mothers in the program
	Denominator: Total number of enrolled mothers in the program
Definition of improvement and calculation	Definition of improvement: Decrease the rate of emergency department visits by enrolled mothers in the program in year 2 compared to emergency department visits by enrolled mothers in the program in year 1
Cohort	Calculation: Number of emergency department visits by enrolled mothers in the program in year 2 divided by the total number of enrolled mothers in the program in year 2 compared to the number of emergency department visits by enrolled mothers in the program in year 1 divided by the total number of enrolled mothers in the program in year 1.
Data Source	Collected by home visitor
Measurement Tool	Home visitor will ask the question, "How many times have you visited the emergency department for any reason?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the question and data entry personnel will enter the data
	Data collection schedule: Quarterly for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	3. Information provided or training of participants on prevention of child injuries including safe sleep, shaken baby, TBI, child passenger safety, poisonings, fire safety, water safety, playground safety
Performance Measure	Percentage of enrolled families who received information or training on the prevention of child injuries during the cohort year
Operational Definition	Target population: Enrolled families
	Numerator : Number of enrolled families who have received information or training on the prevention of child injuries
	Denominator: Total number of enrolled families
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percentage of enrolled families who enrolled during year 2 who received information or training on the prevention of child injuries compared to the percentage of enrolled families who enrolled during year 1 who received information or training on the prevention of child injuries .
Cohort	Calculation: Number of enrolled families who have received information or training on the prevention of child injuries divided by the total number of enrolled families in year 2 compared to the number of enrolled families who have received information or training on the prevention of child injuries divided by the total number of enrolled families in year 1
Data Source	Program administrative records
Measurement Tool	HFA Program's policies and procedures: P & P contain procedures for providing information and training for the prevention of child injuries. Early Head Start - Internal program data PAT-Personal Visit Record
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the policies and procedures and will record completion of information and training.
	Data collection schedule: Quarterly for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	4. Child injuries requiring medical treatment
Performance Measure	Rate of injuries index children receive that require medical treatment (ambulatory care, ED visits, and hospitalization, injury or ingestions)
Operational Definition	Target population: Index children enrolled in the program
	Numerator : Total number of injuries index children receive requiring medical treatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decreased rate in the injuries index children receive requiring medical treatment in year 2 compared to the injuries index children receive requiring medical treatment in year 1 Calculation: Number of injuries index children receive requiring medical treatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of injuries index children receive requiring medical treatment in year 1 divided by the total number of index children in the program in year 1
Cohort	
Data Source	Adult enrolled index participant self report, collected by home visitor
Measurement Tool	HFA and EHS: Self report question administered by home visitor, "In the past 3 months, how many times did your child receive medical treatment for an injury? " (also inquire reason for the visit, kind of injury, type of treatment) PAT: score of 1 or 2 on LSP #8-Safety "Has your child ever had an accident that caused injury?" "Have you ever taken your child to the ER for accidental injury?" "Has he/she been hospitalized?" "Sustain permanent damage?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the questionnaire to the adult enrolled index participant
	Data collection schedule: Quarterly for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	In addition to reporting this as a whole, it will also be reported by the child's age when the incident occurred (0-12 months, 13-36 months, and 37-60 months) Will require raw data from PAT

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	5. Reported suspected maltreatment (allegations)
Performance Measure	Percent of suspected maltreatment cases among index children in the program enrolled during the cohort year
Operational Definition	Target population: Index children in the program
	Numerator : Number of index children in the program who are reported to Child Welfare Services for suspected maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the percentage of suspected maltreatment cases among index children in the program in year 2 compared to suspected maltreatment cases among index children in the program in year 1.
Cohort	Calculation: Number of index children in the program who are reported to Child Welfare Services for suspected maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are reported to Child Welfare Services for suspected maltreatment in year 1 divided by the total number of index children in the program in year 1
Data Source	Hawaii Dept. of Human Services, Child Welfare Services
Measurement Tool	CWS report, report will contain aggregate data on unidentified index children in the program that are involved in cases of suspected maltreatment.
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: Annually reported
Comments/Anticipated Challenges	We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months) The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	6. Reported substantiated maltreatment
Performance Measure	Percent of substantiated maltreatment cases among index children in the program enrolled during the cohort year
Operational Definition	Target Population: Index children in the program
	Numerator : Number of index children in the program who are substantiated by Child Welfare Services for maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	Definition of improvement: Decrease the percent of substantiated maltreatment cases among index children in the program in year 2 compared to substantiated maltreatment cases among index children in the program in year 1
Cohort	Calculation: Number of index children in the program who are substantiated by Child Welfare Services for maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are substantiated by Child Welfare Services for maltreatment in year 1 divided by the total number of index children in the program in year 1.
Data Source	Dept. of Human Services – Child Welfare Services
Measurement Tool	CWS report, report will contain unidentified index children in the program that are involved in cases of substantiated maltreatment
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: annually reported
Comments/Anticipated Challenges	We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months) The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	
Construct	7. First time victims of maltreatment for index children in the program
Performance Measure	Percentage of index children in the program who are first time victims of maltreatment enrolled during the cohort year
Operational Definition	Target population: All index children in the program
	Numerator: Number of index children in the program who are first time victims of maltreatment
	Denominator: Total number of index children in the program
Definition of improvement and calculation	<p>Definition of improvement: Decrease percentage of first time victims of maltreatment of index children in the program in year 2 compared to first time victims of maltreatment of index children in the program in year 1</p> <p>Calculation: Number of index children in the program who are first time victims of maltreatment in year 2 divided by the total number of index children in the program in year 2 compared to the number of index children in the program who are first time victims of maltreatment in year 1 divided by the total number of index children in the program in year 1</p>
Cohort	
Data Source	Dept. of Human Services – Child Welfare Services
Measurement Tool	CWS report, report will contain unidentified number of index children in the program that are involved in cases of first time victimization.
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: MIECHV Statewide Home Visiting Coordinator will submit identifiable program data to CWS and CWS will return de-identified aggregate data to MIECHV Statewide Home Visiting Coordinator
	Data collection schedule: semi annually for CQI
	Analysis: annually reported
Comments/Anticipated Challenges	<p>We will report by physical abuse, neglect, medical neglect, sexual abuse, psychological abuse and threatened harm by age category (0-12 months, 13-36 months, and 37-60 months)</p> <p>The total number of index children in the program could be impacted by parents who do not provide consent to obtain information from DHS-CWS</p> <p>First time victim is defined as a child who had a maltreatment disposition of “victim” and never had prior disposition of victim.</p>

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	1. Parent's support for children's learning and development (toys, talking, reading to)
Performance Measure	Percentage of adult enrolled index participants who demonstrate support of index child's learning and development
Operational Definition	Target Population: Adult enrolled index participants who score below 7 on the Learning Materials subscale of the HOME
	Numerator : Adult enrolled index participants whose Learning Materials subscale score is above 7 at one year post enrollment
	Denominator: The total number of adult enrolled index participants who scored below 7 at one year post enrollment
Definition of improvement and calculation	Definition of improvement: Decrease the percent of adult enrolled index participants who score below 7 on the Learning Materials subscale of the Infant Toddler HOME
Individual	Calculation: Number of adult enrolled index participants whose Learning Materials subscale HOME scores are above 7 on the Infant Toddler HOME at one year post enrollment divided by the total number of adult enrolled index participants whose Learning Materials subscale HOME scores are below 7 on the Infant Toddler HOME
Data Source	Infant Toddler HOME administered by home visitor
Measurement Tool	Infant Toddler HOME Sub scale 4- Learning Materials, #26-34; cut off threshold below 7
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the HOME and the data personnel will enter results into database.
	Data collection schedule: 1 year post enrollment
	Analysis: Annually
Comments/Anticipated Challenges	HOME will be used across all models Adult enrolled index participant is one primary caregiver

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	2. Parent knowledge of child development and of their child's developmental progress
Performance Measure	Percentage of ASQ results that adult enrolled index participant reviewed with the home visitor
Operational Definition	Target population: Adult enrolled index participants
	Numerator : Number of ASQ results reviewed with the adult enrolled index participants
	Denominator: Total number of ASQ s administered at target age (8 months or 36 months)
Definition of improvement and calculation	Definition of improvement: Increase or maintain percentage of ASQ results that were reviewed with the adult enrolled index participant in year 2 as compared to percentage of ASQ results that were reviewed with the adult enrolled index participant in year 1
Cohort	Calculation: Number of ASQ results reviewed with the adult enrolled index participants in year 2 divided by the total number of ASQs administered in year 2 compared to the number of ASQ results reviewed with the adult enrolled index participants in year 1 divided by the total number of ASQs administered in year 1
Data Source	Administrative record review
Measurement Tool	"What was the date the ASQ test result was reviewed with the adult enrolled index participant?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home Visitor will record the date the ASQ was reviewed with the adult enrolled index participant and the data personnel will enter the data into the database.
	Data collection schedule: EHS, HFA, PAT: 8 month ASQ HIPPY: 36 months
	Analysis: At target age and annually
Comments/Anticipated Challenges	Process measure
	Check program policy and procedures to ensure that the ASQ is reviewed w/parent

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	3. Parenting behaviors and parent-child relationship (discipline strategy, play interaction)
Performance Measure	The percentage of adult enrolled index participants that score above the median for the Infant Toddler HOME at one year post enrollment
Operational Definition	Target population: Adult enrolled index participants who score below the median at enrollment
	Numerator: Number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at one year post enrollment
	Denominator: Total number of adult enrolled index participants with a HOME score below 32 at enrollment
Definition of improvement and calculation	Definition of improvement: Decrease the percentage of adult enrolled index participants who score below 32 on the Infant Toddler HOME at one year post enrollment in year 2 as compared to percentage of adult enrolled index participants who score below 32 on the Infant Toddler HOME at one year post enrollment in year 1
Cohort	Calculation: Number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at year one post enrollment divided by the total number of adult enrolled index participants in year one with a HOME score below 32 at enrollment compared to number of adult enrolled index participants whose HOME scores are above 32 on the Infant Toddler HOME at year two post enrollment divided by the total number of adult enrolled index participants in year two with a HOME score below 32 on the Infant Toddler HOME at year two post enrollment.
Data Source	HOME administered by home visitor
Measurement Tool	HOME
Reliability/Validity	HOME Observation for Measurement of the Environment (HOME) Inventory Administration Manual, Third Edition, 2001 (cited 2011 May). Available from: http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phio.html
Data Collection & Analysis Plan	Person Responsible: Home Visitor will administer the HOME and the data entry personnel will enter results into the database
	Data collection schedule: At enrollment (within 90 days) and 1 year post enrollment
	Analysis: Annually
Comments/Anticipated Challenges	HOME will be used across all models

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	4. Parent emotional well-being or parenting stress
Performance Measure	Percent of mothers who screened for depression by 6 months post enrollment
Operational Definition	Target population: Enrolled mothers in the program
	Numerator: Number of enrolled mothers who were screened for depressive symptoms using the Edinburgh Postnatal Depression Scale between enrollment and 6 months post enrollment
	Denominator: Total number of enrolled mothers
Definition of improvement and calculation	Definition of improvement: Increase or maintain the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 2, as compared to the percent of enrolled mothers who are screened for depression between enrollment and 6 months post enrollment in year 1.
Cohort	Calculation: Number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 2 divided by the total number of enrolled mothers in year 2 compared to the number of enrolled mothers who were screened for depression between enrollment and 6 months post enrollment in year 1 divided by the total number of enrolled mothers in year 1.
Data Source	Collected by home visitor
Measurement Tool	Edinburgh Postnatal Depression Scale Question: "Was the EPDS administered?"
Reliability/Validity	The EPDS has been found to have good reliability and validity, with a sensitivity of 86%, a specificity of 78% and a split-half reliability of .99 with a standardized α -coefficient of .87 ²
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data entry personnel will enter the response into the database.
	Data collection schedule: Collected by six months post enrollment
	Analysis: Six months for CQI and report annually
Comments/Anticipated Challenges	

² The origins and development of the Edinburgh Postnatal Depression Scale. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/files/samplechapter/81_1.pdf. Accessed July 11, 2011.

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	5. Child's communication, language, and emergent literacy
Performance Measure	Percentage of index children who are screened for developmentally appropriate Communication skills at the target age
Operational Definition	Target population: enrolled index children at target age
	Numerator: Number of enrolled index children screened for developmentally appropriate communication skills at target age
	Denominator: Total number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who are screened for developmentally appropriate skills at target age
Process Individual comparison	Calculation: Number of enrolled index children screened for developmentally appropriate communication skills at target age divided by the total number of enrolled index children at target age.
Data Source	Administered by home visitor at index child's target age
Measurement Tool	Age relevant ASQ 3
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User's Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: At target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months HIPPI target age: 36 months EHS target age: 8 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	6. Child's general cognitive skills
Performance Measure	Percentage of index children who are screened for general cognitive skills at the target age
Operational Definition	Target population: enrolled index children at target age
	Numerator: Number of enrolled index children screened for general cognitive skills at target age
	Denominator: Total number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who are screened for general cognitive skills at target age
Process Individual comparison	Calculation: Number of enrolled index children screened for general cognitive skills at target age divided by the total number of enrolled index children at target age
Data Source	Administered by home visitor at index child's target age
Measurement Tool	Age relevant ASQ 3
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User's Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months HIPYP target age: 36 months EHS target age: 8 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	7. Child's positive approaches to learning including attention
Performance Measure	Percentage of index children who score above the cut off on the target age ASQ SE
Operational Definition	Target population: Index children at target age
	Numerator: Number of index children at target age that score above the cut off on the target age ASQ- SE
	Denominator: Number of index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who scored above the cut off at the target age
Process Individual comparison	Calculation: Number of index children at target age that score above the cut off on the target age ASQ-SE divided by the total number of index children at the target age.
Data Source	Administered by home visitor at index child's target age
Measurement Tool	age specific ASQ SE
Reliability/Validity	Minnesota Department of Health; Developmental and Social-Emotional Screening of Young children (0-6 years of age) in Minnesota (cited 2011 May). Available from: http://www.health.state.mn.us/divs/fh/mch/devscrn/instr/asqse.html
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ SE and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 6 months PAT target age: 6 months EHS target age: 6 months HIPYP target age: 36 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	8. Child's social behavior, emotional regulation and emotional well-being
Performance Measure	Percentage of index children who score above the cut off on the target age ASQ SE
Operational Definition	Target population: Index children at target age
	Numerator: Number of index children at target age that score above the cut off on the target age ASQ- SE
	Denominator: Number of index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled index children who scored above the cut off at the target age.
Process Individual comparison	Calculation: Number of index children at target age that score above the cut off on the target age ASQ-SE divided by the total number of index children at the target age.
Data Source	Administered by home visitor at index child's target age
Measurement Tool	age specific ASQ SE
Reliability/Validity	Minnesota Department of Health; Developmental and Social-Emotional Screening of Young children (0-6 years of age) in Minnesota (cited 2011 May). Available from: http://www.health.state.mn.us/divs/fh/mch/devscrn/instr/asqse.html
Data Collection & Analysis Plan	Person Responsible: : Home visitor will administer the ASQ SE and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 6 months PAT target age: 6 months EHS target age: 6 months HIPPY target age: 36 months

Benchmark 3: Improvements in School Readiness and Achievement	
Construct	9. Child's physical health and development
Performance Measure	Percentage of index children who score above the cut off on the Gross Motor section of the ASQ 3
Operational Definition	Target population: enrolled index children at target age
	Numerator: number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ3 at target age
	Denominator: number of enrolled index children at target age
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% the percentage of enrolled index children who scored above the cut off at the target age at year 2 compared to index children who scored above the cut off at the target age at year 1
Cohort	Calculation: Number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ 3 at target age in year 2 divided by the total number of enrolled index children at target age in year 2 compared to the number of enrolled index children that score above the cut off for the Gross Motor section of the ASQ 3 at target age in year 1 divided by the total number of enrolled index children at target age in year 1
Data Source	Administered by home visitor at index child's target age
Measurement Tool	age specific ASQ 3 Gross Motor section
Reliability/Validity	ASQ-3 Ages and Stages Questionnaires Third Edition, Excerpted from ASQ-3 User's Guide (cited 2011 May). Available from: http://www.brookespublishing.com/store/books/squires-asq3-technical.pdf
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the ASQ 3 and the data entry personnel will enter the results into the database
	Data collection schedule: at target age
	Analysis: annually
Comments/Anticipated Challenges	HFA target age: 8 months PAT target age: 8 months EHS target age: 8 months HIPPY target age: 36 months

Benchmark 4: Domestic Violence	
Construct	1. Screening for Domestic Violence
Performance Measure	The percentage of adult enrolled index parents who are screened for Domestic Violence within 6 months post enrollment
Operational Definition	Target population: Adult enrolled index mothers
	Numerator: Number of enrolled index mothers who are screened for Domestic Violence within 6 months post enrollment
	Denominator: Total number of enrolled index mothers who remain in the program for at least 6 months
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% of adult enrolled mothers who were screened for Domestic Violence within 6 months post enrollment.
Process Individual comparison	Calculation: Number of enrolled index mothers who are screened for Domestic Violence within 6 months post enrollment divided by the total number of enrolled index mothers.
Data Source	Questionnaire administered by home visitor
Measurement Tool	Women's Experience with Battering Scale
	All models will use the Women's Experience with Battering Scale
Reliability/Validity	Women's Experience with Battering Scale – Reliability/Validity = Cronbach's alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard). Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home visitor will administer the questionnaire to the adult enrolled index mother and the data entry personnel will enter the data in the database
	Data collection schedule: within 6 months post enrollment
	Analysis: annually
Comments/Anticipated Challenges	It may be difficult for us to reach 90% during year 1 due to the need to train staff.

Benchmark 4: Domestic Violence	
Construct	2. Of families identified for DV, no. of referrals made to DV services
Performance Measure	The percentage of enrolled index parents who received referrals to domestic violence services.
Operational Definition	Target population: Enrolled index mothers who scored above 20 on the Women's Experience with Battering Scale
	Numerator: Number of enrolled index mothers who received a referral to domestic violence services
	Denominator: Total number of enrolled index mothers who scored above 20 on the Women's Experience with Battering Scale.
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% the number of enrolled index mothers who received referrals to domestic violence services.
Process Individual comparison	Calculation: Number of enrolled index mothers who received a referral to domestic violence services divided by the total number of enrolled index mothers who scored above 20 on the Women's Experience with Battering Scale
Data Source	Data will be recorded by data personnel when the home visitor refers an enrolled index mother to relevant domestic violence services
Measurement Tool	N/A
Reliability/Validity	Women's Experience with Battering Scale – Reliability/Validity = Cronbach's alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard). Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home Visitor will make the referral to relevant domestic violence services and data personnel will enter the data in the database
	Data collection schedule: Within 30 days of administration of Women's Experience with Battering Scale
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Many rural areas have very limited relevant domestic violence resources

Benchmark 4: Domestic Violence	
Construct	3. Of families identified for Dv, no. of families with a completed safety plan
Performance Measure	The percentage of adult enrolled index parents who scored above 20 on the Women's Experience with Battering Scale who complete a safety plan
Operational Definition	Target population: Enrolled index mothers who scored above 20 on the Women's Experience with Battering Scale.
	Numerator: Number of enrolled index mothers who completed a safety plan
	Denominator: Total number of enrolled index mothers who scored above 20 on the Experience with Battering Scale.
Definition of improvement and calculation	Definition of improvement: Increase or maintain at 90% the number of enrolled index mothers who completed a safety plan.
Process Individual comparison	Calculation: Number of enrolled index mothers who completed a safety plan divided by the total number of enrolled index mothers who scored above 20 on the Women's Experience with Battering Scale.
Data Source	Data will be recorded by data personnel when the home visitor develops a safety plan
Measurement Tool	Completed Safety Plan
Reliability/Validity	Women's Experience with Battering Scale – Reliability/Validity = Cronbach's alpha: 0.95; Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard). Smith, Tessaro, & Earp, 1995 (from Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings Version 1.0)
Data Collection & Analysis Plan	Person Responsible: Home Visitor will develop the safety plan and data personnel will enter the data in the database
	Data collection schedule: Within 30 days of administration of the Women's Experience with Battering Scale
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 5: Family Economic Self Sufficiency	
Construct	1. Household income and benefits
Performance Measure	Total income of the adult enrolled index participants
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Total income for adult enrolled index participants
	Denominator: Total number of adult enrolled index participants
Definition of improvement and calculation	Definition of improvement: Increase in the average total income of the adult enrolled index participants at enrollment and one year post enrollment
Individual	Calculation: Average income of adult enrolled index participants one year post enrollment minus the average income of adult enrolled index participants at month of enrollment
Data Source	Collected by home visitor
Measurement Tool	Question: Please estimate your annual total household income
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	<p>We are only collecting income, rather than ask the home visitor to estimate in-kind benefits.</p> <p>Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private, e.g., rent from tenants/borders, cash assistance from friends or relatives, or they may be linked to public assistance, i.e., child support payments, TANF, Social Security (SSI/SSDI/OAI), and unemployment insurance.</p>

Benchmark 5: Family Economic Self Sufficiency	
Construct	2. Employment of adult members of household
Performance Measure	Number of monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Total number of monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household
	Denominator: Total number of adult enrolled index participants
Definition of improvement and calculation	Definition of improvement: Increase in the average number of monthly paid hours plus unpaid hours devoted to infant care (30 hours max) by all adult enrolled index participant members of the household at enrollment and one year post enrollment
Individual	Calculation: Number of average monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household one year post enrollment minus average monthly paid hours plus unpaid hours devoted to infant child care (30 hours max) by all adult enrolled index participant members of the household in month of enrollment
Data Source	Collected by home visitor in month of enrollment and one year post enrollment
Measurement Tool	Question: Estimate your total monthly paid hours and unpaid hours devoted to infant care (30 hours max)
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	

Benchmark 5: Family Economic Self Sufficiency	
Construct	3. Education of adult members of household
Performance Measure	Number of hours per month spent by adult enrolled index participants in education programs
Operational Definition	Target population: Adult enrolled index participants
	Numerator: Number of hours per month spent by adult enrolled index participants in education programs
	Denominator: Total number of adult enrolled index participants
Definition of improvement and calculation	Definition of improvement: Increase in the average hours per month spent by adult enrolled index participants in education programs at enrollment and one year post enrollment
Individual	Calculation: Number of average hours per month spent by adult enrolled index participants in education programs one year post enrollment minus the average hours per month spent by adult enrolled index participants in education programs in month of enrollment
Data Source	Collected by home visitor in month of enrollment and one year post enrollment
Measurement Tool	Question: Estimate your total monthly hours spent in education programs
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database Home
	Data collection schedule: month of enrollment and one year post enrollment
	Analysis: annually
Comments/Anticipated Challenges	Education programs are defined as secondary, post secondary, trade school.

Benchmark 5: Family Economic Self Sufficiency	
Construct	4. Health Insurance status
Performance Measure	Percent of mothers and index children with health insurance
Operational Definition	Target population: Enrolled mothers and children
	Numerator: Number of mothers with health insurance plus the number of index children with health insurance.
	Denominator: Total number of enrolled mothers and children
Definition of improvement and calculation	<p>Definition of improvement: Increase or maintain the percentage of enrolled mothers and index children with health insurance at enrollment and one year post enrollment</p> <p>Calculation: The number of enrolled mothers and index children with insurance at enrollment divided by the total number of enrolled mothers and index children compared to the total number of enrolled mothers and index children with insurance at one year post enrollment divided by the total number of enrolled mothers and index children one year post enrollment</p>
Individual	
Data Source	Collected by home visitor
Measurement Tool	"Do you currently have health insurance?" "Does your child currently have health insurance?"
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visitor will ask the questions and the data entry personnel will enter the response into the database.
	Data collection schedule: Quarterly
	Analysis: Every 6 months for CQI and reported annually
Comments/Anticipated Challenges	

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	1. Number of families identified for necessary services
Performance Measure	Percentage of enrolled index families screened for necessary services
Operational Definition	Target population: Enrolled families
	Numerator: Number of enrolled families screened for necessary services
	Denominator: Total number of enrolled families
Definition of improvement and calculation Process Individual comparison	Definition of improvement: Increase or maintain at 90% of enrolled families screened for necessary services. Calculation: Number of enrolled families screened for necessary services divided by the total number of enrolled families.
Data Source	Collected by home visitor
Measurement Tool	Question: What services do you think your family needs?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: annually
Comments/Anticipated Challenges	Services: Financial, Women's Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family Planning, Clinical Specialist, Nutrition other, Respite, Child Care, Emp/Adult school, Housing, MH/Fam Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence services, Other

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	2. Number of families that required services and received a referral to available community resources
Performance Measure	Percentage of enrolled families that were screened and received a referral to available community resources
Operational Definition	Target population: Enrolled families
	Numerator: Number of enrolled families screened for necessary services and received a referral
	Denominator: Total number of enrolled families
Definition of improvement and calculation	Definition of improvement: Increase or maintain 90% of enrolled families screened for necessary services and who received a referral.
Process Individual comparison	Calculation: Number of enrolled families screened for necessary services and received a referral divided by the total number of enrolled families.
Data Source	Collected by home visitor
Measurement Tool	Question: What services has the family been referred to?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Services: Financial, Women's Shelter, Support Group, Substance Abuse Treatment, Legal, Material assistance, Family Planning, Clinical Specialist, Nutrition other, Respite, Child Care, Emp/Adult school, Housing, MH/Fam Counseling, PHN, Dental, Financial DHS, Financial Medical, Financial Food Stamps, Nutrition WIC, Nutrition EFNEP, Family Specialist, Preschool, Domestic Violence services, Other

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	3. MOUs: Number of formal agreements with other social service agencies in the community
Performance Measure	Total number of MOUs or other formal agreements home visiting implementing agencies have with other social service agencies in the community
Operational Definition	Target population: Documented MOUs or other formal agreements
	Numerator: The number of documented MOUs or other formal agreements
	Denominator: The number of social service agencies in the community
Definition of improvement and calculation	Definition of improvement: Increase or maintain the number of formal agreements with social service agencies from year 1 compared to year 2
Cohort	Calculation: Number of formal agreements
Data Source	Home visiting implementing agency's record of documented MOUs or other formal agreements
Measurement Tool	How many MOUs or other formal agreements does your agency have with other social service agencies in the community?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visiting implementing agency
	Data collection schedule: Quarterly
	Analysis: annually
Comments/Anticipated Challenges	

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	4. Information sharing: Number of agencies which home visiting provider has a clear point of contact in collaborating, including sharing information between agencies
Performance Measure	The total number of collaborating community agencies with which the home visiting implementing agencies has a clear point of contact
Operational Definition	Target population: Collaborating community agencies
	Numerator: N/A
	Denominator: N/A
Definition of improvement and calculation	Definition of improvement: Increase or maintain the number of collaborating community agencies with which the home visiting implementing agency has a clear point of contact at year 1 compared to year 2
Cohort	Calculation: Number of collaborating community agencies.
Data Source	Home visiting implementing agency's record
Measurement Tool	How many collaborating community agencies does your home visiting implementing agency have a clear point of contact with?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: Home visiting implementing agency
	Data collection schedule: Quarterly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Clear point of contact is defined as having: name, phone number, email address

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports	
Construct	5. Number of completed referrals – received report of the services provided
Performance Measure	Total enrolled families that were screened and received a referral for whom receipt of services was confirmed
Operational Definition	Target population: Enrolled families who were screened and received a referral for necessary services
	Numerator: N/A
	Denominator: N/A
Definition of improvement and calculation	Definition of improvement: Increase or maintain the total number of referrals completed by families at year 1 compared to year 2.
Cohort	Calculation: Number of completed referrals that receive a report that the service was provided.
Data Source	Home visiting implementing agency administrative record
Measurement Tool	Did you receive the service for which you were referred?
Reliability/Validity	N/A
Data Collection & Analysis Plan	Person Responsible: The home visitor will ask the question and the data personnel will enter the data in the database
	Data collection schedule: monthly
	Analysis: quarterly for CQI and reported annually
Comments/Anticipated Challenges	Confirmation is defined as family's self report

 **Early Identification Main Menu**

-   EID Billing
-   Person Information
-   Reports
-   Settings
-   Log Out
-   Exit

Logged in as: BLUE  Export EID Client File

Person Information. Before creating a client record, you should make sure that the client does not already exist in EKAHI. You can check by scrolling thru the names (which are listed in alphabetical order). There are six different types of clients: child, mother, father, caregiver, partner, and other. A client can also be a combination (i.e. mother/caregiver, father/caregiver). If you are planning on creating the client records for a family there is a preferred order in doing so (Mother/caregiver -> father->child). If the “partner” or “other” is selected in tandem with “caregiver”, they should also precede the creation of the “child” record.

 **Person Information**

Clients: Referred, Other Exported?

Name	DOB	Gender	Child	Father	Mother	Caregiver	Partner	Other	Exported?
1ST RECORD, 1ST RECORD	08/18/1990	F	No	No	Yes	Yes	No	Yes	No

Person Count: 1

Selected Person ID: Filter by: Child Father Mother Caregiver Partner Other

Search by Name: Clear Filter

Search by Person ID: Clear Filter

 **Add Person**
 From this screen you will have the ability to add a child, mother, father, caregiver, partner or other.

Person **Child Related Info**

* What type of person are you adding? (Must select at least one.)

Child
 Father
 Mother
 Caregiver
 Partner
 Other

*Last Name: *First Name:

Middle Name: *Date of Birth:
 (i.e. m/d/yyyy)

*Gender: ▼

English Speaking Ability: ▼

*Race/Ethnicity: ▼ Other Race/Ethnicity:

Race/Ethnicity 2: ▼ Other Race/Ethnicity 2:

Race/Ethnicity 3: ▼ Other Race/Ethnicity 3:

Comments:

*Required fields.

English Speaking Ability
Unknown
Not Assigned
Adequate
Needs Interpreter

Ethnicity is based on the Hawaii standard listing.

The “child related info” tab section is required only if “child” was checked. It’s important to note that the “gestational age” is used to calculate adjusted age in administering both the ASQ and ASQSE.

Description
Asian Indian
Black/African American
White/Caucasian
Chinese
Filipino
Hawaiian (including Part-Hawaiian)
Japanese
Korean
Mexican
Portuguese
Puerto Rican
Samoan
Vietnamese
Micronesian
Alaska Native
Melanesian
Not Available
Native American/American Indian
Other
Refused

 **Add Person**
 From this screen you will have the ability to add a child, mother, father, caregiver, partner or other.

Person **Child Related Info**

Child Related Information only:

*Bio Mother: ▼
 Person ID:

Bio Father: ▼
 Person ID:

Birth Facility: ▼

Birth Weight (gr): (Must be whole numbers in grams - No Text)

Gestational Age: (Must be whole numbers in weeks - No Text)

Child HAWI:

*Required field for the child record.

Going back into the client's record via "edit" mode reveals additional tabs that data is collected under.

 **Edit Person** TEST, TEST (1100001) Today's Date: 4/10/2012
DOB: 2/1/2012

Child Father Mother Caregiver Partner Other

Comm. Resource Utilization HV Referral Pregnancy
Person Child Related Info EID Screen and Assessment CPS Status

* What type of person are you adding? (Must select at least one.)

Child Father Mother Caregiver Partner Other EID Person #

*Last Name: test *First Name: test 1100001

Middle Name: *Date of Birth: 02/01/2012
(i.e. m/d/yyyy)

*Gender: Male

English Speaking Ability: Not Assigned

*Race/Ethnicity: Melanesian Other Race/Ethnicity:

Race/Ethnicity 2: Not Assigned Other Race/Ethnicity 2:

Race/Ethnicity 3: Not Assigned Other Race/Ethnicity 3:

Comments:

*Required fields.



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

INTRA-DEPARTMENTAL DIRECTIVE 04-01
May 3, 2004 Page 1 of 5

TO: All Deputies, Division and Branch Chiefs, Staff Officers, District Health Officers, and Administrators of Attached Agencies

FROM: Chiyome Leinaala Fukino, M.D.
Director of Health *Chiyome Leinaala Fukino*

SUBJECT: INTERPERSONAL RELATIONSHIPS BETWEEN STAFF AND CLIENTS/PATIENTS

04-1.1 PURPOSE

This directive provides the policy for the State of Hawaii, Department of Health on interpersonal relationships between staff and clients/patients.

04-1.2 POLICY

- A. Staff shall not use their professional position to exploit others for any reason.
- B. Staff shall avoid engaging in dual/multiple relationships with clients/patients or former clients/patients. When dual/multiple relationships are unavoidable, staff shall take steps ensure that the nature of the dual/multiple relationship shall neither harm nor exploit the client/patient.
- C. Sexual relationships with any client/patient or former client/patient are prohibited. Staff shall not have financial relationships with clients/patients or former clients/patients.

- D. Staff are prohibited from engaging in sexual relationships with clients/patients' relatives or other individuals with whom clients/patients maintain close personal relationships, or to whom clients/patients are reliant upon. Staff are required to set clear, appropriate and culturally sensitive boundaries.
- E. Staff shall neither initiate, assume, nor maintain a treatment relationship to individuals with whom they have had prior sexual relationships. Staff shall inform their supervisor if there have been past relationships with potential clients/patients and arrange to have the care of such patients/clients provided by another qualified staff person.
- F. Staff shall not engage in physical contact with clients/patients when there is a possibility of psychological harm to the clients/patients as a result of the contact (such as cradling or caressing clients/patients). In providing services, staff who are required to have physical contact with clients/patients are responsible for setting clear, appropriate and culturally sensitive boundaries that govern such physical contact.
- G. Staff who anticipate the potential for sexual relationships with former clients/patients shall consult in depth with their supervisors, exploring the various risks and concerns.

04-1.3 SCOPE

This directive applies to all Department of Health employees, including volunteers, who provide treatment and/or services and individuals or agencies that are contracted to provide treatment and/or services on behalf of the Department of Health.

04-1.4 DEFINITIONS

Clients/Patients:	Persons under observation, care, treatment, or receiving services.
Department:	Department of Health
Director:	Director of Health

Dual/multiple relationships:	When an employee has, or has had, more than one relationship with a patient or client, either presently or in the past. These may include professional, business, social, or personal relationships. Dual/multiple relationships can occur simultaneously or consecutively.
Staff:	Department employees, including volunteers, and individuals or agencies that are contracted to provide services on behalf of the Department.
Health:	Includes physical and mental health.
Providers:	Any persons, public or private vendors, agencies, or business concerns authorized by the department to provide health care, services, or activities.
Services:	Appropriate assistance provided to a person with a medical illness, developmental disability, mental illness, substance abuse or dependency disorder, or mental retardation. These services include, but are not restricted to assessment, case management, care coordination, treatment, training, vocational support, testing, day treatment, dental treatment, residential treatment, hospital treatment, developmental support, respite care, domestic assistance, attendant care, habilitation, rehabilitation, speech therapy, physical therapy, occupational therapy, nursing counseling, family therapy or counseling, interpretation, transportation, psychotherapy, and counseling to the person and/or to the person's family, guardian or other appropriate representative.
Treatment:	The broad range of services and care, including diagnostic valuation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, career counseling, and other special services which may be extended to a person in need or with a disabling condition.

04-1.5 **RESPONSIBILITIES**

- A. **Director:** Insure this policy is maintained, interpreted, updated, and communicated to all program managers.

- B. **Deputy Directors:** Insure this policy is communicated to, understood and implemented by program managers within their administrations, and insure needed revisions of this policy are communicated to the Director.

- C. **Program Managers:**
 - (1) Insure this policy is communicated to and understood by all vendors, providers, or contractors, and insert a reference to this policy in appropriate contracts.

 - (2) Insure this policy is enforced.

 - (3) Investigate alleged or reported infractions of this policy and take corrective actions as may be indicated.

 - (4) Recommend needed changes to this policy to their Deputy Directors.

- D. **Employees:** Comply with this policy and report alleged infractions of this policy to their supervisors or superiors.

- E. **Providers:** Insure this policy is communicated, understood, and implemented.

04-1.6 **PROVISIO**

If there is a conflict between this policy and a collective bargaining agreement, the collective bargaining agreement shall prevail.

04-1.7

REFERENCES

- A. Discrimination in Public Accommodations, Chapter 489, Hawaii Revised Statutes, as amended.
- B. Fair treatment, Section 84-13, Hawaii Revised Statutes, as amended.
- C. Rights of persons with developmental or mental retardation, Section 333F-8, Hawaii Revised Statutes, as amended.
- D. Rights of recipients of mental health services, Chapter 334E, Hawaii Revised Statutes, as amended.
- E. Sex Discrimination, Title 12, Chapter 46, Subchapter 4, Hawaii Administrative Rules, as amended.
- F. Disability Discrimination, Chapter 46, Subchapter 9, Hawaii Administrative Rules.

This document should be placed in the Personnel Manual of Policies and Procedures under Section 11, SUBJECT: EMPLOYEE RELATIONS.

Hawaii Home Visiting Network Home Visiting (HV) Billing Definitions

Billing definitions are subject to change by DOH MCHB

Direct Service			
Home Visiting Network Service Description	Limitations	Documentation	MCHB Billable
<p>Prenatal Services: Services provided to pregnant women in home visiting programs.</p>	<ol style="list-style-type: none"> 1. Face-to-face home visit time with eligible pregnant women and family only. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented 	<ol style="list-style-type: none"> 1. Intake 2. Family Service Plan (FSP) 3. Parenting education 4. Crisis intervention 5. Family strengthening activities 6. Administer/discuss screening tools 7. Administer/discuss scales 8. Administer/discuss assessments 9. Administer/discuss pre- post-tests
<p>Home Visit: A scheduled or unscheduled home visit with eligible children and family (ideally should include the target child).</p>	<ol style="list-style-type: none"> 1. Face-to-face home visit time with eligible child or family only. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 2. Home visits must be documented on the Family Service Plan (FSP) 3. Agency time sheet log 	<ol style="list-style-type: none"> 1. Intake 2. FSP 3. Parenting education 4. Crisis intervention 5. Family strengthening activities 6. Parent/child interaction activities 7. Transition activities 8. Administer/discuss developmental screening 9. Administer/discuss screening tools 10. Administer/discuss scales 11. Administer/discuss assessments 12. Administer/discuss pre- post-tests

Hawaii Home Visiting Network Home Visiting (HV) Billing Definitions

Billing definitions are subject to change by DOH MCHB

Direct Service			
Home Visiting Network Service Description	Limitations	Documentation	MCHB Billable
<p>Child Team Meeting: Scheduled meeting for substantive discussion regarding a family and child's progress or lack of progress.</p>	<ol style="list-style-type: none"> 1. This should include as many Family Service Plan (FSP) team members as necessary and appropriate. The Child Team meeting is NOT a part of the FSP meeting, although the FSP meeting may be scheduled as a result of the Child Team meeting. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 2. Agency time sheet log 	<ol style="list-style-type: none"> 1. Discuss FSP progress or lack of progress 2. Discuss developmental screening 3. Discuss screening tools 4. Discuss scales 5. Discuss assessments 6. Discuss pre- post-tests
<p>Groups: Professional facilitation of group activities to support the child's or family's goals on their Family Service Plan (FSP)</p>	<ol style="list-style-type: none"> 1. Group participation by consumer must be indicated as an intervention on the FSP. 2. Only time the home visitor spent in face-to-face group activities with an eligible child or family. 3. Clean-up time or time to develop materials are not included in this category 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 2. Group activities must be documented on the FSP. 3. Records should indicate number and names of group attendees. 	<ol style="list-style-type: none"> 1. Face-to-face group activities with an eligible child or family.

Hawaii Home Visiting Network Home Visiting (HV) Billing Definitions

Billing definitions are subject to change by DOH MCHB

Direct Service			
Home Visiting Network Service Description	Limitations	Documentation	MCHB Billable
<p>Preparation Time: Time for preparation for home visit service activities.</p>	<ol style="list-style-type: none"> 1. Time reflected will be monitored by MCHB 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 2. Agency time sheet log 	<ol style="list-style-type: none"> 1. Gathering materials 2. Planning activities 3. Logistical planning/preparation 4. Referrals - telephone contact and other means of electronic communication with other agencies/organizations. 5. Telephone contact and other means of electronic communication with family. 6. Documentation in progress case notes.
<p>Outreach: “No Show” for a scheduled or unscheduled home visit, regardless of the home visit scheduled in the home or outside of home and the child and/or caregiver is not present. Unscheduled drop-in home visits, telephone or electronic communication may be used to reconnect with the family and reschedule regular home visits.</p>	<ol style="list-style-type: none"> 1. May be a “No Show” with a maximum waiting time of 15 minutes or a cancellation, if the cancellation occurred within twenty-four (24) hours of scheduled visit. 2. Unscheduled drop-in visits 3. Telephone contact and other means of electronic communication to reschedule visits. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 	<ol style="list-style-type: none"> 1. 15 minutes No Show 2. 15 minutes Cancellation within 24 hours of scheduled visit 3. Unscheduled drop-in home visits to reconnect with the family and reschedule home visits 4. Telephone contact and other means of electronic communication with family.
<p>Travel: Time necessary for the home visitor to travel to and from a home or community site to provide services.</p>	<ol style="list-style-type: none"> 1. Travel time is between program site and service site, OR between home visitors home and service site when time and distance is a factor. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 	<ol style="list-style-type: none"> 1. Travel time between program site and service site. 2. Travel time between home visitors home and service site.
Indirect Service			

Hawaii Home Visiting Network Home Visiting (HV) Billing Definitions

Billing definitions are subject to change by DOH MCHB

Home Visiting Network Service Description	Limitations	Documentation	MCHB Billable
<p>Supervision: Supervision is provided to support and assist the home visitor in learning the skills necessary to meet the needs of the family. Supervision may include Administrative, Clinical and or Reflective Supervision.</p>	<ol style="list-style-type: none"> 1. Minimum of one and a half (1.5) hours per home visitor per week. 2. Billed by home visitor for time spent with supervisor for weekly supervision. 3. Does <u>NOT</u> include staff meetings or group supervision. 	<ol style="list-style-type: none"> 1. Case notes – Start and End time must be documented. 2. Supervisor or home visitor personnel files 3. Supervisory notes should minimally document issues, concerns discussed. 	<ol style="list-style-type: none"> 1. Individual supervision
<p>Orientation: Training new employees ninety (90) days following date of hire.</p>	<ol style="list-style-type: none"> 1. Cannot exceed five (5) hours per day. 2. Use other categories when applicable, such as supervision, family training, child team meeting and groups. 	<ol style="list-style-type: none"> 1. Orientation notes – Start and End time must be documented. 2. Case notes- Start and End time must be documented 	<ol style="list-style-type: none"> 1. Orientation training not to exceed five (5) hours per day.
<p>Professional Development: Annual clock hour requirements as required by home visiting model for continued funding, recertification or accreditation.</p>	<ol style="list-style-type: none"> 1. Model specific training 2. Hawaii Home Visiting Network wrap-around training 3. Agency specific training 	<ol style="list-style-type: none"> 1. Home visitor personnel files 	<ol style="list-style-type: none"> 1. Clock hour in model specific, agency specific or wrap-around training

**Hawaii Home Visiting Network Home Visiting
Cost Proposal**

<p style="text-align: center;">Total Budget Request</p> <p style="text-align: center;">Form SPO-H-205 (Total Personnel Costs + Other Current Expenses + Equipment Purchases + Motor Vehicle Purchases)</p>	
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<p>Total Estimated Families Served Per Year</p> <p>(Specify if families served are newly enrolled in the current fiscal year, or if the families served includes carry-over from the previous fiscal year)</p>	
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<p style="text-align: center;">Caseload Goal</p> <p>(number of families receiving services at any moment in time if the Program were operating with a full complement of home visitors hired and trained)</p>	
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<p style="text-align: center;">Average Direct Service Hours Per Family Per Month</p> <p>(Refer to Attachment G for definition of Direct Service Hours)</p>	
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<p>Total Average Direct Service Hours Per Month</p>	
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<p style="text-align: center;">Total Estimated Cost Per Family Per Year</p> <p>(Total Budget Request ÷ Total Estimated Families Served Per Year)</p>	
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CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this application, the prospective primary participant as defined in 45 CFR Part 76 is providing certification regarding debarment and suspension as set out in Appendix A of 45 CFR Part 76. The applicant agrees that by submitting this application it will include, without modification, the clause in Appendix B of 45 CFR Part 76 in all lower tier covered transaction and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76. Should the applicant not certify regarding debarment and suspension, an explanation as to why should be placed after the assurances page in the application package.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

By signing and submitting this application, the applicant is providing certification regarding drug-free workplace requirements as set out in Appendix C to 45 CFR Part 76. For purposes of notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The authorized official signing for the applicant organization certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The official signing agrees that the applicant organization will comply with the DHHS, PHS, and OPHS terms and conditions of award if a grant is awarded as a result of this application.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

OPHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS and OPHS mission to protect and advance the physical and mental health of the American people.

Organization Name

Name of Authorized Representative

Title

Signature

Date

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C – Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan or loan guarantee. The law does not apply to children’s services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this document the applicant/grantee certifies that it will comply with the requirements of the Act. The applicant/grantee further agrees that it will require the language of this certification be included in any subawards which subgrantees shall certify accordingly.

Organization Name

Name of Authorized Representative

Title

Signature

Date