

**Idaho MIECHV Program Benchmarks Plan  
 FY10 Updated State Plan and FY11 Formula Grant  
 April 6<sup>th</sup>, 2012**

The MIECHV program has included requirements to collect all benchmark and demographic data in the contracts with the local service delivery agencies. Demographic data including parent and child age, employment, race, ethnicity, income, education, and primary language spoken in the home will be required at intake for families enrolling in the program. Additionally, home visitors will be required to document screening, assessments, and track referrals made and completed in the MIECHV data system. The MIECHV program has established a data sharing agreement in the form of a Memorandum of Understanding with the Idaho Child Welfare program to exchange administrative data with the child welfare program for linkage and analysis by the MIECHV program. The following are identified screening and assessment tools will be used to measure the constructs defined in Benchmarks Plan. Screening Tools Used: Edinburgh Postnatal Depression Scale, Home Observation for Measurement of the Environment (HOME) Inventory, Everyday Stressors Index, Ages and Stages Questionnaire -3, Ages and Stages Questionnaire – Social Emotional. Local service delivery agencies will also be required to implement the Protective Factors Survey, though not included in the benchmarks plan.

The Idaho MIECHV program has contracted with Social Solutions, LLC to develop an “Efforts to Outcomes” (ETO) enterprise as the data and performance management system for all local MIECHV implementing agencies (“Contractors”). The Idaho MIECHV program is in the midst of the blueprint and configuration process, which includes organizing the forms and assessment tools according the typical and expected processes of the local Contractors. The Idaho MIECHV will enter into the State Contract negotiation process with Nurse-Family Partnership (NFP) within the coming months to outline a data sharing agreement between the NFP ETO and Idaho MIECHV ETO sites.

Clarification: Within the benchmarks plan, the term case file and case file review denotes data which will be extracted from the data system from individual clients (case) electronic files into report forms. Case files are considered the electronic information maintained for individual clients within the NFP and Idaho MIECHV ETO systems, which includes NFP NHV data forms, demographic data, and other client information. For the benchmarks plan, case file review will be completed by the State MIECHV Program staff at the Idaho Department of Health and Welfare or State MIECHV Program contracted evaluation staff at Boise State University from aggregated data extracted from the NFP and Idaho MIECHV ETO systems. In the context of performance monitoring, case file review generally means review and analysis of the entire caseload or individual client files by supervisors and home visitors to assess client progress and program performance.

Idaho has established contractors with four local service delivery agencies to deliver evidence-based home visiting in the target counties in Idaho.

	<i>Kootenai and Shoshone Counties</i>	<i>Twin Falls and Jerome Counties</i>
Panhandle Health District & Spokane Regional Health District	NFP	
Mountain States Group,	EHS	

	<i>Kootenai and Shoshone Counties</i>	<i>Twin Falls and Jerome Counties</i>
St. Vincent de Paul	PAT	
Community Council of Idaho		EHS

## Forms & Data Collection

### Nurse-Family Partnership Data Collection:

- Demographics Update (Form 5.0) –Enrollment, then 6, 12, 18, 24 months of child’s age
- Edinburgh Postnatal Depression Scale (EPDS) (Form 7.0) intake, 36 weeks pregnant, 1-4 weeks postpartum, 4-6 months, 12 months and as needed
- Health Habits Form (Form 8.0) 3<sup>rd</sup> or 4<sup>th</sup> visit, 36 weeks pregnant, then 12 months of child’s age
- Infant Health Care From (Form 11.0) 6, 12, 18, 24 months
- Maternal Health Assessment: Pregnancy – Intake (Form 12.0) – intake
- Patient Health Questionnaire – 9 (PHQ – 9) (Form 13.0) intake, 36 weeks pregnant, 1-4 weeks postpartum, 4-6 months, 12 months and as needed
- Relationship Assessment: Pregnancy – Intake (Form 14.0)
- Relationship Assessment: Pregnancy – 36 weeks (Form 15.0)
- Relationship Assessment: Infancy – 12 months (Form 16.0)
- Use of Government and Community Services (Form 17.0) intake, 1<sup>st</sup> postpartum visit, then 6, 12, 18, 24 months of child’s age
- Home Visit Encounter Form (Form 9.0) – Every visit

### Idaho MIECHV ETO Forms for EHS and PAT:

- Primary Caregiver Intake – Enrollment and every 12 months thereafter
- Index Child Intake – Enrollment (or birth)
- Other Household Member Intake - Enrollment (for referral tracking) and as appropriate thereafter
- Other Child Intake - Enrollment (for referral tracking) and as appropriate thereafter
- Maternal Health: Intake and every 6 months thereafter
- Child Health Form: Intake (or birth) and every 6 months (of age) thereafter: 6, 12, 18, 24, 30, 36, 42, 48, 54 months
- Home Visit Encounter Form: Every Visit
- Future Without Violence: Relationship Assessment Tool – within 3 months of enrollment and every year thereafter
- Ages and Stages Questionnaire – 3<sup>rd</sup> Edition – at 6 months of age and every 6 month interval thereafter
- Ages and Stages Questionnaire – Social Emotional – at 6 months of age and every 6 month interval thereafter
- HOME Inventory – Early Childhood and Infant/Toddler
- Everyday Stressors Index
- Edinburgh Postnatal Depression Scale
- Social and Violence History Form (Optional)
- Parents as Teachers Parent Knowledge Assessment (optional)

Idaho has defined the following reporting years and cohorts for reporting and analysis of benchmarks related data:

- CO1 Cohort 1 = June 1<sup>st</sup>, 2012 – May 31<sup>st</sup>, 2013
- CO2 Cohort 2 = June 1<sup>st</sup>, 2013 – May 31<sup>st</sup>, 2014
- CO3 Cohort 3 = June 1<sup>st</sup>, 2014 – May 31<sup>st</sup>, 2015
- CO4 Cohort 4 = June 1<sup>st</sup>, 2015 – May 31<sup>st</sup>, 2016
- CO5 Cohort 5 = June 1<sup>st</sup>, 2016 – May 31<sup>st</sup>, 2017

**Benchmarks, Constructs, Measures and Definitions for all Constructs required for the MIECHV Program**

Measure	Definition of improvement	Data Source & Population	When	Justification
<b>BENCHMARK AREA 1: Maternal and Newborn Health</b>				
<b>Construct 1.1: Prenatal Care</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of enrolled pregnant women who received information on the recommended schedule of prenatal care visits within four weeks of program participation</p> <p><i>Denominator:</i> Number of enrolled pregnant women</p> <p><i>Definition of Recommended Schedule of Prenatal Care Visits:</i> Every 4 weeks for the first 28 weeks, every 2-3 weeks between 28 and 36 weeks, weekly until birth</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled pregnant women who received information on the recommended schedule of prenatal care visits within four weeks of program participation</p>	<p><u>Method:</u> Home visitor discusses recommended schedule of prenatal care visits with client during home visit</p> <p><u>Target Population:</u> Pregnant women who give birth during CO1 &amp; CO2</p> <p><u>Case Files:</u> NFP: <i>Maternal Health Assessment (Form 12.0)</i> EHS: ETO Form: Maternal Health Form and Home Visiting Encounter Form PAT: ETO Form: Maternal Health Form and Home Visiting Encounter Form</p> <p><i>(Date Prenatal Care Initiated and Estimated Due Date: MM-DD-YYY)</i></p>	<p>Women enrolled in the program prenatally</p> <p><u>Cohort change:</u> Compare the percentage of pregnant women enrolled in CO1 and CO2 who received information on the recommended schedule of prenatal care visits within four weeks of program participation</p>	<p>This method allows for collection of information about whether pregnant women are likely to receive recommended prenatal care. Percentage of pregnant women receiving information on the recommended schedule of prenatal care visits constitutes a continuous variable that is sensitive to small amounts of incremental change.</p>
<b>Construct 1.2: Preconception Care</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> The average multiple vitamin score for all non-pregnant women (15-45 years old) at intake</p>	<p>Increase from intake to 6 months (for non-pregnant women who are ≥6 months postpartum at</p>	<p><u>Method:</u> Field interview Questions: 1. Are you currently taking a</p>	<p>Non-pregnant women who are enrolled in the program asked about multiple vitamin use at</p>	<p>This self-reported measure assesses women’s health and preconception care behaviors. It</p>

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<p>and 6 months of program participation for women who are ≥6 months postpartum at enrollment OR at 6 and 12 months postpartum for women who are pregnant or &lt;6 months postpartum at enrollment</p>	<p>enrollment) OR at 6 to 12 months postpartum (for women who are pregnant or &lt;6 months postpartum at enrollment) the average multiple vitamin score for non-pregnant women (15-45 years old) enrolled in the program</p>	<p>multiple vitamin? If no, Score=0 If yes, then ask: 2. How many times a week do you take a multiple vitamin (a pill that contains many different vitamins and minerals)? a) 1 to 3 times a week (Score = 1) b) 4 to 6 times a week (Score = 2) c) Every day of the week (Score = 3)</p> <p><u>Target Population:</u> Non-pregnant women of childbearing age (15-45 years)</p> <p><u>Case Files:</u> NFP: <i>Maternal Health Assessment (Form 12.0)</i> EHS: ETO Form: Maternal Health Form PAT: ETO Form: Maternal Health Form</p> <p><i>Current and historical use of pre-natal or multiple vitamin (Yes, No, Conditional if yes frequency: Score 1 for 1 to 3 times a week; Score 2 for 4 to 6 times a week; Score 3 for every day of the week)</i></p>	<p>intake and 6 months (for non-pregnant women who are ≥6 months postpartum at enrollment) OR at 6 to 12 months postpartum (for women who are pregnant or &lt;6 months postpartum at enrollment)</p> <p><u>Individual change:</u> The average multiple vitamin score at intake and 6 months compared for all non-pregnant women participating in the program and the average multiple vitamin score at 6 and 12 months postpartum compared for all women who were pregnant when they enrolled in the program</p>	<p>is relevant, cost-effective to support Title V priorities as there are few standardized tools that could be used to measure this construct. Validity and reliability are not known for this measure.</p> <p>It is expected that multiple vitamin use education occurs after the first measurement.</p>
<b>Construct 1.3: Parental Use of Tobacco</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of women enrolled in CO1 and CO2 who screened positive for smoking at intake who received information on risks associated with smoking within 6 months of program participation</p>	<p>Increase or maintain from CO1 to CO2 the % of women who screen positive for smoking at intake who received information on risks associated with smoking within 6 months of program participation</p>	<p>Home visitor discusses the risks associated with smoking with client during home visit</p> <p><u>Population:</u> Women who screened positive for smoking at intake</p> <p><u>Case Files:</u></p>	<p><u>Cohort Change:</u> Compare the % of women enrolled in CO1 and CO2 who screened positive for smoking at intake who received education on risks associated with smoking within 6 months of program participation</p>	<p>This process measure will assess education and information with parents screening positive for smoking regarding the risk of smoking. The MIECHV program anticipates also collecting information on smoking rates throughout the program.</p>

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<i>Denominator:</i> Number of women enrolled in CO1 and CO2 who screened positive for smoking at intake		NFP: <i>Home Visit Encounter Form (Form 9.0)</i> EHS: ETO Form: Home Visit Encounter Form (Drop-down topics Addresses) PAT: ETO Form: Home Visit Encounter Form (Drop-down topics Addresses)  ETO Form Maternal Health <i>Cigarette Use</i> (Exclusive, drop-down, yes/no – number: Current, Before (if pregnant) and During Pregnancy) and NFP Health Habits Form: Form 8.0		
<b>Construct 1.4: Inter-birth Intervals</b>				
<b>Source: Program, Type: Process</b>				
<i>Numerator:</i> Number of mothers and/or fathers of children birth – 2 years old enrolled in the program who received education related to optimum birth spacing (2+ years between births) within 6 months of program enrollment  <i>Denominator:</i> Total number of mothers and/or fathers enrolled in the program	Increase or maintain from CO1 to CO2 the % of mothers and/or fathers receiving any education on optimal birth spacing within 6 months of program enrollment	<u>Method:</u> Home visitor discusses the optimum birth spacing with client during home visit  <u>Target Population:</u> Mothers and/or fathers (caregivers) enrolled in the program  <u>Case Files:</u> NFP: Edinburgh Postnatal Depression Scale (EPDS) (Form 7.0) EHS: ETO Form: Home Visit Encounter Form (Drop-down topics Addresses) PAT: ETO Form: Home Visit Encounter Form (Drop-down topics Addresses)	Documented throughout program participation; case files reviewed at 6 months post-enrollment  <u>Cross-sectional change:</u> Compare the percentage of mothers and/or fathers who received education on optimal birth spacing in CO1 and CO2 within 6 months of program enrollment	This measure will indicate education related to family planning provided by home visitor when family has a child between 0-2 years old. Validity and reliability are not known for this measure.
<b>Construct 1.5 Post-Partum Depression (PPD) Screening</b>				
<b>Source: Program, Type: Process</b>				
<i>Numerator:</i> Number of women screened for post-partum	Increase or maintain from CO1 to CO2 the percentage of mothers	<u>Method:</u> Mother self-report using printed EPDS	Within 45 days after delivery and 6 months post-delivery	The EPDS is widely used to screen for post-partum depression.

Measure	Definition of improvement	Data Source & Population	When	Justification
<p>depression (PPD) using the Edinburgh Postnatal Depression Scale (EPDS) within 45 days after delivery AND at 6 months post-delivery</p> <p><i>Denominator:</i> Number of enrolled women within 45 days of delivery</p>	<p>enrolled in the program within 45 days after delivery who were screened for PPD within 45 days after delivery and 6 months post-delivery</p>	<p><u>Population:</u> Mothers who enrolled in the program within 45 days after delivery</p> <p><u>ETO system</u> (rate of completed screening):  NFP: <i>Home Visit Encounter (Form 9.0)</i>  EHS: ETO Form EPDS  PAT: ETO Form EPDS</p>	<p><u>Cohort change:</u> Compare the percentage of mothers enrolled in CO1 and CO2 who were screened with EPDS within 45 days after delivery AND at 6 months post-delivery</p>	<p>When indicated with a score of 12-13 on the 10-item non-standardized self-report scale, home visitors should refer to further counseling or treatment. The scale can be reproduced at no cost with appropriate citation during publication, and is therefore a cost effective tool. This process measure will likely be used as a CQI measure for local contractors. Multiple studies have demonstrated validity and reliability of EPDS during pregnancy and prenatally.</p>
<b>Construct 1.6: Breastfeeding</b>				
<b>Source: Program, Type: Outcome</b>				
<p><u>Calculation:</u> The average number of weeks mothers breastfed at 6 months after delivery in CO1 and CO2 will be compared</p>	<p>Increase from CO1 to CO2 the average number of weeks mothers breastfed at 6 months after delivery</p>	<p><u>Method:</u> Field interview with mother</p> <p>1. How many weeks or months did you breastfeed or pump milk to feed your new baby?  ____weeks OR ____months</p> <p><u>Population:</u> Mothers who gave birth during program participation</p> <p><u>Case Files</u> (interview recorded in case files):  NFP: <i>Infant Birth (Form 10.0)</i>  EHS: ETO Form Child Health Form  PAT: ETO Form Child Health Form  <i>Initiation of Breastfeeding</i> (Conditional if infant &lt; 6 months, Exclusive, Drop-Down: yes/no and conditional if no reason: work, time, preference for formula/food, age of child, lack of support, other),  <i>Length of Exclusive Breastfeeding or pumping</i> (if infant &lt; 6 months) (Numeric), and <i>Termination of</i></p>	<p>At 6 months after delivery</p> <p><u>Cross-sectional change:</u> Compare the average number of weeks mothers breastfed at 6 months after delivery in CO1 and CO2</p>	<p>Few standardized tools available for this indicator.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		<i>breastfeeding</i> (Date, MM-DD-YYYY and reason: work, time, preference for formula/food, age of child, lack of support, other)		
<b>Construct 1.7: Well-child Visits</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> The average number of recommended well-child visits accessed at 6 months of age for target child enrolled in the program in CO1 and CO2</p> <p><i>Definition of well-child visits according to Bright Futures Visits: 1st week, by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 year, 2 ½ year, 3 year, 4 year, 5 year</i></p> <p><i>Up to date is defined as: completed well-child visit within 2 weeks of child's age (before or after) for first two years and 6 weeks from two – five years</i></p>	<p>Increase from CO1 to CO2 the average number of recommended well-child visits accessed at 6 months of age for all children enrolled in the program in CO1 and CO2</p>	<p><u>Method:</u> Field interview with mother</p> <p><u>Question (EHS &amp; PAT):</u></p> <p>1. Did you take your child to his/her ___ well-child visit:</p> <p>a) 1 week b) 1 month c) 2 months d) 4 months</p> <p><u>Question (NFP):</u></p> <p>1. Have you taken (child's name) for a well-child check-up in the last 6 months?</p> <p><b>Yes</b> _____</p> <p>If yes, please indicate which of these well-child visits were completed; check all that apply:</p> <p>a) 48-72 hours after birth b) By 1 month old c) 2 months old d) 4 months old e) 6 months old f) 9 months old g) 12 months old h) 15 months old i) 18 months old j) 24 months old k) Scheduled but not completed</p> <p><b>No</b> _____</p> <p><u>Population:</u> Target children between 6 and 12 months of age; mothers reporting</p>	<p>This self-report measure will be taken at 6 months of age for target child if enrolled prenatally or between 6 and 12 months of age if child is &gt;6 months and ≤12 months at enrollment)</p> <p><u>Cohort change:</u> Average number of recommended well-child visits accessed at 6 months of age for all target children enrolled in the program in CO1 and CO2</p>	<p>Idaho Medicaid utilized the Bright Futures – AAP guidelines as the guidance to providers for EPSDT and well-child visit schedule. There are few validated surveys relevant to this measure. Validity and reliability are not known for this measure. This is a Title V priority.</p> <p>This construct is context dependent. An assessment of community resources and services (number and type of clinics and health care providers, health insurance, policy changes, economic changes, etc.) will be conducted at the end of every implementation year to assess which community-level factors influence the outcome of the program.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		<p><u>Case Files</u> (records of mother's response to interview questions recorded in case files):  NFP: <i>Infant Health Care (Form 11.0)</i>  EHS: ETO Form Child Health Form  PAT: ETO Form Child Health Form  <i>Well child visit at AAP Bright Future's Recommended Visit Schedule (Non-Exclusive Check-list: 1st week, by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 year, 2 ½ year, 3 year, 4 year, 5 year)</i> shown when appropriate for child's age,  <i>Immunization Status</i> (Immunization Schedule Up to Date: Either Non-Exclusive checklist with schedule, or Exclusive drop-down: Yes/No, conditional if no, reason: Non-immunization: Religion, Government, Non-immunization Personal, Not Up-To-Date)</p>		

**Construct 1.8: Maternal and Child Insurance Status**

**Source: Program, Type: Process**

<p><i>Numerator:</i> Number of enrolled uninsured women and target children referred for insurance coverage (DHW – Medicaid, other provider) between intake and 6 months post-enrollment or 6 months post-delivery within 1 month of determination of insurance status for women who were pregnant at intake</p> <p><i>Denominator:</i> Number of enrolled women and target children without credible health insurance in the same reporting year</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled women and target children without credible health insurance referred for insurance coverage at 6 months post-enrollment or 6 months post-delivery within 1 month of determination of insurance status for women who were pregnant at intake</p>	<p><u>Method:</u> Home visitor refers clients for health insurance coverage during home visit</p> <p><u>Population:</u> Target children and expectant mothers and mothers with no credible health insurance, as reported by caregivers</p> <p><u>Case Files</u> (record of responses in case file):  NFP: <i>Use of Government &amp; Community Services (Form 17.0)</i>  EHS: Child Insurance: ETO Child Health Form</p>	<p>Insurance status collected at intake (within first 4 visits) or post-delivery (for women who were pregnant at intake) and 6 months to determine if a referral has been made within 1 month of determination of insurance status</p> <p><u>Cohort change:</u> Compare the % of uninsured women and target children enrolled in CO1 and CO2 who were referred for insurance coverage at 6 months of program participation or 6 months post-delivery within 1 month of</p>	<p>There are few tools to assess maternal and child health insurance status – this is a cost effective and relevant way to measure this indicator. Validity and reliability are not known for this measure.</p> <p>Because maternal Medicaid eligibility in Idaho expires at the end of the month in which a mother's 60<sup>th</sup> postpartum day falls, this construct will be defined as a process indicator only.</p>
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Measure	Definition of improvement	Data Source & Population	When	Justification
<p><i>Note: Idaho definition of credible health insurance: Coverage that provides benefits for inpatient &amp; outpatient hospital services and physician's medical and surgical services. Credible coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. IDAPA 16.03.01</i></p>		<p>PAT: Child Insurance: ETO Child Health Form</p> <p>Child Health Form: <i>Health Insurance status</i> (Yes/no and conditional if yes, type: None, Health insurance or HMO, Medicaid, Medicare, TRICARE or other military health care (CHAMPUS), Indian Health Service (HIS), SCHIP or CHIP, Other source with free text)</p>	<p>determination of insurance status for women who were pregnant at intake</p>	
<p><b>BENCHMARK AREA 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits</b></p>				
<p><b>Construct 2.1: Child Visits to Emergency Department (ED) all causes</b></p>				
<p><b>Source: Program, Type: Outcome</b></p>				
<p>The average number of child visits to ED for any cause for all target children enrolled in the program in CO1 and CO2 will be compared, at 12 months of age for children enrolled at birth or 12 months of program participation for children enrolled post-delivery</p> <p><i>Data will be collected for the following age categories:</i></p> <ul style="list-style-type: none"> <li>• 0-12 months</li> <li>• 13-36 months</li> <li>• 37-72 months</li> </ul>	<p>Decrease the average number of child visits to ED for any cause at 12 months of age or 12 months of program participation for all target children enrolled in the program in CO1 and CO2</p>	<p><u>Method:</u> Field interview</p> <p><u>Question:</u></p> <ol style="list-style-type: none"> <li>1. How many times did your child visit the ED in the past 6 months?</li> </ol> <p><u>Population:</u> Target children 12 months of age or 12 months post-enrollment</p> <p><u>Case Files</u> (as recorded by home visitor):  NFP: <i>Infant Health Care (Form 11.0)</i>  EHS: ETO Child Health Form  PAT: ETO Child Health Form</p> <p><i>Use of Emergency Services – injury or ingestion (Exclusive, Drop Down – Yes/No if yes, number of visits within last 6 months (numeric) and reason free-text single line if yes), Use of Emergency Services for other causes (Exclusive, Drop Down – Yes/No if yes, number of visits within last 6 months and reason</i></p>	<p>This self-reported data will be collected in field interview with mothers during home visit at intake and every 6 months of program participation; the aggregate from the two forms collected at 6 and 12 months will be used for benchmark reporting.</p> <p><u>Cohort change:</u> Average number of child visits to ED at 12 months of age or 12 months post-enrollment for all target children enrolled in the program in CO1 and CO2</p>	<p>ED utilization data is especially difficult to assess in Idaho. Idaho does not collect hospital discharge or emergency department data for all hospitals or within in any state data repository. Research indicates that home visiting improves health literacy as well as appropriate use of ED. Validity and reliability are not known for this measure.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		free-text single line if yes), <i>Hospital Admission</i> (Exclusive, Drop Down – Yes/No and reason free-text single line if yes)		
<b>Construct 2.2: Maternal visits to Emergency Department (ED) all causes</b>				
<b>Source: Program, Type: Outcome</b>				
<i>Calculation:</i> The average number of maternal visits to ED for any cause at 6 months and 18 months of program participation	Decrease from 6 months to 18 months the average number of maternal visits to ED for any cause for mothers enrolled in the program	<p><u>Method:</u> Field Interview</p> <p>Question:</p> <p>1. How many times did you visit the ED for your own care in the past 6 months?</p> <p><u>Population:</u> Expectant mothers and mothers</p> <p><u>Case Files</u> (self-report by mother tracked in home visit log): NFP: <i>Demographics Update (Form 5.0)</i> EHS: ETO Maternal Health Form PAT: ETO Maternal Health Form</p> <p><i>Use of Emergency Services</i> in past 6 months (Exclusive, Drop Down – Yes/No, number of visits within last 6 months (numeric) and date and reason if yes)</p>	<p>This self-reported data will be collected in field interview with mothers during home visit; data collected approximately every 6 months during service delivery.</p> <p><u>Individual change:</u> Compare the average number of maternal visits to the ED for any cause at 6 months and 18 months post-enrollment</p>	ED utilization data is especially difficult to assess in Idaho. Idaho does not collect hospital discharge or emergency department data for all hospitals or within in any state data repository. Women will self-report this data as there are few standardized tools to measure this indicator. This will be cost effective and relevant to population served and could be integrated into review of well-child visits. Validity and reliability are not known for this measure.
<b>Construct 2.3: Injury prevention education</b>				
<b>Source: Program, Type: Process – Output</b>				
<p><i>Numerator:</i> Number of enrolled caregivers who received any education appropriate to the age of the target child related to injury prevention within 5 months of enrollment</p> <p><i>Denominator:</i> Number of caregivers enrolled in the program during that same reporting year</p>	Increase or maintain from CO1 to CO2 the % of families with children who receive any education or training appropriate to the age of the target child related to injury prevention and child safety within 5 months of enrollment	<p><u>Method:</u> Home visitor discusses target child age appropriate injury prevention topics with caregiver during home visit</p> <p><u>Population:</u> Caregivers enrolled in the program</p> <p><u>Case Files</u> (reported by home visitors in home visit log):</p>	<p>Education regarding illness, injury, and use of ED can occur throughout service delivery, depending on child’s age and family needs.</p> <p><u>Cohort change:</u> Compare the percentage of caregivers who received any injury prevention education or training appropriate</p>	Home safety and injury prevention is a critical component of parent education. Research indicates that home visitors educating families on home safely is associated with decreased incidence of injury and increased health literacy. There are few standardized tools to measure injury prevention education

Measure	Definition of improvement	Data Source & Population	When	Justification
<p><i>Note: Injury Prevention is defined as education on any of the following topics during the appropriate timelines:</i></p> <p>a. Safe Sleep (0-1 yr)  b. Injury Prevention (0-5 yrs)  c. Poison Prevention (0-5 yrs)  d. Fire Safety (0-5 yrs)  e. Car Seat Safety (0-5 yrs)  f. Home Safety (0-5 yrs), OR  g. Shaken Baby Syndrome (0-1 yr)</p>		<p>NFP: Home Visit Encounter (Form 9.0)  EHS: ETO Home Visit Encounter Form  PAT: ETO Home Visit Encounter Form</p> <p><i>Topics addressed (Non-Exclusive, Checklist could include, but not limited to: signs and symptoms of child illness, use of medical services, safe sleep, health and safety and injury prevention)</i></p>	for the age of the child within 5 months of enrollment for families enrolled in CO1 and CO2	Validity and reliability are not known for this measure.

**Construct 2.4: Child Injuries requiring medical treatment**

**Source: Program, Type: Outcome**

<p>The average number of child injuries requiring medical treatment (i.e., ambulatory care, ED, or hospitalization) for all target children enrolled in the program in CO1 and CO2 will be compared, at 12 months of age for children enrolled at birth or 12 months of program participation for children enrolled post-delivery</p> <p><i>Data will be collected for the following age categories:</i></p> <ul style="list-style-type: none"> <li>• 0-12 months</li> <li>• 13-36 months</li> <li>• 37-72 months</li> </ul>	<p>Decrease the average number of child injuries requiring medical treatment (i.e., ambulatory care, ED, or hospitalization) at 12 months of age or 12 months of program participation for all target children enrolled in the program in CO1 and CO2</p>	<p><u>Method:</u> Field Interview  <u>Question:</u>  1. How many times did your child require medical treatment due to injury in the past 6 months?</p> <p><u>Population:</u> Target children 12 months of age or 12 months post-enrollment</p> <p><u>Case Files</u> (self-report tracked in home visit log):  NFP: <i>Infant Health Care (Form 11.0)</i>  EHS: ETO Child Health Form  PAT: ETO Child Health Form</p> <p><i>Use of Medical Services – injury or ingestion</i> (Exclusive, Drop Down – Yes/No if yes, number of visits within last 6 months (numeric) and reason free-text single line if yes)</p>	<p>The data will be collected at intake and every 6 months of program participation; the aggregate from the two forms collected at 6 and 12 months will be used for benchmark reporting.</p> <p><u>Cohort change:</u> Average number of child injuries requiring medical treatment (i.e., ambulatory care, ED, or hospitalization) at 12 months of age or 12 months post-enrollment for all target children enrolled in the program in CO1 and CO2</p>	<p>Without having access to ED discharge data, injuries must be self-reported and may not be reliable. Validity and reliability are not known for this measure.</p>
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**Construct 2.5: Reported suspected maltreatment for children in program**

**Source: Administrative, Type: Outcome**

Measure	Definition of improvement	Data Source & Population	When	Justification
<p><i>Numerator:</i> Number of cases of suspected maltreatment of children participating in the program (allegations that were screened, but not necessarily substantiated), by age and maltreatment type in a reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same reporting year</p> <p><i>Data will be collected for the following age categories:</i></p> <ul style="list-style-type: none"> <li>• 0-12 months</li> <li>• 13-36 months</li> <li>• 37-72 months</li> </ul> <p><i>Data will be collected by the following types of maltreatment:</i></p> <ul style="list-style-type: none"> <li>• Neglect</li> <li>• Physical Abuse</li> <li>• Sexual Abuse</li> <li>• Emotional Maltreatment</li> <li>• Other</li> </ul>	Decrease from CO1 to CO2 the % of cases of suspected maltreatment of children participating in the program	<p><u>Method:</u> State Administrative data request</p> <p><u>Population:</u> Target child</p> <p>State data request with FOCUS system</p>	<p>The state MIECHV program will request a data export from the state Child Welfare program for children enrolled in the MIECHV program annually to conduct data linkage and analysis.</p> <p><u>Cross-sectional change:</u> Compare the % of cases of suspected maltreatment of children participating in the program in CO1 and CO2</p>	The Division of Public Health (MIECHV program) has established a data sharing agreement with the Division of Welfare (Child Welfare program). The data sharing agreement outlines an agreement for the state NCANDS systems (FOCUS) to extract data reports for children five years or younger and send to the MIECHV program for linking/ matching with MIECHV program participants. The agreement includes data exports every four months, including an initial complete export of all children five years or younger at the beginning of the MIECHV program. Data exports will be categorized in at least the following suspected, substantiated, or first time visits of child abuse and neglect. This is likely the most reliable data source to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure.

**Construct 2.6: Reported substantiated maltreatment for children in program**

**Source: Administrative, Type: Outcome**

<p><i>Numerator:</i> Number of cases of substantiated maltreatment of children participating in the program, by age and maltreatment type in a reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same reporting year</p> <p><i>Data will be collected for the following</i></p>	Decrease from CO1 to CO2 the % of cases of substantiated maltreatment of children participating in the program	<p><u>Method:</u> State Administrative data request</p> <p><u>Population:</u> Target child</p> <p>State data request with FOCUS system</p>	<p>The state MIECHV program will request a data export from the state Child Welfare program for children enrolled in the MIECHV program annually to conduct data linkage and analysis.</p> <p><u>Cross-sectional change:</u> Compare the % of cases of substantiated maltreatment of children participating in the program in</p>	The Division of Public Health (MIECHV program) has established a data sharing agreement with the Division of Welfare (Child Welfare program). The data sharing agreement outlines an agreement for the state NCANDS systems (FOCUS) to extract data reports for children five years or younger and send to the MIECHV program for linking/ matching with MIECHV
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Measure	Definition of improvement	Data Source & Population	When	Justification
<p><i>age categories:</i></p> <ul style="list-style-type: none"> <li>• 0-12 months</li> <li>• 13-36 months</li> <li>• 37-72 months</li> </ul> <p><i>Data will be collected by the following types of maltreatment:</i></p> <ul style="list-style-type: none"> <li>• Neglect</li> <li>• Physical Abuse</li> <li>• Sexual Abuse</li> <li>• Emotional Maltreatment</li> <li>• Other</li> </ul>			CO1 and CO2	<p>program participants. The agreement includes data exports every four months, including an initial complete export of all children five years or younger at the beginning of the MIECHV program. Data exports will be categorized in at least the following suspected, substantiated, or first time visits of child abuse and neglect. This is likely the most reliable data source to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure.</p>
<b>Construct 2.7: First time victims of maltreatment for children in program</b>				
<b>Source: Administrative, Type: Outcome</b>				
<p><i>Numerator:</i> Number of children participating in the program who are first-time victims, by age and maltreatment type, in a reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same reporting year</p> <p><i>First time victim defined as: "Had a maltreatment disposition "victim" and never had a prior disposition victim"</i></p> <p><i>Data will be collected for the following age categories:</i></p> <ul style="list-style-type: none"> <li>• 0-12 months</li> <li>• 13-36 months</li> <li>• 37-72 months</li> </ul> <p><i>Data will be collected by the following types of maltreatment:</i></p> <ul style="list-style-type: none"> <li>• Neglect</li> <li>• Physical Abuse</li> </ul>	Decrease from CO1 to CO2 the % of children participating in the program who are first-time victims	<p><u>Method:</u> State Administrative data request</p> <p><u>Population:</u> Target child</p> <p>State data request with FOCUS system</p>	<p>The state MIECHV program will request a data export from the state Child Welfare program for children enrolled in the MIECHV program annually to conduct data linkage and analysis.</p> <p><u>Cross-sectional change:</u> Compare the % of children participating in the program who are first-time victims in CO1 and CO2</p>	<p>The Division of Public Health (MIECHV program) has established a data sharing agreement with the Division of Welfare (Child Welfare program). The data sharing agreement outlines an agreement for the state NCANDS systems (FOCUS) to extract data reports for children five years or younger and send to the MIECHV program for linking/ matching with MIECHV program participants. The agreement includes data exports every four months, including an initial complete export of all children five years or younger at the beginning of the MIECHV program. Data exports will be categorized in at least the following suspected, substantiated, or first time visits of child abuse and neglect. This is</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<ul style="list-style-type: none"> <li>Sexual Abuse</li> <li>Emotional Maltreatment</li> <li>Other</li> </ul>				likely the most reliable data source to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure.
<b>BENCHMARK AREA 3: Improvements in School Readiness and Achievement</b>				
<b>Construct 3.1: Parent support for children’s learning and development</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> Relative change (% increase or decrease) in “Learning Materials” and “Involvement” scores from 6 months to 18 months (or appropriate screen for age at enrollment if enrolling older than 6 months old and one year later)</p> <p>This calculation involves the following:  <i>Numerator:</i> Score at 18 months – Score at 6 months  <i>Denominator:</i> Score at 6 months</p>	Positive relative change (% increase) in “Learning Materials” and “Involvement” scores from 6 months to 18 months (or appropriate screen for age at enrollment if enrolling older than 6 months old and one year later)	<p><u>Method:</u> Home visitor observation of parent and child interaction</p> <p><u>Population:</u> Parents/Caregivers who were observed using the HOME at 6 months and 18 months</p> <p><u>Case files</u> (assessments will be scored and stored in case files):  NFP: HOME Inventory Form  EHS: HOME Inventory Form  PAT: HOME Inventory Form</p>	<p>Home Visitors should observe families interaction over the course of service delivery. Measures should be taken at 6 months and 18 months (or appropriate screen for age at enrollment if enrolling older than 6 months and one year later)</p> <p><u>Individual change:</u> Relative change (% increase or decrease) in “Learning Materials” and “Involvement” scores from 6 months to 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p>	The HOME inventory is widely used by home visiting programs, including NFP and several of the programs in Idaho.
<b>Construct 3.2: Parental knowledge of child development</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of parents who received information on the target child’s development (i.e., reviewed the results of a completed age-appropriate ASQ screen with their home visitor) within 12 months of program participation</p> <p><i>Denominator:</i> Number of parents enrolled in the program with a completed ASQ screen</p>	Increase or maintain from CO1 to CO2 the % of parents who received information on the target child’s development (i.e., reviewed the results of a completed age-appropriate ASQ screen with their home visitor) within 12 months of program participation	<p><u>Method:</u> Home visitor discussed the results of a completed target child age appropriate ASQ screen with client during home visit</p> <p><u>Population:</u> Parent/Caregiver</p> <p><u>Case files:</u>  NFP: <i>Home Visit Encounter (Form 9.0)</i>  EHS: ETO Home Visit Encounter Form  PAT: ETO Home Visit Encounter</p>	<p>At any time during the first year of program participation</p> <p><u>Cohort change:</u> Compare the % of parents who received information on the target child’s development within 12 months of program participation in CO1 and CO2</p>	The MIECHV program anticipates home visitors to complete the ASQ in partnership with parents as a part of the process for imparting knowledge of child development to parents. Home visitors will document completion of the ASQ, and also document that they reviewed results of the ASQ with families.

Measure	Definition of improvement	Data Source & Population	When	Justification
		Form		
<b>Construct 3.3: Parenting behaviors and Parent-Child Relationship</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> Relative change (% increase or decrease) in “Responsivity” and “Acceptance” scores from 6 months to 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p> <p>This calculation involves the following:  <i>Numerator:</i> Score at Toddler 18 months – Score at Infancy 6 months  <i>Denominator:</i> Score at Infancy 6 months</p>	<p>Positive relative change (% increase) in “Acceptance” and “Responsivity” scores from 6 months to 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p>	<p><u>Method:</u> Home visitor observation of parent and child interaction</p> <p><u>Population:</u> Parents/Caregivers who were observed using the HOME at 6 months and 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p> <p><u>Case files</u> (assessments will be scored and stored in case file):  NFP: HOME Inventory Form  EHS: HOME Inventory Form  PAT: HOME Inventory Form</p>	<p>Home Visitors should observe families’ interaction over the course of service delivery. Measures should be taken at 6 months and 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p> <p><u>Individual change:</u> Relative change (% increase or decrease) in “Responsivity” and “Acceptance” scores from 6 months to 18 months (or appropriate screen for age of enrollment if enrolling older than 6 months old and one year later)</p>	<p>The HOME inventory is widely used by home visiting programs, including NFP and several of the programs in Idaho.</p>
<b>Construct 3.4: Parental Stress or Parental emotional well-being</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> The average Everyday Stressors Index (ESI) scores at one month post-delivery (or at program enrollment if enrollment is postpartum) and 12 month later</p>	<p>Decrease average score on ESI at second administration compared to first administration</p>	<p><u>Method:</u> Client completes ESI in interview with home visitor</p> <p><u>Population:</u> Parent/Caregiver with a completed ESI</p> <p><u>Case files</u> (completed ESI will be maintained in home visiting log for scoring, review and follow-up):  NFP: Everyday Stressors Index  EHS: Everyday Stressors Index  PAT: Everyday Stressors Index</p>	<p>Parents should complete the ESI at one month post-delivery or at enrollment (within 4 visits) and then 12 months later</p> <p><u>Individual change:</u> Change (% increase or decrease) in the average ESI score from one month post-delivery (or at program enrollment if enrollment is postpartum) to 12 months later</p>	<p>The ESI is a standardized inventory with acceptable reliability and validity that is self-administered and in the public domain.</p>
<b>Construct 3.5: Child communication, language, and emergent literacy</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of enrolled children who have at least one completed ASQ-3 screen using the “Communication” subscale within</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled children with at least one completed ASQ-3 screen using the</p>	<p><u>Method:</u> Parent led completion with assistance from home visitor, as needed, to complete the ASQ – 3 (Communication subscale)</p>	<p>Home visitor will complete the ASQ-3 “Communication” subscale with the family.</p>	<p>The ASQ-3 is a standardized tool used by many home visiting programs. It has clearly indicated cut-off scores at each age-</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<p>6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same cohort year who were eligible for ASQ-3 screening</p>	<p>“Communication” subscale within 6months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p>	<p><u>Population:</u> Target child</p> <p><u>Case files</u> (assessments scored and stored in case files):  NFP: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition  EHS: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition  PAT: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition</p>	<p><u>Cross-sectional change:</u> Compare screening rates between CO1 and CO2</p>	<p>appropriate screen.</p> <p><i>The ASQ – 3 starter kit in English is approximately \$250 and comes with an User’s Manual and 21 photocopiable questionnaires; The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. The questionnaires can be completed online, sent home in advance of a visit, or taken on home visits. Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people. The ASQ-3 has been extensively tested for reliability and validity. The sensitivity is 85% and specificity is 85%.</i></p>
<b>Construct 3.6: Child cognitive skills</b>				
<b>Source: Program, Type: Process – Output</b>				
<p><i>Numerator:</i> Number of enrolled children who have at least one completed ASQ-3 screen using the “Problem Solving” subscale within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same cohort year who were eligible for ASQ-3 screening</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled children with at least one completed ASQ-3 screen using the “Problem Solving” subscale within 6months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p>	<p><u>Method:</u> Administrative review of ASQ-3 assessments in case files; Parent led completion with assistance from home visitor, as needed, to complete the ASQ-3 (“Problem Solving” subscale)</p> <p><u>Population:</u> Target children</p> <p><u>Case files:</u>  NFP: Ages and Stages Questionnaire – 3<sup>rd</sup> Edition  EHS: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition  PAT: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition</p>	<p>Home visitor will complete the ASQ-3 “Problem Solving” subscale with the family.</p> <p><u>Cross-sectional change:</u> Compare screening rates between CO1 and CO2</p>	<p>The ASQ-3 is a standardized tool used by many home visiting programs. It has clearly indicated cut-off scores at each age-appropriate screen.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<b>Construct 3.7: Child's positive approaches to learning</b>				
<b>Source: Program, Type: Process - Output</b>				
<p><i>Numerator:</i> Number of enrolled children who have at least one completed ASQ-3 screen using the "Personal-Social" subscale within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same cohort year who were eligible for ASQ-3 screening</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled children with at least one completed ASQ-3 screen using the "Personal-Social" subscale within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p>	<p><u>Method:</u> Parent led completion with assistance from home visitor, as needed, to complete the ASQ-3 ("Personal-Social" subscale)</p> <p><u>Population:</u> Target children</p> <p><u>Case files</u> (assessments scored and stored in case files): NFP: Ages and Stages Questionnaire – 3<sup>rd</sup> Edition EHS: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition PAT: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition</p>	<p>Home visitor will complete the ASQ-3 "Personal-Social" subscale with the family.</p> <p><u>Cross-sectional change:</u> Compare screening rates between CO1 and CO2</p>	<p>The ASQ-3 is a standardized tool used by many home visiting programs. It has clearly indicated cut-off scores at each age-appropriate screen.</p>
<b>Construct 3.8: Child social behavior, emotional regulation, and emotional well-being</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of enrolled children who have at least one completed ASQ-SE screen within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same cohort year who were eligible for ASQ-3 screening</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled children with at least one completed ASQ-SE screen within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p>	<p><u>Method:</u> Parent led completion with assistance from home visitor, as needed, to complete the ASQ-SE</p> <p><u>Population:</u> Target children</p> <p><u>Case files</u> (assessments scored and stored in case files): NFP: Ages and Stages Questionnaire – Social Emotional EHS: Ages and Stages Questionnaire – Social Emotional PAT: Ages and Stages Questionnaire – Social Emotional</p>	<p>Home visitor will complete the ASQ-SE subscale with the family.</p> <p><u>Cross-sectional change:</u> Compare screening rates between CO1 and CO2</p>	<p>The ASQ-SE is a standardized tool used by many home visiting programs. It has clearly indicated cut-off scores at each age-appropriate screen.</p>
<b>Construct 3.9: Child's physical health and development</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of enrolled children who have at least one completed ASQ-3 screen using the "Gross Motor Skills" and/or "Fine</p>	<p>Increase or maintain from CO1 to CO2 the % of enrolled children with at least one completed ASQ-3 screen using the "Gross Motor</p>	<p><u>Method:</u> Parent led completion with assistance from home visitor, as needed, to complete the ASQ-3 "Gross Motor Skills" and/or "Fine</p>	<p>Home visitor will complete the ASQ-3 "Gross Motor Skills" and/or "Fine Motor Skills" subscale with the family.</p>	<p>The ASQ-3 is a standardized tool used by many home visiting programs. It has clearly indicated cut-off scores at each age-</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<p>Motor Skills” subscale within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p> <p><i>Denominator:</i> Total number of children enrolled in the program in the same cohort year who were eligible for ASQ-3 screening</p>	<p>Skills” and/or “Fine Motor Skills” subscale within 6 months of age for children enrolled at birth, or within 6 months of program participation for children who are older than one month at enrollment, during the reporting year</p>	<p>Motor Skills” subscale</p> <p><u>Population:</u> Target children</p> <p><u>Case files</u> (assessments scored and stored in case files):  NFP: Ages and Stages Questionnaire – 3<sup>rd</sup> Edition  EHS: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition  PAT: Ages and Stages Questionnaire - 3<sup>rd</sup> Edition</p>	<p><u>Cross-sectional change:</u> Compare screening rates between CO1 and CO2</p>	<p>appropriate screen.</p>
<b>BENCHMARK AREA 4: Domestic Violence</b>				
<b>Construct 4.1: Domestic Violence Screening</b>				
<b>Source: Program, Type: Process - Output</b>				
<p><i>Numerator:</i> Number of enrolled families screened for domestic violence using the Futures Without Violence Relationship Assessment Tool (RAT) or NFP Relationship Assessment (RA) within 3 months of enrollment during the reporting year</p> <p><i>Denominator:</i> Number of enrolled families during the same reporting year</p>	<p>Increase or maintain from CO1 to CO2 the % of families screened for domestic violence using the RAT or NFP RA within 3 months of enrollment</p>	<p><u>Method:</u> Field interview, self-report</p> <p><u>Population:</u> Enrolled women who are participating in the program at 3 months post enrollment</p> <p><u>Case File</u> (completed screen will be maintained in home visiting log for scoring, review and follow-up):  NFP: Relationship Assessment (Forms 14.0, 15.0, 16.0)  EHS: Relationship Assessment Tool  PAT: Relationship Assessment Tool</p>	<p>This self-report inventory will be completed within 3 months of enrollment</p> <p><u>Cross-sectional comparison:</u>  Compare percentage of families screened for domestic violence during CO1 to CO2</p>	<p>The RAT is a 14-item inventory measuring various aspects of emotional, physical and sexual violence in the context of relationships. It yields scores ranging from 14-84, with higher numbers indicating greater levels of domestic violence. Referral should be made during the same visit if a mother scores at or above the score of 20.</p>
<b>Construct 4.2: Referrals made for families identified with Domestic Violence</b>				
<b>Source: Program, Type: Process - Output</b>				
<p><i>Numerator:</i> Number of enrolled families identified during the reporting year as at-risk for domestic violence who received a referral to domestic violence services within two weeks of screening</p>	<p>Increase or maintain from CO1 to CO2 the % of families identified as at-risk for domestic violence who received a referral to domestic violence services within two weeks of screening</p>	<p><u>Method:</u> Home visitor refers families identified as at-risk for domestic violence to domestic violence services during home visit</p> <p><u>Population:</u> Families at risk for domestic violence</p>	<p>Local contractor and state administrators should review this measure at least every 6 months. It will also likely be included in an annual report measure submitted by local contractor to state MIECHV program annually to report for contract performance</p>	<p>This process measure will be an important measure in the CQI efforts to assess community networks, partnerships and available resources as well as program performance. The need for accurate and timely documentation is critical in</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<p><i>Denominator:</i> Number of enrolled families who were identified during the reporting year as being at-risk for domestic violence</p>		<p><u>Case File</u> (documentation of referrals [given &amp; completed] maintained in case files):  NFP: <i>Home Visit Encounter (Form 9.0)</i>  EHS: ETO Referral Form  PAT: ETO Referral Form</p> <p><i>Referred to organization</i> (Non-exclusive, check-list), <i>Date of referral</i> (Date, MM-DD-YYYY), <i>Follow-up for referral status</i> (Exclusive, drop-down), <i>Status of referral</i> (Exclusive, drop-down: completed, not completed, reason for incomplete referral [conditional]: transportation, not eligible, wait list, other), <i>Date of follow-up</i> (Date, MM-DD-YYYY)</p>	<p>metrics</p> <p><u>Cross-sectional comparison:</u>  Compare number of families screened positive for domestic violence who received a referral to domestic violence services within two weeks of screening during CO1 and CO2</p>	<p>measuring our CQI efforts for this measure. It is hoped that the identified program MIS will produce ticklers when a referral is given and completed.</p> <p>Geographic differences may occur in the data since the resources vary greatly across the state particularly comparing frontier and urban areas. Disparities that exist because of a lack of resources will be addressed at the state and local level. Validity and reliability are not known for this measure.</p>
<p><b>Construct 4.3: Completion of safety plan for families identified with Domestic Violence</b></p>				
<p><b>Source: Program, Type: Process - Output</b></p>				
<p><i>Numerator:</i> Number of enrolled families identified during the reporting year as at-risk for domestic violence who completed a safety plan within one month of screening</p> <p><i>Denominator:</i> Number of enrolled families identified during the reporting year as at-risk for domestic violence</p>	<p>Increase or maintain from CO1 to CO2 the % of families identified as at-risk for domestic violence who completed a safety plan within one month of screening</p>	<p><u>Method:</u> Home visitor completes a safety plan with families identified as at-risk for domestic violence during home visit</p> <p><u>Population:</u> Families at risk for domestic violence</p> <p><u>Case File</u> (documentation of completed safety plan maintained in case files):  NFP: <i>Home Visit Encounter (Form 9.0)</i>  EHS: Futures Without Violence Safety Plan and ETO Home Visit Encounter Form  PAT: Futures Without Violence Safety Plan and ETO Home Visit</p>	<p>Local contractor and state administrators should review this measure at least every 6 months. It will also likely be included in an annual report measure submitted by local contractor to state MIECHV program annually to report for contract performance metrics.</p> <p><u>Cross-sectional comparison:</u>  Compare number of families identified as at-risk for domestic violence who completed a safety plan within one month of screening between CO1 and CO2</p>	<p>This process measure will be an important measure in the CQI efforts to assess community networks, partnerships and available resources as well as program performance. The need for accurate and timely documentation is critical in measuring our CQI efforts for this measure. It is hoped that the identified program, MIS, will produce ticklers when a referral is given and completed.</p> <p>Geographic differences may occur in the data since the resources vary greatly across the state particularly comparing frontier and urban areas. Disparities that</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		Encounter Form		exist because of a lack of resources will be addressed at the state and local level. Validity and reliability are not known for this measure.
<b>BENCHMARK AREA 5: Family Economic Self-Sufficiency</b>				
<b>Construct 5.1: Household Income and Benefits</b>				
<b>Source: Program, Type: Outcome</b>				
<p><i>Calculation:</i> Change in dollar value of client's income and benefits from intake to 12 months of program enrollment</p>	<p>Increase dollar value of client's income and benefits from intake to 12 months of program enrollment</p>	<p><u>Method:</u> Field interview</p> <p>Questions:</p> <ol style="list-style-type: none"> <li>1. What are your sources of income, including paid work, cash assistance from family and friends, and public benefits (unemployment insurance, SSI, TANF, WIC, SNAP, child support payments, food stamps, energy assistance, housing vouchers, etc.)?</li> <li>2. How much money do you get from _____ (insert sources of income and benefits from Q1)               <ol style="list-style-type: none"> <li>a) Less than or equal to \$6,000</li> <li>b) \$6,001 - \$9,000</li> <li>c) \$9,001 - \$12,000</li> <li>d) \$12,001 - \$16,000</li> <li>e) \$16,001 - \$20,000</li> <li>f) \$20,000 - \$30,000</li> <li>g) Over \$30,000</li> </ol> </li> </ol> <p><u>Population:</u> Primary caregiver for whom household income and source of income are collected</p> <p><u>Case File:</u> NFP: <i>Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics</i></p>	<p>The self-report about client's income collected at intake (within first 4 visits) and approximately every 6 months during service delivery.</p> <p>Although data may be collected more frequently, only data collected at intake and 12 months will be used for benchmark reporting.</p> <p><u>Individual change:</u> Compare dollar value of client's income and benefits from intake to 12 months of program enrollment.</p>	<p>Dollar values constitute a continuous variable that is sensitive to small amounts of incremental change.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		<p><i>Update (Form 5.0)</i>  EHS: ETO Form Intake and Intake Demographic Update  PAT: ETO Form Intake and Intake Demographic Update</p> <p><i>Household Income</i> (Numeric &amp; Numeric for number of household members included, check-list of household members included from above), <i>Household Benefits</i> (Non-Exclusive, Check-list: Unemployment Insurance, Child Support Payments, TANF, Medicaid, SNAP, WIC, SSI, PSR, Energy Assistance, Housing Vouchers, Other)</p>		
<b>Construct 5.2: Employment or Education of Adults in Household</b>				
<b>Source: Program, Type: Outcome</b>				
<p><b>Employment</b>  <i>Calculation:</i>  Change from intake to 12 months of program enrollment in the number of paid hours worked plus unpaid hours devoted to care of an infant (up to 30 hours a week) by clients</p>	<p>Increase from intake to 12 months of program enrollment in the number of paid hours worked plus unpaid hours devoted to care of an infant (up to 30 hours a week) by clients</p>	<p><u>Method:</u> Field interview</p> <p>Questions:</p> <ol style="list-style-type: none"> <li>1. How many hours do you work per week? <ol style="list-style-type: none"> <li>a) 37 or more hours</li> <li>b) 20 – 36 hours</li> <li>c) 10 – 19 hours</li> <li>d) Less than 10 hours</li> <li>e) Unemployed</li> </ol> </li> <li>2. How many hours are devoted to providing unpaid childcare each week? <ol style="list-style-type: none"> <li>a) More than 40 hours</li> <li>b) 30 – 39 hours</li> <li>c) 20 – 29 hours</li> <li>d) 10 – 19 hours</li> <li>e) Less than 10 hours</li> </ol> </li> </ol> <p><u>Population:</u> Primary caregivers for whom employment data is collected</p>	<p>The client self-report about the employment status collected at intake (within first 4 visits) and approximately every 6 months during service delivery.</p> <p>Although data may be collected more frequently, only data collected at intake and 12 months will be used for benchmark reporting.</p> <p><u>Individual change:</u> Compare from intake to 12 months of program enrollment the number of paid hours worked plus unpaid hours devoted to care of an infant by clients</p>	<p>Hours employed and hours spent caring for an infant constitute a continuous variable that is sensitive to small amounts of incremental change.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		<p><u>Case File:</u>  NFP: <i>Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</i>  EHS: ETO Form Intake and Intake Demographic Update  PAT: ETO Form Intake and Intake Demographic Update</p> <p><i>Unpaid hours caring for child per week</i> (Numeric – primary client and all adult members of the household), <i>Employment Status</i> (Conditional, Exclusive, Drop-Down: Yes/No/NA, if yes – Average hours per week (numeric) and description, for all adult members of the household),</p>		
<p><b>Education</b>  <i>Calculation:</i> Change from intake to 12 months of program enrollment in the percentage of primary clients engaged in educational activities</p>	<p>Increase from intake to 12 months of program enrollment in the percentage of clients engaged in educational activities (alternatively: in the number of hours devoted to educational activities by the primary caregivers)</p>	<p><u>Method:</u> Field interview</p> <p>Question:  1. Are you currently enrolled in any school, vocational, or educational program?  Yes _____ No _____</p> <p>If the answer is yes, then ask:  2. How many hours during the average week do you spend on educational activities (e.g., in class, studying, etc.)?  _____</p> <p><u>Population:</u> Primary caregivers for whom education data is collected</p> <p><u>Case File:</u>  NFP: <i>Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics</i></p>	<p>The client self-report about the education status collected at intake (within first 4 visits) and approximately every 6 months during service delivery.</p> <p>Although data may be collected more frequently, only data collected at intake and 12 months will be used for benchmark reporting.  <u>Individual change:</u> Compare from intake to 12 months of program enrollment the percentage of clients engaged in educational activities</p>	<p>Percentage of primary caregivers engaged in educational activities constitutes a continuous variable that is sensitive to small amounts of incremental change.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
		<p><i>Update (Form 5.0)</i>  EHS: ETO Form Intake and Intake Demographic Update  PAT: ETO Form Intake and Intake Demographic Update</p> <p>Highest Education Level attained (Exclusive, Drop-Down: &lt;7<sup>th</sup> grade, 7<sup>th</sup> Grade, 8<sup>th</sup> Grade, 9<sup>th</sup> Grade, 10<sup>th</sup> Grade, 11<sup>th</sup> Grade, 12<sup>th</sup> Grade, High School Diploma, High School GED, 1 year Vocational School, 2 years Vocational School, 1 year Community College, 2 years Community College, Associates Degree, Bachelor's Degree, Advanced Degree) Enrollment in Educational Program (Conditional, Exclusive, Drop-Down: Yes/No/NA for all adult members of the household, if yes – Average hours per week (numeric)</p>		

**Construct 5.3: Health Insurance Status**

**Source: Program, Type: Outcome**

<p><i>Calculation:</i>  Change from intake to 12 months of program enrollment in the percentage of participating clients and target children with credible health insurance</p> <p><i>Note: Idaho definition of credible health insurance: Coverage that provides benefits for inpatient &amp; outpatient hospital services and physician's medical and surgical services. Credible coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. IDAPA</i></p>	<p>Increase from intake to 12 months of program enrollment in the percentage of participating clients and target children with credible health insurance</p>	<p><u>Method:</u> Field Interview</p> <ol style="list-style-type: none"> <li>1. Do you have health insurance?  If yes,</li> <li>2. What type of health insurance do you have? <ol style="list-style-type: none"> <li>a) Public Benefits (Medicaid, Medicare, VA, Military, etc.)  _____</li> <li>b) Private Insurance  _____</li> </ol> </li> <li>3. Does your child have health insurance? Yes ___ No ___</li> </ol>	<p>The self-report of insurance status of participating clients and target children collected at intake (within first 4 visits) and approximately every 3-4 months during service delivery – integrated into assessment of well-child visits.</p> <p>Although data may be collected more frequently, only data collected at intake and 12 months will be used for benchmark reporting.</p> <p><u>Individual change:</u> Compare from intake to 12 months of program</p>	<p>Average percentage of participating primary caregivers and target children with credible health insurance constitutes a continuous variable that is sensitive to small amounts of incremental change.</p>
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Measure	Definition of improvement	Data Source & Population	When	Justification
16.03.01		<p>If the answer is yes, then ask:</p> <p>4. What type of health insurance does your child have?</p> <p>a) Medicaid b) SCHIP or CHIP c) Private Insurance</p> <hr/> <p><u>Population:</u> Primary caregivers and target children for whom insurance status is collected</p> <p><u>Case Files</u> (record in case file): NFP: <i>Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</i> EHS: ETO Form Intake and Intake Demographic Update PAT: ETO Form Intake and Intake Demographic Update</p>	enrollment the percentage of participating primary caregivers and target children with credible health insurance	

**BENCHMARK AREA 6: Coordination and Referrals for Other Community Resources and Supports**

**Construct 6.1: Number families identified for necessary services**

**Source: Program, Type: Process**

<p><i>Numerator:</i> Number of families enrolled in CO1 and CO2 screened for need of additional services (defined below) within the first 6 months of program participation</p> <p><i>Denominator:</i> Number of enrolled families in the same time period</p> <p><i>Note: Necessary services defined as any of the following services:</i></p> <ul style="list-style-type: none"> <li>• Health care (participants, adults or children, without a regular source of care (cannot be the ED or urgent care)</li> <li>• Substance Abuse Treatment or Counseling</li> <li>• Mental Health Services ( positive Post-Partum Depression screen,</li> </ul>	<p>Increase or maintain from CO1 to CO2 the % of families screened for ALL necessary services (i.e., health care, substance abuse, mental health, SNAP/heating/housing, domestic violence, developmental) within the first 6 months of program participation</p>	<p><u>Method:</u> Administrative Review of Case Files</p> <p><u>Population:</u> Families</p> <p><u>Case Files</u> (record of completed screens for need of additional services): NFP: <i>Home Visit Encounter (Form 9.0)</i> EHS: ETO Referral Form PAT: ETO Referral Form</p>	<p>The home visitor will conduct interviews and screens throughout the first year of program participation. This measure should be assessed every 6 months and may be included in an annual report measure submitted by local contractor to state MIECHV program as a contract performance metric or be used in a CQI process.</p> <p><u>Cohort comparison:</u> Compare % of families screened for need for additional services at 6 months of program participation for families enrolled in CO1 &amp; CO2</p>	<p>A number of sensitive issues are addressed in home visiting programs, it will be critical that the home visitor is trained to effectively administer tools which screen for sensitive topics. Through reflective supervision and performance review supervisors should be assessing home visitors needing additional training or consultation.</p> <p>It will be critical that a management information system have the capacity to track referrals, follow-ups and produce reminders for home visitors in</p>
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Measure	Definition of improvement	Data Source & Population	When	Justification
<p>EPDS)</p> <ul style="list-style-type: none"> <li>• SNAP, Heating or Housing Assistance</li> <li>• Domestic Violence Services (screened positive)</li> <li>• Developmental Services (Children identified with potential developmental delay for the following developmental services on ASQ-3 or ASQ – SE Infant Toddler Program(Part C) or Developmental Preschool (Part B)</li> </ul>				<p>order to assess needs identified through screening and interviews, referrals made and completed. Additionally, it will be important for the MIECHV program to assess local resources in target communities as there may be a hesitance for home visitors to refer families with need if no resource is available. Validity and reliability are not known for this measure.</p>
<b>Construct 6.2: Number of families receiving referral to necessary services</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of families enrolled in CO1 and CO2 identified as needing any necessary services (defined in Construct 6.1) during the first year of program participation and received referral to appropriate service when these services were available in the communities</p> <p><i>Denominator:</i> Number of enrolled families identified as needing any necessary services in the same time period</p>	<p>Increase or maintain from CO1 to CO2 the % of families identified with a need for necessary services during the first year of program participation who receive an appropriate referral, when there are services available in the community</p>	<p><u>Method:</u> Administrative Review of Case Files</p> <p><u>Population:</u> Families identified as needing any necessary services</p> <p><u>Case Files</u> (record of referrals made according to need identified in interviews):  NFP: <i>Use of Government &amp; Community Services (Form 17.0)</i>  EHS: ETO Forms and Referral Forms  PAT: ETO Forms and Referral</p>	<p>The home visitor will conduct interviews and screens throughout the first year of program participation. This measure should be assessed on an ongoing basis and may be included in an annual report measure submitted by local contractor to state MIECHV program as a contract performance metric or be used in a CQI process.</p> <p><u>Cohort comparison:</u> Compare the % of enrolled families in CO1 and CO2 identified with a need for necessary services during the first year of program participation who received an appropriate referral, when there are services available in the community</p>	<p>A number of sensitive issues are addressed in home visiting programs, it will be critical that the home visitor is trained to effectively administer tools which screen for sensitive topics. Through reflective supervision and performance review supervisors should be assessing home visitors needing additional training or consultation. It is critical that a management information system have capacity to track referrals, follow-ups and produce reminders for home visitors to assess needs identified through screening and interviews, referrals made and completed. Additionally, it is important for the MIECHV program to assess local resources in target communities as there may be a hesitance for home visitors to refer families with need if no resource is available. Validity and reliability not known for this measure.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<b>Construct 6.3: Number of Memoranda of Understanding (MOUs) within community Service Agencies</b>				
<b>Source: Program, Type: Process</b>				
<p><i>Numerator:</i> Number of MOUs or other formal agreements with social service, health, or community services organization within the service delivery area (coverage area) at end of CO2</p> <p><i>Denominator:</i> Number of MOUs or other formal agreements with social service, health, or community services organization within the service delivery area (coverage area) at the end of CO1</p>	<p>Increase or maintain from CO1 to CO2 the number of MOUs or other formal agreements with social services, health, or community organization within service delivery area (Ratio <math>\geq 1</math> is improvement)</p>	<p><u>Method:</u> Local contractors' Administrative Records</p> <p><u>Population:</u> Local contractors</p> <p>Program Administrative Records reported annually to the State MIECHV program and also maintained within the ETO Entities Characteristics</p>	<p>This process indicator will be reviewed every 6 months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.</p> <p><u>Cross-sectional comparison:</u> Compare number of MOUs or other formal agreements with social services, health, or community organizations within the service delivery area at the end of CO1 and CO2</p>	<p>This is an important measure for CQI for the MIECHV program to assess the disparities in community resources in different areas of the state. Because the program will be implemented in both rural and frontier areas, there will be interesting opportunities to assess access to resources and participant outcomes. The MIECHV program intends to provide TA to local contractors as needed to facilitate MOUs with community partners. Validity and reliability are not known for this measure.</p>
<b>Construct 6.4: Point of contact in agency responsible for connecting with other community-based organizations</b>				
<b>Source: Program, Type: Process – Input</b>				
<p><i>Numerator:</i> Number of unduplicated community-based organizations with a clear point of contact (defined as: organization name, organization address, contact name and contact phone or e-mail – this could be clinic manager, case worker, intake worker, school counselor, etc.) at the end of CO2</p> <p><i>Denominator:</i> Number of unduplicated community-based organizations with a clear point of contact (defined as: organization name, organization address, contact name and contact phone or e-mail – this could be clinic manager, case worker, intake worker, school counselor, etc.) at the end of CO1</p>	<p>Increase or maintain from CO1 to CO2 the number of unduplicated community-based organizations with a clear point of contact over time (Ratio <math>\geq 1</math> indicates improvement)</p>	<p><u>Method:</u> Local contractors' Administrative Records</p> <p><u>Population:</u> Local contractors</p> <p>Program Administrative Records reported annually to the State MIECHV program and also maintained within the ETO Entities Characteristics</p>	<p>This process indicator will be reviewed every 6 months and submitted to state annually (likely to meet contract for performance metrics.) This may be a part of the CQI process for more frequent review.</p> <p><u>Cross-sectional comparison:</u> Compare number of unduplicated community-based organizations with a clear point of contact at the end of CO1 and CO2</p>	<p>This will be an important measure for CQI for the state MIECHV program to assess the disparities in community resources in different areas of the state. Since the program will be implemented in rural and frontier areas, there will be opportunities to assess access to resources and participant outcomes. The MIECHV program intends to provide significant TA to local contractors as needed to facilitate establishing points of contact with community partners. Validity and reliability are not known for this process measure.</p>

Measure	Definition of improvement	Data Source & Population	When	Justification
<b>Construct 6.5: Number of completed referrals</b>				
<b>Source: Program, Type: Process – Output</b>				
<p><i>Calculation:</i> Average percentage of referrals to household members that lead to service contacts (i.e., are completed referrals) during the first 12 months of program participation for families enrolled in CO1 and CO2</p> <p>This calculation involves the following: <i>Numerator:</i> Number of referrals made to household members that lead to service contacts for families enrolled in CO1 and CO2 <i>Denominator:</i> Number of referrals made to household members enrolled in CO1 and CO2</p>	<p>Increase from CO1 to CO2 the average % of completed referrals (families identified with a need, referred and service received) during the first 12 months of program participation for families enrolled in CO1 and CO2</p>	<p><u>Method:</u> Administrative Review of Case Files</p> <p><u>Population:</u> Families referred to any necessary services</p> <p><u>Case Files</u> (record in case file): NFP: <i>Use of Government &amp; Community Services (Form 17.0)</i> EHS: ETO Forms and Referral Forms PAT: ETO Forms and Referral</p>	<p>This process indicator will be reviewed every 6 months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.</p> <p><u>Cohort comparison:</u> Compare the average % of completed referrals (families identified with a need, referred and service received) during the first 12 months of program participation for families enrolled in CO1 and CO2</p>	<p>Average percentage of completed referrals is a continuous variable that is sensitive to small amounts of incremental change.</p> <p>It is important that home visitors follow up with program participants to assess clients' follow-through with a referral. In some cases a participant may or may not want to follow-up on a service. This measure may be used for CQI purposes and to assess the availability of resources in the community. It will be important for the MIECHV program to assess home visitors with the highest success rate of completed referrals for attributes or resources available within a certain community. Validity and reliability are not known for this process measure.</p>

Edinburgh Postnatal Depression Scale: The EPDS was designed in 1987 as a simple means of screening for postnatal depression in health care settings. It can also be used by researchers seeking information on factors that influence the emotional well-being of new mothers and their families. The EPDS has undergone numerous reliability and validation studies and refinement to the 10 question scale in use today. The EPDS is in use in numerous countries and has been successfully translated to many other languages. In a community setting, the EPDS is useful in the secondary prevention of postnatal depression by identifying the early onset of depressive symptoms.

Ages and Stages Questionnaires – 3<sup>rd</sup> Edition and the Ages and Stages Questionnaires – Social-Emotional: The ASQ system was originally developed in the 1970s with the belief that parents are equal partners in assessing child development. The ASQ has been tested for inter-rater reliability and validity numerous times over the corresponding years. Reliability scores are traditionally at 90 percent or higher when comparing parent's scores with health care professional's scores. Additional testing has proven that parents from extremely high risk populations are able to accurately complete the questionnaires on their infants and young children. The ASQ's sensitivity ranges from 70 to 90 percent, and its specificity ranges from 76 to 91 percent. The ASQ-SE was developed in the early 2000s as

the emergence for early detection of social and emotional well-being in young children was recognized. The Idaho Infant Toddler Program (IDEA – Part C) utilized the screening tool in the Developmental Milestones to assess children for developmental delay or as at-risk for developmental delay, monitoring and follow-up.