Section 5: Florida's Plan for Meeting Legislatively-Mandated Benchmarks

Florida's MIECHV Program evaluation will collect and analyze program implementation and child and family outcome data for three purposes: (1) to measure the success of the program; (2) inform and help communities in developing and implementing home visiting models and (3) to allow state administrators to provide technical assistance and continuously improve the quality of Florida's program.

Activities during the start-up years will focus on building evaluation infrastructure and process evaluation of early implementation that can serve as a basis for successful implementation and continued evaluations of Florida's system.

DATA SOURCES

Web-based Case Management System

The web-based case management system, the Efforts to Outcomes (ETO) System provided by Social Solutions, will have the capacity to guide a home visitor through the various assessment tools for the development of a well-integrated case management plan. In addition, it can provide reminders to home visitors regarding necessary follow-up activities with their clients and to record services provided, referrals made, and referrals completed. It will give home visitors the tools they need for effective case management, while providing useful reports for supervisors, evaluators, and centrally located agency staff to guide the provision of technical assistance that will support CQI.

This system will contain web-based versions of all the screening tools that will be used to assess characteristics and needs for families being served, and it will collect data for benchmark indicators that will be obtained through direct interactions with families. The web-based case management system will serve as a data source for benchmark indicators as well as for monitoring process indicators, such as local model enrollment and retention rates, for the community and for individual home visitors.

The system will capture data required by Florida's MIECHV Program and by each of the national offices of the home visiting models being implemented. Agreements will be forged with national offices to regularly upload required data elements to the national systems. Likewise, data will also be uploaded on a regular basis into the Comprehensive Birth Registry System described below.

Although every effort will be made to ensure that the web-based case management system is comprehensive before it is launched, undoubtedly, based on input from home visitors, supervisors, agency staff and evaluation team analysts, modifications will be made to the system. Those modifications will be documented and included in any reports based on data collected.

COMPREHENSIVE BIRTH REGISTRY SYSTEM

The Comprehensive Birth Registry (Registry) system will be a proprietary database that will: be available to the evaluation team as specified by data use agreements and IRB; import data from the web-based case management system and administrative data sources; and provide unrestricted capability for generation of ad hoc reports. Depending on the research question, different statistical analyses are appropriate and should be possible with the Comprehensive Birth Registry System. To the extent that post-delivery data can be imported from

administrative sources for many of these children, the number of questions that can be answered via the Registry will be increased.

The comprehensive birth registry will be used to analyze data for all constructs as required by HRSA, create reports addressing progress on statewide goals and objectives, and provide quarterly reports to agency staff for CQI purposes.

Consent forms will be sought from all families receiving services to ensure maximum availability of data for analysis. However, in order to obtain identified data to populate the birth registry, detailed data use agreements will have to be forged with the Department of Health and the Department of Children and Families.

Qualitative and Non-Identified Data Sources

Qualitative data about program implementation will be acquired from several sources. To document and evaluate state-level implementation, meeting summaries and other documents will be reviewed, analyzed, and summarized using the state plan as a benchmark for implementation progress. To supplement data collected from community implementers in the web-based case management system, reporting templates will be created quarterly and implementing communities will be required to complete and submit the template to the evaluation team. The evaluation team will combine the two data sources, analyze the data, and prepare quarterly reports for agency staff that will serve as the basis for conversations with community implementers, technical assistance efforts, and CQI.

Further analysis will be based on data collected during annual site visits conducted collaboratively by Chiles Center and Agency staff. These site visits will focus on assessing the communities' adherence to the terms of their contracts, verifying content of quarterly reports, and collecting information about how the state system should be modified to promote a more effective program. Data at site visits will be obtained through a combination of record review, structured interviews and/or focus groups. The exact nature of what will be collected and the method of collection will be determined in collaboration with community partners to ensure that the resulting information is informative and useful to community implementers.

Measuring Benchmarks as Required by HRSA

To reduce the burden on home visitors and to maximize the time they can devote to building a trusting relationship with families during the first months of service provision, tools for assessment of client status have been selected using the following criteria:

- When identified data can be obtained from an administrative source, they will be.
- Screening tools should be validated whenever possible.
- Screening tools should be easy for home visitor to use (e.g., minimal training required).
- If the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire addressed the indicator, that instrument was given preference.
- Status should be assessed using the fewest number of questions and the fewest number of screening tools.
- Model implementers will be consulted in the final selection of screening tools.

Even though the home visiting models being implemented were selected because they are "evidence-based," we note that evidence does not exist in the literature indicating that each model has an effect on every construct required to be measured. When we report results in the future, therefore, we will include a table clearly stating, based on the models implemented, the constructs where an effect is expected based on published studies, other constructs where an

effect has not been previously reported but may be expected, and, finally, constructs where an effect is probably not expected.

Since Florida's ability to report benchmark constructs relies heavily on home visitors conducting timely and accurate screenings and recording the results of those screenings in the web-based case management system, partnerships will be developed with local program implementers before final decisions are made about who will record data and under what circumstances. These partnerships will focus on collection of meaningful, timely and reliable data while maintaining model fidelity. Decisions about what will be measured when and by whom will be made in consultation with the Evaluation Workgroup which contains members from each of the models being implemented in Florida. All home visitors and other staff will have to be adequately trained to ensure appropriate use of the web-based case management system for conducting screenings, recording needs, and recording services and referrals provided. Because a high proportion of Florida residents have Spanish as the primary language spoken in the home, when available, assessment tools will be incorporated in the web-based case management system in Spanish as well as English.

Reliability and Validity of Assessment Tools

Several tools will be used to provide data for measurement of benchmark constructs. For efficient use of space, the reliability and validity of the tools is described below.

ASQ-3

The sensitivity of ASQ-3, or the ability of ASQ-3 to correctly identify those children with delays, ranged from 75% for the 6-month questionnaire to 100% for the 4-month, 14-month, 54-month, and 60-month questionnaires, with 86% overall agreement.

Internal consistency of ASQ-3 items was examined using correlational analyses and Cronbach's coefficient alpha (Cronbach, 1951):

> *Test-Retest reliability* – The percent agreement for 145 parents was 92%. Intra-class correlations raged from .75 to .82 suggesting the ASQ-3 has strong test-retest reliability.
>
> Inter-observer reliability – the percent agreement between ASQ-3clasisfications between parents and trainer examiners was 93%. Intra-class correlations by area ranged from .43 to .69, suggesting robust agreement between parents and trainer examiners when completing the ASQ-3 on a group of 107 children.
>
> *Internal Consistency* – The correlation between the developmental area and overall score is consistent and generally range from .60 to .85. Only in the Gross Motor area are two correlations below .60. All correlations are significant at $p < .01$. Cronbach's coefficient alpha was calculated for developmental area scores for 20 age intervals. Alphas range from .51 to .87. These alphas indicate that ASQ-3 items have good to acceptable internal consistency.
>
> *Concurrent validity* – the ASQ-3 has moderate to high agreement with BDI classifications. Users of the ASQ-3 can be relatively confident that ASQ-3 results will identify those children whose development is suspect and those whose development is falling within typical developmental norms.

Excerpted from the ASQ-3 User's Guide. By J. Squires, PhD., E. Twombly, M.S., D. Bricker, PhD. And L. Potter, M.S.

ASQ-SE

Investigated with over 3,000 children across the age intervals and their families. Internal consistency measured by coefficient alpha was found to be high across intervals, ranging from .67 to .91 with an overall alpha of .82. Test–retest reliability, measured as the agreement between two ASQ:SE questionnaires completed by parents at 1- to 3-week intervals was 94%. Sensitivity ranged from 71% at 24 months to 85% at 60 months, with 78% overall sensitivity.

Excerpted from the ASQ-SE User's Guide. By J. Squires, PhD., E. Twombly, M.S., D. Bricker, PhD. & L. Potter, M.S.

Edinburgh Postnatal Depression Scale (EPDS)

Two major studies by Cox, et al. were conducted to validate use of the EPDS in postnatal women. In 1987, Cox, et al. validated the 10-item EPDS on a cohort of 84 mothers. Participants were visited in their homes and interviewed by Goldberg's Standardized Psychiatric Interview followed by the EPDS. A threshold score of 12/13 was found to identify all 21 women who also had a Research Diagnostic Criteria (RDC) diagnosis of Definite Major Depressive Illness. Cox, et al. (1987) suggested that a threshold of 9/10 might be considered for use in a primary care setting to indicate mild depression.

In 1996, the EPDS was further validated by Cox, et al. on postnatal and non-postnatal women. Using a 12/13 threshold score, 15 of 19 non-postnatal women with major or minor depression were identified via the RDC. In the postnatal group, 13 of 21 women with major or minor depression were identified. In both studies, Cox, et al. recommended using a 12/13 score to indicate major depression. (*Use and Validation of the Edinburgh Postnatal Depression Scale,* Michigan Families Medicaid Project).

HFPI (Healthy Families Parenting Inventory)

In "Measuring Outcomes: The Development and Empirical Validation of the Healthy Families Parenting Inventory", the study determined that construct validity to guide the fine tuning of the instrument reliability analysis found the HFPI subscales have alpha coefficients ranging from .76 to .86, indicating excellent internal consistency. Factor analysis supported the existence of nine distinct subscales.

IT-EC HOME

The first study conducted to assess the psychometric properties of HOME suggested that there is a 90% agreement between observers and internal consistency ranges from moderate to strong (.44 to .89). Test-retest reliability was moderate for a period of 18 months. As for concurrent validity, small to moderate correlations were found between HOME and seven socioeconomic status variables: welfare status, maternal education, maternal occupation, presence of father in the house, paternal occupation and crowding in the home (Elardo et al., 1975). Since this initial study, several researchers have studied the psychometric properties of ITHOME and it has been concluded that inter-observer agreement has never fallen below .80 while the internal consistency of the total scores was found to be as high as .80 and internal consistency of the subscales ranged from .30 to 80 (Bradley, 1993).

Perceived Stress Scale

The Perceived Stress Scale was normed using a group of 2,387 respondents, establishing mean and standard deviations by gender, age and race. Its results are correlated with other stress measures, self-reported health measures, failure to quit smoking, failure among diabetics to control blood sugar levels, greater vulnerability to stressful-life-events-elicited depressive symptom, and more colds. Predictive validity and, hence, reliability, is expected to fall off rapidly after four to eight weeks.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Florida Pregnancy Risk Assessment Monitoring System (FL PRAMS) is an ongoing population-based surveillance system to monitor maternal behaviors and experiences occurring before, during, and after pregnancy among women who deliver live-born infants in Florida. The Florida Department of Health frequently uses FL PRAMS response data to assess associations of maternal characteristics and behaviors on pregnancy and infant health outcomes. FL PRAMS response data is also used to assess the impact of programmatic interventions on intermediate and distal health outcomes.

The PRAMS questionnaire consists of two parts - core questions that are part of every participating state's surveys and state-added questions. The current 185 PRAMS core questions were developed after extensive testing and input from state. Validity of specific questions is addressed through pre-testing. Specifically, according to a Morbidity and Mortality Weekly Report (Centers for Disease Control and Prevention, 2003):

> *New questions are tested through cognitive interviewing, in which respondents are asked to describe their understanding of the question's meaning and how they arrived at their response. On the basis of the results of the cognitive testing, questions are revised. A second round of testing involves administering the questionnaire to respondents, who are asked to complete it and provide written feedback. Before the next revision cycle, questions are evaluated for item non-response, write-in responses, and whether respondents correctly followed skip patterns. Questions that fare poorly in these evaluations are revised accordingly and pre-tested before being included in the questionnaire.*

Benchmark Construct Summary Table

The table below summarizes Florida's current intentions for measuring improvement on each of the benchmark constructs. An effort will be made to collect data from all clients; there will be no sampling. We consider this a living document that may be modified, based on input from the Evaluation Workgroup. Once the document is finalized Florida's team will provide all data collection information to Social Solutions to assist in the discovery phase for their creation of the Florida-specific ETO system.

Benchmark 1: Improved Maternal and Newborn Health											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
1) Prenatal care	Percent of pregnant women with an adequate Kotelchuck Index.	# pregnant women beginning home visiting services at or before 20 weeks gestation with an adequate Kotelchuck Index/ # pregnant women beginning home visiting services at or before 20 weeks gestation	Administrative data Adequacy will be defined as infants whose mother received adequate or adequate plus Prenatal Care based on the Kotelchuck Index. The Kotelchuck Index uses the date prenatal care began and the number of prenatal visits to classify the adequacy of prenatal care into these groups: Inadequate prenatal care, Intermediate Prenatal Care, Adequate Prenatal Care, Adequate Plus Prenatal Care, Unknown	The data in vital statistics are derived from birth certificate data. This indicator has face validity for the construct.	Increase in the percentage of pregnant women with an adequate Kotelchuck Index from the first year cohort to the second.	Analyst	Administrative data: Vital Statistics	Pregnant women who began receiving home visiting services at or before 20 weeks of gestation	The Kotelchuck Index will be derived from Vital statistics within two months of the birth of the child	Outcome	Cohort
2) Parental use of alcohol, tobacco, or illicit drugs	Percent of non-pregnant mothers **NOT** smoking.	# of mothers who do not smoke/ # of mothers enrolled in home visiting services	Question derived from PRAMS question 38. How many cigarettes do you smoke on an average day now? (A pack has 20 cigarettes.) - 41 cigarettes or more - 21 to 40 cigarettes - 11 to 20 cigarettes - 6 to 10 cigarettes - 1 to 5 cigarettes - Less than 1 cigarette - I don't smoke now For smokers: Have you received any help or been in any kind of program to quit smoking in the past year?	Indicator relies on self report. The PRAMS is well validated (see above). This indicator has face validity.	A greater percentage of mothers enrolled in home visiting will **NOT** smoke when the child is 12 months of age than at enrollment or when the child is 2 months of age whichever comes later.	Home visitor	Web-based case management system	Post partum mothers receiving home visiting services	At enrollment or when the child is 2 months of age (whichever comes later); then annually a month after the child's birthday.	Outcome	Individual
3) Preconception care	Percentage of non-pregnant women enrolled in services using multivitamins or folic acid	# non-pregnant women enrolled in services using multivitamins or folic acid at least 4-6 times per week/ # non-pregnant women enrolled in services	Derived from PRAMS question 9. How many times a week do you take a multivitamin, a prenatal vitamin, or a folic acid vitamin? - I don't take a multivitamin, prenatal vitamin, or folic acid - 1 to 3 times a week - 4 to 6 times a week - Every day of the week	Indicator relies on self report. The PRAMS questionnaire is used extensively and has a high degree of reliability and validity (see above).	Increase in the percent of non-pregnant mothers receiving services reporting taking multivitamins or folic acid between when the child is two months of age and 12 months of age.	Home visitor	Web-based case management system	Non-pregnant mothers receiving home visiting services	At enrollment or 2 months of age (child) whichever comes later and annually one month after the birth date	Outcome	Individual
4) Inter-birth intervals	The percent of mothers receiving services **without a subsequent pregnancy** during the first 12 months after giving birth	# mothers receiving services who did not become pregnant within 12 months of giving birth/# mothers enrolled in home visiting during pregnancy or within two months of giving birth	At the first home visit of each month, the HV will ask: Do you think you may be pregnant? Y/N If yes, how many weeks pregnant are you?	Indicator relies on self-report. We expect the numbers of mothers who become pregnant while receiving services to be relatively small. This indicator has face validity for the construct.	The percent of mothers receiving home visiting services **who do not become pregnant with an interpregnancy interval equal to or less than 12 months** will be greater for the second year cohort than for the first.	Home visitor	Web-based case management system	Mothers who began receiving home visiting services prenatally or within two months of giving birth	At the first home visit of every month	Outcome	Cohort
5) Screening for maternal depressive symptoms	Percent of mothers screened for depression.	# mothers screened for depression within 12 weeks of birth/# mothers enrolled before 8 weeks post-partum	Administrative data: Edinburgh Postpartum Depression Scale	This should be both a reliable and valid measure in that the screening tool will be contained in the web-based system and thus its use will be automatically recorded. This indicator has face validity for the construct and for measuring improvement.	The percent of mothers screened for depression Within 12 weeks post-partum will increase or be maintained from the first cohort to the second.	Home visitor	Web-based case management system	Post-partum mothers receiving home visiting services	The depression scale should be administered within 12 weeks post-partum and one month after the child's first birthday.	Process	Cohort

Benchmark 1: Improved Maternal and Newborn Health											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
6) Breastfeeding	Average number of weeks mothers breastfeed.	Total # weeks mothers breastfed for mothers receiving home visiting services 6 months post-partum/ # mothers receiving home visiting services at 6 months postpartum who initiated breast feeding	PRAMS questions 57. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time? - No - Yes and 60. How many weeks or months did you breastfeed or pump milk to feed your baby? - Less than 1 week Weeks OR Months	Indicator relies on self report. The PRAMS questionnaire is used extensively and has a high degree of reliability and validity (see above).	The average number of weeks mothers breastfeed will be greater for the second year cohort than for the first.	Home visitor	Web-based case management system	Mothers receiving home visiting services who enrolled in the program prenatally and who initiated breast feeding	Six months after birth	Outcome	Cohort
7) Well-child visits	Percent of children with at least 70% of AAP recommended well-child check-ups by 12 months of age	# children receiving services starting by at least one month of age who receive at least 70% (5) of AAP recommended well child checkups by 12 months of age/# children 12 months of age receiving home visiting services starting by at least one month of age.	In the past month, has _CHILD_ seen a doctor, nurse or other medical professional? Y/N If yes, was the visit for: __ a regular (well-child) checkup __ treating an injury __ diagnosing and treating an illness __ immunization __ special healthcare needs __ Other: _____ If yes, where was the care provided? __ Emergency room __ Doctor's office __ County Health Department or Federally Qualified Health Center (A clinic) __ Urgent Care __ Other	This indicator relies on parental report. This indicator has face validity for the construct.	Increase the percent of children that have had at least 70% well-child check-ups by 12 months of age from the first cohort to the second.	Home Visitor	Web-based case management system	Children with home visiting services at 12 months of age and enrolled by at least one month of age	Question asked at the first home visit every month and evaluated when the child reaches 13 months of age	Outcome	Cohort
8) Maternal and child health insurance status	Percent of mothers and children with health insurance	# mothers + # children receiving home visiting services with health insurance/ # mothers + # children receiving home visiting services	Derived from PRAMS question 71. Ask two separate questions, one for the mother and one for the child. What kind of health insurance does your child have now? -Private health insurance from your job or the job of your spouse, partner, or parents -Private health insurance purchased directly from an insurance company by you or someone else -Medicaid or Medicaid HMO -Florida KidCare -TRICARE or other military health care -Medicare -Some other kind of health insurance Please tell us: -I do not (my child does not) have health insurance now	Indicator relies on self report. The PRAMS questionnaire is used extensively and has a high degree of reliability and validity (see above).	Increase the percent of mothers and children that have health insurance from 13 months to 18 months (child's age). (i.e., mothers and children are both evaluated when child reaches these ages)	Home visitor	Web-based case management system	Mothers and children receiving home visiting services	At enrollment, at 2 months of age, at 6 months of age and at 6 month intervals starting at 13 months of age for both mothers and children.	Outcome	Individual

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
9) Visits for children the emergency department from all causes	Percent of children with emergency room visits	# children receiving services with an emergency room visit within the past 6 months/ # children receiving services	In the past month, has _CHILD_ seen a doctor, nurse or other medical professional? Y/N If yes, was the visit for: __ a regular (well-child) checkup __ treating an injury __ diagnosing and treating an illness __ immunization __ special healthcare needs __ Other: _____ If yes, where was the care provided? __ Emergency room __ Doctor's office __ County Health Department or Federally Qualified Health Center (A clinic) __ Urgent Care __ Other	This indicator is both valid and reliable. This indicator has face validity for the construct.	At 12 months of age the percent of children with emergency room visits in the past 6 months will be lower for the second year cohort than for the first.	Home visitor	Web-based case management system	Children receiving home visiting services who were enrolled when they were equal to or less than 6 months of age	Question will be asked monthly at the first home visit of the month but data will be evaluated when the child is 12 months of age.	Outcome	Cohort
10) Visits for mothers the emergency department from all causes	Percent of mothers who visited a hospital emergency room for any reason in the past six months.	# non-pregnant mothers receiving services with an emergency room visit within the past six months/ # non-pregnant mothers receiving services	In the past month, have you seen a doctor, nurse or other medical professional? Y/N If yes, where was the care provided? __ Emergency room __ Doctor's office __ County Health Department or Federally Qualified Health Center (A clinic) __ Urgent Care __ Other	This indicator is both valid and reliable. This indicator has face validity for the construct.	Reduce the percentage of mothers receiving services who have visited the emergency room in the past six months when their child is 12 months of age from the first cohort to the second.	Home visitor	Web-based case management system	Non-pregnant women receiving home visiting services	Question will be asked monthly at the first home visit of the month but data will be evaluated when the child is 12 months of age.	Outcome	Cohort
11) Information provided or training on prevention of child injuries	Percent of clients having received safety training or information on at least three topics.	# families receiving safety information or training on at least three of the topics/ # families receiving services	Administrative data. ETO will capture each time the home visitor provides information or education on the specific topic	This indicator has face validity for the construct.	The percent of families receiving safety training or information on three or more topics by the end of the first year of home visiting services will be greater for the second year cohort than for the first.	Home visitor	Web-based case management system	Families with children receiving home visiting services	Administrative data will be evaluated at the end of the first year of service.	Process	Cohort

Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
12) Incidence of child injuries requiring medical treatment	Percent of children receiving services who received medical treatment for injuries	# children receiving services who require medical care for injuries within the past six months/ # children receiving services	In the past month, has _CHILD_ seen a doctor, nurse or other medical professional? Y/N If yes, was the visit for: __ a regular (well-child) checkup __ treating an injury __ diagnosing and treating an illness __ immunization __ special healthcare needs __ Other: _____ If yes, where was the care provided? __ Emergency room __ Doctor's office __ County Health Department or Federally Qualified Health Center (A clinic) __ Urgent Care __ Other	NA.	The percent of 12 month old children requiring medical care for injuries in the prior six months will be less for the second year cohort than for the first.	Home Visitor	Web-based case management system	Children receiving home visiting services	At the first home visit each month	Outcome	Cohort
13) Reported suspected maltreatment for children in the program	Percent of children whose families are receiving services for whom there was a report of maltreatment to the Hotline within the previous six months (broken down by ages: 0-12 months, 13-36 months, and 37-84 months)"	For each age group above, # children receiving services with a report of maltreatment to the hotline within the past six months/ # children receiving services	Administrative data from FSFN	This indicator has face validity for the construct.	The percent of children twelve months of age whose families are receiving services for whom there was a report of maltreatment to the Hotline will be the same or lower for the second cohort than for the first.	Administrative data from FSFN	Department of Children and Families	Children at 12 months of age in families receiving home visiting services	Evaluated annually one month after the child's birthday	Outcome	Cohort
14) Reported substantiated maltreatment	Percent of children whose families are receiving services with substantiated maltreatment (broken down by ages: 0-12 months, 13-36 months, and 37-84 months)".	# children receiving services with substantiated maltreatment within the prior six months / # children receiving services	Administrative data from FSFN	This indicator has face validity for the construct	The percent of children with substantiated maltreatment will be the same or lower when the child is 12 months of age for the second cohort than for the first.	Administrative data from FSFN	Department of Children and Families	Children at 12 months of age in families receiving home visiting services	Evaluated when the child is 13 months of age and annually thereafter (this timing may change based on available data regarding investigation results)	Outcome	Cohort
15) First-time victims of maltreatment	Percent of children whose families are receiving services with first time ever substantiated maltreatment	# children receiving services with a first substantiated maltreatment within the past six months/ # children receiving services	Administrative data from FSFN	This indicator has face validity for the construct.	The percent of children with first time ever substantiated maltreatment will be the same or lower when the child is 12 months of age for the second cohort than for the first.	Administrative data from FSFN	Department of Children and Families	Children at 12 months of age in families receiving home visiting services	Evaluated when the child is 13 months of age and annually thereafter (this timing may change based on available data regarding investigation results)	Outcome	Cohort

Benchmark 3: Improvements in School Readiness and Achievement											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
16) Parent support for children's learning and development	Difference between the score on both the Parental Involvement and Learning Materials Scale on the IT HOME (for children<3) or on the HFPI Home Environment Subscale from 6 months of age to 18 months of age	Sum of the difference between the total score on both the Parental Involvement and Learning Materials scales on the IT HOME / # families receiving services who were assessed at both 6 months of age and 18 months of age. Sum of the difference between the score on the HFPI Home Environment Subscale / # families receiving services who were assessed at both 6 months of age and 18 months of age.	The Parental Involvement and Learning Materials scales on the IT HOME or the Home Environment Subscale of the HFPI	The IT-HOME is a well validated instrument (see above). The HFPI has internal validity. This indicator has face validity for the construct.	The average change in score on both the Parental Involvement and the Learning Materials scale of the IT HOME or on the HFPI Home Environment Subscale from six months of age to eighteen months of age will be positive.	Home visitor	Screening results will be recorded in the web-based case management system	Families with children receiving services who are at least six months old	At enrollment (or when the child is six months of age, whichever is later), when the child is 18 months of age and annually thereafter during the month after the child's birthday	Outcome	Individual
17) Parent knowledge of child development and of their child's developmental progress	Difference between the score on the IT HOME (for children<3) or on the HFPI Parent Child Interaction Subscale from 6 months of age to 18 months of age	Sum of the difference between the total score on the IT HOME / # families receiving services who were assessed at both 6 months of age and 18 months of age. Sum of the difference between the total score on the HFPI Parent Child Interaction Subscale / # families receiving services who were assessed at both 6 months of age and 18 months of age.	The IT HOME Full scale or the Parent Child Interaction Subscale of the HFPI	The IT-HOME is a well validated instrument (see above). The HFPI has internal validity. The use of the IT-HOME for this indicator was recommended as valid for the construct by NFP.	The average change in score on the IT HOME or on the HFPI Parent Child Interaction Subscale from six months of age to eighteen months of age will be positive.	Home visitor	Screening results will be recorded in the web-based case management system	Families receiving home visiting services	At enrollment (or when the child is six months of age, whichever is later), when the child is 18 months of age and annually thereafter during the month after the child's birthday	Outcome	Individual

Benchmark 3: Improvements in School Readiness and Achievement											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
18) Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	Difference between the score on both the Acceptance of Child and Parental Involvement scales of the IT HOME (for children<3) or on the HFPI Parent Child Interaction Subscale from 6 months of age to 18 months of age	Sum of the difference between the total score on the Acceptance of Child and Parental Involvement scales on the IT HOME / # families receiving services who were assessed at both six months of age and 18 months of age. Sum of the difference between the score on the HFPI Parent Child Interaction Subscale / # families receiving services who were assessed at both 6 months of age and 18 months of age.	The responsiveness to parents scale on the IT- or EC-HOME assessment or the Parent Child Interaction Subscale of the HFPI	The IT HOME is a well validated tool (see above). The HFPI has internal validity.	The average change in score on the Acceptance of Child and Parental Involvement scales of the IT HOME or on the HFPI Parent Child Interaction Subscale from six months of age to eighteen months of age will be positive.	Home visitor	Screening results will be recorded in the web-based case management system	Families receiving home visiting services	At enrollment (or when the child is six months of age, whichever is later), when the child is 18 months of age and annually thereafter during the month after the child's birthday	Outcome	Individual
19) Parent emotional well-being or parenting stress (note: <u>some</u> of these data may also be captured for maternal health under that benchmark area).	Average score on the Perceived Stress Scale	Total score on the ten Perceived Stress Scale questions/ # mothers receiving services who were assessed on the scale	Average score on the Perceived Stress Scale	The Perceived Stress Scale is a well-validated instrument. Norms were established from 2,387 respondents.	The mean score on the Perceived Stress Scale will be lower when the child is 12 months of age than at enrollment or when the child is two months of age.	Home visitor	Screening results will be loaded into the web-based case management system	Primary clients receiving home visiting services	At enrollment or when the infant is two months of age whichever comes later and then annually one month after the birth date.	Outcome	Individual
20) Child's communication, language and emergent literacy	Percent of children receiving services who score below the cutoff in the communications area of the Ages and Stages Questionnaire (ASQ-3) who are referred for appropriate services.	# of children receiving services who score below cut off in the communications area of the ASQ-3 who receive an appropriate referral within two months of screening/ # children who score below cut off in the communications area of the ASQ-3	The ASQ-3 Communications Scale.	The ASQ-3 is a well-validated tool (see above).	The percent of children twelve months of age scoring below cut off in the communications area of the Ages and Stages questionnaire (ASQ-3) who receive an appropriate referral within two months of screening will be greater for the second year cohort than for the first year cohort.	Home visitor	Screening results will be recorded in the web-based case management system	Children receiving home visiting services who are 12 months of age and score below the cut off on the communications area of the Ages and Stages Questionnaire (ASQ-3)	The Communications subscale of the ASQ-3 will be administered at 4 months (or at enrollment for children greater than 4 months of age at enrollment), at 14 months of age and annually thereafter one month after the birthdate.	Process	Cohort
21) Child's general cognitive skills	Percent of children receiving services who score below the cutoff in the ASQ-3 Problem Solving subscale who are referred for appropriate services.	# of children receiving services who score below cut off in the ASQ-3 Problem Solving subscale who receive an appropriate referral within two months of screening / # of children receiving services who score below typical cut off in the ASQ-3 Problem Solving subscale	The ASQ-3 Problem Solving subscale.	The ASQ-3 is a well-validated tool (see above).	The percent of children twelve months of age scoring below cut off in the ASQ-3 Problem Solving subscale who receive an appropriate referral will be greater for the second year cohort than for the first year cohort.	Home visitor	Screening results will be recorded in the web-based case management system	Children receiving home visiting services who are 12 months of age and score below cut off in the ASQ-3 Problem Solving subscale	The Problem solving subscale of the ASQ-3 will be administered at 4 months (or at enrollment for children greater than 4 months of age at enrollment), at 14 months of age and annually thereafter one month after the birthdate.	Process	Cohort

Benchmark 3: Improvements in School Readiness and Achievement											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
22) Child's positive approaches to learning including attention	The percent of children scoring below the cutoff on the Personal-social subscale of the ASQ-3 who receive an appropriate referral within two months of screening	# of children receiving services who score below cut off on the Personal-social subscale of the ASQ-3 who receive an appropriate referral within two months of screening/ # of children receiving services who score below cut off on the Personal-social subscale of the ASQ-3	Personal-social subscale of the ASQ-3	The ASQ-3 is a well-validated tool (see above).	The percent of children twelve months of age scoring below cut off in the Personal-social subscale of the ASQ-3who receive an appropriate referral within two months of screening will be greater for the second year cohort than for the first year cohort.	Home visitor	Screening results will be recorded in the web-based case management system	Children receiving home visiting services who score below cutoff on the personal-social subscale of the ASQ-3	The Personal-Social subscale of the ASQ-3 will be administered at 4 months (or at enrollment for children greater than 4 months of age at enrollment), at 14 months of age and annually thereafter one month after the birthdate.	Process	Cohort
23) Child's social behavior, emotion regulation, and emotional well-being	Percent of children receiving services who score below the cut-off in the Ages and Stages Social/Emotional Questionnaire (ASQ-SE) who receive an appropriate referral within two months of screening.	# of children receiving services who score below cut off on the ASQ-SE who receive an appropriate referral within two months of screening / # children receiving services who score below cut off on the ASQ-SE	The ASQ-SE	The ASQ-SE is a well-validated instrument (see above).	The percent of children twelve months of age scoring below cut off on the ASQ-SE who receive an appropriate referral within two months of screening will be greater for the second year cohort than for the first year cohort.	Home visitor	Screening results will be recorded in the web-based case management system	Children receiving services who are twelve months of age and score below cut off on the ASQ-SE	The ASQ-SE will be administered at 6 months of age (or at enrollment for children greater than 6 months of age at enrollment), at 14 months of age and annually one month after the birth date.	Process	Cohort
24) Child's physical health and development.	Percent of children receiving services who score below the cutoff on either the gross motor or fine motor scales of the ASQ-3 who receive an appropriate referral within two months of screening.	**#** of children receiving services who score below cut off on either the gross motor or fine motor scales of the Ages and Stages Questionnaire (ASQ-3) who receive an appropriate referral within two months of screening / # of children who score below cut off on either scale	The gross and fine motor skills subscales of the ASQ-3	The ASQ-3 is a well-validated instrument (see above). Children in poor health or who are experiencing developmental delays are more likely to perform poorly on this scale.	The percent of children twelve months of age scoring below cut off on either the gross or fine motor skills subscales of the ASQ-3 who receive an appropriate referral within two months of screening will be greater for the second year cohort than for the first year cohort.	Home visitor	Screening results will be recorded in the web-based case management system	Children receiving home visiting services who score below the cutoff on either the gross motor or fine motor scales of the ASQ-3	The ASQ will be administered at 4 months (or at enrollment for children greater than 4 months of age at enrollment), at 14 months of age and annually thereafter one month after the birthdate.	Process	Cohort

Benchmark 4: Crime or Domestic Violence											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
Crime	N/A										
25) Arrests	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
26) Convictions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Domestic Violence											
27) Screening for domestic violence	Percent of families screened for domestic violence within six month of enrollment	# families receiving screening for domestic violence within six months of enrollment/# families receiving services for at least 6 months	Modified PRAMS question 44: During the past six months, have you been in a relationship that involved pushing, hitting, slapping, kicking, choking, or physically hurting one another in any other way? • No • Yes Or a domestic screening question commonly used by the model.	The PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity (see above).	The percent of families receiving home visiting services who have been screened for domestic violence within six months of enrollment will be the same or greater for the second year cohort than for the first.	Home visitor	Web-based case management system	Families receiving home visiting services	Within 6 months of enrollment and annually one month after the birthdate	Process	Cohort

Benchmark 4: Crime or Domestic Violence											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
28) Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries)	Percent of families identified with domestic violence referred to domestic violence services	# families who reported domestic violence who are referred for relevant domestic violence services within 7 days of identified need/ # families receiving services with reported domestic violence	Administrative data about referrals	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system. The PRAMS is well validated (see above).	The percent of women receiving services who have experienced domestic violence who are referred for domestic violence services will be greater for the second cohort than for the first.	Home visitor	Web-based case management system	Families receiving home visiting services	Administrative data queried annually.	Process	Cohort
29) Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	Percent of families who reported domestic violence with a safety plan in place	Of families who reported domestic violence # with a safety plan in place/ # families receiving services with domestic violence	Administrative data regarding the Family Safety Plan	This measure is both reliable and valid as safety plan dates will be captured in the web-based automated system.	The percent of families receiving services who have experienced domestic violence who have a safety plan in place within 3 months of identified need will be the same or greater for the second cohort than for the first.	Home visitor	Safety plan dates will be recorded in the web-based case management system	Families receiving services who have experienced domestic violence	Initial question asked by the home visitor between enrollment and six months after enrollment followed by administrative data. Queried at the end of each year of service. Safety plan dates will be recorded in the web-based case-management system.	Process	Cohort

Benchmark 5: Family Economic Self-Sufficiency											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
30) Household income and benefits (See SIR for definitions.)	Total household income for the previous calendar year	The average answer to PRAMS question 81 after the child is 12 months of age minus the average of the answer at enrollment. Calculate the average of this difference for families enrolling in each quarter.	PRAMS question 81 During the past 12 months, what was your yearly total household income before taxes? Include your income, your spouse's or partner's income, and any other income you may have received. (All information will be kept private and will not affect any services you are now getting.)	This indicator relies on the mothers' self-report, detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity (see above). This indicator has face validity for the construct.	There will be a positive difference between household income at enrollment and income after the child is 12 months of age for families receiving service.	Home visitor	Web-based case management system	Families receiving home visiting services	Question at enrollment, and when the child is 12 months of age and annually thereafter	Outcome	Individual

Benchmark 5: Family Economic Self-Sufficiency											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
31) Employment or Education of adult members of the household	Percent of primary clients receiving services with an improvement in educational status	# clients receiving services with some educational improvement since enrollment/ # clients receiving services	At enrollment ask: 1. What level of education have you completed: Less than 8th grade, High school or GED, Associate's degree , technical certification, Bachelor's Degree, Post graduate degree 2. Are you currently enrolled in an educational program (such as HS, GED, college, certificate programs, ESOL, Vocational Training)? 3. If no, are you interested in enrolling in an educational program? At the first visit after the child reaches one month of age, ask: 4. What level of education have you completed: Less than 8th grade, High school or GED, Associate's degree , technical certification, Bachelor's Degree, Post graduate degree 5. Are you currently enrolled in an educational program?	NA. This indicator has face validity for the construct.	The percent of clients with some educational improvement when the child is 12 months of age compared to at enrollment	Home visitor	Web-based case management system	Clients receiving home visiting services	At enrollment and annually one month after the birth date thereafter	Outcome	Individual
32) Health insurance status	Percent of mothers and children with health insurance	# mothers + # children receiving home visiting services with health insurance/ # mothers and children receiving home visiting services	Derived from PRAMS question 71. Ask two separate questions, one for the mother and one for the child. What kind of health insurance does your child have now? - Private health insurance from your job or the job of your husband, partner, or parents - Private health insurance purchased directly from an insurance company by you or someone else - Medicaid - TRICARE or other military health care - Some other kind of health insurance Please tell us: - I do not have health insurance now	Indicator relies on self-report. The PRAMS questionnaire is used extensively and has a high degree of reliability and validity (see above).	Increase the percent of mothers and children that have health insurance from enrollment to 18 months (child's age). (i.e., mothers and children are both evaluated when child reaches these ages)	Home visitor	Web-based case management system	Mothers and children receiving home visiting services	At enrollment, at 2 months of age, at 6 months of age and at 6 month intervals starting at 13 months of age for both mother and child. Insurance coverage for all household members will be collected at enrollment and when the child is 12 months of age.	Outcome	Individual

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
33) Number of families identified for necessary services	Percent of families with a case-management plan	# of families with a case-management plan/# families receiving home visiting services	Administrative data: Results of assessments and administrative data regarding referrals and their completion. Needs will be identified using the following instruments: NFP: Home Visitor Encounter Form; Client Funding Source Form, Patient Health Questionnaire; Edinburgh Postnatal Depression Scale; Interview; ASQ-3; ASQ-SE; Perceived Stress Inventory; IT-HOME; Interview questions HFF: Structured interview; ASQ-3; ASQ-SE; Edinburgh Postnatal Depression Scale; Monthly Screening Information Form; Assessment Information Form; Participant Information Form; Participant Training/Treatment Information Form; Employment Information Form; Home Safety Information Form; Participant Housing Information Form; Participant Education Information Form; Subsequent Pregnancy Information Form; Health Families Parenting Inventory Data Collection Form; Child Information Form; Child Insurance Information Form; Developmental Screening Information Form; Service Ledger Form; Referral Log; Perceived Stress Inventory; HFPI; PAT: Life skills progression; Edinburgh Postnatal Depression Scale; ASQ-3; ASQ-SE; ; Interview; PAT Parent Survey; PFS; KIPS; Batelle; Brigance;DIAL-3; Early Screening Inventory; First STEP; DECA; BITSEA; Parents as Teachers Health Record; Affiliate Performance Report; Personal Visit Record; Perceived Stress Inventory; IT-HOME; Interview questions	This measure is both reliable and valid in that case-management plans will be recorded automatically in the web-based case management system.	The percent of families with case-management plans will be the same or higher when the child is 12 months of age for the second year cohort than for the first.	Home Visitor	Case-management plans will automatically be recorded in the web-based case management system and will consist of identified needs (based on each model's standard assessment tools), referrals or services provided, and referrals or services completed	Families receiving home visiting services	When the child is 12 months of age; Evaluated quarterly for CQI purposes	Process	Cohort
34) Number of families that required services and received a referral to available community resources	Percent of families who received referrals appropriate to the family's needs	# Families with identified needs who received at least one referral appropriate to one need within one month of need identification/ # families with identified needs	Administrative data	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system.	The percent of families receiving appropriate referrals within one month of need identification will be the same or greater for the second year cohort than for the first year cohort.	Home Visitor	Referrals will be recorded in the web-based case management system	Families receiving services with an identified need	Evaluated at the end of the first 12 months of service	Process	Cohort
35) MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community	Number of formal agreements with community providers	Count of agreements attached to quarterly reports	Each quarter, communities will be asked to submit a list of existing MOUs and attach any new MOUs signed in that quarter	This measure is reliable and valid as communities will have to attach copies of MOUs to their quarterly reports.	The number of MOUs with community providers will be maintained or increase from the February 2012 level to the level In February 2014.	Chiles Center	Communities will report Quarterly Progress regarding program implementation on templates developed, collected, and analyzed by the Chiles Center.	Communities implementing MIECHV	Quarterly	Process	Cross-sectional

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports											
Construct	**Performance Measure**	**Operational Definition**	**Measurement Tool (or Administrative Data)**	**Reliability/Validity**	**Definition of Improvement**	**Persons Responsible**	**Source**	**Population**	**Schedule (Frequency)**	**Type of Indicator**	**Type of Comparison**
36) Information sharing: Number of agencies with which the home visiting provider has a clear point of contact.	Number of agencies with which the home visitor provider has a clear point of contact.	Count of agencies listed in quarterly reports; all communities will provide information based on the same template.	Each quarter, communities will be asked to submit a list of agencies and contacts. The specific question asked is: Please complete this form for all community partners who have agreed to provide services to your clients. Headings on the form are as follows: Community organization; services provided; contact information (name, phone, e-mail); date MOU or formal agreement is in effect; mark here if there is no formal agreement but a working relationship exists.	This indicator has face validity for the construct.	The number of agencies with which the home visitor provider has a clear point of contact will be maintained or increase from the February 2012 level to the level In February 2014.	Chiles Center	Communities will report Quarterly Progress regarding program implementation on templates developed, collected, and analyzed by the Chiles Center.	Communities implementing MIECHV	Quarterly	Process	Cross-sectional
37) Number of completed referrals	Percent of families with at least one referral for which referred services were received	# of families receiving services with referrals for whom at least one referral service was received within 3 months of need identification/ # families receiving services with referrals	Administrative data	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system.	The percent of families receiving appropriate services for referrals within three months of need identification will be the same or greater for the second year cohort than for the first year cohort.	Home Visitor	Needs, referrals, and referral completion will be recorded in the web-based case management system continuously	Families receiving home visiting services with referrals	Evaluated at the end of the first year of service for each cohort	Process	Cohort

Measuring the Development and Implementation of Florida's MIECHV Program

State Activities, Processes, and Outcomes

Based on meeting summaries and other documentation, a chronological description of implementation efforts on the state level will provide a basis for evaluating Florida's efforts to achieve statewide goals and objectives. Also, the state's implementation efforts will be evaluated in comparison to the proposed timeline included in the updated state plan.

In addition to describing the state's activities related to achievement of each goal, by December 31, 2012, baseline values will be collected for each of the statewide objectives. Annual values will be obtained each December to determine if Florida is experiencing improvement on statewide goals and objectives.

The evaluation will include answers to the following questions:

1. How is agency staff interacting with communities and national offices to solve problems and ensure the success of Florida's MIECHV Program?
2. What systems does the state have in place for managing the program and how are they being implemented?
3. What does the collaboration among state agencies and other statewide organizations look like? Are those collaborations facilitating program implementation?

Community Activities and Processes

Two data sources, in addition to ETO data, will be used to describe and evaluate community implementation activities: quarterly reports and annual site visits. Beginning with the quarter ending December 31, 2011, local agencies implementing MIECHV projects will be required to submit structured quarterly reports about their implementation activities in the previous quarter. So that similar information is collected from all implementing agencies, unique templates for reports will be created by the evaluation team. Templates will vary from quarter to quarter, depending on the expected stage of development of local programs. Beginning with the quarter ending March 1, 2012, the first quarter during which it is expected that local programs will be providing services for families, selected data from the Web-based case management system will be analyzed to evaluate how services are being provided and to whom.

From these two sources of data many process variables can be evaluated including but not limited to:

- What kinds of services are being provided?
- What is the attrition rate?
- How is coordination of care actually working?
- What are the demographic characteristics of the population being served?
- How close to capacity is the local program operating?
- Is the program on track for national accreditation?
- Are assessments being conducted in a timely manner?
- Are clients receiving appropriate referrals and services?

In addition, agency staff and the evaluation team will conduct structured annual site visits with each implementing agency to ensure that community implementers are meeting their contractual obligations, validate the content of quarterly reports, assess actions taken related to technical assistance that has been provided, determine the degree to which program data are being used locally for CQI, and ascertain how state level management might be improved to better meet the needs of program implementers.