

HEALTH RESOURCES AND SERVICES ADMINISTRATION
Maternal and Child Health Bureau

Guidance for Meeting Legislatively-Mandated Reporting on Benchmark
Areas, Demographic Data, and Service Utilization Data

Purpose

This document provides guidance to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program grantees to meet the legislatively-mandated reporting on benchmark areas, as well as the demographic data, and service utilization data.

Overview

To meet the requirements for establishment of quantifiable, measurable 3- and 5-year in benchmarks,¹ eligible entities² for the MIECHV program must develop a benchmark plan for the initial and ongoing data collection for each of the six benchmark areas listed below. Technical assistance is available to successful applicants and grantees to develop plans for meeting benchmark area requirements for the MIECHV program. Once approved, the grantee must make any proposed additions, deletions, or revisions in consultation with the Regional Project Officer.

Requirements for Related to Measurable Improvement Under the Benchmark Areas

The following requirements relate to measurable improvement under the benchmark areas:

- The grantee must collect data on all benchmark areas.
- The data must be collected for eligible families enrolled in the program who receive services supported by MIECHV program funds.³
- Each benchmark area includes various related constructs (or measurement concepts). The applicant must collect data for all constructs under each benchmark area. (Please see Overall Measurement Plan Requirements below, a more detailed description with illustrations of the various components of each indicator associated with individual constructs under the benchmark areas specified in the legislation.)

¹Benchmark areas (which encompass the broad goals of the MIECHV program) include: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; Improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports (per Section 511 (d) (1) of the Social Security Act).

² In this document, the term “Eligible entities” refers to current MIECHV program grantees and /or eligible entities responding to Funding Opportunity Announcements for the MIECHV program.

³ A family is to be considered enrolled as of the date of the first home visit.

- A standard performance measure for each of the constructs within a benchmark area across all utilized home visiting models is strongly encouraged (if the applicant plans to implement more than one home visiting model).
- We recommend that applicants utilize these program-wide performance measures (or a subset of these indicators) for the purpose of CQI to enhance program operation and decision-making and to individualize services.⁴
- Applicants may propose either to collect data on each participating family or to use a sampling approach for some or all benchmark areas. Technical assistance will be provided to grantees in utilizing data for CQI.
- The performance measures and associated measurement tools proposed by applicants must be developmentally appropriate and appropriate for use with the populations served by the home visiting program.
- For the purposes of the benchmark area-related requirements, it is recommended that data collected across all benchmark areas take into account the importance of interoperability of systems and therefore be coordinated and aligned to the extent possible with other relevant state or local data collection efforts. For example, aligning indicators or linking data on children and families served by the home visiting program, with appropriate privacy protections, to data on the same children and families served by early childhood care and education, child welfare, early intervention programs, medical home/primary health care, substance abuse, Medicaid, statewide immunization registries, Special Supplemental Nutrition Program for Women and Infants (WIC) or other programs is strongly encouraged.
- Utilizing forms provided by HRSA, grantees must report annually on benchmark data as well as aggregate demographic and service-utilization data on the participants in their program, as necessary to analyze and understand the progress children and families are making. Grantees will also be required to report annually on progress in achieving improvement in the six benchmark areas.

The due date for the submission of data for the first (baseline) year of program implementation is February 4, 2013. Individual-level demographic and service-utilization data collected by grantees should include but are not limited to the following:

- Indicators of families' participation in the home visiting program (e.g., families receiving services, families successfully completing the program, families that terminated services, clients served under the legislatively specified priority populations).⁵

⁴ Section 511 (d) (2)(A) of the Social Security Act.

⁵ The legislatively specified priority populations include: eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under this section; low-income eligible

- Demographic data for the participant children, pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: age in months and gender of the index child; age, racial and ethnic background of all participants in the family; index child's exposure to a language other than English; family socioeconomic indicators (e.g., family income; employment, academic or training status of care giving adults).

Technical Assistance:

Technical assistance will be available to grantees to strengthen any benchmark area-related indicators or other features of the performance measurement system. The Benchmark Technical Assistance Brief issued in November 2011 provides additional recommendations to strengthen benchmark area-related measurement plans. The document can be found at: http://www.mdrc.org/dohve/dohve_resources.html.

In addition, HRSA intends to provide training and technical assistance to grantees throughout the implementation of the MIECHV program. HRSA will use a multi-dimensional and multi-faceted approach and will provide technical assistance including collaboration and coordination with other Federal Government agencies and the national model developers. HRSA intends to tailor technical assistance to meet needs identified by grantees.

Overall Measurement Plan Requirements

As noted above, the program measurement system should contain information about each performance measure selected for the individual constructs under each benchmark area, including a plan for data collection and analysis for each performance measure. Specifically, for each construct the measurement system should include:

A) Name and type of performance measure selected or developed

- For each construct within each benchmark area (e.g. "breastfeeding" under benchmark area I, Maternal and Child Health), specify one proposed indicator (e.g., breastfeeding at three months post-partum; breastfeeding at six months post-partum, or exclusive breastfeeding at six months post-partum).

families; eligible families who are pregnant women who have not attained age 21; eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; eligible families that have a history of substance abuse or need substance abuse treatment; eligible families that have users of tobacco products in the home; eligible families that are or have children with low student achievement; eligible families with children with developmental delays or disabilities; eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

- Indicate the type of performance measure selected. Performance measures can be process-or outcome-oriented. Process measures typically relate to program operations or implementation. Outcome measures generally capture the intended results achieved by program participants.

B) Operational definition

- Provide a detailed, specific definition of the performance measure. Describe how the value of the measure can be unambiguously constructed from the data by specifying:
- Key terms: clarify the meaning of the terms utilized in the definition (e.g., what counts as “care received” or “information provided”?); describe the criteria to be used to obtain consistent data (e.g., the time window during which the measurement ought to occur such as prenatally, post-partum, first month of life, or first year of life).
- Subgroups of focus: for each specific measure define the categories of participants included and excluded from the calculation (e.g., is “child” the index child, all children in the household, or all siblings 0-5 years old?).
- Type of scoring: Indicate if the measure is a count, a percentage, a rate or other type of scoring. If the measure is a percentage or a rate provide a clear description of the numerator and denominator.

C) Measurement tool utilized or question(s) posed to capture the construct of interest

- If a measurement tool is utilized to capture the construct, provide evidence of its reliability/validity for the population with which the tool will be used.
- Articulate the question or questions utilized (e.g., posed by the home visitor to a parent) that would suffice, given their face validity, to capture the construct of interest when no measurement tool or scale is needed.

D) Definition of improvement

- Grantees have discretion to define improvement for each construct in a way that is meaningful for their program taking into account contextual factors and different stages of measurement system implementation across grantees. Statistically significant change is not required. Any incremental change in the desired direction will count as improvement. Maintenance of program performance at or above an acceptable target for a given construct could also constitute an instance of improvement. For example, in some instances, ongoing quality improvement efforts will result in a grantee reaching a level of performance, over time, that is considered desirable or realistically acceptable. Frequently, after testing and implementation, a period of consolidation is needed to institutionalize the change or changes that resulted in improvement and to maintain the gains achieved (i.e. making the change a day-to-day feature of the program).
- Grantees should propose a definition of improvement for each individual construct. The definition of improvement (increase, decrease, maintain above a certain level) should be

based on the performance measure selected. (e.g., “Increase in the percentage of pregnant women who are screened for cigarette use at intake”).

- The specific population and the points of comparison for determining change should be included in the definition. For example, “Increase the rate of mothers enrolled prenatally with adequate health insurance coverage at the index child’s first birthday for participants enrolled in year 2 compared to those enrolled in baseline year 1.”
- A numeric target is not required in the definition of improvement, unless the definition includes maintenance of an acceptable performance level.
- Note whether the comparison is within a cohort or across a cohort of enrollees. An example of measuring a characteristic at two points in time for the same group of individuals would be the percent of mothers enrolled in a given year at risk for post-partum depression and the percent of the same mothers at risk of depression six months later. An example of a comparison across groups of enrollees would be the percent of mothers enrolled in baseline year one who were screened for post-partum depression during the reporting period compared to the percent of mothers enrolled in year 3 who were screened for post-partum depression during the reporting period.

E) Plan for data collection and analysis

- For all indicators under all benchmark areas, the data collection plan would include the following basic specifications:
 - The persons responsible for actually collecting the data initially at the source (e.g., the home visitor, the analyst with access to a sister agency’s relevant administrative data set, etc.) and those participating in subsequent data collection steps.
 - The data source, e.g., self report by parent, home visitor’s observation, or administrative data set from another agency.
 - Frequency: when and how often will data be collected (e.g., within three months of enrollment, monthly, quarterly).
 - Any other consideration including how the data will be collected (e.g., manually entered into a log, sent via tablet to a secure server, etc.), analyzed (e.g., what statistics or graphs will be used), and reported (e.g., who will receive the results and how often).
 - Indicate the population to be assessed by each performance measure (e.g., parent or index child).
 - A plan for sampling, if proposed, that includes the sample selection procedures and data to ensure the sampling approach will be representative and produce stable estimates.
 - A plan and progress made on the selection and implementation of a local data system. The plan should consider the interoperability of management information systems and the ability to perform linkages between data on children and families served by the

- State Home Visiting Program and data on the same children and families served by early childhood care and education programs, child welfare, medical home/primary health care, substance abuse, Medicaid, statewide immunization registries, WIC or other programs.
- A data collection schedule including how often the data are collected and analyzed (the minimum is annually for purposes of reporting to HRSA and ACF but programs should consider more frequent data collection for CQI purposes).
 - A plan for ensuring the quality of data collection and analysis. The plan should include minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management at the implementing agency, qualifications of personnel responsible for data analysis at the implementing agency, and the time estimated for the data collection-related activities by personnel categories.
 - A plan for analyzing the data. This should include how data are being aggregated and disaggregated to assess the progress made within different communities and for different groups of children and families.
 - A plan for gathering and analyzing demographic and service-utilization data on the children and families served in order to assess the progress children and families are making. This may include data on the degree of participation in services, the child's age in months, the child's race and ethnicity, the child's home language, the child's sex, the parent's education or employment, and other relevant information about the child and family.
 - A plan for using benchmark measurement system data for CQI at the local program level and the community level.
 - A plan for data safety and monitoring including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. The plan must include training for all relevant staff on these topics.

Individual Benchmark Areas

Listed below are the given constructs under each of the six legislatively mandated benchmark areas for which performance measures need to be proposed and tracked. Information collected by model developers for these benchmarks is collected from participants voluntarily enrolled in the home visiting program and who have provided informed consent. The collected data is aggregated for state-level data reporting and personal identifiers are not reported to the federal government.

Under each benchmark area, we offer illustrations and comments relevant to the constructs listed. These examples and suggestions are organized under the following generally accepted steps involved in indicator development: A) name and type of performance measure, B) operational definition, C) measurement tool utilized or question(s) posed, D) definition of measurable improvement, and E) plan for data collection and analysis.

I. Improved Maternal and Newborn Health

A) Name of performance measure

Constructs for which performance data must be reported under this benchmark area follow (all constructs must be measured that are relevant for the population served; if newborns are not being served, constructs related to birth outcomes will not need to be reported):

- Prenatal care
- Parental use of alcohol, tobacco, or illicit drugs
- Preconception care
- Inter-birth intervals
- Screening for maternal depressive symptoms
- Breastfeeding
- Well-child visits
- Maternal and child health insurance status (note: these data may also be utilized under the family economic self-sufficiency benchmark area)

B) Operational definition

- Percentages and rates are frequent metrics utilized for indicators corresponding to the above constructs. Examples include the percentage of children birth-to-age-three in families participating in the program who receive the recommended schedule of well- child visits during the reporting period or the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.
- For certain constructs under benchmark area I, such as breastfeeding, smoking for pregnant women or prenatal care, grantees may select performance measures currently operationally defined and utilized for federal reporting under Title V Maternal and Child Health Block Grant. For information about these performance measures see:
 - Maternal and Child Health Bureau National Performance Measures-
<https://mchdata.hrsa.gov/TVISReports/MeasurementData/MeasurementDataMenu.aspx>
 - For information on other nationally utilized indicators under this benchmark area (e.g., well child visits, maternal depression screening, health insurance coverage), see

the list of measurement standards endorsed by the National Quality Forum (such as NQF # 1401, NQF #1332, NQF # 1392, NQF # 0723) at http://www.qualityforum.org/Measures_List.aspx#.

- See also Healthy People 2020 at <http://www.healthypeople.gov/hp2020>.

C) Measurement tools utilized or questions posed

- For constructs such as depression screening that require a measurement tool, grantees may define their program performance measure in such a way that accommodates the use of different scales by individual home visiting models as long as all scales utilized are considered valid and reliable for the construct and population of interest.
- Grantees should articulate the question(s) posed to participants to capture constructs that do not require a measurement tool (e.g., timing of the first prenatal care visit or actual duration of inter-birth interval).

D) Definition of measurable improvement

- For prenatal care, preconception care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-child visits, and health insurance coverage, increases over time for participating mothers and infants or maintenance would constitute instances of improvement. As with other benchmark areas, once an acceptable level is reached, maintenance of performance at or above that threshold (during a period to consolidate the gains achieved) could also count as improvement for a given construct.
- For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs, decreases in use over time would indicate improvement. A reduction in the percentage of adult participants who use alcohol, illicit drugs or tobacco may be documented for the same population or across different cohorts of participants. Alternatively, an illustration of improvement utilizing a process measure for this construct would be an increase in the rate of screening among program participants to assess use of these substances noted between the baseline year and a subsequent year.

E) Data collection plan

- Data for the constructs under this benchmark area can be collected from interviews with family members, from observations by the home visitor or through administrative data, if available, at the individual and family level.

II. Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits⁶

A) Name of performance measure

Constructs that must be captured and reported under this benchmark area are:

- Visits for children to the emergency department from all causes
- Visits of mothers to the emergency department from all causes
- Information provided or training of adult participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (e.g., drowning; unsafe levels of lead in tap water), and playground safety
- Incidence of child injuries requiring medical treatment
- Reported suspected maltreatment for children in the program (allegations that were screened in by the child protective service agency but not necessarily substantiated)
- Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
- First-time victims of maltreatment for children in the program

B) Operational definition

- For reductions in emergency department visits: the operational definition could include emergency department visits divided by the number of children or mothers enrolled in the program.
- For training or information related to child injury prevention: the construct may be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program. Criteria for what constitutes adequate training or information should be spelled out (i.e., operationalized).
- For reduction of incidence of child injuries: the performance measure selected would likely include child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the program.
- For child abuse, neglect and maltreatment, the denominator used in the calculation of the rate or percentage in the definition could include all children participating in the program.
- The rate for suspected maltreatment is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.

⁶ The benchmark reporting requirements for Benchmark Area II were updated in October 2012; grantees received notification on October 25, 2012, and changes made to this benchmark area are reflected in the guidance below.

- The rate for substantiated maltreatment should be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
- To calculate the rate of first-time victims count the number of children in the program who are first-time victims divided by the total number of enrolled children in the program. A first time victim is defined as a child who:
 - had a maltreatment disposition of “victim” and
 - never had a prior disposition of victim

C) Measurement tools or questions posed to participants

- Injury-related medical treatment includes ambulatory care, emergency department visits, and hospitalizations due to injury or ingestions.
- For child abuse, neglect and maltreatment it is preferred that data be collected through administrative data provided by the state and local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if the assessment utilizes a valid and reliable tool.
- Please see the Compendium issued by HRSA and ACF for resources and measurement tools for this and other benchmark areas.⁷

For additional information on child injury and maltreatment, see:

- Child Maltreatment; and List of the state contacts for National Child Abuse and Neglect Data System collection, available at: <http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf#page=155>.
- National Data Archive on Child Abuse and Neglect (NDACAN): <http://www.ndacan.cornell.edu>.
- Centers for Disease Control and Prevention: <http://www.cdc.gov/injury/>
- National Health Survey: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/english.
- Children’s Safety Network and Child Death Review Resource Center’s Best Practices website: <http://www.childinjuryprevention.org>.
- Children’s Safety Network: State Injury Prevention Profiles:

⁷ See http://www.mdrc.org/dohve/dohve_resources.html.

<http://www.childrensafetynetwork.org/states>.

D) Definition of measurable improvement

- Improvement for individual performance measures under this benchmark area would include decreases over time for constructs other than information provided or training on preventing child injuries, for which an increase over time would count as improvement.

E) Data collection plan

- For reductions in emergency department visits and child injury prevention: data source options include participant report, medical records, emergency department patient records or hospital discharge systems.

III. Improvements in School Readiness and Achievement

a. Name of performance measure

Constructs for which an indicator must be selected and reported under this benchmark area are:

- Parent support for children's learning and development (e.g., having appropriate toys available, talking, and reading with their child)
- Parent knowledge of child development and of their child's developmental progress
- Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
- Parent emotional well-being or parenting stress (note: some of these data may also be captured for maternal health under benchmark area I)
- Child's communication, language, and emergent literacy
- Child's general cognitive skills
- Child's positive approaches to learning including attention
- Child's social behavior, emotion regulation, and emotional well-being
- Child's physical health and development

For more information see:

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html.
- http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/eecd/Assessment/Child%20Outcomes/edudev_art_00090_080905.html.
- Kagan, S. L., Moore, E., & Bradekamp, S. (1995). Reconsidering children's early development and learning: Toward common views and vocabulary. Washington, DC:

National Education Goals Panel, Goal 1 Technical Planning Group. (See Child Trends summary here: http://www.childtrends.org/schoolreadiness/testsr.htm#_Toc502715209)

b. Operational definition

- Depending on the measure selected and the grantee plan for using the data, the definition of the performance measure could incorporate scale scores and thresholds when available. A score would be the calculated score for the individual scale utilized. The scale scores should be calculated as instructed in the manual or other documentation provided by the measurement tool developer. The operational definition for the performance measures under this benchmark area could center on, for instance, the percentage of participants who are screened as being at risk at a point in time (e.g., the proportion of enrolled children screened at age one during the reporting period who appear at risk for language delay).

c. Measurement tools or questions posed to participants

- Suggested ideas or sources for scales within the area of “Improvements in School Readiness and Achievement” are included in the Compendium of measurement tools or scales issued by HRSA and ACF mentioned above, which can be found at http://www.mdrc.org/sites/default/files/img/DOHVE%20TA%20Compendium_Updated.pdf.

d. Definition of measurable improvement

- For example, an increase over time (e.g., between baseline Year 1 and Year 3) in the screening rates for children of a certain age (e.g., one year old) enrolled in the program would constitute an instance of improvement utilizing a process measure (in this case involving a comparison across cohorts).
- For example, the reduction between two assessment points in the percentage of enrolled children (who are screened utilizing age-appropriate scales) at risk of developmental delays would show desirable change utilizing an outcome measure.

e. Data collection plan

- Data can be collected from a variety of sources including observation (e.g., by teacher, home visitor or other independent observer), direct assessment with a measurement tool, administrative data or health records (e.g. program-specific clinical information systems), parent-report, or teacher-report.

IV. Reduction in Crime or Domestic Violence

The legislation includes a requirement for grantees to report on reduction in “crime or domestic violence.” States and non-profit organizations are not required to report on both domains, but must report on at least one.

Crime

A) Name of performance measure

If the grantee chooses to report crime, constructs that must be reported for this benchmark area for caregivers served by the home visiting program are:

- Arrests
- Convictions

B) Operational definition

- Data may be reported as annual aggregate rates for adults participating in the program.

C) Measurement tools

- Questions posed could distinguish the reason for the arrest or conviction.

D) Definition of measurable improvement

- For family-level crime rates, improvement may be defined as rate decreases over time in the arrests and/or convictions.

E) Data collection plan

- Data may be collected from interviews and surveys with families (i.e., with validated and reliable instruments) or through administrative data if available at the individual level.

Domestic Violence

A) Name of performance measure

If the grantee chooses to report on domestic violence, constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) include:

- Screening for domestic violence

- Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters)
- Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.

B) Operational definition

- Depending on the measure used for each construct and the grantee plan for using the data, the data reported could incorporate the following:
 - Percentage of screenings for domestic violence of program participants.
 - With respect to referrals and safety plans, indicators for these constructs that are scored as percentages could include in the numerator the number of referrals to appropriate identified services and the number of safety plans completed respectively; the denominator would include the total number of identified participants in need of these services.

C) Measurement tools or questions

- For more information, please see the Compendium of measures at http://www.mdrc.org/dohve/dohve_resources.html.

D) Definition of measurable improvement

- For screenings, improvement could be defined as increases in the percentage of participants screened over time.
- For referrals related to domestic violence, improvement could be defined as an increase in the proportion of participants referred over time.
- For completion of safety plans related to domestic violence, improvement could be defined as an increase over time in the proportion of completed plans for participants who need them.

E) Data collection plan

- For family-level data, data can be collected from interviews and surveys with families using either administrative data or reliable and valid measures.

For more information, see:

- http://www.mdrc.org/sites/default/files/img/DOHVE%20TA%20Compendium_Updated.pdf.

o

http://www.cdc.gov/ncipc/dvp/Compendium/Measuring_IPV_Victimization_and_Perpetration.html.

o <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/datasources.html>.

V. Improvements in Family Economic Self-Sufficiency

A) Name of performance measure

Constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) are:

- Household income (including earnings, cash benefits, and in-kind and non-cash benefits)
- Employment or education of participating adults
- Health insurance status of participating adults and children

B) Operational definition

- Household includes the person(s) enrolled in the home visiting program funded by MIECHV. At a minimum this category should include the primary enrolled adult in the home visiting program. This unit of analysis can extend to more than one member of the household if more than one adult is enrolled in the program, participate in home visits or otherwise contributes to the support of the index child or pregnant woman.
- Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private, e.g., rent from tenants/boarders, cash assistance from friends or relatives, or they may be linked to public systems, i.e. child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance. In-kind benefits include non-cash benefits such as nutrition assistance programs (including SNAP, WIC, etc.), energy assistance, housing vouchers, etc. and could be estimated as the value of the benefit received.

C) Measurement tools or questions

- Programs may collect all sources of income and the amount gathered from each source. Alternatively, grantees could report on the aggregate amount received from all sources during the reporting period by the adults in the household participating in the program.
- For in-kind and non-cash benefits, programs should capture program participation among eligible participant households. At their discretion, programs can collect/impute the value of in-kind benefits and add such benefits as a source of income. In either case, HRSA strongly recommends that home visitors discuss with participants available benefits for which the family may qualify.

- With respect to employment, grantees should collect the number of months employed in a year or the average hours per month worked by those participating adults.
- With respect to educational achievement, data collected should include either program completion/degree attainment or hours per month spent by participating adult household member in educational programs.
- Include health insurance status of all participants in the program or, at a minimum, of index child and primary enrolled adult.

D) Definition of measurable improvement

- For household income, improvement could be defined as: an increase in total household income over time; or an increase in income from earnings or employment; or an increase in the take-up of in-kind benefits among program participants; or an increase in the total amount of income and the value of in-kind benefits.
- Note: the second construct above refers to employment or education. We recognize that there can be an inverse relationship between the two in the short-run, i.e., while people are pursuing education, they may reduce their participation in the labor force, and vice versa. Therefore, sites should measure both of these related components but reporting on an improvement in one or the other shall be considered sufficient to show positive results for this construct.
 - For employment, improvement could be defined as an increase between two comparison points in time in the number of paid hours worked plus (up to 30) unpaid hours devoted to care of an infant by all participating adults.
 - For education, improvement could be defined as an increase in the educational attainment of participating adults over time or hours per month spent by participating adult household members in educational programs. Educational attainment may be defined by the completion not only of academic degrees, but also of training or certification programs.
 - For health insurance status, improvement could be defined as an increase over time in the number of participating household members (or at a minimum of the index child and primary enrolled adult) who have adequate health insurance or maintenance of adequate insurance coverage for all participants.

E) Data collection plan

- Data may come from interviews or surveys with families. Data on child support and public benefit receipt may be gathered or verified from the relevant agencies, if data-sharing agreements can be developed. For employment, family-level data may also be gathered or verified using Unemployment Insurance data.

- For the purposes of federal reporting, family economic self-sufficiency data would be collected for the month of enrollment and the month one-year post enrollment.

The following are suggested sources for ideas, questions or measures within the area of “Family Self-Sufficiency:”

- “Observations from the Interagency Technical Working Group on Developing a Supplemental Poverty Measure,” March 2010, http://www.census.gov/hhes/www/povmeas/SPM_TWGObservations.pdf.
- “National Directory of New Hires,”
- <http://www.acf.hhs.gov/programs/css/resource/a-guide-to-the-national-directory-of-new-hires>
- Evaluation Data Coordination Project http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html

VI. Improvements in Coordination and Referrals for Other Community Resources and Supports

For the purposes of the measurement system for improvement in home visiting, referrals include both internal referrals (to other services provided by the local organization implementing the program) and external referrals (to services provided in the community but outside of the local agency). As part of their initial and ongoing needs assessments, grantees should track the number of services available and appropriate for the participants in the program. The constructs related to coordination include capturing linkages both at the agency and the individual family level.

A) Name of performance measure

Constructs for which performance measures must be reported under this benchmark area are:

- Number of families identified for necessary services;
- Number of families that required services and received a referral to available community resources;
- Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided);
- MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community;

- Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies.

B) Operational definition

- With respect to families identified for necessary services, a percentage could be calculated, for example, as the number of families screened divided by the total number of families enrolled in the program during the reporting period. The need or needs for which participants are screened and the corresponding services provided should be defined.
- For families that required a specific service and received the appropriate referral, the performance measure could be calculated as a percentage (with the numerator and denominator respectively being the number of families who received the referral and the total number of families or participants identified as needing the service of interest).
- For completed referrals, the definition of the performance measure could involve the proportion of referrals of participating families with identified needs whose receipt of service was verified, divided by the total number of participating families with identified needs, or by the total number of families who received a referral from the home visitor.
- With respect to formal agreements and communications with other agencies, grantees could report the total number of social service agencies with which the implementing organizations have an MOU and/or regular communication.

C) Measurement tools and/or questions posed to participants

- For resources and examples of measures in this benchmark area, please see the Optional Tool for the Measurement of Coordination and Referral Benchmark Constructs issued by HRSA and ACF and available at http://www.mdrc.org/dohve/dohve_resources.html.

D) Definition of measurable improvement

- A meaningful definition of improvement for the first construct would involve an increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes.
- For families in need of specific services, program improvement would entail an increase over time in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.
- For number of completed referrals: Increase in the percentage of families or individual participants with referrals for whom receipt of services can be confirmed.
- For MOUs: Increase in the number of formal agreements with other social service agencies.

- Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider.

Additional Information

Continuous Quality Improvement Program

The use of Continuous Quality Improvement (CQI) methods is likely to result in more effective program implementation and improved participant outcomes. Through consistent data collection and its regular use, home visiting programs can identify and rectify impediments to effective performance as well as document changes and improvements.⁸ For these reasons, it is expected that the program will benefit from the grantee's CQI Plan and structure for oversight of its data system, human resources, and program implementation. Widespread use of the CQI approach in the prevention field has been encouraged for several reasons. A CQI approach has the potential to:

- Provide a means for community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups;
- Inform the adaptation of evidence-based home visiting models to the unique community settings in which they are implemented, taking advantage of local insights;
- Develop and incorporate new knowledge and practices in a data-driven manner;
- Inform programs about training and technical assistance needs;
- Help monitor fidelity of program implementation;
- Strengthen referral networks to support families; and
- Identify key components of effective interventions.

Accordingly, the MIECHV grantee CQI program plans should provide a description of how CQI strategies and processes will be utilized in addition to strategies that include but are not exclusive of:

- Description of the CQI leadership at all levels of the State Home Visiting Program and how accountable parties will involve the entire staff and subcontractors in the process.
- Personnel assigned to CQI;
- Administrative schedule of CQI cycle review(s) and feedback;
- Instruments and CQI tools deployed;
- Status of data systems deployed for CQI purposes;
- Description of data quality control;

⁸ R Ammerman et al. Development and Implementation of a Quality Assurance Infrastructure in a Multisite Home Visiting Program. *Journal of Prevention and Intervention in the Community*. 2007.

- A matrix for the CQI data collection processes, reporting structure, timelines and frequency;
- Community and model specific CQI data collection processes, reporting structure, timelines and frequency;
- Description of the CQI priorities;
- Description of the relevant subjects of CQI in home visiting that may include:
 - The home visitor
 - The home visit occurrence
 - Content of the home visits
 - The home visitor/family relationship
 - Supervision and management of home visiting
 - Benchmark area-related indicators (or a subset)
 - Universal screening and coordinated intake (outreach, screening, and referral for ancillary services)
 - Interface and networking in the early childhood system.