

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program:

Summary of Benchmark Measures Selected by Grantees

JULY 2014



DESIGN OPTIONS FOR HOME VISITING EVALUATION (DOHVE) –
A DOHVE TA RESOURCE DOCUMENT

OPRE REPORT # 2014-25

About DOHVE TA

The purpose of the Design Options for Home Visiting Evaluation (DOHVE) is to provide research and evaluation support for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program.

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Introduction and Overview

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program facilitates collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The statutory purposes of the program are to (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The program is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF).

The legislation which created the home visiting program requires that grantees demonstrate measurable improvement among eligible families participating in the program in at least four of the six following benchmark areas:

- 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.

HHS identified a list of constructs that grantees were required to measure within each benchmark area and gave grantees the flexibility to develop their own performance measures for each construct. This flexibility allowed grantees to develop performance measures that were meaningful for their specific programs.¹

For over two years, Home Visiting² grantees have worked with federal staff, regional project staff, and DOHVE technical assistance (TA) staff to develop strong benchmark measurement plans. This has involved many rounds of individualized TA for each grantee to ensure that grantees are meeting federal requirements, meeting the requirements of the model developer(s), and setting performance measures that are meaningful to their programs and will provide data that may be used internally to help programs continuously improve the quality of their home visiting program. Grantees implementing multiple models have also had to ensure that their plans align performance measures across each of the implementing models.

¹ It is important to note that the data collected through this effort is performance management data rather than impact data. The data can inform program administration by allowing HHS to monitor and assess grantees' progress over time. However, it cannot tell us about the effectiveness of the program in achieving its ultimate intended outcomes. A separate effort, the "[Maternal, Infant, and Early Childhood Home Visiting Evaluation](#)" (MIHOPE), is assessing the effect of MIECHV programs on child and parent outcomes, including with respect to each of the benchmark areas. For more information about the MIHOPE evaluation, see <http://www.acf.hhs.gov/programs/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope>.

² Throughout this document, "Home Visiting" will be used specifically to refer to the Maternal, Infant and Early Childhood Home Visiting Program.

The purpose of this summary document is to provide an overview of all 56 approved Home Visiting benchmark plans. Information was gathered from each plan, including the stated performance measure, the type of measure (outcome or process³), the data source (client, home visitor, or administrative records), the target population being measured, the tool or measure identified by the grantee, and the measurement period. Information was also collected on the type of comparison being made (individual, cohort, or cross-sectional comparison of data), the direction of improvement needed to demonstrate success, and the type of scoring that will be used to demonstrate change. Included here is a summary of Home Visiting grantee benchmark plans across constructs (to the greatest extent possible) and within constructs.

Summary Across Measures

Home Visiting grantees were given the leverage to develop performance measures that were meaningful for their programs, in a way that made the most sense given the context of their program/populations. The flexibility given to grantees to set and define their own performance measures has meant that, across grantees, various aspects of each construct are being measured using a variety of tools and across a range of different time points. While this is a strength because it allows for varying dimensions of each construct to be captured, it also adds a challenge in summarizing grantee performance measures across programs, constructs, and benchmark areas. The information is summarized below.

Constructs with the highest degree of alignment across grantees include:

- **Maternal Depressive Symptoms:** About 86% of grantees are using the Edinburg Postnatal Depression Scale (EPDS) to measure maternal depressive symptoms. Although there is alignment in use of the tool, there is diversity among grantees in the population being assessed: over half (57%, n=32) of the performance measures focus on mothers during the postpartum period⁴ while a significant number (34%, n=19) focus on all mothers, including those that are pregnant and those with infants or young children.
- **Well-Child Visits:** The overwhelming majority of grantees are focusing on adherence to a recommended well-child visit schedule (98%, n=55), with American Academy of Pediatrics (AAP)/Bright Futures being the most common adherence schedule selected (25%, n=14).
- **Child and Mother Visits to Emergency Department:** All grantees are using an outcome measure to capture visits to the emergency department, with most (91%, n=51) relying on parent self-report of visits.
- **Information/Training on Prevention of Child Injuries:** All grantees are using a process measure to capture information and training on the prevention of child injuries, with most (96%, n=54) focusing on the provision of information about child injuries.

³ Process data is collected to describe program services and activities, programmatic policies and procedures implemented, and characteristics of both service recipients and service providers. Outcome data is collected to measure change in child, family, and system-level outcomes. For more information on process and outcome measures, see James Bell Associates. (2007, October). *What's the Difference? Understanding Process and Outcome Evaluation*. Arlington, VA: James Bell Associates.

⁴ The period of time considered postpartum varied across grantees and postpartum mothers may refer to mothers with infants up to 12 months of age.

- Child Injuries: All grantees are using an outcome measure for child injuries. Most grantees are relying on parent self-report (91%, n=51) of injuries.
- Reported, Substantiated, and First-Time Victim of Child Maltreatment: All grantees are using an outcome measure for reported, substantiated, and first time victim of child maltreatment. Most grantees are using administrative data to assess these constructs (89%, 96%, and 96% respectively).
- Child Communication, Language, and Emergent Literacy: All 56 grantees are using the Ages and Stages Questionnaire-3 (ASQ-3) to screen for developmental concerns related to child communication.
- Child Cognitive Skills: All 56 grantees are using the ASQ-3 to screen for delays related to child cognitive skills.
- Arrests and Convictions: Grantees have the option of choosing either the crime constructs (arrests and convictions) or the domestic violence constructs (screenings, referrals and safety plans). The two grantees that selected the crime constructs proposed an outcome measure.
- Screening for Domestic Violence: All grantees examining domestic violence (n=54) are relying on process measures to capture screening for domestic violence, referrals for domestic violence services, and completion of a safety plan.
- Number of Memoranda of Understanding (MOU) to Increase Coordination of Resources and Referrals: Most grantees are counting the number of MOU's either at the state agency level or between Home Visiting local implementing agencies and other community organizations (91%, n=51).

Constructs with the highest degree of diversity include:

- Parent Support for Child Learning and Development: There is significant variation in the instrument(s) chosen to measure this construct.
- Parent Emotional Well-being/Parenting Stress: About half (54%, n=30) of grantees are using a process measure. There is significant variation in the instrument(s) chosen to measure this construct.
- Child Physical Health and Development: Over half (66%, n=37) of grantees are using a process measure to assess child physical health and development. There is significant variation in the defined performance measures.
- Screening for Domestic Violence: Grantees are using a wide range of tools to screen for domestic violence.

Construct Specific Summaries

Below is a brief summary of grantee performance measures across the 37 benchmark constructs, including how they aligned across type of measure, target population, tools/measures, and types of comparisons being made to assess improvement.

Benchmark I - Maternal and New Born Health

Construct 1.1: Prenatal Care

- Ninety-one percent (n=51) of grantees are using an outcome measure to capture prenatal care among pregnant participants.

- The majority of the outcome measures focus on the onset of prenatal care (45%, n=25) or the adequacy of prenatal care (45%, n=25), with 16% (n=9) of grantees comparing participant prenatal care to an identified recommended prenatal care schedule.
- Of the five grantees (9%) that identified a process measure, two are measuring referrals for prenatal care, two are measuring the completion of prenatal care status assessments at enrollment, and one is measuring the provision of information on adequate prenatal care.
- The most common source of data for this construct is mother's self-report (75%, n=42) and most grantees (79%, n=44) are using their program forms to capture this information.

Construct 1.2: Alcohol, Tobacco, and Illicit Drugs

- Most grantees are relying on outcome measures (64% outcome, n=36) to capture substance use. Performance measures focus on the use of tobacco (71%, n=40); alcohol (7%, n=4); or some combination of alcohol, tobacco and illicit drugs (21%, n=12).
- Thirty-eight percent (n=20) of grantees are using a standardized tool to capture the data. However, there is very little alignment across the standardized tools identified (see snapshot report for list of individual tools).
- A similar number of grantees are targeting pregnant mothers (34%, n=19) or all mothers enrolled (38%, n=21) for measurement.

Construct 1.3: Preconception Care

- Most performance measures capturing preconception care utilize outcome measures (91%, n=51).
- Performance measures focus on postpartum checkups (34%, n=19), routine preventative or well-women exams (34%, n=19), folic acid or other vitamin supplement use (14%, n=8), provision of information on preconception care (5%, n=3), or contraception use (4%; n=2).
- Most of these performance measures target postpartum mothers (77%, n=43) with nearly all of the remaining measures targeting all mothers enrolled (22%, n=12). One grantee targeted both caregivers.

Construct 1.4: Inter-Birth Interval

- Grantees are almost evenly split across using process (46%, n=26) and outcome measures (54%, n=30) to assess this construct.
- Close to half of the performance measures focus on the provision of information related to birth spacing (45%, n=25). Other performance measures concentrate on contraception use (27%, n=15), 12 month pregnancy spacing (16%, n=9), 6 month pregnancy spacing (9%, n=5), referrals (2%, n=1), or testing postpartum mothers on their knowledge of the benefits on inter-birth spacing (2%, n=1).

Construct 1.5: Maternal Depressive Symptoms

- All 56 grantees are relying on a process measure to capture screening of maternal depressive symptoms, with 89% (n=50) focusing on the rates of screenings and 11% (n=6) on referral rates for those participants screened positive for depressive symptoms.
- Over half (57%, n=32) of the performance measures target postpartum mothers enrolled in the program, while 34% (n=19) of performance measures target all mothers, including pregnant mothers and mothers with infants and young children.
- The most common tool identified for the screening of depressive symptoms includes the EPDS (86%, n=48), followed by the Patient Health Questionnaire (PHQ-9; 23%, n=13) and Center for Epidemiologic Studies Depression Scale (CES-D; 7%, n=4).

Construct 1.6: Breastfeeding

- All 56 grantees are using an outcome measure to capture information on breastfeeding, with 86% (n=48) focusing on postpartum mothers and 14% (n=8) focusing on children.
- While the majority (56%, n=32) of performance measures focus on the duration of breastfeeding behavior, there is variation in how duration is operationalized – grantees concentrated on the duration of breastfeeding at 1 month (4%, n=2), 3 months (5%, n=3), 6 months (23%, n=13), and 2 weeks (2%, n=1) postpartum, and others are capturing the average number of weeks mothers spent breastfeeding (23%, n=13).
- In addition to duration, 43% (n=24) of grantees are measuring whether mothers initiated breastfeeding at all.

Construct 1.7: Well-Child Visits

- The overwhelming majority of grantees captured well-child visits using an outcome measure (98%, n=55), focusing on adherence to well-child visits.
- Well-child recommendation schedules identified to operationalize adherence include AAP/Bright Futures (25%, n=14), Medicaid recommended schedule (7%, n=4), immunization cards (2%, n=1), CDC recommendation schedule (4%, n=2), state recommended schedules (2%, n=1), and WebIZ (4%, n=2).
- The one grantee using a process performance measure is focusing on referrals for preventative health care for those children identified as not having adequate well-child care at enrollment.

Construct 1.8: Maternal and Child Health Insurance Status

- Grantees are predominantly using outcome measures to capture maternal and child health insurance status (95% outcome, n=53; 5% process, n=3).
- Most performance measures focus on the health insurance status of both the mother and child (84%, n=47) with a few capturing status of mother only (5%, n=3).

Benchmark II - Child Injuries, Child Maltreatment, and Reduction of Emergency Department Visits

Construct 2.1: Visits for Children to Emergency Department

- All 56 grantees are relying on outcome measures to capture visits for children to the emergency department (ED).
- Measures focus on the incidents/number of visits to the ED (59%, n=33) or the number of children with visits to the ED (41%, n=23).
- Most grantees are collecting data via self-report through interview questions and program forms (91%, n=51). Only five grantees (9%) are using administrative data (hospital or health records).

Construct 2.2: Visits for Mothers to Emergency Department

- All 56 grantees are using outcome measures to capture visits for mothers to the ED.
- Measures focus on the incidents/number of visits to the ED (55%, n=31) or the number of mothers with visits to the ED (45%, n=25). One grantee is focusing on all caregivers who visit the ED.
- Most grantees are collecting data via self-report through interview questions and program forms (91%, n=51). Only five grantees are using administrative data (i.e., hospital or health records).

Construct 2.3: Information/Training on Prevention of Child Injuries

- All 56 grantees are using a process measure to capture information and training on the prevention of child injuries.

- The vast majority of measures focus on the provision of information about the prevention of child injuries (96%, n=54). Two grantees are focusing on the completion of a home safety checklist with families.
- All 56 grantees are collecting data via program documentation.

Construct 2.4: Child Injuries

- All 56 grantees are using an outcome measure to capture child injuries.
- The measures focus on the number of children with injuries (68%, n=38) and the number of incidents of injuries (32%, n=18).
- Most grantees are collecting data via parent self-report (91%, n=51). Five grantees are using administrative data (health records; 9%).

Construct 2.5: Reported Suspected Maltreatment

- All 56 grantees are relying on outcome measures to capture reports of suspected child maltreatment.
- The measures focus on the number of children with reports of suspected maltreatment (64%, n=36), the number of reports of suspected maltreatment (30%, n=17), and the number of families with reports of suspected child maltreatment (5%, n=3).
- Most grantees are collecting administrative data from the child welfare agency (89%, n=50). However, five grantees are relying on programmatic forms through parent self-report (9%, n=5).

Construct 2.6: Reported Substantiated Maltreatment

- All 56 grantees are using an outcome measure to capture substantiated reports of child maltreatment.
- The measures focus on the number of children with substantiated reports of maltreatment (61%, n=34), the number of substantiated reports of maltreatment (36%, n=20), and the number of families with substantiated reports of child maltreatment (4%, n=2).
- Most grantees are collecting administrative data from the child welfare agency (96%, n=54). However, two grantees are relying on programmatic forms through parent self-report (4%).

Construct 2.7: First Time Victims of Maltreatment

- All 56 grantees are using an outcome measure to capture first time victims of child maltreatment.
- Most grantees (88%, n=49) are focusing on the number of children who are first-time victims of child maltreatment while others are focusing on the number of reports of first time victims (11%, n=6). One grantee is examining the number of families that experience first time victim status (2%).
- Most grantees are collecting administrative data from the child welfare agency (96%, n=54). However, four grantees are relying on programmatic forms through parent self-report (4%).

Benchmark III - School Readiness and Achievement

Construct 3.1: Parent Support for Child Learning and Development

- Eighty-four percent (n=47) of grantees are using an outcome measure to capture parent support for child learning and development.
- The most common instrument selected for this construct was the Home Observation for the Measurement of the Environment (HOME) (70%, n=39).
- Over half of the grantees defined the performance measure to capture parental support for learning and development (59%, n=33).

Construct 3.2: Parent Knowledge of Child Development

- Of the 56 grantees, over half (54%, n=30) are using an outcome measure to capture parent knowledge of child development.
- The most common instrument chosen was the HOME (41%, N=23), followed by the ASQ-3 (38%, n=21).
- Thirty-six percent (n=20) of grantees are capturing global knowledge of child development.
- Grantees selecting process performance measures generally focused on the provision of information on child's developmental progress (e.g., home visitor reviewing the results of the ASQ-3 with the parent) (45%, n=25).

Construct 3.3: Parenting Behaviors/Parent-Child Relationship

- Most grantees (84%, n=47) are using an outcome measure to capture parenting behaviors or the parent-child relationship.
- Sixty-eight percent (n=38) of grantees are using the HOME to measure parenting behaviors/parent-child relationship.
- Most performance measures focus on the parent-child relationship in general (54%, n=30).

Construct 3.4: Parent Emotional Well-Being/Parenting Stress

- Over half (52%, n=29) of the 56 grantees are using a process measure to capture parent emotional well-being or parenting stress.
- A wide variety of tools are being used to assess this construct, including the EPDS (32%, n=18), the Parenting Stress Index (16%, n=9), the Patient Health Questionnaire (16%, n=9), the Protective Factors Survey (13%, n=7), the Healthy Families Parenting Inventory (11%, n=6), the Perceived Stress Scale (4%, n=2), and the Center for Epidemiological Studies Depression Scale (4%, n=2).

Construct 3.5: Child Communication, Language, and Emergent Literacy

- All 56 grantees (100%) chose to use the ASQ-3 to capture child communication, language, and emergent literacy.
- Forty-eight percent (n=27) are assessing whether a child was screened by a certain time point in enrollment or age, 18% (n=10) are assessing whether the family received a referral for a positive screening, and one grantee is monitoring the home visitor provision of information to the family regarding the screening results.
- All 18 (32%) of the outcome performance measures are capturing communication skills.

Construct 3.6: Child Cognitive Skills

- Of the 56 grantees, 68% (n=38) are utilizing a process measure.
- All 56 grantees chose to use the ASQ-3 to assess this construct.
- Of the 38 grantees implementing a process measure, 26 (68%) are assessing whether a child is screened by a certain age or time point in enrollment.
- Of the 18 grantees using an outcome measure, 13 (72%) are focusing specifically on problem solving.

Construct 3.7: Child Positive Approaches to Learning

- To capture positive approaches to learning among children, most grantees are using a process measure (66%, n=37), with the majority focusing on screening rates (46%, n=26).

- Outcome measures (34%, n=19) primarily concentrate on child development across personal-social domains (23%, n=13).
- Among tools selected by grantees to measure this construct, 93% chose either the ASQ-3 (66%, n=37) or the Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) (32%, n=18).

Construct 3.8: Child Social Behavior/Emotional Well-Being

- Most grantees (68%, n=38) are using a process measure to capture child social behavior/emotional well-being.
- Of those assessing child social behavior/emotional well-being, 46% (n=26) are examining whether a child is screened by a certain age or time point.
- Thirty-two percent (n=18) of grantees have set outcome measures which focus specifically on social-emotional ratings.
- The most common tool used to assess child social behavior/emotional well-being is the ASQ-SE (41%, n=23).

Construct 3.9: Child Physical Health and Development

- Of the 56 grantees, 66% (n=37) are using a process measure to assess child physical health and development.
- There is a wide range of performance measures for this construct. Of those using a process measure, grantees are looking at whether a child is screened for gross and fine motor development (39%, n=22), whether a child at risk for delay is referred to appropriate services (16%, n=9), or whether a child is screened for height, weight, and head circumference (11%, n=6).
- Of those using an outcome measure, grantees are examining cutoff scores on the gross and fine motor scales of the ASQ-3 (20%, n=11), height, weight, and head circumference results (5%, n=3), whether a child is up to date on well child visits (4%, n=2), has a medical home (2%, n=1), is eligible for WIC (2%, n=1), or has been exposed to second hand smoke (2%, n=1).

Benchmark IV - Crime or Domestic Violence

Following the statute, grantees were permitted to choose between reporting on the domestic violence constructs (constructs 4.1, 4.2, and 4.3) or the crime constructs (constructs 4.4 and 4.5). Of the 56 Home Visiting grantees, 54 chose to report on the domestic violence constructs and 2 chose to report on the crime constructs.

Construct 4.1: Screening for Domestic Violence

- All 54 grantees reporting on this construct chose a process measure capturing screening for domestic violence.
- Most of the process measures capture the number of women screened for domestic violence (89%, n=48).
- Grantees are using a wide range of tools to screen for domestic violence: 41% (n=22) are using the Nurse-family Partnership Relationship Assessment Form, 9% (n=5) are using the Domestic Violence Ended instrument, 13% (n=7) are using the Women's Experience with Battering instrument, and 6% (n=3) using the Conflict Tactics Scale. Twenty-nine grantees (55%) are using some other tool and/or program form.

Construct 4.2: Referrals for Domestic Violence Services

- All 54 grantees are relying on a process measure to capture referrals for domestic violence services.

- Eighty-seven percent of grantees (n=45) are reporting on the percentage of participants with referrals.
- All 52 grantees will track referrals using program forms.

Construct 4.3: Domestic Violence - Safety Plan

- All 54 grantees are using a process measure to capture the completion of domestic violence safety plans.
- Eighty-five percent of grantees (n=46) are reporting on the number of families with safety plans.

Construct 4.4: Arrests

- Two (4%) of the 56 grantees chose to report on arrests.
- Both grantees are using an outcome measure, examining the rate of arrests for mothers.
- One is using administrative crime records and the other is using parent self-report through interviews.

Construct 4.5: Convictions

- Two (4%) of the 56 states chose to report on convictions.
- Both grantees are using an outcome measure, examining the rate of convictions for mothers.
- One grantee is using administrative crime records and the other is using parent self-report through interviews.

Benchmark V - Family Economic Self-Sufficiency

Construct 5.1: Income and Benefits

- All 56 grantees are using an outcome performance measure relying on participant self-report. Most are capturing income and benefits (54%, n= 30), with over a third capturing income alone from all sources (39%, n=22). Three grantees are capturing wages only (5%).
- The most common method of data collection is through program forms (96%, n=54), but standardized tools have also been identified by five grantees (10%), which include the Life Skills Progression, and the Missouri Family Self-Sufficiency Scale.
- Grantees are assessing household members (43%, n=24), families (25%, n=14), caregivers (20%, n=11), or mothers (13%, n=7).

Construct 5.2: Employment or Education

- Ninety-eight percent (n=55) of the 56 grantees are using outcome measures, while one selected a process measure capturing referrals to unemployed women for job training, education, or employment.
- Fifty-three percent (n=29) of the performance measures focus on education while 28% (n=16) captured employment; 20% (n=11) of the performance measures concentrate on both education and employment combined.
- Of those assessing education alone, dimensions of education include enrollment in educational programs (29%, n=16), educational attainment other than a GED or diploma (20%, n=11), and attainment of a GED or diploma (4%, n=2).
- Performance measures capturing employment assess employment status of participants (7%, n=4), paid hours worked (5%, n=3), paid plus unpaid hours devoted to childcare (14%, n=8), and referrals for unemployed mothers (2%, n=1).

Construct 5.3: Health Insurance Status

- All 56 grantees are assessing health insurance status using an outcome measure, primarily through participant self-report (98%, n=55).
- Most grantees are assessing health insurance status of mothers and children (64%, n=36), followed by household status (29%, n=16). Two grantees are assessing the status of mother alone (4%, n=2) and one is assessing the status of the child alone (2%, n=1). One grantee is capturing the number of months uninsured among participants for a given period of time (2%, n=1).

Benchmark VI - Coordination and Referrals for Other Community Resources and Supports

Construct 6.1: Identification for Necessary Services

- All grantees are using process measures for identification of necessary services.
- Eighty percent (n=45) of grantees are focusing on comprehensive screening of needs and 18% (n=10) proposing screening in a single need area.
- The majority of grantees selected screening needs for this construct that overlapped with needs screened in other benchmark domains (e.g., 30% depressive symptoms, 30% child development, and 30% substance use).

Construct 6.2: Referrals for Necessary Services

- All grantees are using process measures, with program documentation providing information on rates of service referrals (84% tracking the number of families referred, and 16% tracking the number of referrals made).
- The majority of grantees are proposing to measure service referrals among family units (61%, n=34), followed by mothers (11%, n=6), mothers and/or children (7%, n=4), and caregivers and/or household members (4%, n=2).

Construct 6.3: Receipt of Necessary Services

- All grantees selected outcome measures (100%, n=56) to assess of receipt of necessary services.
- Most grantees are relying on self-reported completion of services (96%, n=54) as the data source for this indicator.

Construct 6.4: Number of MOU

- All 56 grantees chose to report on a process measure for the number of MOUs with community agencies, with 91% (n=51) reporting a simple count of MOUs and 9% (n=5) reporting a percent.

Construct 6.5: Information Sharing

- All 56 grantees are using process measures to report on information sharing with community agencies.
- The majority of grantees proposed having a clear point of contact in another agency (52%, n=29) as an indicator for this construct.

Contact Information

For more information about the Home Visiting Grantee Benchmark Performance Measures, please contact the Federal Project Officer or a member of the DOHVE team:

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