“SUPPORTING EVIDENCE-BASED HOME VISITATION PROGRAMS TO PREVENT CHILD MALTREATMENT”
FIRST ANNUAL PREVENTION SUMMIT, APRIL 10, 2013, KEARNEY, NEBRASKA

Presented by:
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NE DHHS, Division of Public Health
OBJECTIVES

Session attendees will –

1. Be familiar with the history of home visiting as a strategy, including recent emphasis on evidence-based home visiting.

2. Be able to describe evidence-based practice as a concept.

3. Be able to describe evidence-based home visiting as a strategy to improve child outcomes, especially prevention of abuse and neglect.
OBJECTIVES, continued

4. Understand the importance of performance management as a critical element of implementing evidence-based home visiting.

5. Be familiar with recent developments in evidence-based home visiting in Nebraska.

6. Identify 3 key take-home ideas about evidence-based home visiting
WHY HISTORY OF HOME VISITING?

- Many of the same issues of concern today were raised years ago.
- The roles of home visitors have shifted as philosophy and beliefs about human services have changed.
- Now challenged to take what has been learned to position home visiting so that it can play a key role as part of a comprehensive strategy to help families create a better life for themselves and their children.
HISTORY OF HOME VISITING

Mid-1800’s – Kindergarten movement
- In U.S., typically focused on immigrant populations living in poverty in large cities
- Funded by philanthropic groups
- Teachers taught children in the morning and did home visiting in the afternoons
- Home visits used to teach families about child rearing, stimulate learning, and build community and family relationships.
- By 1930’s, demand increased for morning and afternoon classes, and elimination of home visiting component
HOME VISITING HISTORY

Public Health Nursing -

• Began in U.S. in 1870’s, modeled after nurse home visiting programs in England
• Lillian Wald coined term “public health nurse” and is credited with pioneering public health nursing in Manhattan in 1890’s
• Early public health nursing included community activism to address social conditions in impoverished communities
• When funding shifted from philanthropic to a government base in the U.S., approach changed to that of a medical model, with little attention to the social support that was included in European nurse home visiting programs
HOME VISITING HISTORY

Settlement House movement –
• Began in the U.S. in 1880’s, with upper class reformers seeking to improve the living conditions of the immigrant poor
• Sought to influence early childhood education, provide support for families dealing with crises, and force improvement in environmental conditions through legislative advocacy
• Reformers lived and worked in the poverty communities
HISTORY OF HOME VISITING

Trends over time –

• The Great Depression resulted in many philanthropic organizations shutting down
• Prosperous period following WWII led to decline in interest in funding social initiatives
• Resurgence in 1960’s with War on Poverty; home visiting programs were funded with focus on social issues such as poverty and teen parenting and health issues such as low birth weight
• 1970’s saw a shift to family support, developmentally appropriate parenting practices, and parent self-efficacy
HISTORY OF HOME VISITING

Growing body of evidence -
• Longitudinal studies implemented in 1960’s and 1970’s (such as the David Old’s nurse home visitation program in Elmira, NY)
• US DHHS, US Advisory Board on Child Abuse & Neglect publications of the early 1990’s – “no other single intervention has the promise that home visitation has.”
• CDC’s Morbidity and Mortality Weekly Report, October 3, 2003, First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation and Firearms Laws
Affordable Care Act – Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

- Signed into law in March 2010
- Appropriated funds for 5 years
- Major impetus for current focus on evidence-based home visiting
FEDERAL MIECHV REQUIREMENTS

- Each state conduct a needs assessment within 6 months of the law’s passage.
- Programs to be evidence-based and address a range of outcomes – improved prenatal, maternal, newborn, and child health including the prevention of child injuries and maltreatment; improved parenting skills; school readiness and child academic achievement; reductions in crime or domestic violence; improved family economic self-sufficiency; and improved coordination of referrals for, and the provision of, other community resources and supports for eligible families.
- Quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program.
MIECHV IN NEBRASKA

Major steps in implementing federally supported MIECHV in Nebraska

- Needs assessment identified 17 at-risk counties
- Implemented evidence-based home visiting in Scotts Bluff, Morrill, and Box Butte counties
- Soon to implement in Lincoln County
- Enhancements underway in Lancaster County
- Community assessment underway in Douglas County
- Performance accountability system built
A CLOSER LOOK AT
“EVIDENCE-BASED PRACTICE”
EBP is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

EVIDENCE-BASED PRACTICE

Applications of interventions tested in more than one rigorous study (multiple case studies, randomized control trials) and consistently found better than a placebo or no intervention.

Organized and typically multi-component interventions with clearly identified linkages between core components and expected outcomes for an identified target population and established necessary organizational supports for implementation.

An “evidence-based early childhood home visiting service delivery model,” program models must meet at least one of the following criteria:

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains; or
- At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples find one or more favorable, statistically significant impacts in the same domain.

EVIDENCE-BASED PRACTICE IN MIECHV

- Selection of a prescribed model, delivered with fidelity
- Within a comprehensive system of early childhood services, resources, and supports
- Supported by an engaged local community
- Serving a high-risk target population
- With sustained services from prenatal to child age 5
- With a system for performance measurement and improvement in place
WHY EVIDENCE-BASED PROGRAMS?

- Accountability
- Efficiency
- Transparency
- Fairness

- What Works?
- Will what works today, work tomorrow?
- What will work even better?
WHAT WORKS?

• To reduce the risk of child abuse and neglect?
• To improve the readiness of a young child for school?
• To reinforce family stability and resilience?
• To mediate the effects of poverty?
• To improve health across the lifespan?
• To diminish inequalities in health and education?
Decision-making

Best available research evidence

Environment and organizational context

Population characteristics, needs, values, and preferences

Resources, including practitioner expertise
EVIDENCE-BASED APPROACHES TO PREVENTION OF CHILD ABUSE

Primary prevention activities

• Directed at the general population and attempt to stop maltreatment before it occurs.
• Raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment.
• Public service announcements that encourage positive parenting
• Parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting
• Family support and family strengthening programs that enhance the ability of families to access existing services, and resources to support positive interactions among family members
• Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect
EVIDENCE-BASED APPROACHES TO THE PREVENTION OF CHILD ABUSE

Secondary prevention activities

- A high-risk focus - offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities.
- Targeted services for communities or neighborhoods that have a high incidence of any or all of these risk factors.
- Parent education programs for teen parents, or in substance abuse treatment programs for mothers and families with young children
- Parent support groups to help parents cope with their everyday stresses and meet the challenges and responsibilities of parenting
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes
- Respite care for families that have children with special needs
- Family resource centers that offer information and referral services to families living in low-income neighborhoods
EVIDENCE-BASED REGISTRIES TO IMPROVE OUTCOMES FOR FAMILIES

US HHS Administration for Children and Families Child Welfare Information Gateway Preventing Child Abuse and Neglect

- https://www.childwelfare.gov/preventing/evidence/

SAMHSA National Registry of Evidence-based Programs and Practices

- http://nrepp.samhsa.gov/
MORE RESOURCES


Home Visiting Evidence of Effectiveness http://homvee.acf.hhs.gov/

Ten evidence-based practices for home visiting programs. http://www.state.ia.us/earlychildhood/docs/EvidenceBasedHomeVisitingTool.pdf
MORE RESOURCES


- [http://supportingebhv.org/resources/miechv-home-visiting-program](http://supportingebhv.org/resources/miechv-home-visiting-program)

THE ROLE OF DATA IN EVIDENCE-BASED PUBLIC HEALTH

- Community assessment;
- Applying program planning frameworks;
  - Using data to inform decisions;
  - Making decisions on the basis of the best available peer-reviewed evidence (both quantitative and qualitative);
- Performance Management
- Evaluation
<table>
<thead>
<tr>
<th>Factor</th>
<th>Indicator</th>
<th>Source</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Child Welfare CAN reports (rate)</td>
<td>DHHS/DCF</td>
<td>2005-2009</td>
</tr>
<tr>
<td>2</td>
<td>Child Welfare CAN reports, substantiated (rate)</td>
<td>DHHS/DCF</td>
<td>2005-2009</td>
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<td>4</td>
<td>Child Welfare Out of Home Care (rate)</td>
<td>LHDs</td>
<td>2007</td>
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<td>5</td>
<td>Child Welfare State Wards (rate)</td>
<td>DHHS/DCF</td>
<td>2009</td>
</tr>
<tr>
<td>7</td>
<td>Crime Juvenile Arrests (rate)</td>
<td>LHDs</td>
<td>2007</td>
</tr>
<tr>
<td>8</td>
<td>Crime Juvenile Drug Arrests (rate)</td>
<td>LHDs</td>
<td>2007</td>
</tr>
<tr>
<td>9</td>
<td>Crime Juvenile DUI (rate)</td>
<td>LHDs</td>
<td>2007</td>
</tr>
<tr>
<td>10</td>
<td>Crime Juvenile Violent Crime Arrests (rate)</td>
<td>LHDs</td>
<td>2007</td>
</tr>
<tr>
<td>11</td>
<td>Economic Food Stamps (rate)</td>
<td>DHHS/FAPA</td>
<td>2005-2008</td>
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<tr>
<td>12</td>
<td>Economic Poverty, All Ages (%)</td>
<td>SAIPE</td>
<td>2004-2008</td>
</tr>
<tr>
<td>13</td>
<td>Economic Unemployment Change, 2009-2010</td>
<td>DOL</td>
<td>2010</td>
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<tr>
<td>14</td>
<td>Economic Unemployment (%)</td>
<td>RWJ</td>
<td>2008</td>
</tr>
<tr>
<td>15</td>
<td>Education High School Dropouts (%)</td>
<td>NDE</td>
<td>2004-2008</td>
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<tr>
<td>16</td>
<td>Education Education Less than 9th Grade (%)</td>
<td>LHDs</td>
<td>2000</td>
</tr>
<tr>
<td></td>
<td>Category</td>
<td>Measure</td>
<td>Source</td>
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<tr>
<td>17</td>
<td>Health Behaviors</td>
<td>Adult Smoking (%)</td>
<td>RWJ</td>
</tr>
<tr>
<td>18</td>
<td>Health Behaviors</td>
<td>Binge (%)</td>
<td>RWJ</td>
</tr>
<tr>
<td>19</td>
<td>Health Behaviors</td>
<td>Chlamydia (rate)</td>
<td>RWJ</td>
</tr>
<tr>
<td>20</td>
<td>Health Behaviors</td>
<td>Inadequate Prenatal Care (%)</td>
<td>DHHS/VR</td>
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<tr>
<td>21</td>
<td>Health Behaviors</td>
<td>No Prenatal Care (%)</td>
<td>DHHS/VR</td>
</tr>
<tr>
<td>22</td>
<td>Health Behaviors</td>
<td>Births To Teens (% of all births)</td>
<td>DHHS/VR</td>
</tr>
<tr>
<td>23</td>
<td>Pregnancy Outcome</td>
<td>Low Birth Weight (%)</td>
<td>DHHS/VR</td>
</tr>
<tr>
<td>24</td>
<td>Pregnancy Outcome</td>
<td>Very Low Birth Weight (%)</td>
<td>DHHS/VR</td>
</tr>
<tr>
<td>25</td>
<td>Pregnancy Outcome</td>
<td>Prematurity (%)</td>
<td>DHHS/VR</td>
</tr>
<tr>
<td>26</td>
<td>Pregnancy Outcome</td>
<td>Infant Mortality (rate)</td>
<td>LHDs</td>
</tr>
<tr>
<td>27</td>
<td>Health Outcomes</td>
<td>Poor/Fair Health (%; self-reported)</td>
<td>RWJ</td>
</tr>
<tr>
<td>28</td>
<td>Health Outcomes</td>
<td>Poor Mental Health Days (mean)</td>
<td>RWJ</td>
</tr>
<tr>
<td>29</td>
<td>Health Outcomes</td>
<td>Poor Physical Health Days (mean)</td>
<td>RWJ</td>
</tr>
<tr>
<td>30</td>
<td>Health Outcomes</td>
<td>Premature Death (YPLL)</td>
<td>RWJ</td>
</tr>
<tr>
<td>31</td>
<td>Social Welfare</td>
<td>Aggravated Domestic Violence Complaints (rate)</td>
<td>NCC</td>
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<tr>
<td>32</td>
<td>Social Welfare</td>
<td>Domestic Violence Crisis Line Calls (rate)</td>
<td>LHDs</td>
</tr>
<tr>
<td>33</td>
<td>Social Welfare</td>
<td>Simple Domestic Violence Complaints (rate)</td>
<td>NCC</td>
</tr>
<tr>
<td>34</td>
<td>Social Welfare</td>
<td>Single Parent Household (%)</td>
<td>RWJ</td>
</tr>
</tbody>
</table>
COUNTY LEVEL RESULTS

HTTP://DHHS.NE.GOV/PUBLICHEALTH/DOCUMENTS/HOME%20VISITING%20-
%20LEVEL%20COUNTY%20RESULTS%20(2012).PDF

Legend

County at Risk
COMMUNITY PLANNING FOR EBHV

N-MIECHV

HOME VISITING ASSET ANALYSIS AND READINESS GUIDE
# Community Planning for EBHV

## Matching Data, Needs and Evidence Based Models

<table>
<thead>
<tr>
<th>Community Priorities or Needs</th>
<th>Community Risks Level 1 Analysis</th>
<th>HFA (Healthy Families America)</th>
<th>EHS (Early Head Start) + Early Head Start New Zealand</th>
<th>PAT</th>
<th>CPU (Child First)</th>
<th>EIP (Early Intervention Program for Adolescent Mothers)</th>
<th>FCU (Family Check Up)</th>
<th>Healthy Steps</th>
<th>HIPPY (Home Instructions for Parents of Preschool Youngsters)</th>
<th>NFP (Nurse Family Partnership)</th>
<th>Oklahoma Community-Based Family Resource and Support Program</th>
<th>PALS (Play and Learning Strategies Infant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter your community priorities or desired outcomes compared to outcomes the model can achieve</td>
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<tr>
<td>Linkages &amp; Referrals</td>
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<td></td>
<td>Linkages &amp; Referrals</td>
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</tbody>
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PERFORMANCE MANAGEMENT
THE FUTURE OF PUBLIC HEALTH

**Public Health Performance Management System**

**Performance Standards**
- Identify relevant standards
- Select indicators
- Set goals and targets
- Communicate expectations

**Performance Measurement**
- Refine indicators
- Define measures
- Develop data systems
- Collect data

**Reporting of Progress**
- Analyze and interpret data
- Report results broadly
- Develop a regular reporting cycle

**Quality Improvement**
- Use data for decisions to improve policies, programs, outcomes
- Manage changes
- Create a learning organization

*Leadership & Culture*
PERFORMANCE STANDARDS

PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM

PERFORMANCE STANDARDS
- Identify relevant standards
- Select indicators
- Set goals and targets
- Communicate expectations

PERFORMANCE MEASUREMENT
- Refine indicators
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REPORTING OF PROGRESS
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QUALITY IMPROVEMENT
- Use data for decisions to improve policies, programs, outcomes
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Leadership & Culture
PERFORMANCE STANDARDS
IDENTIFY STANDARDS AND SELECT INDICATORS

- Healthy Families & Children
  - Maternal and Infant Health (8 Constructs)
  - Prevention of Injuries & Maltreatment (7 Constructs)
  - School Readiness & Achievement (9 Constructs)
  - Reducing Domestic Violence (3 Constructs)
  - Family Economic Self Sufficiency (3 Constructs)
  - Coordinated Referral & Support (5 Constructs)

8 Constructs
7 Constructs
9 Constructs
3 Constructs
PERFORMANCE STANDARDS
FEDERAL TO STATE PERFORMANCE EXPECTATIONS

- All States must show improvement in 4 out of the 6 Benchmark Areas
- All States must show improvement on half of the constructs within a Benchmark Area
- All States must show improvement across all programs in Year 3 and Year 5
- Federal funding for continued home visiting services is linked to performance
PERFORMANCE MEASUREMENT

PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM

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QUALITY IMPROVEMENT
- Use data for decisions to improve policies, programs, outcomes
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Leadership & Culture
## PERFORMANCE MEASUREMENT

### REFINE INDICATORS

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measurement Tool</th>
<th>Measure</th>
<th>Population Assessed</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Direction of Improvement</th>
<th>Data Source</th>
<th>Timing of Data Collection</th>
<th>Frequency of Reporting</th>
<th>Comparison</th>
<th>Outcome Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1: Prenatal care</td>
<td>Kotelchuck Index</td>
<td>Percent of postpartum women with Kotelchuck Index of Adequate or above</td>
<td>All target women who are pregnant while receiving program services</td>
<td>Number of women with Kotelchuck score of Adequate or Adequate Plus</td>
<td>Number of postpartum women</td>
<td>Increase, or maintain at 80% or better</td>
<td>FamilyWise; Vital Records</td>
<td>Every visit while pregnant</td>
<td>Annually</td>
<td>Across cohorts</td>
<td>Outcome</td>
</tr>
<tr>
<td>1.2: Parental use of ATOD</td>
<td>UNCOPE</td>
<td>Percent of women screened for ATOD abuse in past 12 months</td>
<td>All target women</td>
<td>Number of women screened for ATOD abuse</td>
<td>Number of women</td>
<td>Increase or maintain</td>
<td>FamilyWise</td>
<td>Intake</td>
<td>Annually</td>
<td>Across cohorts</td>
<td>Process</td>
</tr>
<tr>
<td>1.3: Preconception care</td>
<td>N/A</td>
<td>Percent of women with one or more primary care visits in past 12 months while not pregnant</td>
<td>All target women</td>
<td>Women with one or more primary care visits while not pregnant</td>
<td>Number of women</td>
<td>Increase</td>
<td>FamilyWise/home visiting log</td>
<td>Every visit</td>
<td>Once per pregnancy</td>
<td>Across cohorts</td>
<td>Outcome</td>
</tr>
<tr>
<td>1.4: Inter-pregnancy interval</td>
<td>N/A</td>
<td>Percent of women referred for family planning or reproductive health services</td>
<td>All target women</td>
<td>Number of women referred</td>
<td>Number of women</td>
<td>Increase or maintain</td>
<td>FamilyWise; Vital Records</td>
<td>Once per pregnancy</td>
<td>Annually</td>
<td>Across cohorts</td>
<td>Process</td>
</tr>
<tr>
<td>1.5: Maternal depression screening</td>
<td>Center for Epidemiological Studies Depression scale (CES-D)</td>
<td>Percent of post-partum women screened for depression in past 12 months</td>
<td>All target women</td>
<td>Number of women screened for depression</td>
<td>Number of women</td>
<td>Increase or maintain</td>
<td>FamilyWise</td>
<td>12 months postpartum</td>
<td>Annually</td>
<td>Across cohorts</td>
<td>Process</td>
</tr>
<tr>
<td>1.6: Breastfeeding</td>
<td>N/A</td>
<td>Mean LSP breastfeeding score</td>
<td>All target women who entered the program prenatally, at delivery, or have a subsequent live birth, through 1 year post-partum</td>
<td>Sum of breastfeeding scores</td>
<td>Number of women</td>
<td>Increase</td>
<td>FamilyWise/home visiting log</td>
<td>Every visit</td>
<td>12 months post-partum</td>
<td>Across cohorts</td>
<td>Outcome</td>
</tr>
<tr>
<td>1.7: Well-child visits</td>
<td>N/A</td>
<td>Percent of children whose immunization status is current at 15 months</td>
<td>All target 15-month old children</td>
<td>Number of children with full 12 month immunization status by 15 months</td>
<td>Number of ever-enrolled children</td>
<td>Increase</td>
<td>Nebraska State Immunization Information System (NIS); FamilyWise/home visiting logs; Immunization cards</td>
<td>Once per child, at 15 months</td>
<td>Annually</td>
<td>Across cohorts</td>
<td>Outcome</td>
</tr>
</tbody>
</table>
PERFORMANCE MEASUREMENT
N-MIECHV DATA SYSTEM

Data Input

Benchmark Reporting
Evaluation
CQI and Quality Management
Local Level Data Support

Data Output

Child & Family Services
NESPIS
Vital Records
Vendor Specific

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

1. In the past seven days, I have been able to laugh and see the funny side of things.
   - As much as I always could
   - Not quite so much now
   - Definitely not as much now
   - Not at all
   - Reset Value

2. In the past seven days, I have looked forward with enjoyment to things.
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all
   - Reset Value

3. In the past seven days, I have blamed myself unnecessarily when things went wrong.
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never
   - Reset Value

4. In the past seven days, I have worried for no good reason.
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often
   - Reset Value

5. In the past seven days, I have felt scared or panicky.
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all
   - Reset Value
PERFORMANCE MEASUREMENT
DATA COLLECTION
1. An organizational culture that promotes the belief that good data are a key part in understanding program impact
   - “Are the services we are providing families and children making a difference?”

2. An organizational culture that in which everyone who has a role in family and child outcomes shares this belief
   - “My role and the work I do is important for helping families and children achieve positive outcomes. Quality data helps us tell an accurate story of our work and how we are doing.”

3. An organizational culture that invests time and effort in achieving useful information and respects the effort taken to produce it
   - “We value quality data as much as we value quality service; both are important investments of time and effort by individuals.”
QUALITY IMPROVEMENT
DATA UTILIZATION - ACTIONABLE

[Diagram showing a chain of actions from data collection to analysis and decision-making.]
QUALITY IMPROVEMENT CQI CYCLE
REPORTING

PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM

PERFORMANCE STANDARDS
- Identify relevant standards
- Select indicators
- Set goals and targets
- Communicate expectations

PERFORMANCE MEASUREMENT
- Refine indicators
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REPORTING OF PROGRESS
- Analyze and interpret data
- Report results broadly
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QUALITY IMPROVEMENT
- Use data for decisions to improve policies, programs, outcomes
- Manage changes
- Create a learning organization

Leadership & Culture
REPORTING
ANALYZING AND INTERPRETING DATA

[Diagram showing the flow of data from federal to state to local levels, with icons representing analysis and data.]
REPORTING
ANALYZING AND INTERPRETING DATA
CONTEXTUAL
REPORTING CYCLE
ANNUAL BENCHMARK-QUARTERLY DASHBOARD

N-MIECHV

CQI BENCHMARK REPORT
(SAMPLE PAGE WITH SAMPLE DATA)

QUARTER 4: Oct 1 - December 31, 2012

### # of Families Provided with Child Development and Safety Education

<table>
<thead>
<tr>
<th>Quarters</th>
<th>Provided</th>
<th>Not Provided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>45</td>
<td>35</td>
<td>80</td>
</tr>
<tr>
<td>Q2</td>
<td>40</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>Q3</td>
<td>45</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>Q4</td>
<td>35</td>
<td>45</td>
<td>80</td>
</tr>
<tr>
<td>Not reported</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

### # of Mothers Screened for Domestic Violence, Mental Health, and Substance Abuse

<table>
<thead>
<tr>
<th>Quarters</th>
<th>Screened</th>
<th>Baseline</th>
<th>Annual Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>92%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>98%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>93%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>84%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Not screened</td>
<td>93%</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

### # of Children Screened with ASQ 3 and the ASQ SE at Least Twice between the Ages of 3 and 12 Months

<table>
<thead>
<tr>
<th>Quarters</th>
<th>Screened</th>
<th>Baseline</th>
<th>Annual Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>98%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>98%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>100%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>100%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Not screened</td>
<td>98%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>
EVALUATION

NEBRASKA MATERNAL, INFANT EARLY CHILDHOOD HOME VISITING (N-MIECHV) EVALUATION STUDY PROPOSAL
SUMMARY

• Home visiting has been an important strategy in serving children and families for many years.
• Federal MIECHV has provided an opportunity to learn about evidence-based home visiting and the systems needed to implement with fidelity.
• Data driven, community level planning and performance accountability are important in delivering high quality evidence-based strategies such as home visiting.
• Evidence-based home visiting is one strategy for communities to consider in an array of services to support families.
DISCUSSION

• Questions?

• Three key points?
Paula Eurek, Lifespan Health Services Administrator
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