MIECHV Data and Evaluation: Essential Pieces & Partnerships

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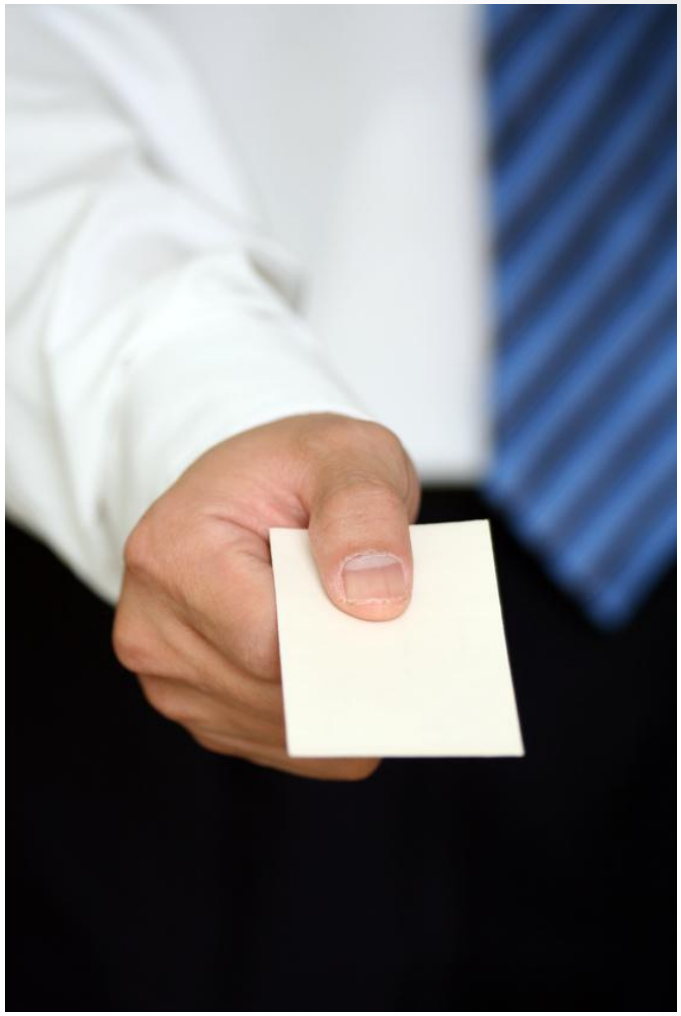
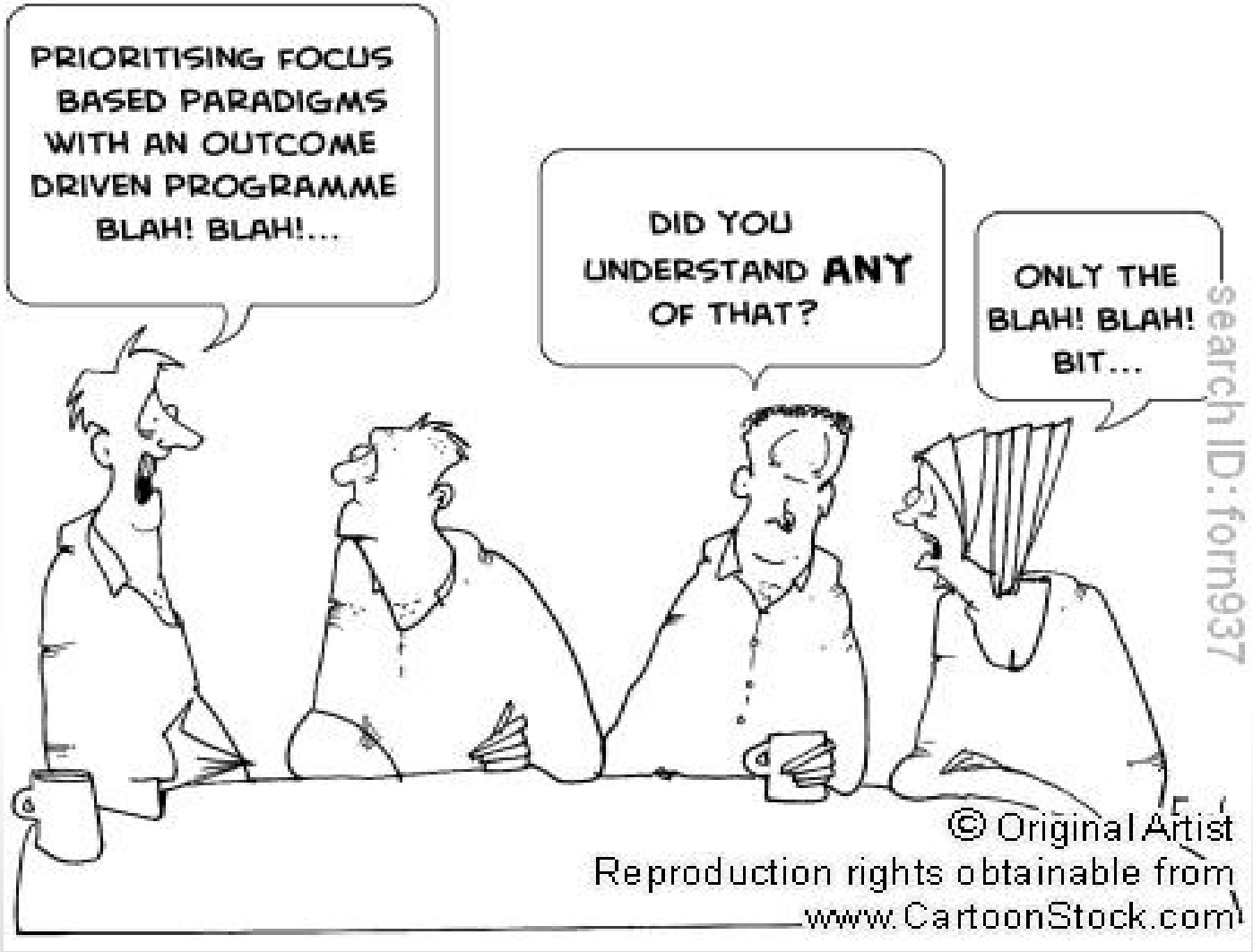
Introductions



Purpose of Presentation

- Increase communities' understanding for role of Benchmarks
- Understand the reporting and data collection requirements for the MIECHV programs
  - Address concerns surrounding benchmark data collection and reporting
  - Identify the roles that each organization involved in Benchmark reporting will play, and what additional roles that CPRD can play for MIECHV and home visiting services
- Identify key performance measures for MIECHV programs, both for Benchmarks and continuous quality improvement efforts
- Provide opportunities to identify key information by sites

And what is not the purpose of this presentation?



How do we define success?

- Providing high-quality home visiting services that positively impact the lives of children and families enrolled in the MIECHV programs
- Meeting and exceeding Benchmarks
- Findings ways to pool our knowledge collectively to improve statewide delivery of home visiting services.

How does MIECHV fit in?

- MIECHV was designed to address home visiting service delivery framework for five components of Early Childhood Comprehensive Systems (HRSA):
  - Access to health care and medical homes
  - Social-emotional development and mental health
  - Early care and education
  - Parenting education
  - Family support

How does MIECHV fit in?

- MIECHV designed to expand HV services into priority populations:
  - Reside in communities in need of services & have low income
  - Include pregnant women who have not attained the age of 21
  - Have a history of child abuse
  - Have a history of substance abuse
  - Have users of tobacco products
  - Have a history of, or have children with, low student achievement
  - Have children with developmental delays or disabilities
  - Include members of the military

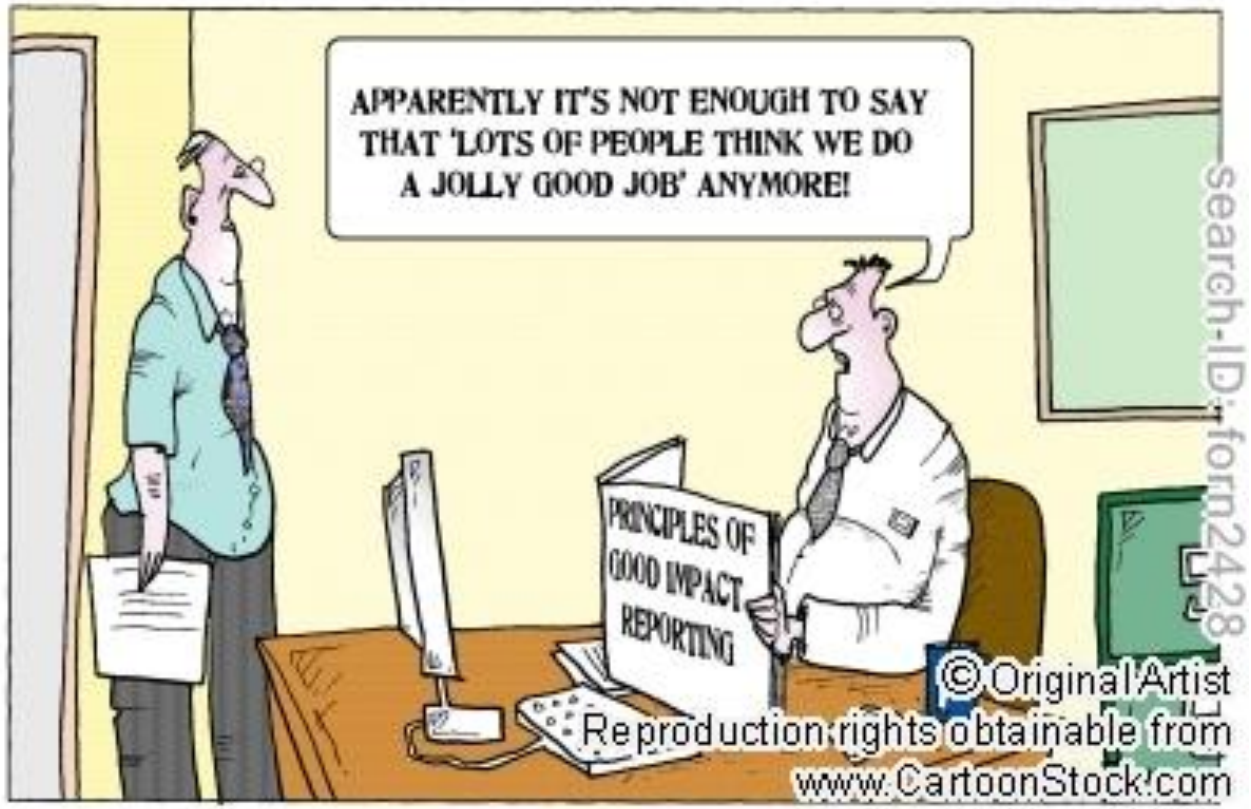
How does MIECHV fit in?

- The program goals, per the HRSA website are as follows:
  1. Strengthen and improve the programs and activities
  2. Improve coordination of services for at-risk communities
  3. Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities
  4. MIECHV reflects federal and state collaboration initiative to foster collaboration among agencies within the states, HRSA , and ACF

Why do we have Benchmarks?

- The legislation funding MIECHV required quantifiable, measurable improvements for the populations receiving services.
  - Programs must demonstrate improvement in the following Benchmark areas:
    1. Improved maternal and newborn health
    2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits
    3. Improvement in school readiness and achievement
    4. Reduction in crime or domestic violence
    5. Improvements in family economic self-sufficiency
    6. Improvements in the coordination and referrals for other community resources and supports

Where do the Benchmarks come from?



What the Evaluation is and is not

- The Evaluation is:
  - A way to measure and address the challenges in scale-up implementation of HV services
  - A way to show Congress that tax money spent on additional HV services is important and useful
  - A way to introduce statewide continuous quality improvement efforts
  - A goal setting mechanism
- The Evaluation is not:
  - A performance assessment to be used for funding decisions
  - A method to weed out the poor performing HV sites
  - A way to collapse the variety of model HV programs into a single government-managed HV organization

What if we don't make improvements on the benchmarks after 3 years?

- Would need to develop a plan of action
- CPRD, the Governor's Office, and individual community programs would work together to develop a plan and next steps
- The CQI is crucial to next steps

What is MIHOPE -- is it related to the Benchmarks?

- MIHOPE is a randomized controlled trial of the MIECHV project itself
- Carried out by the independent contractor -- Mathematica
- CPRD is not involved with or associated with the MIHOPE study
- CPRD will try to coordinate with MIHOPE researchers

Illinois MIECHV: A Partnership Approach

- CPRD has or will be involved in the following areas:
  - In partnership with the state developing measurement procedures and systems which adequately address the Benchmark reports
  - Coordinate with state and sites the Benchmark data collection
    - Work together with home visitors
  - Query data from ETO data system and prepare reporting to the feds annually
  - Utilize data to track individuals through time in services
  - Collect home visiting services satisfaction information
    - Help clarify possible barriers to engagement

What is CQI and how will CPRD aid in the CQI efforts?

What is CQI and how will CPRD aid in the CQI efforts?

- CQI: Continuous Quality Improvement
- CPRD's role in data collection and monitoring
  - Interpretation of results and aiding in important decision-making around findings
  - Linking of improvement efforts to participant outcomes

Key Programmatic Issues

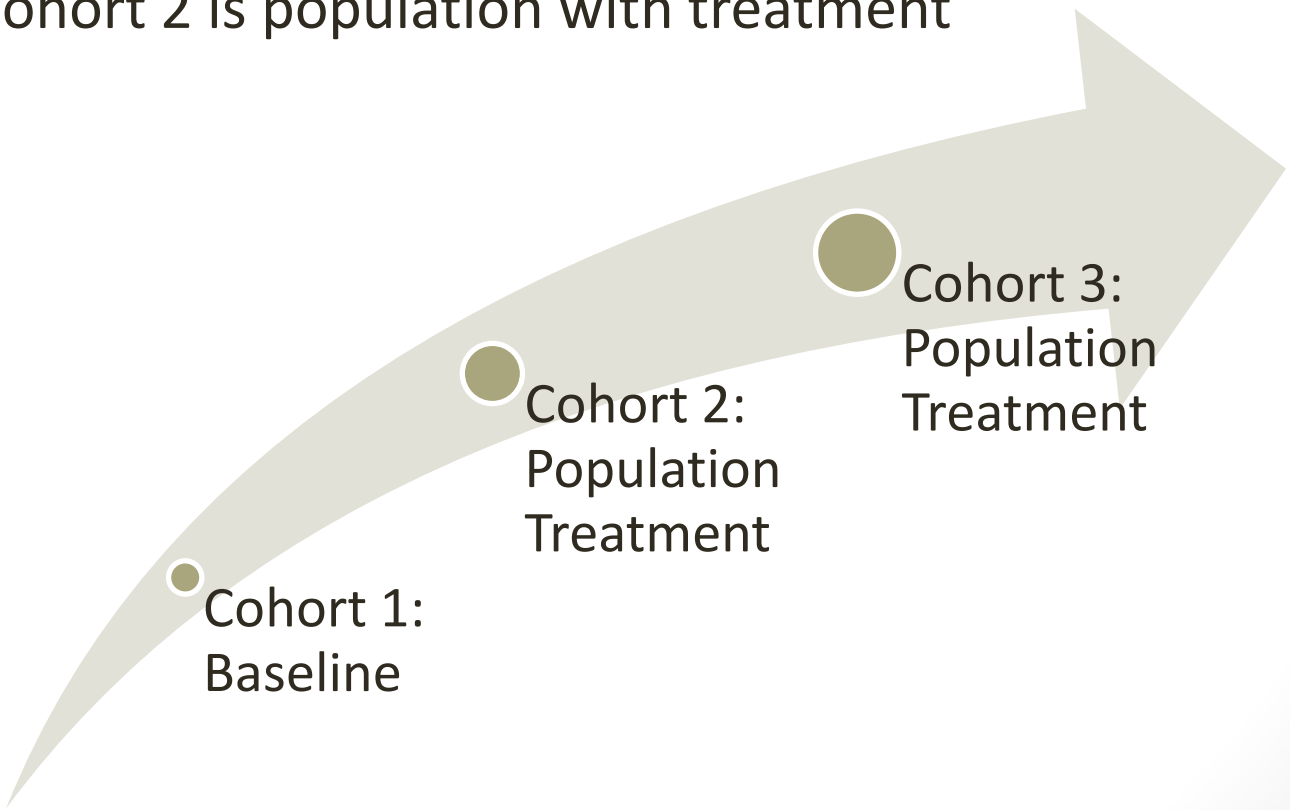
- What will CPRD address?
  1. Is the program model appropriate for the community and culture for the families served?
  2. Is the program model being implemented with fidelity?
  3. What adaptations to the model have been made and why?
  4. Are families with the greatest needs being serviced by the program?
  5. What are the major recruitment or feeder sources for families entering HV services?
  6. Are any families being systematically excluded from receiving services?
  7. What factors contribute to engagement and retention of families in home visiting services?
- Adaption is key to engagement and retention.
- Question to the audience (10-minute activity)

What are the cohorts mentioned in the Benchmarks?

- The term “cohort” refers to the idea of a group of families who enter and exit home visiting services together.
  - But are families entering and exiting services all the time?
    - Cohort is population of families in services at time of data collection
- Cohorts in MIECHV?
- How will we know if individuals are changing?
  - Individual change and CQI

How can we attribute change across years to the HV services?

- Population change across cohorts
- Cohort 1 is baseline population
- Cohort 2 is population with treatment



How can we attribute change across years to the HV services?

- Similar to our study, here was a population study looking at the impact community wide fluoridation on tooth decay.

Why track parents within cohorts if the Benchmarks don't require it?

- Important for Continuous Quality Improvement
- Help to better understand factors associated with retention and engagement
- Help improve services statewide
- Population measures may hide important change

Now, let's look at the Benchmarks individually

- The Benchmarks contain constructs
  - specific measures to address each construct
- Reflect outcomes of home visiting services

1. Improved Maternal and Newborn Health

- Prenatal Care
- Prenatal use of alcohol, tobacco, or illicit substances
- Postpartum use of contraception and Interpartum Interval
- Screen for Maternal Depressive Symptoms
- Duration of breastfeeding, well-child visits, and maternal health insurance coverage

2. Child Injuries, Child Abuse, or Maltreatment and Reduction of Emergency Department Visits

- Constructs
  - Visits for child and mother to the emergency department from all causes
  - Information provided or training of participants on prevention of child injuries
  - Incidence of child injuries requiring medical treatment
  - Reports of suspected maltreatment for children in the program, reported substantiated maltreatment, and first time victims of maltreatment

3. Improvements in School Readiness and Achievement

- Constructs
  - Parent support and knowledge for children's learning and development
  - Parenting behaviors and parent-child relationship
  - Parent emotional well-being or parenting stress
  - Child's communication, language and emergent literacy, cognitive skills
  - Child's positive approaches to learning and attention
  - Child's social behavior, emotional regulation and emotional well-being
  - Child's physical health and development

4. Domestic Violence

- Constructs
  1. Screening for domestic violence
  2. Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services

5. Family Economic Self-Sufficiency

- Constructs
  1. Household income and benefits
  2. Employment or education of adult (mother and father) members of the household
  3. Health Insurance Status

6. Coordination and Referrals for Other Community Resources and Supports

- Constructs
  1. Number of families identified and referred to available community resources
  2. The number of families who complete referrals to available community resources
  3. Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency
  4. Number of agencies with which the home visiting provider has established a formal memorandum of understanding

Illinois Maternal Infant Early Childhood Home Visiting Outcomes Model

Contextual Factors

Socio-demographics
Urbanicity
Family Support/Network
Employment
Poverty
Access to health and social services

MIECHV Programs, Policies and Practices

- Model programs are appropriately selected for community and cultural context
- Model Programs are implemented with fidelity
- Cultural and community adaptations made and documented

Process Indicators

- Outreach for targeted and indicated families (who, what, when, where)
- Number eligible for HV programs versus number enrolled
- Number of families completing HV programs
- Number of HV per family
- Number and length of time women breast feed

Process Flow

Service Outcomes – Parents and Family

- Family receives health and safety education lessons (Benchmark 100% of parents and families)
- Intake screening (100% of parents and family)
- Appropriate entry and completion prenatal (100%)
- Depression screening (100% of parents and family)
- Maternal and family screening for tobacco, alcohol and drug use and abuse (as indicated)
- Domestic Violence Screening (90% of family members are screened)
- Access to WIC (100% of eligible families)
- Access to Medicaid or Healthy Kids (100% eligible families)
- Participation in Parent Education (95% of all families)
- Participation in family planning education (95% of all families)
- Number of domestic violence indicated parents who have a safety plan (100% of indicated parents and family)
- Comprehensive services are coordinated, culturally appropriate and high quality

Service Outcomes for Child

- Number of well-baby visit s (% of children receiving 5 or more visits in an 18-month period)
- ASA Screening

Early Parent and Family Outcome

- Increase parent knowledge regarding developmental stages of child development
- Increase knowledge of home health and safety conditions
- Development of an educational or employment plan
- Increase use of family planning and contraceptive services

Early Child Outcomes

- Increase parent-child interactions
- Improve health and wellness
- ASA development within normal range
- Improved safe living and play environments

Intermediate Parent and Family Outcomes

- Parents and family members report/observed engaging in developmentally appropriate play and interactions
- Parent report/observe providing developmentally appropriate discipline practices
- Percent of parent and family members who report harsh discipline (harsh norm scale on the Conflict Tactics Scale)
- Family/Child follow through on referrals

Intermediate Child Outcomes

- Increase child's exposure to healthy/safe living environment
- Increase child's responses to parent stimulation
- Increase child resiliency ratings (need to id measure)

Long-Term Outcomes – Parents and Family

- Increase in family self-sufficiency mother and family
- Completion of education milestone
- Career readiness and gainful employment measured by income and fringe benefit levels from entry to child's first birthday
- Increase number of hours employed
- Reduction of second child within a two-year period

Lon- Term Outcomes - Child

- School ready (literacy, numeracy, cognitive skills)
- Social-emotionally resilient
- Physically healthy
- Reduce use of the emergency room services for both emergency and non-emergency causes
- Reduce number and severity of injuries that require medical services
- Reduction of reported or confirmed child neglect or abuse

Measures for Success and Improvement

- Small Group Activity
- Let's think about how we define quality services?
  - How can you characterize high-quality home visiting services?
  - Break up into small groups of 3-5 people
- Within the small groups:
  - Discuss some of the ways to measure the quality of services
  - How can the CQI be useful to sites?
    - What should it measure?
    - What should the reports look like to be most useful?

Data Sources for Benchmark Reporting

Agency and Data System	Data System	Data Type	Key Variables
ETO – Social Solutions	Case Management System	Database	Case Management of HV Programs
IDHS - Cornerstone	Administrative	Database	Case Management of HFI
Department of Health and Family Services	Medicaid	Database	Health and Medical Care Data
ISBE	Longitudinal Data Set	Database	Educational Readiness
Illinois Department of Children and Family Services	Administrative	Database	Involvement in the DCFS System
CPRD/UofI – Evaluator Family Observations	Online Web Surveys	SPSS files	Key Performance Measures and Constructs

Key Challenges for Programs and Evaluation

- Accessing and recruiting the families in greatest need
- Providing high-quality services that address child and family needs and access to referral services
- Readiness of families for the key services
- Retaining and engaging families for the requisite time needed to provide high-quality HV services
- Maintaining contact and engagement with families

On-site Data Collection

- CPRD research staff will work with home visitors to collect measures from families
- Assess the families at three time periods
  - 2-4 weeks after enrollment
  - 1 year and 2 year follow-ups
- Online system to U of I
  - Computer, web site, Internet service providers
- Informed Consent – depending on age or emancipation status
  - Parental consent – if mother is less than 18 years old, written parental/guardian consent is required and self-assent
  - Self-consent – emancipated or 18 years or older, written assent is required

Incentives for Participation in the Evaluation

- Research unequivocally demonstrates that paying individuals for participating in research studies results in better participation and continuation
- We are proposing a schedule of modest cash or gift cards for participating in survey administration

Common or Core Measures – Self-Completed Surveys

- Home Visitor Collected
  - Participant demographics
  - MIECHV assessment on head of household
  - 4 P screening for behavioral risk factors (alcohol, tobacco and other drugs)
  - Edinburg Depression
- CPRD Collected
  - Knowledge of Infant Development Inventory
  - Parent Stress Index (PSI)
  - Home Observation for Measurement of the Environment (HOME)
  - Satisfaction with HV Services Survey

MIECHV Measures – Observations and Child Interactions

- Home Visitor Collected
  - Ages and Stages
    - ASQ-3
    - ASQ-SE
- CPRD Collected
  - Parenting Interactions with Children: Checklist Linked to Outcomes (PICCOLO)
  - HOME

Where do we go from here?

- Training, engaging, and implementing of CPRD research staff
- Gather baseline data for initial report
  - Back-entering initial service data
- Questions or concerns
  - Contact Questions

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