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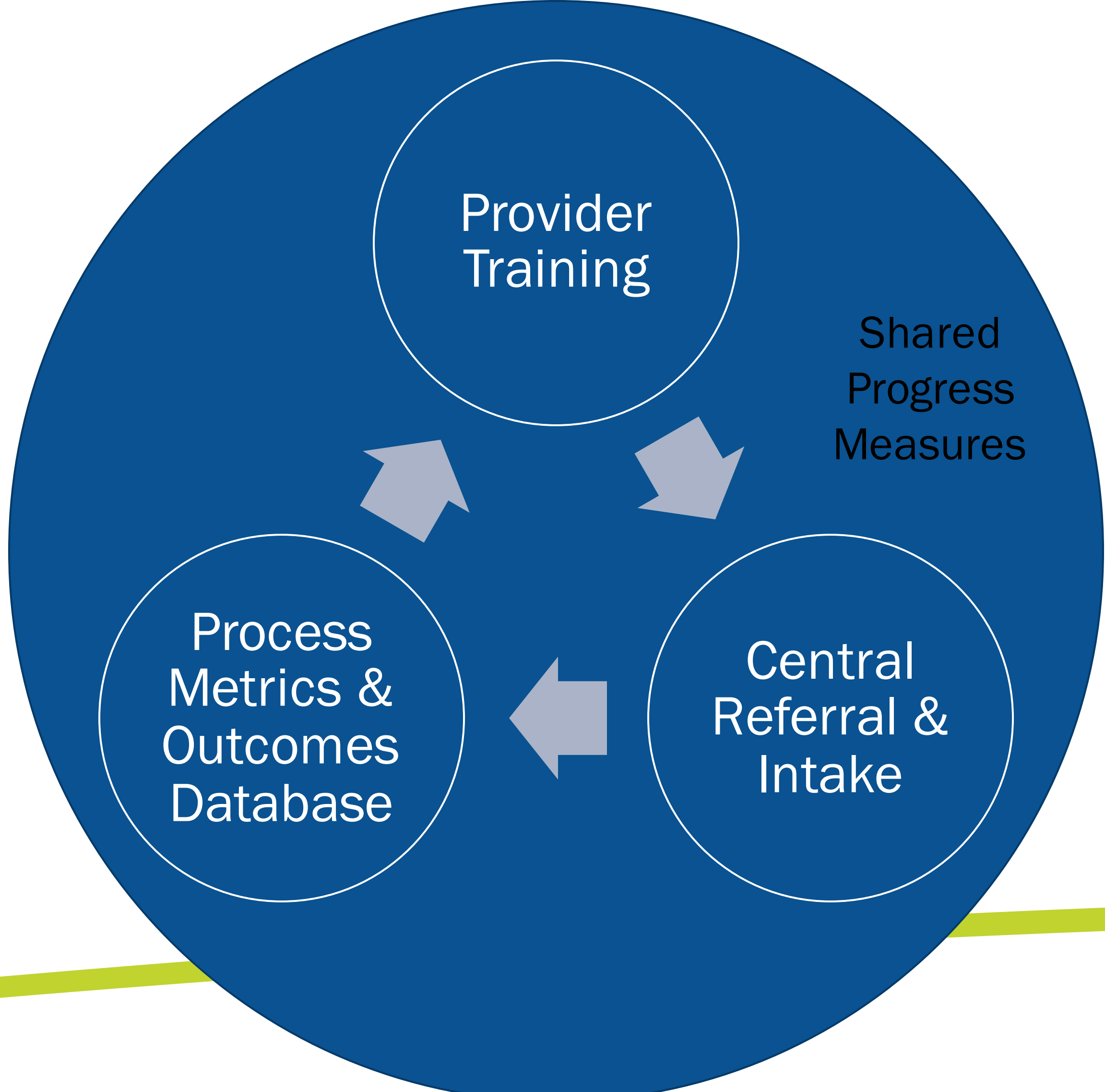
Champions of Family and Community

Promise 1000–
3 Inter-related Elements Informed by the Shared Progress Measures



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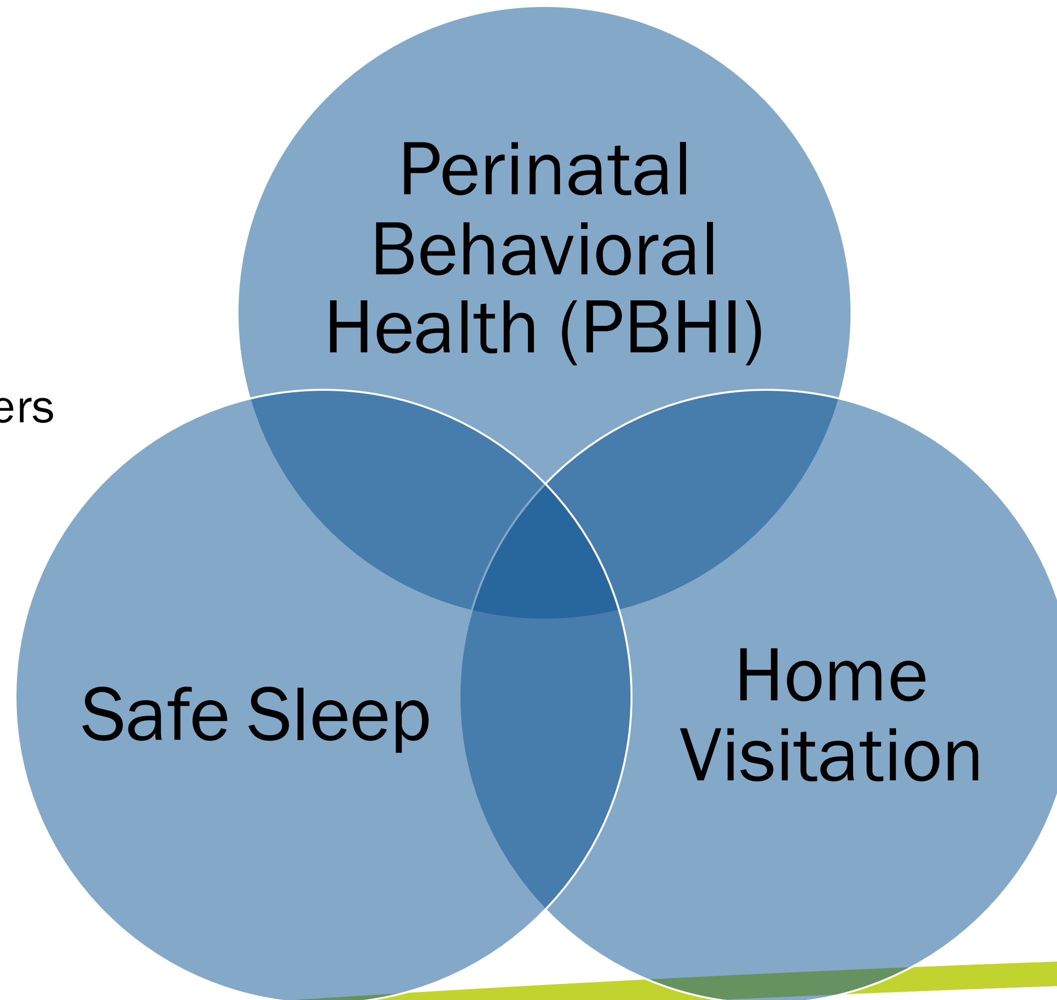
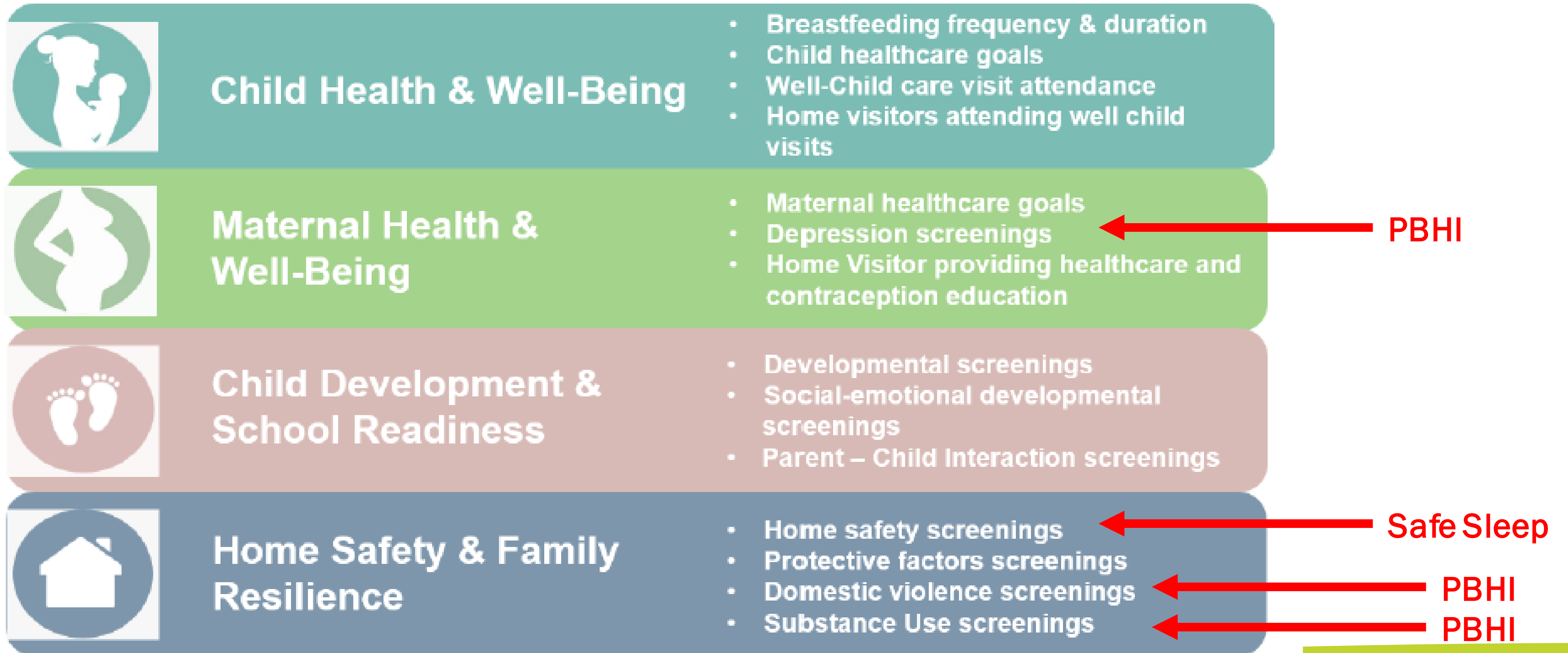
Generate Health–
3 Shared Measurement Systems

Each System has:
Unique Partners + Overlap Partners



Step 1: Choosing Metrics & Outcomes

Promise 1000 – Shared Progress Measures



Funder Mandated Reporting Requirements

Developing Shared Data, Outcomes & Activities

MIECHV Benchmarks

- Measure 01: Preterm Birth
- Measure 02: Breastfeeding
- Measure 03: Depression Screening
- Measure 04: Well-Child Visits
- Measure 05: Postpartum Care
- Measure 06: Tobacco Cessation Referrals
- Measure 07: Safe Sleep
- Measure 08: Child Injury
- Measure 10: Parent-Child Interaction
- Measure 11: Early Language and Literacy Activities
- Measure 12: Developmental Screening
- Measure 13: Behavioral Concerns
- Measure 14: Intimate Partner Violence Screening
- Measure 15: Primary Caregiver Education
- Measure 16: Continuity of Insurance Coverage
- Measure 17: Completed Depression Referrals
- Measure 18: Completed Developmental Referrals
- Measure 19: Intimate Partner Violence Referrals

Demographics
Total number of PCGs served
Total number of children served
Total number of home visits provided
PCGs by age
Children by age
PCGs by race
Children by race
PCGs by ethnicity
Children by ethnicity
PCGs by marital status
PCGs by employment status
PCGs by housing status
Primary language spoken at home

*See MIECHV Decipher Key

Note: Promise 1000 just doesn't have a shared measurement system with anyone that uses Nurse Family Partnership

Nurse Family Partnership Metrics

(Need more info)

What other funding requirements exist in the home visitation network?

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Promise 1000 Process Measures

The "Big Picture" – Process Measures that lead to Outcomes!

Maternal/Child Health & Well-Being Examples...

MATERNAL HEALTH & WELL-BEING

Metric: Maternal Depression Screening/Referrals
Potential Outcomes: improved depression treatment rates, improved depression rates, improved child outcomes and relationships, etc.

Metric: Maternal Health-Related Goal
Potential Outcomes: improved maternal and fetal health, decrease in pre-term delivery, etc.

Metric: Family Planning Education/Guidance (contraception)
Potential Outcomes: increased birth spacing, decreased poverty, etc.

Metric: Guidance for Appropriate ED/UCC/PCP Attendance
Potential Outcomes: cost savings for Medicaid management, increased funding stream for home visiting services, etc.

Metric: Maternal Postpartum Healthcare Attendance
Potential Outcomes: improved maternal health and mortality, reduced untreated postpartum Depression, improved maternal capacity to work and care for children, etc.

Metric: Tobacco Cessation/Substance Use Referrals
Potential Outcomes: improved maternal & child health, reduction of CA/N, improved bonding, improved parent-child interactions, etc..

Metric: Inter-Birth Spacing
Potential Outcomes (combo): improved pre-term birth rates, improved infant mortality, improved bonding, improved parent-child interactions, improved maternal health and stress, etc.

CHILD HEALTH & WELL-BEING

Metric: Breastfeeding Rates (frequency & duration)
Potential Outcomes: improved bonding, improved infant health, improved maternal health, etc.

Metric: Well Child Care Visits
Potential Outcomes: reduced preventative health conditions, improved caretaking by parent, reduced hospitalizations, etc.

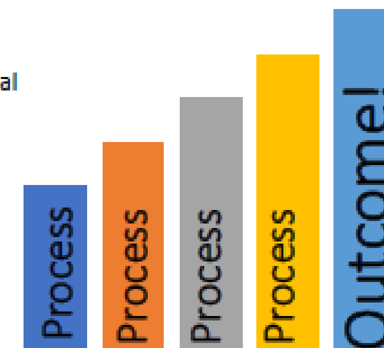
Metric: Child Health-Related Goal (similar outcomes to well child care visits), etc.

Metric: Preterm Birth Rates
Potential Outcomes: improved infant health, cost savings for healthcare, etc.

Metric: Child Behavioral Concerns
Potential Outcomes: improved school-readiness, decreased CA/N, improved usage of mental health Services, etc.

Metric: Insurance Coverage (mother & child)
Potential Outcomes: improved health, reduced preventative health conditions, reduced hospitalizations, etc..

Metric: Prenatal Enrollment
Potential Outcomes: improved pre-term birth rates, improved birth weights, improved infant health, improved maternal health, etc.



The "Big Picture" – Process Measures that lead to Outcomes!

Child Development, Early Learning, Home and Child Safety Examples…

HOME AND CHILD SAFETY

Metric: Protective Factors Screening
Potential Outcomes: reduced risk factors associated with CA/N, increased protective factors that help to prevent CA/N including: family functioning and parental resilience, positive social supports, concrete supports, parental nurturing and attachment, parental knowledge of positive parenting practices and child development, etc.

Metric: Intimate Partner Violence Screening/Referrals
Potential Outcomes: reduced domestic violence rates, increased empowerment and healthy relationships, improved parental health and mortality, and decreased CA/N, etc.

Metric: Home Safety Screening/Education
Potential Outcomes: improved home environment safety and safe sleep practices, reduced childhood injury, decreased neglect, and increased medical cost savings, etc.

Metric: Safe Infant Sleep Practices
Potential Outcomes: improved infant mortality, improved maternal quality of sleep/health, etc.

Metric: Child Maltreatment Screening
Potential Outcomes: reduced substantiated CA/N

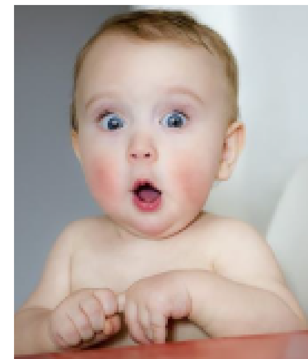
CHILD DEVELOPMENT/EARLY LEARNING

Metric: Parent-Child Interactions
Potential Outcomes: improved bonding and attachment, improved affection, improved parental responsiveness and encouragement, and improved child learning/development

Metric: Early Language & Literacy Activities
Potential Outcomes: improved reading and learning, improved bonding and attachment, increased parental engagement, improved school achievement, and increased educated workforce, etc.

Metric: Developmental Screening/Referrals (covers fine/gross motor, receptive/expressive language, cognition, etc.)
Potential Outcomes: improved child development, improved parental knowledge/understanding of appropriate child development, increased appropriate expectations of children, increased usage of developmental services, improved school-readiness, etc.

Metric: Caregiver Education
Potential Outcomes: improved economic stability, decreased parental stress, increased engagement of child in early learning activities, etc.



Step 2: Building the System

Promise 1000 REDCap Database

- Series of screening tools & forms to collect process metrics
- Links to the overall long-term outcomes the collaborative is hoping to achieve.

Screening Tools Used

PBHI Screening

Promise 1000 – Shared Screening Tools

- Ages & Stages Questionnaire-3 (ASQ-3) – child development
- Ages & Stages Questionnaire-Social Emotional (ASQ-SE)– child social emotional development
- Edinburgh Postnatal Depression Scale – maternal depression
- Women's Experience With Battering Scale (WEB) – IPV
- Protective Factors Survey – family functioning and strengths tool for measuring improvements
- Home Safety Inventory – environmental safety in the home
- Parent Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) – parent-child interaction tool
- UNCOPE – Substance Use Screen

*See Screening Schedule.................................

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Screening Tools Schedule

Promise 1000 - Shared Evaluation/Information Forms

- Short Forms to feed reporting, identified benchmarks, goals and process measures
- Some forms may be agency specific and only turned on for agencies that need them for their specific model

Record ID	1000
Date	Today M-D-Y
Baby's insurance status:	Medicaid (including presumptive eligibility)
Baby/Child Medicaid Number or DCN	(If has Medicaid, please complete)
If baby/child has Medicaid, and the Medicaid is not filled in above, please list the reason:	Parent refused/declined giving the Medicaid # Parent did not have the Medicaid #/Card at this time (Is getting it to you later). Other reset
Form Status	
Complete?	Incomplete
	Save & Exit Form Save & ...

PROMISE 1000 FORMS SCHEDULE		
Form	How Often	Due Dates
STATIC FORMS (Done Only Once)		
Centralized Intake & Referral Form	Once	Intake/Start
Agency & Eligibility Form	Once	Intake/Start
Program Consent Form	Once	Intake/Start
Baby.Child Information Form	Once (possibly more if more than once child)	Intake and/or Child's birth
Breastfeeding Form	Once	Date Stopped Breastfeeding
Case Closure Form	Once	Closure
ONGOING & AS NEEDED FORMS		
Lost to Follow Up Status	As needed	When LFU starts/ends
Prenatal Healthcare Visits	as occur	When healthcare visits occur
Prenatal Visits Form	Everytime mom is pregnant, every visit	As prenatal visits occur
Postnatal Visits Form	Everytime mom is postnatal, every visit	As postnatal visits occur
Referrals Form	As needed	As Referrals Happen
Baby.Child Health Insurance	As needed	Intake/Start & As Changes/Updates
Primary Care Physician Child	As needed	Intake/Start & As Changes/Updates
Primary Parent Health Insurance	As needed	Intake/Start & As Changes/Updates
Demographic Updates	Quarterly	Quarterly/Every 6 months from enrollment-see popup
Maternal Health Goals	As needed	Intake/As goals get created and completed (should always have a goal)
Child Health Goals	As needed	Intake/As goals get created and completed (should always have a goal)
Immunizations	As needed	Same timeframes at well-child visits (as they occur)
Child ER/UCC Visits	As needed	As ER/UCC visits happen
Parent ER/UCC Visits	As needed	As ER/UCC visits happen
Child Abuse or Neglect Form	As needed-Postnatal	If Child Abuse/Neglect is reported
AGENCY SPECIFIC FORMS (Only see if required by your agency)		
Family Goals	Ongoing-As needed	See Supervisor
Groups, Graduation, Other	Ongoing-As needed	See Supervisor
Attempted Visit Documentation	Prenatal & Postnatal	See Supervisor
Phoneletter Documentation	Prenatal & Postnatal	See Supervisor
Visit Documentation	Prenatal & Postnatal	See Supervisor

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Promise 1000 Developed Dashboards to Compare Provider Agencies

Reports: Example Edinburgh Screening

Location	Case Worker	ID	DOB	Prenatal	2 month	9 month	21 month	33 month	Date Range %	Other Screen Dates	
		1157-56				06/17/19			100%		EDIT
		1175-117					07/29/19		100%		EDIT
Easter Seals	Closed Cases	1175-23						07/09/19	100%		EDIT
Easter Seals	WaitList - Victoria Campos	1175-106					06/17/19		100%		EDIT
Easter Seals	Closed Cases	1175-20						03/18/19	100%		EDIT
Easter Seals	Closed Cases	1175-105		02/25/19					50%		EDIT
Easter Seals	Closed Cases	542-14						07/29/19	100%	03/07/19	EDIT
Easter Seals	Closed Cases	1167-23						08/01/19	100%		EDIT
Easter Seals	Closed Cases	1166-33				12/18/18			100%		EDIT
Easter Seals	Toni Reynolds	1174-75	08/01/18			04/09/19			100%		EDIT
Easter Seals	Closed Cases	1166-96	08/29/18			05/31/19			100%	04/18/19	EDIT
				100%	75.86%	79.63%	69.05%	72.73%	76.28%		
Screening Windows Closed in Date Range		156									
Screens Completed for Closed Windows		119									

MBD	On Schedule	Off Schedule
# of Screens	119	59
Scored 10+	32	16
Action		
Referral FAXED/SENT to Moving Beyond Depression (MBD)	9	10
Referral FAXED/SENT to other community mental health agency	2	0
Other reason no referral faxed or mental health program not presented (previously "no referral")	5	0
MBD Program Presented/Discussed-NO REFERRAL FAXED	10	3
Other community mental health agency presented/discussed-NO REFERRAL FAXED	6	3
No Referral Reason		
Declined MBD	0	0
Declined any treatment for depression	2	1
Mother already receiving treatment	5	2
Mother is on a waitlist for services	10	0
MBD not presented to mother	6	0
Referred to another agency	0	0
Score does not indicate a need for a referral	0	0
Mother ineligible due to language barrier	0	0
Mother ineligible due to age (under 16 years old)	0	0
Other	0	3
MBD Presented, mom will follow up later	0	0

Guidelines
1. Prenatal - any time prenatally, we encourage home visitors to screen moms in the first month enrolled.
2. Birth – home visitors have 60 days after birth to administer the screen.
3. 9 months postpartum – home visitor can screen 30 before or 30 days after.
4. 21 months postpartum - home visitor can screen 30 before or 30 days after.
5. 33 months - home visitor can screen 30 before or 30 days after.

De-identified here, but shows up if you select the agency or ALL, or can select de-identify and it will just say "home visitor" or "agency"

Blue = Due & Completed "On Time"
Yellow = Missed
Other Screen Dates = Completed "Not on time"

Records in REDCap™

-Layout of Forms

Data Collection Instrument	Static Information	Ongoing Events	Prenatal Visit	Postnatal Visit
Centralized Referral Intake (survey)	○			
Agency And Eligibility	○			
Lost To Follow Up Status		○		
Program Consent Form	○			
Kempe Assessment	○			
Parent Information		○		
Baby/Child Information	○			
Prenatal Visit			○	
Postnatal Visit				○
Visit Documentation			○	○
Referrals		○		
Breastfeeding	○			
Baby/Child Health Insurance		○		
Primary Care Physician Child		○		
Primary Parent Health Insurance		○		
Maternal Health Goals		○		
Child Healthcare Goals		○		
Family Goals		○		
Well Child Visit		○		
Immunizations		○		
Child ER UCC Visits		○		
Parent ER UCC Visits		○		
ASQ3.ASQSE2				○
ASQ-3		○		
Edinburgh			○	○
Womens Experience With Battering Scale			○	○
Protective Factors Survey			○	○
Home Safety			○	○
Attempted Visit Documentation			○	○
Phone/letter Documentation			○	○
Groups, Graduation, Other		○		
Child Abuse or Neglect				○
Case Closure	○			

Static Information-Events/data that should only occur once for a case (i.e. Enrollment, etc…)
Ongoing Events- Events that are repeatable, but are not necessarily tied to a visit (i.e. well child checks, insurance, etc…)
Prenatal Visit- Completed when mom is pregnant
Postnatal Visit- Completed when mom is not pregnant

Things to know!

- Must complete the Agency & Eligibility Form at enrollment & complete intake form, if necessary
- Click on any corresponding dot to add that form
- If repeated form, click on + sign to add additional forms
- Click on multiple circles to see all forms entered thus far
- REDCap automatically turns the dots green for "completed" and red for "Incomplete". Agencies can determine if/how they use the colored dots for case management purposes, but they do not impact Promise 1000 reporting.

QI Measure Comparisons over the last 3 Years

	5/1/16-4/30/17	5/1/17-4/30/18	5/1/18-4/30/19
Breast Feeding Avg (Goal: 6mo, 0 days)	7 mo, 1 days	9 mo, 11 days	9 mo, 11 days
Breast Feeding % (Goal: 50%)	51.71%	56.6%	58.71%
Child Healthcare Goal (Goal: 75%)	56.59%	89.38%	90.29%
Maternal Healthcare Goal (Goal: 70%)	4%	55.83%	76.71%
Well Child Visits (Goal: 50%)	30.73%	27.92%	41.14%
Home Visitor Attendance (Goal: 50%)	19.51%	20.64%	18.95%
Edinburgh Screens (Goal: 70%)	29.31%	54.93%	70.05%
HV Healthcare Education* (Goal: 70%)	N/A	72.83%	83.94%
HV Contraception Education* (Goal: 60%)	N/A	60.91%	83.21%
ASQ 3 Screen Rate* (Goal: 50%)	N/A	25.49%	64.75%
ASQ SE Screen Rate* (Goal: 50%)	N/A	39.85%	67.44%
Home Safety Screens** (Goal: 70%)	N/A	40.34%	70.92%
Protective Factors** (Goal: 70%)	N/A	39.06%	68.69%
WEB Screens** (Goal: 70%)	N/A	35.51%	64.06%

71% of our indicators were meeting the criteria for our goals in the 2018-2019 fiscal year!!!

Highlights

(comparing 17/18 to 18/19)

- Breastfeeding Average: same
- Breastfeeding Percentage: increase by 2.11%
- Child Healthcare Goal: increase by .91%
- **Maternal Health Care Goal: increase by 20.88%**
- Well Child Visits: increase by 13.22%
- Home Visitor Attendance: decrease of 1.69%
- Edinburgh Screens: increase by 15.12%
- HV Healthcare Education: increase by 11.11%
- **HV Contraception Education: increase by 22.3%**
- **ASQ 3 Screen Rate: increase by 39.26%**
- **ASQ SE Screen Rate: increase by 27.59%**
- **Home Safety Screens: increase by 30.58%**
- **Protective Factors Screens: increase by 29.63%**
- **WEB (IPV) Screens: increase by 28.55%**

Applications

- Alerts & Notifications
- Calendar
- Data Exports, Reports, and Stats
- Data Import Tool
- Data Comparison Tool
- Logging
- Field Comment Log
- File Repository
- User Rights and DAGs

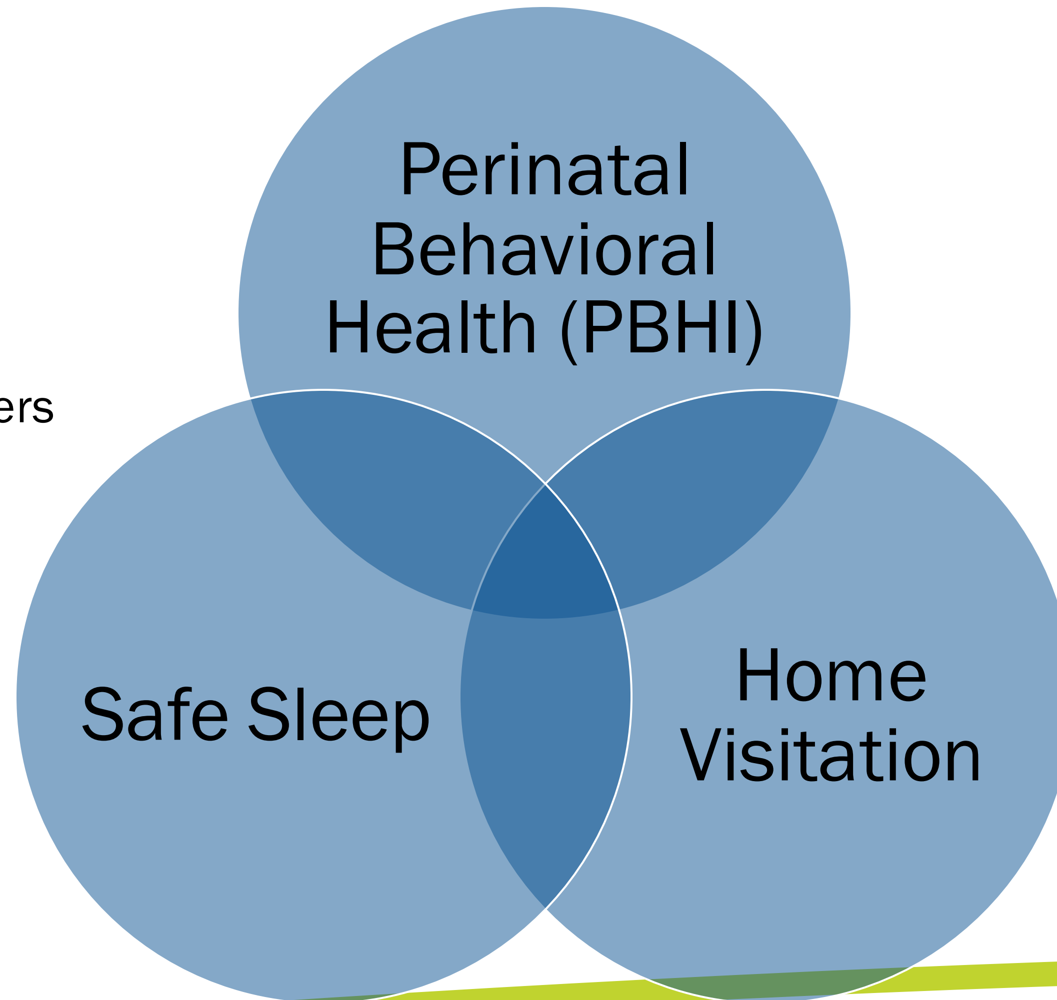
Outcomes /Raw Data Analysis

Measure	Agency #1	Agency #2	Agency #3	Agency #4	Agency #5	Agency #6	Agency #7	Agency #8	Agency #9	Agency #10	All
September 2018	**Child Health & Well-Being Indicators**										
Breast Feeding Avg	6 mo, 10 days	7 mo, 11 days	5 mo, 20 days	1 yrs, 11 mo	8 mo, 7 days	9 mo, 7 days	12 mo, 4 days	8 mo, 24 days	10 mo, 26 days	5 mo, 22 days	8 mo, 15 days
Breast Feeding % (Goal: 50%)	82.14%	39.26%	66.67%	60%	85.71%	68.18%	73.08%	72.73%	31.48%	83.33%	57.51%
Child Healthcare Goal (Goal: 75%) September 2018	98.21%	85.93%	66.67%	20%	80.95%	100%	100%	81.82%	70.37%	62.5%	85.23%
Well Child Visits (Goal: 50%)	46.43%	48.15%	0%	0%	52.38%	40.91%	65.38%	18.18%	37.04%	45.83%	46.11%
Home Visitor Attendance (Goal: 50%)	26.79%	5.19%	16.67%	0%	23.81%	54.55%	26.92%	9.09%	57.41%	37.5%	24.61%
	Maternal Health & Well-Being Indicators										
Maternal Healthcare Goal (Goal: 70%)	92.98%	79.65%	66.67%	0%	84%	95.45%	93.75%	54.55%	73.33%	53.57%	79.1%
Edinburgh Screens (Goal: 70%)	100%	85%	100%	0%	N/A	33.33%	66.67%	0%	14.29%	33.33%	61.9%
HV Healthcare Education (Goal: 70%)	96.23%	82.02%	75%	75%	78.95%	100%	72.09%	50%	58.33%	13.33%	76.9%
HV Contraception Education (Goal: 60%)	94.55%	81.82%	80%	60%	90%	100%	83.72%	14.29%	63.04%	30%	77.99%
	Child Development/School Readiness Indicators										
ASQ 3 Screen Rate (Goal: 50%)	80%	80%	N/A	0%	N/A	100%	88.89%	50%	37.5%	75%	72.55%
ASQ SE Screen Rate (Goal: 50%)	80%	86.67%	N/A	0%	N/A	100%	88.89%	50%	33.33%	50%	71.15%
	Home Safety & Family Resilience Indicators										
Home Safety Screen Rate (Goal: 70%)	85.71%	80%	100%	N/A	100%	100%	80%	N/A	50%	100%	80.56%
PFS Screen Rate (Goal: 70%)	100%	90.91%	100%	N/A	100%	100%	70%	100%	14.29%	100%	78.26%
WEB Screen Rate (Goal: 70%)	83.33%	82.35%	100%	N/A	75%	100%	83.33%	N/A	28.57%	100%	78.18%

Generate Health's Previous Experiences & Considerations

Generate Health–
3 Shared Measurement Systems

Each System has:
Unique Partners + Overlap Partners



Perinatal Behavioral Health

- System Developed
- St. Louis City Only
- Tracks Screening Results, Referrals
- Connected to Mental Health Board Bi-annual Reporting
- Demographics collected by Generate Health separate from results
- All partners can see each other’s data (difficult to export agency’s data)
- Partners sign annual MOU agreements
- No dashboarding capabilities

Safe Sleep Shared Measurement

- Engaged funders and service providers to determine key metrics
- Compared 7 different regional surveys to determine key metrics.
- REDCap built and piloted by 4 partners
- Linked to reporting for FLOURISH Aligned Activities Partners
- Interest in statewide expansion
- Demographics collected in the database
- Partners have access to their data only and its easy to export their own data
- Partners sign a Business Associates Agreement with UMSL MIMH
- Generate Health signs a Data Sharing Agreement with UMSL MIMH for access to all data.

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Home Visitation

- Planning stages with the Home Visitation Collaborative
- Work Groups:
  - Data Work Group
  - Central Referral Intake Work Group
  - Provider Training Work Group
- Built by Promise 1000 & potentially available for adaption by Generate Helath
- Outstanding Question: How does community voice & expertise play into the planning phase for the shared measurement system?
  - Determination of Key Progress Metrics?
  - Serve on Work Groups?
- Ability to do cross-state comparisons

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