General Feedback from EIC 12.20.17

1. Recommend use of common terminology to utilize with ELD/OHA home visiting programs ~ consider aligning with definitions and terms of the Equity Lens. Simplify the language of the document wherever possible to make it accessible to all providers.

[AGREE—but in guidance document]

1. Consider the need for a mechanism statewide to ensure that families, our “customers” confirm that their needs are met through home visiting services. A measurement question such as “did you feel your needs were met? Or “ Did you get what you asked for with this service?”

[COMMITTEE AGREED]

## *Outcomes Metrics*

SB 5507 Charge: Develop a set of outcome metrics connected to evidence of impact for consideration by the Early Learning Council and the Oregon Health Policy Board that any home based service that receives state dollars must meet in order to continue to receive state funds, effective July 1, 2016.[[1]](#footnote-1)

## Values and Guiding Principles:

The Committee was committed to identifying metrics that have been demonstrated as effective in making a difference and took the approach to build on existing metrics that already guide and drive the work of the Early Learning Hubs and the Coordinated Care Organizations. Home visiting works in, and serves as, a critical link between both health and early learning systems. In addition, the Committee explored metrics used in other states that have similar home visiting standards and accountability systems, specifically, Vermont and New Mexico. Lastly, the Committee reviewed the Child and Family Well-Being Measures Workgroup report as a source of measures that have been vetted by a committee of experts across many disciplines and developed specifically for Oregon.

## Recommendations:

Based on this guiding information, the Committee recommends grouping the metrics for home visiting program accountability into five categories:

1. Improved cultural responsiveness of programs: All families have equitable access to culturally and linguistically diverse services.
2. Improved maternal, infant, and family health and well-being: Children and families have a health home and are receiving physical, behavioral, and oral health care.
3. Prevention of childhood accidental injury, abuse, and neglect, and reduction in crime and family violence: Children live in stable, attached, and nurturing families, free of abuse, neglect, and violence.
4. Improved school readiness and achievement: Children are physically, socially, and emotionally on track by age three.
5. Improved family self-sufficiency and coordination of community resources: Families have consistent and stable access to basic needs for their family to support healthy child development.

The following outcome measures address key factors that strengthen family bonds and understanding of human development to support healthy growth and development and family self-sufficiency.

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| **1. Improved cultural responsiveness of programs: All families have equitable access to culturally and linguistically diverse services.** | | | |
| Measure | Rationale/ Evidence | EL Hubs | CCOs |
| 1.1. Percentage of home visiting program sites that have policies and practices to serve culturally diverse populations. | Cultural adaptation of policies and practices is essential to ensuring an equitable system of services and is a gold standard component of home visiting programs. | X | X |
| 1.2. Percentage of home visiting program sites that have staff who reflect the diversity of the populations served \. |
| 1.3. Percentage of children from priority populations served (as defined by local home visiting programs) compared to the community population of eligible children. |

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| **2. Improved maternal, infant, and family health and well-being: Children and families have a health home and are receiving physical, behavioral, and oral health care.** | | | |
| Measure: ***For families served by home visiting programs***: | Rationale/Evidence | EL Hubs | CCOs |
| 2.1. Percentage of pregnant women who receive adequate prenatal care as defined by the Oregon Health Authority. | Prenatal care is widely considered the most productive and cost-effective way to support the delivery of a healthy baby. | X | X |
| 2.2.A Percentage of all mothers screened for depression both pre- and perinatally. Recommended with the addition of a definition of the perinatal period to be specified after review of current best practice and requirements for NFP and HFO. | Maternal depression prior to or following the birth of a child is highly prevalent in Oregon and left untreated may be detrimental to the mother, family, and well-being of the child. | X | X |
| 2.2.B. Percentage of mothers who screen positive for depression who are referred for services/supports and have a follow up plan. Guidance should specify definition of a follow up plan. |
| 2.3A. Percentage of all children with 6 or more well-child visits by 15 months of age.  2.3B Percentage of all children with a dental home. | Regular well-child visits are one of the best ways to detect physical, developmental, and social-emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents and are considered a component of gold standard programs. |  |  |
| **3. Prevention of childhood accidental injury, abuse, and neglect, and reduction in crime and family violence: Children live in stable, attached, and nurturing families, free of abuse, neglect, and violence** | |  |  |
| Measure: : ***For families served by home visiting programs***: | Rationale/Evidence | EL Hubs | CCOs |
| 3.1.A. Percentage of primary caregivers screened for substance abuse. | Substance abuse and domestic violence are detrimental to family stability and harmony, and create a toxic environment for the health and well-being of the child both pre- and perinatally. | X | X |
| 3.1.B. Percentage of primary caregivers who screen positive for substance abuse issues who are referred for services/supports and have a follow up plan. |  |  |
| 3.2.A. Percentage of families screened for domestic violence. | X |  |
| 3.2.B. Percentage of families that screen positive for domestic violence issues, are referred for services/supports and have a follow up plan. |  |  |
| 3.3. Percentage of primary caregivers who demonstrate improved parenting skills from enrollment to at least 6 months post-enrollment (not applicable to the prenatal period). | Parenting skills are essential in developing a warm, nurturing, and attached parent-child bond that improved child development. |  |  |
| **4. Improve school readiness and achievement: Children are physically, socially, and emotionally on track by age three.** | |  |  |
| Measure: ***For families served by home visiting programs***: | Rationale/Evidence | EL Hubs | CCOs |
| 4.1.A. Percentage of children with a developmental screen completed by three years of age. | Developmental and social-emotional screening helps detect delays or disabilities early in life and increase the likelihood of specialty care during this critical developmental period that may improve school readiness.  Adds a measure of language/cognitive developmental support to the set of outcome metrics. Early reading and language interactions with young children have been shown to be positively related to early language and cognitive development. | X | X |
| 4.1.B. Percentage of children who screen positive for a developmental delay who are referred for services/supports and have a follow up plan. |  |  |
| 4.2. Percentage of children with a social-emotional screen by three years of age. | X | X |
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| 4.2.B. Percentage of children who screen positive for a social emotional delay who are referred for services/supports and have a follow up plan. |  |  |
| 4.3. Percentage of children with a family member who reported that during a typical week h/she read, told stories, or sang songs daily. |  |  |
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| **5. Improve family self-sufficiency and coordination of community resources: Families have consistent and stable access to basic needs for their family to support healthy child development.** | |  |  |
| Measure | Rationale/Evidence | EL Hubs | CCOs |
| 5.1 Percentage of families who are identified as having food insecurity and who are referred for services/supports and have a follow up plan. | Improvements in child and family health and well-being are most likely to occur when basic needs are met and community services are aligned, coordinated, and consistent in order to help families become self-sufficient. While a myriad basic needs may be present in a family, food and housing were selected as two that are fundamental to family stability and most closely related to children’s health and well-being. | X |  |
| 5.2. Percentage of families who are identified as having unstable/unsafe housing and who are referred for services/supports and have a follow up plan. |  |  |

In order to effectively collect and track this data, there is a need to expand the current home visiting data system capacity to enable participation of all funded programs.

1. The timeline for implementation is not realistic given the need to notify programs about the metrics and add language and expectations to 17-19 contracts. Outcome measures will be incorporated into contracts in the next biennium. [↑](#footnote-ref-1)