DCF HOME VISITATION INITIATIVE Annex A - <u>Healthy Families</u> Performance Outcome Measures

Agenc	ey:	LOS:	Total # Families Served (undup):		FTE FAWs:	
Site/County:		case wt	Total # of New Families Enrolled:		FTE FSWs:	
Reporting Period:		families	Total # of Families Terminated:		FTE Spv:	
					Annual Per	formance
PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES					number	percent
1	Referrals/Screens Received by HV Pro	ogram (targe	t number)	85%		
2	Assessments Completed by HV Progr	rogram (target number)				
3	rogram Enrollment: a. Reach and Maintain Service Capacity (case weight)			80%		
	b. Minimize enrolled families that are Lost to Care (Level X)			<10%		
4	Women Enrolled Prenatally in HV Program (NFP=100% / PAT =60%)			80%		
5	Achieve Completion of Expected Home Visits			80%		
6	Participant Retention: a. Families remain enrolled for at least 1 Year			60%		
	b. Families r	emain enrolle	d for at least 2 Years	50%		
	c. Families r	c. Families remain enrolled for at least 3 Years				
Parti	cipant Health and Well Being Servi	ces / Impac	t Objectives:			
7	Pregnant / Postpartum Women		Number of pregnant women serv	/ed:		ххх
	a. Eligible pregnant women enrolled in WIC			80%		
	b. On Schedule for Prenatal Care Med	ical Visits (ACC)G schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical	Visits		80%		
8	Parenting Women (Interconceptional-I	otw pregnanci	es)			
	a. Have a Primary Care Provider (GYN, FQHC, local clinic)			100%		
	b. Receive an Annual Primary Care/Women's Health Care Visit			80%		
9	Infants and Children (birth to age 3) (target child only) Number of infants & children			served:		xxx
	a. Eligible children have health insurance			80%		
	b. All children have a Primary Care Pro			100%		
	c. All children up-to-date for Well-Child Medical Visits (AAP schedule)			85%		
	d. All children up-to-date for Developm	ental Screen	(if positive ASQ, child is assessed)	90%		
	e. Eligible children enrolled in WIC			80%		
	f. All children are up-to-date for Immur			85%		
	g. All children are up-to-date for Lead Screening (by age 1)			80%		
Parti	cipant Outcome Objectives:					
10	Improve Breastfeeding Rates: a. Enro		nitiate breastfeeding	80%		
	b. Enrolled infants breastfed for at least			60%	ļ	
11	Increase Interpregnancy Interval/Reduce Subsequent Pregnancy					
	a. Increase average interpregnancy int		• •	80%	ļ	
	b. Decrease Subsequent Teen Births (ote: NJ rate for 15-19 yo = 18%]	<20%		
12	Improve Parent-Child Interaction / Rec		k Neglect		ļ	
	a. Improve Ratings for Maternal Bondir			80%		
	b. Improve Ratings for Parenting (HOM			80%		
13	Improve Quality of the Home Environ		ning / Early Literacy		ļ	
	a. Infant-Toddler Books in the Househo	· · · /		80%	ļ	
	b. Reading (storytelling) to Infants/Child	dren (HOME)		80%	ļ	
14	Family Self-Sustainability			e = t :		
	a. TANF families connected to employ			95%		
	b. Mother/parent working or in school b	by the time the	e child is 2 year old.	60%		

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DCF HOME VISITATION INITIATIVE Annex A - <u>Nurse-Family Partnership</u> Performance Outcome Measures

Agency:		Total # Families Served (undup):		LOS families:	
Site/County:		Total # of New Families Enrolled:		FTE Spv:	
		Total # of Families Terminated:		FTE RNs:	
			Annual	Annual Per	formance
PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES				number	percent
1	Referrals/Screens Received by HV Program (target	number)	85% 85%		
2		by HV Program (target number)			
3	Program Enrollment: a. Reach and Maintain Service	gram Enrollment: a. Reach and Maintain Service Capacity (NFP = families)			
	b. Minimize enrolled families that are Lost to Care or inactive (to be defined)		<10%		
4	omen are Enrolled by 28 Weeks of Gestation		100%		
5	Achieve Completion of Expected Home Visits	•			
6	Participant Retention: a. Families remain enrolled through Pregnancy		90%		
	b. Families remain enrolled up to Age 1				
	c. Families remain enrolled up to Age 2				
Parti	cipant Health and Well Being Services / Impact	Objectives:			
7	Pregnant / Postpartum Women Number of pregnant women server		d:		xxx
	a. Eligible pregnant women enrolled in WIC		80%		
	b. On Schedule for Prenatal Care Medical Visits (ACO	G schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical Visits		80%		
8	Parenting Women (Interconceptional-btw pregnancie	s)			
	a. Have a Primary Care Provider (GYN, FQHC, local clinic)		100%		
	b. Receive an Annual Primary Care/Women's Health Care Visit		80%		
9	Infants and Children (birth to age 3) (target child only)	Number of infants & children se	erved:		ххх
	a. Eligible children have health insurance		80%		
	. All children have a Primary Care Provider (Pediatrician, Family Practice, etc.)		100%		
	c. All children up-to-date for Well-Child Medical Visits	c. All children up-to-date for Well-Child Medical Visits (AAP schedule)			
	d. All children up-to-date for Developmental Screen (if positive ASQ, child is assessed)		90%		
	e. Eligible children enrolled in WIC		80%		
	f. Up-to-date for Immunizations		85%		
	g. Up-to-date for Lead Screening (at 12 months of age	e)	80%		
	cipant Outcome Objectives:		1		
10	Improve Breastfeeding Rates				
	a. Enrolled families initiate breastfeeding		80%		
	b. Enrolled infants breastfed for at least 4 weeks		60%		
11	Increase Interpregnancy Interval/Reduce Subsequent Pregnancy				
	a. Increase average interpregnancy interval (birth to c	• •	80%		
		e: NJ rate for 15-19 yo = 18%]	<20%		
12	Improve Parent-Child Interaction / Reduce Abuse & Neglect				
	a. Improve Ratings for Maternal Bonding (HOME)		80%		
	b. Improve Ratings for Parenting (HOME)		80%		
13	Improve Quality of the Home Environment for Learning / Early Literacy		80%		
	a. Infant-Toddler Books in the Household (HOME)				
	b. Reading (storytelling) to Infants/Children (HOME)		80%		
14	Family Self-Sustainability				
	a. TANF families connected to employment through the		95%		
	b. Mother/parent working or in school by the time the C:\Documents and Settings\mnewman\Local Settings\Temporary Inte		60%		

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DCF HOME VISITATION INITIATIVE Annex A - <u>Parents As Teachers</u> Performance Outcome Measures

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		Total # Families Served (undup):		LOS families:	
Site/County: To		Total # of New Families Enrolled:		FTE Spv:	
Reporting Period: Total # of Families Terminate		Total # of Families Terminated:		FTE PEs:	
PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES			Annual	Annual Per	formance
			Target	number	percent
	Referrals/Screens Received by HV Program (target		85% 85%		
		sessments Completed by HV Program (target number)			
3	ogram Enrollment: a. Reach and Maintain Service Capacity (NFP = families)		80%		
	b. Minimize enrolled families that are Lost to Care or inactive (to be defined)		<10%		
4	Women are Enrolled during Pregnancy		60%		
5	Achieve Completion of Expected Home Visits	Achieve Completion of Expected Home Visits			
6	Participant Retention: a. Families remain enrolled for at least 1 Year		60%		
	b. Families remain enrolled for at least 2 Years		50%		
	c. Families remain enrolled for at least 3 Years		40%		
Parti	cipant Health and Well Being Services / Impact	Objectives:			
7	Pregnant / Postpartum Women	Number of pregnant women served	:		xxx
	a. Eligible pregnant women enrolled in WIC		80%		
	b. On Schedule for Prenatal Care Medical Visits (ACOG	G schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical Visits		80%		
8	Parenting Women (Interconceptional-btw pregnancie	s)			
	a. Have a Primary Care Provider (GYN, FQHC, local of	clinic)	100%		
	b. Receive an Annual Primary Care/Women's Health	Care Visit	80%		
9	Infants and Children (birth to age 3) (target child only) Number of infants & children se		rved:		xxx
	a. Eligible children have health insurance		80%		
	b. All children have a Primary Care Provider (Pediatrici	ian, Family Practice, etc.)	100%		
	c. All children up-to-date for Well-Child Medical Visits	(AAP schedule)	85%		
	d. All children up-to-date for Developmental Screen (if	f positive ASQ, child is assessed)	90%		
	e. Eligible children enrolled in WIC		80%		
	f. Up-to-date for Immunizations	<u>,</u>	85%		
	g. Up-to-date for Lead Screening (at 12 months of age	e)	80%		
Parti	cipant Outcome Objectives:				
10	Improve Breastfeeding Rates				
	a. Enrolled families initiate breastfeeding		80%		
	b. Enrolled infants breastfed for at least 4 weeks		60%		
11	Increase Interpregnancy Interval/Reduce Subseque	nt Pregnancy			
	a. Increase average interpregnancy interval (birth to c	• •	80%		
		e: NJ rate for 15-19 yo = 18%]	<20%		
12	Improve Parent-Child Interaction / Reduce Abuse &	Neglect			
	a. Improve Ratings for Maternal Bonding (HOME)		80%		
	b. Improve Ratings for Parenting (HOME)		80%		
13	Improve Quality of the Home Environment for Learn	ning / Early Literacy			
	a. Infant-Toddler Books in the Household (HOME)		80%		
	b. Reading (storytelling) to Infants/Children (HOME)		80%		
14	Family Self-Sustainability				
	a. TANF families connected to employment through th	•	95%		
	 b. Mother/parent has improved education status and/or is workin C:\Documents and Settings\mnewman\Local Settings\Temporary Int 		60%		

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