DCF HOME VISITATION INITIATIVE

Annex A - Healthy Families Performance Outcome Measures

Agency:	LOS: ___ case wt ___ families	Total # Families Served (undup):		FTE FAWs:	
Site/County:		Total # of New Families Enrolled:		FTE FSWs:	
Reporting Period:		Total # of Families Terminated:		FTE Spv:	

	PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES	Annual Target	Annual Performance number	Annual Performance percent
1	**Referrals/Screens Received by HV Program** (target number ___)	85%		
2	**Assessments Completed by HV Program** (target number ___)	85%		
3	**Program 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 remain enrolled for at least 2 Years	50%		
	c. Families remain enrolled for at least 3 Years	40%		
	Participant 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 schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical Visits	80%		
8	**Parenting Women** (Interconceptional—btw pregnancies)			
	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 Provider (Pediatrician, 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 positive ASQ, child is assessed)*	90%		
	e. Eligible children enrolled in WIC	80%		
	f. All children are up-to-date for Immunizations	85%		
	g. All children are up-to-date for Lead Screening (by age 1)	80%		
	Participant 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 Subsequent Pregnancy**			
	a. Increase average interpregnancy interval (birth to conception) to 18 months	80%		
	b. Decrease Subsequent Teen Births (<age 19) [Note: 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**			
	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 the One-Stop center.	95%		
	b. Mother/parent working or in school by the time the child is 2 year old.	60%		

DCF HOME VISITATION INITIATIVE

Annex A - Nurse-Family Partnership Performance Outcome Measures

Agency:	Total # Families Served (undup):		LOS families:	
Site/County:	Total # of New Families Enrolled:		FTE Spv:	
Reporting Period:	Total # of Families Terminated:		FTE RNs:	

	PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES	Annual Target	Annual Performance	
			number	*percent*
1	**Referrals/Screens Received by HV Program** (target number ___)	85%		
2	**Assessments Completed by HV Program** (target number ___)	85%		
3	**Program 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 by 28 Weeks of Gestation**	100%		
5	**Achieve Completion of Expected Home Visits**	80%		
6	**Participant Retention:** a. Families remain enrolled through Pregnancy	90%		
	b. Families remain enrolled up to Age 1	70%		
	c. Families remain enrolled up to Age 2	60%		
	Participant 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 schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical Visits	80%		
8	**Parenting Women** (Interconceptional—btw pregnancies)			
	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 Provider (Pediatrician, 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 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)	80%		
	Participant 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 Subsequent Pregnancy**			
	a. Increase average interpregnancy interval (birth to conception) to 18 months	80%		
	b. Decrease Subsequent Teen Births (<age 19) [Note: 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**			
	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 the One-Stop center.	95%		
	b. Mother/parent working or in school by the time the child is 2 year old.	60%		

DCF HOME VISITATION INITIATIVE
Annex A - Parents As Teachers Performance Outcome Measures

Agency:	Total # Families Served (undup):		LOS families:	
Site/County:	Total # of New Families Enrolled:		FTE Spv:	
Reporting Period:	Total # of Families Terminated:		FTE PEs:	

	PROGRAM SPECIFIC OBJECTIVES & PERFORMANCE MEASURES	Annual Target	Annual Performance number	Annual Performance percent
1	**Referrals/Screens Received by HV Program** (target number ___)	85%		
2	**Assessments Completed by HV Program** (target number ___)	85%		
3	**Program 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**	80%		
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%		
	Participant 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 schedule)	80%		
	c. Keep 6-8 Week Postpartum Medical Visits	80%		
8	**Parenting Women** (Interconceptional—btw pregnancies)			
	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 Provider (Pediatrician, 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 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)	80%		
	Participant 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 Subsequent Pregnancy**			
	a. Increase average interpregnancy interval (birth to conception) to 18 months	80%		
	b. Decrease Subsequent Teen Births (<age 19) [Note: 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**			
	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 the One-Stop Center.	95%		
	b. Mother/parent has improved education status and/or is working by the time the child is Age 2.	60%		