

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan**



**Washington State
Home Visiting Updated State Plan**

June 2011

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Introduction

In Washington, we work together so that all children start life with a solid foundation for success, based on strong families and a world class early learning system for all children prenatal through third grade. Accessible, accountable, and developmentally and culturally appropriate, our system partners with families to ensure that every child is healthy, capable and confident in school and life.

--Washington State Early Learning Plan Vision Statement

Washington's Early Learning Plan (ELP) is our state's 10-year roadmap for building an early learning system that ensures all children in our state start life with a solid foundation for success in school and in life. This comprehensive system will include care, education, programs and services for children.

Home visiting is a key strategy in the plan: ***“Make evidence-based and promising prenatal and child (birth to 5 years) home visitation services more widely available to at-risk families and caregiver.”*** This strategy is critically necessary to help ensure that:

- Children have optimal physical health, mental health, oral health and nutrition.
- Pregnant and postpartum women receive health, nutrition, and support services to optimize the pregnancy and the health of their newborns.
- Children have developmentally appropriate social-emotional, language, literacy, numeracy, and cognitive skills, and demonstrate positive mental health and well-being.
- Families have access to high-quality early learning programs and services that are culturally competent and affordable for those who choose them.
- Children enter kindergarten healthy and emotionally, socially, and cognitively ready to succeed in school and in life.

A growing body of research is illuminating the significance of the first three years of life on long-term health and well-being. The brain undergoes its most significant growth and development in the first three years of life, building the neurological structures and foundations for linguistic, cognitive, social-emotional, and regulatory capacities. Positive development during these early years is largely influenced by interactions between primary caregivers and babies. Interactive play and back-and-forth communication stimulate and strengthen the baby's developmental capacities.

Informed by this important research, we in Washington have taken a close-up look at the needs of families, caregivers and systems that support our youngest children. The 2010 Legislature charged the Department of Early Learning (DEL) with developing a comprehensive Birth to 3 Plan to identify research-based strategies that could best improve care for our youngest children. Again, home visiting was identified as one of the key strategies to impact the health and development in the earliest years.

Washington is experiencing a significant demographic shift, one characterized by a growing number of children, especially from poor and racially marginalized families. Today, in Washington:

- More than half of births are funded by Medicaid.
- Nearly 35 percent of children ages birth to 3 live in or near poverty.
- A substantial proportion of the state's growing numbers of poor children are racial and ethnic minorities, with complex barriers contributing to vast disparities in outcomes.
- Researchers estimate that the number of people of color in Washington will grow from 1-in-5 in 2000 to 1-in-3 by 2030. Among the largest and most quickly growing groups are Asian Pacific Islander (API), Hispanic/Latino, and those identifying as "2 or more races."
- Of the estimated 29 percent increase in the number of children in Washington from 2000 to 2030, 81 percent will be children of color.
- Nearly 20 percent of Washington's children ages 5 to 17 speak a language other than English at home.
- Data from the Washington Kindergarten Inventory of Developing Skills (WaKIDS) pilot reveal that more than one-third of children in Washington are entering kindergarten below expected skill levels in each of four key developmental domains: physical, well-being, health, and motor; social-emotional; cognition and general knowledge; and language, communication, and literacy. Among low-income children (those eligible for free and reduced-price lunch) and racial/ethnic minority children, up to half are below developmental expectations in the four measured domains.

At the same time our state was doing the foundational work in early childhood system planning, the Washington State Department of Health (DOH) conducted the State Home Visiting Needs Assessment. The needs assessment provided an in-depth analysis of risk factors in communities and identified the considerable unmet need for home visiting among Washington families. We learned that:

- Between 2 and 11 percent of eligible families in Washington receive evidence-based home visiting services.
- Seventeen of the state's 39 counties have no evidence-based home visiting programs.
- For at-risk families receiving home visiting services, there is great variability geographically, as well as variability in the duration, intensity and impact of the services.

Evidence-based home visiting has increasingly become a top legislative priority in Washington as we get more data and research about its effectiveness and the need in our state:

- In 2007, the Legislature allocated state funding to our state's Title II Child Abuse and Prevention Treatment Act agency—the Council for Children and Families—to develop and support a portfolio of evidence-based home visiting services in Washington.
- In 2010, the Legislature created the Home Visiting Services Account (HVSA) to align and leverage public funding with matching private funding to increase the number of families being served and support infrastructure development to ensure high-quality services. DEL and Thrive by Five Washington administer the HVSA in partnership. Through the HVSA, our state is investing in a portfolio of home visiting programs and is

engaging in targeted technical assistance of quality implementation for evidence-based, research-based and promising practices.

The momentum continues to build, and the opportunity to build and support high-quality home visiting services through this new federal funding opportunity has Washington stakeholders thinking carefully about how we can best work together, build on what we have in place, and ultimately move toward a robust, coordinated system of high-quality home visiting in communities throughout the state. *See Attachment A “Washington State Home Visiting Planning Structure”*

Washington Governor Chris Gregoire asked DOH to lead the Needs Assessment process, and DEL to lead in planning and implementation with key partners. Through a cross-agency planning structure, Washington has worked with public and private partners in health, social services, early learning, and child abuse prevention to develop this plan. More on this collaborative planning structure is included in Section 6.

For the final stage of Washington’s grant application for the Maternal, Infant and Early Childhood Home Visiting Program, we submit this updated state plan. It is a snapshot of Washington’s work to build high-quality home visiting services and link them with other key early learning systems development work. Specifically, this plan: provides information about the work we will do in at-risk communities implementing evidence-based models; and outlines our approach to meeting the data/benchmark requirements connected to our continuous quality improvement efforts.

Section 1: Identifying Our Targeted At-Risk Communities

Overview of Process for Identification of At-Risk Communities

The Washington State Home Visiting Needs Assessment identified tremendous needs throughout the state. At-risk communities were identified geographically and based on race/ethnicity. A total of 57 geographic areas were identified. These areas are primarily counties, with larger counties divided into sub county areas used in health planning. Risk indicator data were available for seven race/ethnic communities: Hispanic, Non Hispanic (NH) American Indian/Alaska Native, NH Asian, NH Black, NH Pacific Islander, NH White and NH Multi-race.

Fifteen risk indicators were used to develop risk scores comparing relative risk between the state and each of the 64 individual communities (57 geographic areas + seven race/ethnic communities). Ten of the risk factors were required by the initial supplemental information request (SIR). As allowed in the initial SIR, Washington added five additional indicators.

All communities were scored and ranked on each individual risk factor. At-risk communities were ultimately defined as those with composite risk scores (using all indicators) that were higher than the state average. Three different methods were used to aggregate the 15 indicators. Of the 64 communities scored, 32 geographic regions and five racial/ethnic groups were designated as at-risk communities. *See Attachment B: "WA Map of Geographic Risk and EBHV Programs."* American Indian/Alaska Natives had the highest risk scores of all geographic and racial/ethnic groups. Data suggested that between 2 and 11 percent of all eligible families in Washington receive evidence-based home visiting services. With this high level of unmet needs, the specific ranking of geographic communities and racial/ethnic risk were used to prioritize communities for this federal funding opportunity.

The agency partners agreed that for the first year of the MIECHV grant, funded programs would be in at-risk communities (as defined by the State Home Visiting Needs Assessment) that:

1. Have in operation evidence-based home visiting models that meet the federal criteria.
2. Demonstrate capacity to meet the needs of at-risk populations and achieve results with the evidence-based home visiting model.

The selection of at-risk communities and model matching for MIECHV funding was a four-step process. The first two steps focused primarily on the selection of the at-risk communities and will be outlined briefly below. Steps 3 and 4 focus on development of the Washington home visiting portfolio and implementation planning in the selected communities. These will be further explained in Section 3 and Section 4. Figure 1 (below) outlines the four steps in the selection process.

Washington State Selection of MIECHV Communities and Models FY 2010

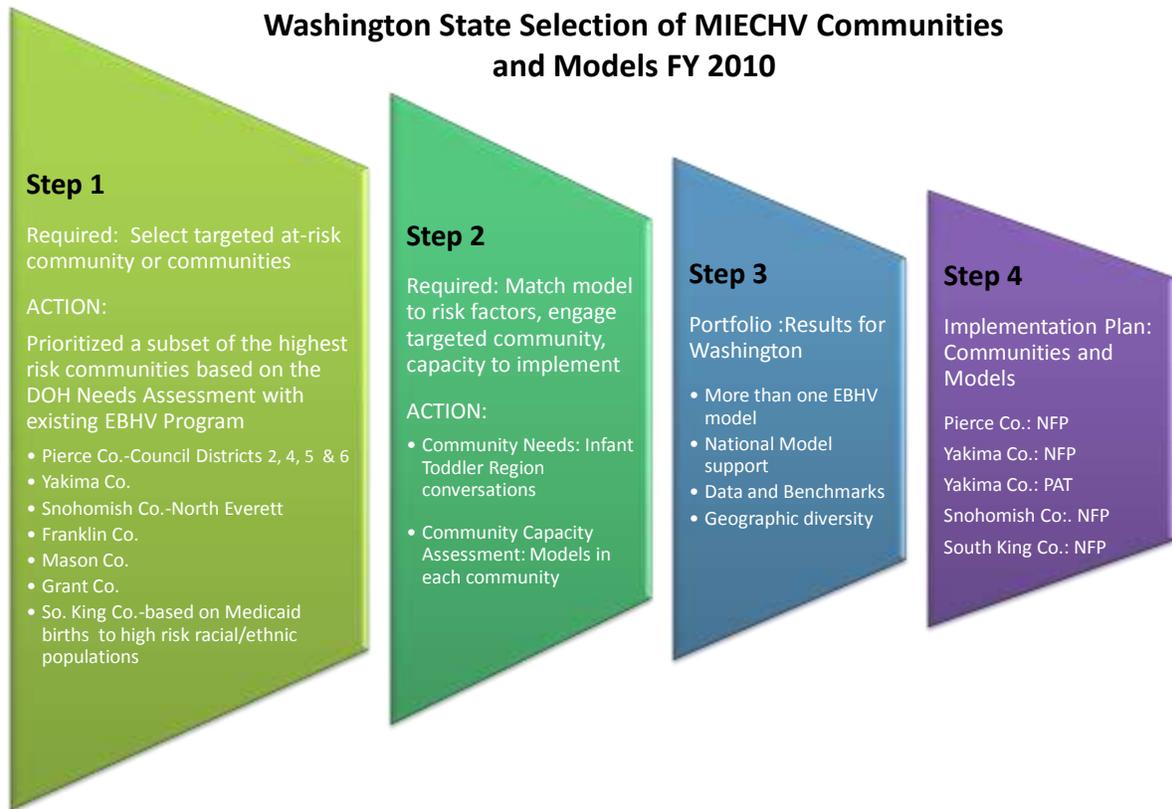


Figure 1: Process for Selection of MIECHV Communities.

Step 1 in Selection of MIECHV Communities:

Of the 32 geographic regions and five racial/ethnic groups that were designated as communities at-risk through the Washington State Home Visiting Needs Assessment, those ranked highest based on the 15 risk factors were considered. Of the highest at-risk groups, those already implementing one or more of the evidence-based home visiting models identified in the federal grant guidance were given higher consideration. In Washington, the evidence-based models currently implemented include Early Head Start Home-Based Option, Nurse-Family Partnership and Parents as Teachers. Another consideration was ensuring representation from both eastern and western Washington in the initial community prioritization process.

On March 22, 2011, Washington notified seven communities as potential grantees and invited them to move into the next phase of the selection process:

1. Pierce Co.- Council Districts 2, 4, 5 & 6 (Ranked #1, 2, 6, 8 in Needs Assessment)
2. Yakima Co. (Ranked #3 in Needs Assessment)
3. Snohomish Co.-North Everett (Ranked #4 in Needs Assessment)
4. Franklin Co. (Ranked #7 in Needs Assessment)
5. Mason Co. (Ranked #9 in Needs Assessment)

6. Grant Co. (Ranked #11 in Needs Assessment)
7. So. King Co.-(based on high number of Medicaid births to American Indian/Alaska Native and African American women)

Step 2 in Selection of MIECHV Communities:

The seven communities selected in Step 1 were invited to participate in a community needs and community capacity assessment process. Local birth-to-3 planning entities, called “infant/toddler regions,” provided specific information about community strengths, risks and priorities. *See Attachment C: “WA Map of Infant Toddler Regions”*

(A note about these infant/toddler regions: DEL is building a regionally based system in which state and local entities work together to improve the quality of care for infants and toddlers and their families through interdisciplinary consultation strategies and collaborative efforts. Over the past six months, 10 DEL infant/toddler regions have engaged in data collection, analysis and planning efforts culminating in a submission of prioritized regional plans to improve the care of infants and toddlers. The infant/toddler regions were contacted for a more in-depth look at community strengths, needs, and characteristics of the populations. A summary of the comments they provided are included for each of the targeted at-risk communities below.)

Details about the community capacity assessment to implement the evidence-based home visiting model will be covered in more detail in Section 3 and Section 4.

The final communities selected for MIECHV funding are: Yakima County, Pierce County, Snohomish County and South King County. *See Attachment D: “WA Map of MIECHV Communities FY 2010”*

1. Yakima County

Assessment of Needs and Existing Resources

A. Community Strengths and Risk Factors

Yakima County ranked high in most or all risk of the 15 indicator areas identified in the Home Visiting Needs Assessment, achieving a statewide ranking of #3. For specific indicator data, see the Washington State Home Visiting Needs Assessment, Appendix B: Data Report Information, Tables B-1 and B-3 (p 92-95):

www.doh.wa.gov/cfh/micah/hvna/default.html

Based on the Home Visiting Needs Assessment, the highest risk factors for this community include: Teen Births, Poverty, Infant Mortality, Child Maltreatment, and Preterm Birth.

According to the infant/toddler region, Yakima has identified the following community strengths and opportunities:

1. A diverse array of services available to families with multiple entry points for services.
2. A strong capacity to implement evidence-based home visiting models.
3. A strong system of child/family serving agencies that work together to coordinate services for families.

4. Existence of multiple local coalitions committed to supporting families and young children.

B. Community Characteristics and Needs of Participants

According to the infant/toddler region, Yakima is interested in focusing on caregiver/parent education and skills development. They are focused on reaching the underserved communities and want to build capacity to serve families as needs grow in economic and the racial diversity in the region.

In this rural area, lack of public transportation is a challenge for families and for the service providers dealing with escalating transportation costs. Head Start and the state funded pre-k program have a waiting list of more than 250 families. A lack of early intervention services for infants and toddlers, and an increase in infant referrals for these services has been a challenge. There has been a decrease in mental health providers in the area with increases in reported cases of post-partum depression. This is seen by the community as contributing to the likelihood of child abuse and neglect. Parents and child care providers report the need for more birth-to-3 supports to foster the healthy social/emotional development of infant and toddlers, especially related to responding to infant behavioral cues, and to early identification of developmental concerns.

Additionally, Yakima is facing rising unemployment rates. An increasing number of legal and illegal immigrants add barriers related to documentation, language needs and access to services. The capacity for programs to serve immigrant and low-income Hispanic families is limited and decreasing.

C. Existing Home Visiting Services

Information provided in the Washington State Home Visiting Needs Assessment shows Yakima County provides the following home visiting programs/models:

1. Early Head Start - Home-Based Option: 2 organizations
2. Nurse-Family Partnership: 2 organizations
3. Parents as Teachers: 3 organizations
4. Parent-Child Home Program: 2 school districts
5. First Steps - Maternity Support Services / Infant Case Management: 3 organizations
6. Other: Children with Special Health Care Needs, public health, Early Support for Infants and Toddlers, Positive Behavioral Support (Project LAUNCH), Partnering with Families for Early Learning, Parent Child Assistance Program, SafeCare, and Strengthening Fragile Families.

Yakima County has not discontinued any home visiting programs since March 23, 2010.

D. Existing Mechanisms for Screening and Referral

Yakima County has two evidence-based programs participating in the MIECHV program. The following responses are specific to Parents as Teachers and Nurse-Family Partnership.

There is no centralized intake system for home visiting programs in Yakima County. Referrals come from primary care providers; other home visiting programs and educators; mental health service providers; the Department of Social and Health Services (DSHS) Division of Children and Family Services; specialty service providers, such as Children’s Village and La Casa Hogar/Interfaith Coalition; the migrant program within Yakima School District; and local food banks. In lower Yakima Valley, through the Project LAUNCH program, referrals are made through Readiness to Learn case managers located on-site in school districts in the communities served, as well as through partners of the Mid Valley Providers Consortium, a group of more than 50 community entities that meet monthly for networking and sharing resources. The consortium is led by the local educational service district. Word of mouth also is a very effective referral tool among the Hispanic families in Yakima County.

Home visiting service providers in Yakima County have a long history of coordinating and partnering to provide appropriate care for families in the community. Families and children are identified through different mechanisms within the delivery system, but identifications occur primarily through their primary provider/physician or community clinics. Other referral sources include DSHS or other government agencies, schools, pregnancy testing clinics, or self-referral. Agencies communicate about current openings in programs, program eligibility and when new services are offered. This communication may be through community service provider meetings, or direct communication. Agencies share referral forms and eligibility with one another and communicate the referral process through direct contact, written forms, email and by telephone. Referrals are made by fax or by direct phone referral to support staff.

E. Referral Resources Currently Available and Needed in the Future

The following tables outline the referral resources currently available through the Yakima Parents as Teachers and Nurse-Family Partnership programs.

Table 1: Parents as Teachers Program Referral Resources in Yakima County

| | Health | Mental Health | Early Child Development | Substance Abuse | DV Prevention | Child Maltreatment Prevention | Child Welfare | Education | Other (Specify) |
|---|--------|---------------|-------------------------|-----------------|---------------|-------------------------------|---------------|-----------|--|
| Yakima Valley Farm Workers Clinic | X | X | | | | | | X | Dental; Incredible Years, WIC |
| Catholic Family & Child Services | | X | | | | | | X | PAT, Nutrition, Kinship Navigator, housing, child care, clothing & food bank |
| Yakima Neighborhood Clinic | X | X | | | | | | | Dental |
| La Casa Hogar | | | X | | | | | X | ESL, GED |

| | | | | | | | | | | |
|---|---|--|---|---|---|---|---|---|--|-----------------------|
| EPIC | | | X | | | X | | | | Youth Programs |
| Triumph Service | | | | X | | | | | | |
| Children’s Village | X | | X | | | | | X | | NFP, WIC |
| Consejo Counseling & Referral | | | | | X | | | | | |
| Kid’s Screen | | | | | | | | | | Children’s screenings |
| Lower Valley Crisis & Support Services | | | | | X | X | | | | Crisis Clinic |
| CLEAR | | | | | | | | | | Legal issues |
| Memorial Hospital | | | | | | | | | | First Steps |
| Yakima Consumer Credit Counseling | | | | | | | | | | Financial assistance |
| DSHS- Yakima, Sunnyside, CSO Wapato | | | | | | X | X | | | |

Table 2: Nurse-Family Partnership Referral Resources in Yakima County.

| Referral Resources: (See key below) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|-----------|-----------|
| Community Needs: | | | | | | | | | | | | |
| Health | X | X | X | X | | | | | | | X | X |
| Mental Health | X | X | X | X | | | | X | X | | | X |
| Early Childhood Development | | | | X | | | | | X | | | X |
| Substance Abuse | | | | | | X | | | | | | X |
| DV Prevention | | | | | | | X | | | | | X |
| Child Maltreatment Prevention | | | | | | | | | X | | | X |
| Child Welfare | | | | | X | | | | | | | X |
| Education | | | | | | | | | | X | | X |

- | | |
|---|---|
| 1. Medical providers | 7. YWCA (DV shelter and community advocacy) |
| 2. Community Clinics | 8. Community Mental Health Agencies(CWCMH, BHS) |
| 3. Indian Health Services | 9. Catholic Family and Child Services |
| 4. Children’s Village (0-3 Neurodevelopmental) | 10. Local School Districts/GED/work training programs |
| 5. Division of Children and Family Services | 11. DSHS/SCHIP |
| 6. Triumph Treatment Center/Merit Resources Svc | 12. Information Line: 211 |

In the future Yakima County has identified a number of needs that impact the Parents as Teachers and Nurse-Family Partnership programs. Yakima Valley Farm Workers Clinic Casa de Esperanza recently closed its doors, resulting in substance abuse services lacking

for the non-English speaking population. Triumph Services only provides services to those who are able to speak English. In addition to replacing those services, Yakima County has identified the need for a coordinated referral system and more accessible and affordable mental health services for families. Families in Yakima County also need access to quality child care and affordable housing.

Plan for Coordination Among Existing Programs and Resources

Parents as Teachers: There are three Parents as Teachers (PAT) programs in the county, each targeting services to specific geographic locations in the county. All three programs are included in the state implementation plan for Yakima. First-year funding has been designated for Catholic Family and Child Services (CFCS) and Parent Trust for Washington Children (PTWC) because of a loss of non-state dollars that will affect services for 25 families (seven families-CFCS; 19 families PTWC).

Yakima Valley Farmworkers Clinic (YVFC) PAT is in the third year of a federal project and is not in jeopardy of a budget shortfall at this time. While they will *not* receive funding during this first year, they are committed to being a full partner of the implementation plan for MIECHV funding. Currently, one parent educator serves eight rural communities. Looking to future funding periods of the federal project, YVFC PAT hopes to increase their number of parent educators, as well as expand services to this underserved area of the lower Yakima Valley. Sites already have made closer ties working together on the implementation plan. The Home Based Early Learning (HBEL) Initiative has proven that a collaborative approach to home-based early learning increases quality of services to families in the eastern end of the city of Yakima. All three PAT programs will increase collaboration to enhance quality of home visits, resource referrals and family well-being to all those being served in the community.

Nurse-Family Partnership:

Yakima Valley Memorial Hospital has been the coordinator for Yakima County Maternal Child Health (MCH) home visiting services since 1981. Although these services are typically provided through a county health department, the community and the state agreed Memorial should coordinate these public health services and sub-contract with local organizations, which include Yakima Neighborhood Health Services and Yakima Valley Farm Workers Clinic. Because of this agreement and the collaborative relationships, most home visiting agencies who serve pregnant and parenting families have an agreement to share caseload lists with Yakima Valley Memorial Hospital Maternal Health Services. This helps ensure no duplication of services, and that families are linked with their home visiting provider at delivery of their child.

Coordination of services occurs at both intake and graduation/discharge from services. At intake, referrals are reviewed by each agency for eligibility. If the client does not meet eligibility requirements of the program, the provider will offer the individual other services within the community that may meet their needs, such as First Steps or PAT. If the client declines the services being offered, the client is offered the option of having the referral sent to a program/provider with services more closely matching the needs and preferences of the client/family.

All home visiting providers have agreed to explain their home visiting program to clients, and to inform them that other services are available in the community, so that the family can make an informed choice about what program will be the best fit for them. Additional coordination happens among all of the NFP programs in Washington. If a client is enrolled in Yakima County but is moving to another county that has an NFP program, if the family desires, a referral will be made to the NFP program in the new county of residence. In this way, this population of very young and very mobile clients can continue in NFP services while meeting their individual or family need to relocate.

Local Capacity to Integrate Home Visiting Services into an Early Childhood System

Parents as Teachers: Yakima coordination exists through the Mid Valley Providers Consortium, Ready by Five and the HBEL Initiative.

Nurse-Family Partnership: A new regional early learning coalition (Investing in Children) is forming with clear governance and decision-making processes. This coalition will be used for regional recommendations around early learning, including home visiting.

2. Pierce County - Council Districts 2, 4, 5 and 6

Assessment of Needs and Existing Resources

A. Community Strengths and Risk Factors

Pierce County is a large and highly populated county that is divided into four sub county geographical areas. Of these four sub county areas, each ranked high in most or all risk indicator areas identified in the Home Visiting Needs Assessment, achieving a statewide ranking of #6, #1, #2 and #8, respectively. For specific indicator data, see the Washington State Home Visiting Needs Assessment, Appendix B: Data Report Information, Tables B-1 and B-3 (p 92-95): www.doh.wa.gov/cfh/micah/hvna/default.html

Based on the Home Visiting Needs Assessment, the highest risk factors for this community include: Domestic Violence, Child Maltreatment, Unemployment, Infant Mortality, Teen Births, and Late/No Prenatal Care.

According to the infant/toddler region, Pierce County has identified the following community strengths and opportunities:

1. Prepared to implement and coordinate initiative due to advanced planning, awareness and infrastructure.
2. Expansion capacity in current home visiting programs.
3. Momentum for multicultural collaborations based on organizational commitment and culturally responsive programs shaped by participants.
4. Community awareness about needs of military families and growing communication between civilian and military sectors.

B. Community Characteristics and Needs of Participants

According to the infant/toddler region, Pierce County (Council Districts 2, 4, 5 and 6) is interested in focusing on populations most in need of services. The community is experiencing significant growth among military families, immigrant and refugee families, and American Indian families. The drastic military growth has increased the need for a

variety of services with varying intensities. They noted a need for services for children with special needs or medically fragile conditions, and increasing access to services for military families living off-post.

The community is interested in addressing rising levels of family violence and adverse childhood experiences. The current resources do not meet the demand in the areas of highest growth. Populations identified in need of services by the infant/toddler regions include: mothers who are young, single, in the military or navigating poverty.

Pierce County also is focused on improving school readiness.

C. Existing Home Visiting Services

Information provided in the Washington State Home Visiting Needs Assessment shows Pierce County provides the following home visiting programs/models:

1. Early Head Start: Home-Based Option: 1 organization
2. Nurse-Family Partnership: 1 organization
3. Parents as Teachers: 1 organization
4. First Steps: Maternity Support Services and Infant Case Management: 6 organizations
5. Other: Children with Special Health Care Needs, Early Family Support Services, Early Intervention Program, Triple P, Promoting First Relationships, Early Support for Infants and Toddlers, Parenting Partnership Program and Parent Child Assistance Program

In Pierce County, there has been one discontinued home visiting program since March 23, 2010. The Parents as Teachers: Heroes at Home program closed in fall 2010.

D. Existing Mechanisms for Screening and Referral

Pierce County Maternity Support Services Centralized Intake – Provided by the Tacoma-Pierce County Health Department. One local phone number and highly trained and experienced staff member that community services offices (CSOs), medical providers, secondary schools and other referents call to make a referral for maternity support services (MSS) for any qualified pregnant woman in Pierce County. Since it is operated by the same division in the health department that implements the NFP program, the centralized MSS intake screens all referred women for eligibility for NFP into the program if there is capacity to serve them.

Maternal Child Outreach Program – Provided by the Tacoma-Pierce County Health Department. Two health department social workers visit hospitals daily and screen records to identify women who have just delivered babies and who are eligible for MSS home visiting services but are not receiving them. These social workers also visit WIC offices, OB/GYN clinics, churches, secondary schools, CSOs, and other community sites that serve low-income individuals in the target area (Council Districts 2, 4, 5 and 6).

Pierce County Family Support Partnership – The Family Support Partnership operates 12 family support centers throughout Pierce County. In addition to providing family support workers who conduct evidence-based home visiting, family support centers offer parenting classes, food and clothing banks, information and referral, and a variety of other family support services. MSS public health nurses are housed in these centers and

are on the center teams. Staff members are familiar with the MSS and NFP programs and make referrals to them when appropriate.

E. Referral Resources Currently Available and Needed in the Future

The following tables outline the referral resources currently available through the Pierce County Nurse-Family Partnership programs.

Table 3: Currently Available Referral Resources in Pierce County Council Districts 2, 4, 5, 6

| Referral Resources: (See key below) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|------------|----------|----------|----------|----------|----------|----------|----------|----------|--------------------|-------------|-----------|-------------------------------|-----------|
| Community Needs: | | | | | | | | | | | | | | |
| Health | | X | | X | | | | X | X | X | | X | X | |
| Mental Health | | X | | | X | X | | | X | | | X | | |
| Early Childhood Development | | X | | X | | | | | X | | | | X | X |
| Substance Abuse | | X | | | | | | | | | | | X | |
| DV Prevention | | X | | | | | | | X | | | | | |
| Child Maltreatment Prevention | | X | | X | | X | | | X | | | | X | |
| Child Welfare | | | | | | X | X | | | | | | | |
| Education | | X | | X | | | | | X | | | | | |
| Other (specify) | Child care | many | Housing | | | | | | | Medicaid providers | Oral health | | STDs breast & cervical cancer | |

- | | |
|--|---|
| 1 P.C. Child Care Information & Referral | 8 Pierce County Project Access |
| 2 United Way HelpLine & 211 | 9 Family Support Centers (12) |
| 3 Access Point 4 Housing (Associated Ministries) | 10 SHIBA |
| 4 First 5 Fundamentals | 11 ABCD Children’s Oral Health |
| 5 Optum Health RSN | 12 Pierce County Aids Foundation |
| 6 Mary Bridge Children’s Advocacy Center | 13 Tacoma-Pierce Co. Health Dept. |
| 7 Region 3 Children’s Administration Intake | 14 Pierce County Child Find & Child Reach |

The information and referral resources in Pierce County are well-organized and accessible. Families access resources in Family Support Centers, through telephone-based systems, and online. However, mental health and housing services are vastly underfunded and inadequate to meet the need.

Coordination Among Existing Programs and Resources

Three mechanisms facilitate coordination between home visiting programs in Pierce County:

First 5 Fundamentals (F5F): A coalition of organizations serving young children whose mission is to “build and sustain an integrated early learning system of community partners and organizations to support our young children and their families.” Most of the

organizations which provide home visiting services to families of young children in Pierce County are participating members of F5F.

First Steps Coordinators Group: This group consists of all the managers overseeing the provision of MSS and infant case management (ICM) (including those provided through home visiting) by all the providers in Pierce County. This group coordinates the continuum of services for all MSS and ICM services in the county. Since these clients include those who are enrolled in NFP, the group regularly coordinates referral and access to NFP services with the other MSS/ICM providers in the county.

Family Support Partnership: The Family Support Partnership has been growing and coordinating the provision of home visiting services to families in Pierce County for more than 15 years. The Partnership works through the Tacoma-Pierce County Health Department, contracting with community organizations and school districts to provide family support centers and home visiting staff. About four years ago, the decision was made to convert most of the home visiting offered to evidence-based practice models, specifically the Positive Parenting Program and Promoting First Relationships (a promising practice). Those services are available to all families in Pierce County through the coordination work of the Family Support Partnership and its many community partner contractors.

Local Capacity to Integrate Home Visiting Services into an Early Childhood System

The Pierce County provider community is well-networked, and has a long and strong history of working together to coordinate services for clients. The Pierce County Human Service Coalition supports that collaboration. The Pierce County Family Support Partnership coordinates the funding and provision of family support centers and evidence-based parent education to hundreds of families annually throughout Pierce County. Relatively new and very effective coalitions include Access Point 4 Housing (housing services coordinated by Associated Ministries), P.C. Project Access (medical services), and First 5 Fundamentals (early childhood education).

3. Snohomish County: North Everett

Assessment of Needs and Existing Resources

A. Community Strengths and Risk Factors

Snohomish County is a large county divided into 10 health planning districts corresponding to zip codes. Snohomish County: North Everett ranked high in most or all risk indicator areas identified in the Home Visiting Needs Assessment, achieving a statewide ranking of #4. For specific indicator data, see the Washington State Home Visiting Needs Assessment, Appendix B: Data Report Information, Tables B-1 and B-3 (p 92-95): www.doh.wa.gov/cfh/micah/hvna/default.html

Based on the Home Visiting Needs Assessment, the highest risk factors for this community include: Child Maltreatment, Domestic Violence, Unemployment, Late/No Prenatal Care, Poverty, and Infant Mortality.

According to the infant/toddler region, Snohomish County: North Everett has identified the following community strengths and opportunities:

1. Existing NFP program provides an opportunity to leverage current programming to focus on improved maternal and newborn health.
2. Recent assessments conducted in the region will help move home visiting forward and expand services.
3. There are opportunities for partnerships with area schools, the Housing Authority, minority community building, and natural leader development efforts.

B. Community Characteristics and Needs of Participants

According to the infant/toddler region, Snohomish County: North Everett is interested in focusing home visiting efforts on improving maternal and newborn health. Of the 4,071 Medicaid births in Snohomish County in 2008, 526 births occurred in North Everett. Services have been cut in the last three years, resulting in fewer services for at-risk families. Voluntary and preventative approaches are eroding. Eligibility criteria have eliminated services for families that may need services but “just miss” qualification cut-offs. There are waiting lists for Head Start across the region, and no Early Head Start slots are available in North Everett. The PAT program no longer serves the Everett area.

C. Existing Home Visiting Services

Information provided in the Washington State Home Visiting Needs Assessment shows Pierce County provides the following home visiting programs/models:

1. Early Head Start: Home-Based Option: 1 grantee
2. Nurse-Family Partnership: 1 public health entity
3. Parents as Teachers: 2 organizations
4. First Steps: Maternity Support Services and Infant Case Management: 6 organizations
5. Other: Children with Special Health Care Needs, Early Family Support Services, Early Intervention Program, Triple P, Promoting First Relationships, Early Support for Infants and Toddlers, Parenting Partnership Program and the Parent Child Assistance Program

None of North Everett’s home visiting programs have been discontinued since March 23, 2010

D. Existing Mechanisms for Screening and Referral

Currently, Snohomish County does not have a centralized intake system for home visiting. Referrals come in from the DSHS office and are forwarded to the Step by Step program, Visiting Nurse Services (VSN) or the health district. For the most part, agencies delivering home visiting services informally communicate about current programming and eligibility and let other service providers know when they have openings in current programs or when they are beginning a new program. For instance, the Early Head Start family worker will call to inform other agencies about their current openings and will have applications available. Snohomish Health District staff then inform fellow staff of eligibility and openings, and they will in turn inform eligible families of the available services.

Referrals are often made by telephone, or faxed from one agency to another. For NFP, updates are made monthly in the Maternal Child Health Care Coalition meetings, WIC and First Steps meetings. Flyers and emails are sent out to other community partners and providers to remind them of program services, eligibility criteria and available openings. In this way, information about current home visiting programs is shared across community providers who connect families to available services to meet identified family need.

E. Referral Resources Currently Available and Needed in the Future

The following tables outline the referral resources currently available through the Snohomish County NFP programs serving North Everett.

Table 4: Currently available referral resources for Snohomish County – N Everett.

| Referral Resources: (See key below) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|-----------|
| Community Needs: | | | | | | | | | | | |
| Health | X | X | | | | | | | | | |
| Mental Health | | X | X | X | | | | | | | X |
| Early Childhood Development | | | | | X | | | | | | |
| Substance Abuse | | | | | | X | | | | | |
| DV Prevention | | | | | | | X | | | | X |
| Child Maltreatment Prevention | | | | | | | | X | X | | X |
| Child Welfare | X | | | | | | | | X | | |
| Education | | | | | | | | | | X | |

- | | |
|--------------------------------------|---|
| 1. Everett Clinic/ Providence | 8. Everett Gospel Mission and Children’s Refuge |
| 2. Community Health Clinics Services | 9. Division of Family and Children |
| 3. Compass Mental Health Programs | 10. Local School Districts/Work Training |
| 4. Sea Mar and Pathways for Women | 11. Latina Women’s Support Group |
| 5. Neurodevelopment (0-3) Centers | |
| 6. Pacific Treatment Alternatives | |
| 7. Domestic Violence Services | |

Currently in North Everett there is a lack of affordable and accessible adult mental health and infant mental health services. Additionally, there is a severe shortage of affordable and accessible low-income housing and transitional housing to support families with multiple needs.

Coordination Among Existing Programs and Resources

There is coordination among the existing home visiting programs in Snohomish County. This happens both at intake and at graduation/discharge as client needs are matched with the program best able to support the family to achieve their goals. At intake, referrals are reviewed by each program. If the client does not meet eligibility, then the supervisor or provider will consider what other services/programs might meet the client’s needs. They may refer to the Early Head Start program, Step by Step, or VSN. If the structure of a program does not meet the client’s needs, the referral would be sent on to a program/provider with services more closely matching the needs and preferences of the client/family. NFP providers will explain the program to a newly referred client, but will also let the client know that other services are available, so that the family can make an informed decision of what program will best meet its needs. Additional

communication and regular meetings would increase the knowledge base of all the home visiting programs and increase the likelihood of cross referrals and coordination to best meet family need.

At discharge/graduation, providers will work with the family to assess ongoing need and goals. The home visitor may then make a referral to another home visiting program so that the family can continue to receive the services they need. Examples of this include referrals to Early Head Start (EHS) if a client is graduating from NFP but still has significant basic needs and additional goals that can be addressed in EHS. Enrollment in EHS home visiting services at age 2 also increase the likelihood that eligible children will transition to Head Start when age appropriate.

Another example would be a client graduating from NFP who has a child with special health care needs. That family may be referred for continued services in the Children with Special Health Care Needs program. Additional coordination happens among all of the NFP programs in Washington. If a client enrolled in Snohomish is moving to another county that has an NFP program, if the family desires, a referral will be made to the NFP program in the new county of residence. In this way, this population of very young and very mobile clients can continue in NFP services while meeting their individual or family need to relocate.

Local Capacity to Integrate Home Visiting Services into an Early Childhood System

Currently, coordination of the resources mentioned above happens through the maternal Child Health Care Coalition. This group, made up of representatives from Maternity Support Service providers serving Snohomish County, meets regularly to discuss current services and gaps, and collaborates on efforts to coordinate and improve care to the customers in Snohomish County. They also discuss training and funding for sustainability of programs and services.

4. South King County

Assessment of Needs and Existing Resources

A. Community Strengths and Risk Factors

King County is a large county divided into South, Seattle, North and East Regions. South King County was specifically identified as high-risk based on the high numbers of Medicaid births to American Indian/Alaska Native and African American women.

Based on the Home Visiting Needs Assessment Non-Hispanic Blacks have significantly higher rates of: Preterm Birth, Low Birth Weight, Infant Mortality, Poverty, Child Protective or Child Welfare Services, High School Dropouts, Late/No Prenatal Care, Youth Illicit Drug Use, and Teen Births. Blacks have the highest rates of low birth weight births in the state.

Based on the Home Visiting Needs Assessment, Non-Hispanic American Indian/Alaska Natives have significantly higher rates of: Preterm Birth, Low Birth Weight, Infant Mortality, Poverty, Late/No Prenatal Care, Child Protective or Child Welfare Services, Rates of DSHS women who need substance abuse treatment, High School Dropouts, Youth Illicit Drug Use, and Teen Births compared to non-Hispanic Whites. American Indian/Alaska Native women have the highest rates among all race/ethnic groups except low birth weight rates, late/no prenatal care, youth illicit drug use, and teen births.

For additional information about Race/Ethnic Disparities in Risk Factors, see the Washington State Home Visiting Needs Assessment (p 15-20): www.doh.wa.gov/cfh/micah/hvna/default.html

According to the infant/toddler region, South King County has identified the following community strengths and opportunities:

- Existing evidence-based home visiting programs for populations most impacted by health disparities.
- Expansion capacity in current home visiting programs.
- Linkages to connect families to programs tailored to meet their needs.

B. Community Characteristics and Needs of Participants

According to the infant/toddler region, South King County is interested in addressing persistent disparities and disproportionality in the areas of maternal/newborn health, child maltreatment, school readiness and achievement. The community has had extensive conversations about disparities in birth outcomes and infant mortality in this part of the county.

South King County, Infant mortality rates by race (per 1,000 births):

| | |
|-------------------------------|------|
| All South King County | 5.1 |
| White Non-Hispanic | 4.8 |
| Black Non-Hispanic | 9.6 |
| American Indian/Alaska Native | 15.0 |

South King County, Low Birth Weight rates by race (per 1,000 births):

| | |
|-------------------------------|-----|
| All South King County | 5.4 |
| White Non-Hispanic | 4.5 |
| Black Non-Hispanic | 8.6 |
| American Indian/Alaska Native | 6.1 |

In the area of child maltreatment, both racial/ethnic populations experience disproportional numbers of out-of-home placements and extended time periods of care received outside of the home. Cultural practices around diet, toileting and discipline are significant issues that have resulted in lack of trust and misunderstanding between families and the agencies and organizations that serve them.

School readiness and achievement are areas of focus for the region. Third grade test scores in reading lag behind the state average. There are limited culturally sensitive and culturally relevant resources to identify special needs and limited mental health services for children with identified challenges.

C. Existing Home Visiting Services

According to the NFP program in South King County, the evidence-based programs serving populations living in South King County include:

1. Early Head Start: Home-Based Option: 3 organizations
2. Nurse-Family Partnership: 1 organization

3. Parents as Teachers: 1 organization
4. Information provided in the Washington State Home Visiting Needs Assessment shows King County also provides the following home visiting programs/models which may serve some families in South King County:
5. Parent Child Home Program: 3 organizations
6. First Steps: Maternity Support Services and Infant Case Management: 11 organizations
7. Other: Children with Special Health Care Needs, Partnering with Families for Early Learning, Early Family Support Services, Early Intervention Program, Early Support for Infants and Toddlers, Outreach Doula Program, Secure Families Project, Parent Child Assistance Program, Improving Parent-Child Relations, Mental Health Services for Parents of Young Children with Special Health Needs, Hearing, Speech & Deafness Center.

None of South King County's home visiting programs have been discontinued since March 23, 2010.

D. Existing Mechanisms for Screening and Referral

Currently, South King County does not have a centralized intake system for home visiting. Agencies delivering home visiting services communicate about current programming and eligibility and let other service providers know when they have new services, or openings in current programs. For instance, the Early Head Start family support worker in White Center will call White Center Public Health to notify them of openings. White Center Public Health staff will then obtain applications, inform staff of eligibility and openings, and inform eligible families of the available services. Referrals are often made by telephone, or faxed from one agency to another. Public health does an annual update with school health staff and local WIC providers and family-serving agencies to remind them of NFP services, eligibility criteria and available openings. In this fashion, information about current home visiting programs is shared across community providers who connect families to available services to meet identified family need.

In King County, there is a "no wrong door" mandate across the three existing NFP teams serving different geographic areas of the county. Intake supervisors review referrals for eligibility, accepts it for their team, or forwards the referral on to the team serving the area in which the eligible client resides. This collaborative process across teams ensures that no eligible client will be turned away if programs have available capacity.

E. Referral Resources Currently Available and Needed in the Future

The following tables outline the referral resources currently available.

Table 5: Currently available referral resources for King County – South.

| Referral Resources: (See key below) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|-----------|
| Community Needs: | | | | | | | | | | | |
| Health | X | X | | | | X | | | | | |
| Mental Health | | X | X | X | | X | | | | | |
| Early Childhood Development | | | | | X | | | | | | |
| Substance Abuse | | | | | | X | X | | | | |
| DV Prevention | | | | | | | | X | | | |
| Child Maltreatment Prevention | | | | | | | | | X | | |
| Child Welfare | X | | | | | | | | | X | |
| Education | | | | | | | | | | | X |

- | | |
|---|---|
| 1 Public Health Seattle King County | 7 Perinatal Treatment Services |
| 2 Community Health Clinics | 8 DAWN(DV shelter/community advocate) |
| 3 Navos and Valley Cities Mental Health | 9 Parent Trust |
| 4 Renton and Kent Youth and Family Services | 10 Division of Family and Children Services |
| 5 Neurodevelopmental (0-3) Centers | 11 Local School Districts/Work Training |
| 6 Seattle Indian Health Board | |

Currently in South King County, there is a lack of affordable and accessible mental health and infant mental health services. Additionally, there is a severe shortage of affordable and accessible low-income housing to support families with multiple needs.

Coordination Among Existing Programs and Resources

There is effective coordination among the existing home visiting programs in South King County. This happens both at intake and at graduation/discharge when client needs are matched with the program best able to support the family to achieve their goals. At intake, referrals are reviewed by each program. If the client does not meet eligibility then the supervisor or provider will consider what other services/programs might meet the client's needs. They may refer to the PAT or EHS program, or to First Steps Home Visiting available at all Public Health Seattle-King County Centers. In addition, if the structure of a program does not meet the client's needs the referral would be sent on to a program/provider whose program/services more closely match the needs and preferences of the client/family.

NFP providers in South King County will explain the NFP program to a newly referred client, but will also let her know that other services are available so that the family can make an

informed decision of what program will best meet their needs. At discharge/graduation, providers will work with the family to assess ongoing need and goals. The home visitor may then make a referral to another home visiting program so that the family can continue to receive the services they need. Examples of this include referrals to Early Head Start as a client is graduating from NFP but still has significant basic needs and additional goals that can be addressed in EHS. Enrollment in EHS home visiting services at age 2 also increases the likelihood that eligible children will transition to Head Start when age appropriate.

Another example would be a client graduating from NFP who has a child with special health care needs. That family may be referred for continued services in the Children with Special Health Care Needs program. Additional coordination happens among all of the NFP programs in Washington State. If a client is enrolled in King County but is moving to another county that has an NFP program, if the family desires, a referral will be made to the NFP program in the new county of residence. In this way, this population of young and very mobile clients can continue in NFP services while meeting their individual or family need to relocate.

Currently most of the coordination of the resources mentioned above happens through the South King Council of Human Resources Council. This group made up of representatives from the health and human service providers serving South King County meets regularly to discuss current services and gaps; and collaborates on efforts to secure funding and increase services to address unmet need in South King County.

Integrate Home Visiting Services into an Statewide Early Childhood System

Each of the at-risk communities identified local efforts to integrate home visiting into the broader system of supports and services for children and families. Significant work has been done in local communities to build early learning coalitions, develop the infant/toddler region structure, and foster collaboration and planning through a variety of other early learning focused initiatives.

At the state level, Washington is in the process of developing a collaborative governance structure as outlined in the state Early Learning Plan. The federal State Advisory Council grant will enable us to build a long-term, integrated governance and planning structure. In this updated state plan for home visiting, a primary goal is to integrate home visiting into the early learning planning and governance structure at the state and local level. Local planning structures that work across systems will be explored, and linkages will be made with partners in health, human services and K-12 education to plan for a comprehensive approach to supports and services for children and families. See Section 2 (Goals and Objectives).

Final Selection of MIECHV Communities:

Through this process, four of the seven communities were identified as highest risk with high capacity to implement evidence-based home visiting and achieve results. The four communities selected are:

1. Yakima County
2. Pierce County - Council Districts 2, 4, 5 and 6
3. Snohomish County: North Everett
4. South King County

List of At-Risk Communities not selected for MIECHV funding

32 geographic regions and five racial/ethnic groups were designated as communities at-risk in the Washington State Home Visiting Needs Assessment. The following communities have not been selected for the first year of MIECHV funding.

| | |
|---------------------|--------------------------------|
| Adams County | Mason County |
| Asotin County | Okanogan County |
| Benton County | Pacific County |
| Chelan County | Pend Oreille County |
| Clallam County | Skagit County |
| Cowlitz County | Skamania County |
| Ferry County | Snohomish (Lake Stevens) |
| Franklin County | Snohomish (Marysville-Tulalip) |
| Grant County | Snohomish (South Everett) |
| Grays Harbor County | Spokane County |
| Kittitas County | Stevens County |
| Klickitat County | Walla Walla County |
| Lewis County | Whatcom County |

Section 2: State Home Visiting Program Goals and Objectives

The goals and objectives of Washington’s home visiting program are based on strategies in Washington’s Early Learning Plan (ELP) and the state’s Birth to 3 Plan. These plans clearly identify how implementation of the home visiting program will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety and development; and strong parent-child relationships.

The ELP is online at www.del.wa.gov/plan.

The ELP provides a framework for a comprehensive system of care, education, programs and services to support children and families. The plan is organized as an “equation” for what is needed in a “ready and successful state.” This includes all stakeholders in the system: children, families and caregivers, communities, schools, educators and related systems.



Figure 2: Ready Framework

The ELP includes 36 strategies to build a ready and successful state system. Strategies from the ELP that support the home visiting program goals and objectives include:

- *Build continuum of infants and toddlers services and programs (ELP Strategy # 4)*
- *Make home visiting available to at-risk families (ELP Strategy #5)*

Figure 3 shows how these comprehensive plans provide the foundation for Washington’s Home Visiting Program.

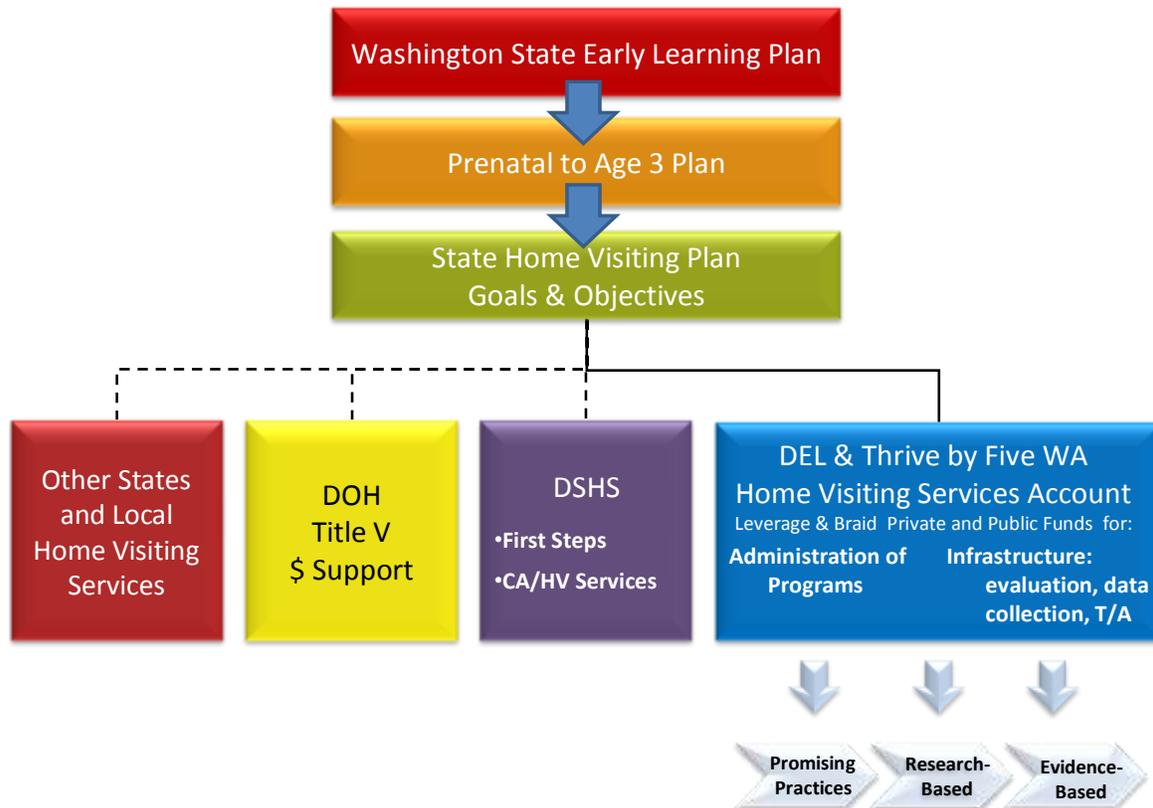


Figure 3: Using the ELP to Develop a State Home Visiting Plan

Washington’s Birth to 3 Plan

Washington’s Birth to 3 Plan provides recommendations on policies and critical next steps to build a continuum of services to support families with our youngest children. The plan can be downloaded from the DEL website at:

www.del.wa.gov/publications/research/docs/Birthto3Plan.pdf

Aligned with the key strategies in the ELP, this plan includes seven recommendations to improve outcomes for infants and toddlers. The recommendations include two specific goals related to home visiting:

- *Optimize the physical health, mental health and developmental wellbeing of infants and toddlers by sustaining support for and building services, systems and infrastructure, including universal developmental screening for infants and young children.*
- *Increase availability of quality home visiting services to at-risk families with infants and toddlers by supporting a “portfolio” of effective evidence-based home visiting programs.*

Both the key recommendations and specific policies to support a strong state system for home visiting were identified by an “Infant Toddler Think Tank” in 2010. Input from stakeholders and specialists in infant and toddler development was used to develop a theory of change and prioritize actions and investments critical to children birth to three years old. The following home visiting strategies, to be developed over the next three years, were identified:

- Expand investments in home visiting programs to reach a greater number of vulnerable children.
- Ensure quality implementation by assessing and monitoring fidelity and building organizational capacity for programs and program models.
- Expand the capacity for evaluation of the EBHV portfolio and develop statewide structure for and require common reporting of activities, outputs, fidelity measures, indicators, and outcomes across programs implementing the same EBHV models.
- Assess the effectiveness of a portfolio approach to positively impact targeted child and family outcomes.
- Build the knowledge and evidence base for implementation of EBHV in diverse communities. Move effective promising home visiting programs along the continuum from research- to evidence-based.
- Support interagency coordination and stakeholder involvement in statewide efforts to plan and implement home visitation services.

Using the foundational work of the Early Learning Plan and the Birth to 3 Plan, the collaborative partners identified in the Home Visiting Planning Structure developed goals and objectives for the statewide home visiting work. These goals represent what Washington wants and is willing to do at the state and local level. The goals and objectives were developed with input from the Home Visiting Advisory Committee, the Partnership Group, and stakeholders participating in an on-line survey. The Cross Agency Governance Group agreed to the goals and objectives framework that outlines the Washington work to build and support a home visiting system across federal, state, local and private funding.

Goals and Objectives

The State Plan for a Home Visiting Program provides **high-level goals** and a set of clearly prioritized, feasible and **actionable objectives** that are necessary to foster a home visiting system in Washington. These priorities were identified through a collaborative process that involved stakeholders who are the most knowledgeable about the needs of at-risk populations and communities in our state. These goals and objectives are the critical next steps our system must take to continue building a comprehensive home visiting system, as well as contribute to the development of Washington's comprehensive early learning system.

The goals and objectives for Washington's State Plan for a Home Visiting Program fall within five strategic "buckets": Governance and Planning; Finance and Sustainability; Service Delivery and Access; Quality and Accountability; and Public Engagement.



Figure 4: The Five Strategic “Buckets” for the Goals of the State Home Visiting Program.

1. Governance and Planning

Washington is in the process of developing a collaborative governance structure over the next two to three years, as outlined in the state Early Learning Plan. A federal grant for continued development of the Early Learning Advisory Council (ELAC) will be used to build a long-term, integrated governance and planning structure at both the state and local levels. Over the long-term, home visiting will be integrated into the broad early learning governance structure.

Goal 1: Integrate the home visiting system as part of the broader early learning planning and governance structure, encourage collaboration at the state and local levels, and engage and reflect the communities served.

Objectives:

- A. Use the current home visiting planning structure to provide ongoing input and strategic direction in the development of the home visiting system. This structure includes ELAC, the Home Visiting Advisory Committee, the Home Visiting Partnership Group, and the Home Visiting Executive Team (formerly the Cross Agency Governance Structure or CAGS).
- B. Encourage strong local planning structures.
- C. Link with partners in health, human services and K-12 to plan for a comprehensive approach to home visiting and linkages to other services and supports for families.

- D. Listen to diverse local communities' views about culturally competent home visiting services, and use their input and local programs' expertise to assess the cultural competency of promising, research-based and evidence based home visiting models.
- E. Ensure that home visiting work is informed and influenced by families, consumers and stakeholders, and aims to reflect the diversity of communities served at the local, regional and state levels.

2. Finance and Sustainability

To enhance and expand home visiting benefits prenatal through age 5 requires alignment of current funding and development of new funding resources. Many young children in Washington are living in families that are low-income or living in poverty, as described in our ELP. Funding for home visiting services is not commensurate with the demonstrated need. The 2010 Legislature created a **Home Visiting Services Account (HVSA)** to align and leverage public funding with matching private funding to increase the number of children and families being served by home visiting.

Goal 2: Build finance strategies and generate resources to sustain and grow the home visiting system in Washington state.

Objectives:

- A. Seek funding from current sources, and new public (including local government) and private sources. Explore opportunities for leverage and to braid and blend funding sources through the HVSA.
- B. Build finance strategies to support evidence-based, research-based and promising practice home visiting programs.
- C. Secure resources to fund home visiting services and the infrastructure to support quality in local programs and at the state level.
- D. Develop strategies to build long-term sustainability of high-quality home visiting programs.
- E. Ensure that the finance strategies are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

3. Service Delivery and Access

The Washington State Home Visiting Needs Assessment identified 32 geographic areas and five racial/ethnic groups as being at-risk compared to the state. The needs assessment found that four evidence-based and nine other home visiting programs are in use in the state, but only an estimated 2 to 11 percent of at-risk children and families are receiving these services. Through the U.S. Census and Washington Kids Count, there is ample evidence that to develop an early learning system that meets the needs of all children requires explicit attention to a number of current gaps that exist—by income, race/ethnicity, language, and culture—both in child outcomes and opportunities and system capacity and response. Washington continues to build off a strong foundation of work that has been done at the state and local level to provide high-quality

home visiting programs and models to support families with young children get a good start in life.

Goal 3: Ensure that high-quality, culturally competent home visiting services that meet the needs of local communities are available and accessible to at-risk families across the state.

Objectives:

- A. Make evidence-based, research-based and promising program models more widely available and accessible to local communities.
- B. Build capacity to increase access to home visiting services in rural, tribal and other underserved communities.
- C. Identify and support effective intake and referral processes at the community, regional and state levels with organizations/entities that work closely with families.
- D. Conduct culturally competent outreach to recruit and retain families in home visiting programs in underserved communities.
- E. Work with communities and developers/representatives of evidence-based, research-based and promising home visiting models to ensure the cultural competency of home visiting services.

4. Quality and Accountability

Funders and policymakers want their investments to improve children’s outcomes and overall readiness for school. This calls for programs to be accountable. In Washington, we are responding to accountability in diverse ways as outlined in our Early Learning Plan. For home visiting there is an emphasis on continuous quality improvement of the home visiting programs. Efforts also are under way in Washington to evaluate evidence-based home visiting programs in terms of the outcomes for healthy parenting and child development, early literacy and children’s school readiness.

Goal 4: Ensure high-quality services and effective implementation of home visiting models and programs.

Objectives:

- A. Increase the capacity to collect and analyze meaningful data at the program, model and systems levels for use in home visiting program improvement efforts.
- B. Support communities in using these data for continuous quality improvement and ongoing learning in their organizations.
- C. Support communities in ongoing evaluation of promising/innovative practices to develop stronger evidence of effectiveness.
- D. Ensure that the processes for assuring the quality of home visiting are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

- E. Build professional development opportunities, training, and technical assistance for specific models/programs to support quality implementation of home visiting services.
- F. Identify opportunities to share information and collaborate across home visiting programs and with partners in health, education and human service systems.
- G. Build an integrated accountability system that meets local, state and federal needs, is consistent with program models and is cost-effective.

5. Public Engagement

Nationally and in Washington, interest has been growing in using home visiting to enhance parenting, and promote the optimal growth and development of young children. Research has shown the effectiveness of home visiting to buffer the effects of multiple risk factors and benefit children's health and development. Organizations and agencies supporting children and families are engaging the public in support of home visiting and building a coordinated early learning system.

Goal 5: Build community and public will for a home visiting system that provides high-quality services to families in local communities.

Objectives:

- A. Educate the public about home visiting services and provide information about home visiting services offered in Washington.
- B. Cultivate champions to support local home visiting services and programs, and provide information about ways to get involved.
- C. Build off of existing public awareness campaigns that focus on early childhood health, development and learning, in order to inform parents, families and communities about home visiting.
- D. Ensure that public engagement efforts are informed and influenced by families, consumers and stakeholders, and aim to reflect the diversity of communities served at the local, regional and state levels.

Washington State Logic Model for Home Visiting

Values:

- Evidence based program implementation and evidence based policy development interactive and integrated processes that inform each other
- Utilization of implementation science framework
- Use of participatory research principles
- Input from consumers and local communities at all levels

| Resources | Activities | Outputs | Short-term outcomes (1 to 2 years) | Medium-term outcomes | Long-term outcomes |
|--|--|---|---|--|---|
| <p>Families in communities identified in WA state DOH Need Assessment</p> <p>Agencies implementing EBHV model</p> <p>EBHV Model’s National Services Offices and EBHV Model’s WA State Representatives</p> <p>WA State Early Learning Plan</p> <p>WA State Birth to 3 Plan</p> <p>Washington State Cross Agency Governance Structure (CAGS): DEL, DOH, and DSHS & Thrive by Five Washington</p> <ul style="list-style-type: none"> • Partnership & Advisory Groups <p>DEL Home Visiting Lead</p> <p>Home Visiting Services Account</p> | <p>Governance & Planning</p> <ul style="list-style-type: none"> • Cross Agency Governance • Partnership Group • Home Visiting Advisory Committee <p>Finance & Sustainability Build a finance strategy and seek funding for sustainability and growth of WA HV system</p> <p>Service Delivery & Access/Quality & Accountability</p> <p>1. Fund communities to implement quality EBHV models</p> <p>1a) provide TA for data collection & management at the program level</p> <p>1b) Develop state level infrastructure for CQI</p> <p>1c) provide TA for CQI at program & model level</p> <p>2. Cultural Competency Review Team community/programs</p> | <p>Governance & Planning Consistent Governance, Partnership and Advisory Committee meetings for planning and implementation</p> <p>Finance & Sustainability</p> <ul style="list-style-type: none"> • Finance strategy finalized • Increase funding from existing sources & new public/ private sources. • Increase opportunities for leverage & branding • & blend funding sources • Funding focus finalized for portfolio <p>Service Delivery & Access/Quality & Accountability</p> <p>1. Fund 4 MIECHV communities implementing PAT and/or NFP with quality and fidelity</p> <ul style="list-style-type: none"> • Baseline Capacity Assessments & Technical Assistance Plans Developed for each community/EBHV implementing • Development & Alignment of Logic Models • 3 quarterly reports for each | <p>Governance & Planning Link with partners in health, human services & K-12 to plan for a comprehensive approach to home visiting & improve linkages to other human services</p> <p>Finance & Sustainability Secure funding from existing sources & new public and private sources. Increase opportunities for leverage and branding and blend funding sources</p> <p>Service Delivery & Access/Quality & Accountability Integrated accountability & CQI system that meets local, state & federal</p> | <p>Governance & Planning Integrate the WA home visiting system as part of the broader early learning planning and governance structure</p> <p>Finance & Sustainability Increased resources to sustain & grow WA home visiting system</p> <p>Service Delivery & Access/Quality & Accountability Ensure high-quality services effective implementation of HV models and programs Ensure high-quality, culturally competent home visiting services that meet the needs of local communities and are available to “at risk” families across the state</p> <p>Public Engagement Build community & public support will to support high-quality services to families in local communities</p> | <ul style="list-style-type: none"> • Improve maternal & newborn health • Reduced child injury and maltreatment • Improvement in school readiness & achievements • Reductions in domestic violence • Improve family economic self-sufficiency |

| | | | | | |
|--|--|---|---|--|--|
| <p>WSU Area Health Education Center</p> <p>Home Visiting Coalition</p> <p>Other State Stakeholders</p> <p>Funding Sources: State Federal Private Match</p> | <p>input on culturally competent suggested enhancements to EBHV services to meet the needs of families and communities</p> <p>Public Engagement Provide outreach engagement to identified rural communities</p> | <p>community/EBHV model</p> <ul style="list-style-type: none"> • 1 annual report with data analysis and CQI <p>1a) WSU participatory evaluation – TA Plans developed for data collection & management for each community/EBHV model</p> <p>1b) State level infrastructure for CQI developed:</p> <ul style="list-style-type: none"> • Research & develop system to train & support TA coaching staff • Training system plan & timeline <p>1c) TA for CQI at program & model level:</p> <ul style="list-style-type: none"> • Develop formalized, consistent TA provided by state model reps to ensure quality implementation • Develop model specific guidelines/state standards for quality implementation of EBHV model • Develop for CQI TA plans for each community/model & identify cross training opportunities <p>2. Develop workgroup to review cultural appropriate practice in EBHV</p> <p>Public Engagement Develop outreach plan for identifying and engaging rural communities</p> | <p>needs and is consistent w/program models and is cost-effective</p> <p>Coordinating with EBHV model and Cultural Competency Workgroup to improve home visiting implementation to be culturally competent to meet the needs of families & communities</p> <p>Public Engagement Support & strong high quality local, state planning structures & provide ongoing input & strategic direction for the HV system</p> | | |
|--|--|---|---|--|--|

Integrating Home Visiting with Other Early Childhood Work

Significant strides are being made in other key work in Washington that is directly connected to the home visiting work or offers opportunities we plan to pursue this year in building out our system. Several will be outlined in this section.

A. Universal Developmental Screening

Related to Goal 3: Service Delivery and Access

As part of the Early Learning Plan and Birth to 3 Plan, Washington is working with multiple partners to advance the development of a Universal Developmental Screening (UDS) system. DOH, DEL, DSHS and the Office of Superintendent of Public Instruction have engaged in dialogue with key partners to build a strong system for developmental screening. Collaborators include: Early Childhood Comprehensive Systems grant (ECCS), Project LAUNCH, Children with Special Health Care Needs, Within Reach, and Thrive by Five Washington. Work groups are looking at screening systems, data needs, reaching populations/equity, and resources and care coordination. As both of these systems are evolving, there will be intentional linkages explored. Also, Washington has a Help Me Grow National Replication Grant. This work offers opportunities to explore how families entering a door for developmental screening might be connected to home visiting resources, and how to build out home visiting programs that offer robust screening and referral in their local communities as part of their model implementation.

With a comprehensive view of young children's development, the ELP, Birth to 3 Plan, and the State Home Visiting Plan all include strategies to integrate home visiting services with community level maternal and child health systems and systems that support early childhood health and well-being. Representatives from the maternal-child health and early childhood health systems at both the local and state level are part of the Home Visiting Plan CAGS, Partnership Group and Advisory Committee, and will continue to advise the DEL implementation.

B. Media Campaign for Parents

Related to Goal 5: Public Engagement

Thrive by Five Washington has launched *Love.Talk.Play.*, a media campaign launched to help parents in supporting children's healthy growth and development. *Love.Talk.Play.* serves as a vehicle to provide parenting education and family support. There are opportunities to integrate these key messages in the home visiting work. This has been part of a larger collaboration across partners and is part of our state's ECCS grant.

C. State Advisory Council authorized by the Head Start Act

Related to Goal 1: Governance and Planning

Washington is in the process of developing a collaborative governance structure as part of the federal State Advisory Council (SAC) grant. This grant will be used to continue in the development of the Early Learning Advisory Council to build an integrated system at the state and local level. Home visiting will be integrated into the governance discussions to build a mechanism for strong planning and decision-making.

D. Connections and Referrals to High-Quality Early Learning Services

Related to Goal 3: Service Delivery and Access

There is an explicit goal throughout the early childhood work in Washington to build a coordinated, integrated, linked system that meet the unique strengths and needs of families and communities. Home visiting linkages exist in local communities where home visitors and other service providers connect families to supports and services. While the home visiting work is growing we will be exploring more intentional ways to enhance the local collaborations and explore options for better state-level linkages. DSHS can help create linkages between families accessing Temporary Assistance for Needy Families and home visiting services. Play and Learn Groups offered to family, friend and neighbor caregivers can introduce options for home visiting supports to families that are interested. The state pre-K program and Head Start offer services for 4-year-olds in many communities. Home visitors can continue to build strong individualized referral pathways for families that might benefit from comprehensive pre-K services.

E. Strengthening Families

Related to Goal 1: Governance and Planning

Washington's active involvement in the Strengthening Families initiative, supported across the partner agencies, the ECCS grant, Project Launch, and the Head Start State Collaboration Office will be an ongoing foundation in the home visiting work. Home visiting is about building protective factors in families. The longstanding work of the state CAPTA agency, the Council for Children and Families, in supporting implementation of home visiting is tightly tied to the overall protective factor framework. The research clearly shows that supporting and strengthening families can reduce child abuse and neglect and support healthy children and families. Also, this framework and the work of the Community Café Collaborative strongly support parent leadership efforts in Washington. To be successful with home visiting, parents will be asked to share their experiences, talk to us about what they want and need, and provide advice about support communities need to make it happen.

Section 3: Selection of Proposed Home Visiting Models and How They Meet the Needs of Washington's Four Targeted Communities

Washington has three federally designated evidence-based home visiting models operating in local communities: 1) Early Head Start: Home-Based Option; 2) Parents as Teachers; and 3) Nurse-Family Partnership. We obtained approval from the three national model developers to implement the models as part of our program, pending a final review of the updated state plan.

To initiate a matching process, matching community needs to home visiting models, we engaged in conversations with the high-risk regions in the state. These conversations allowed us to augment the risk indicator data in the Needs Assessment to gain a local perspective.

Understanding Community Needs through Regional Planning Conversations

The local birth-to-3 planning entities (infant/toddler regions) provided specific information about community strengths, risks and priorities. These regional entities, not specifically focused on

home visiting, were able provide a more in-depth look at community strengths, needs and characteristics of the populations from a neutral stance.

Conversations with the individual communities addressed the following:

- What do the infant/toddler data tell us about your community's needs?
- What are parents saying about needs?
- Using the Home Visiting Needs Assessment indicators of risk and the home visiting program outcomes, what rises to the level of most need in your community?
- What are the gaps or opportunities around services offered in your community?
- What do the data tell us about your community?
- What are your community priorities?

The responses to these questions are included in Section 1, in the summary information about each community.

Assessing the Community Capacity to Implement Evidence-Based Home Visiting

The prioritized subset of semi-finalist communities engaged in a capacity assessment process coordinated by their home visiting model representative. This process required local home visiting programs to reflect on their community as a whole, the target populations, and assess their capacity to implement the evidence-based model with fidelity. If more than one organization in the community implements the same model, they worked collaboratively to articulate the capacity at the community level, not the capacity of a single organization. Technical assistance was provided to the communities and the model leads to assist them in this process. Communities were able to engage in conversations about outreach, staff training and retention, data management and quality assurance in this process.

Community and Model Matching and Washington Portfolio Development

In Step 2, the information gathered from local communities provided the cross agency partners information needed to identify models to match community needs and achieve results. To determine which models would receive FY 2010 funding, the partnership group and cross-agency governance structure reviewed information related to community needs:

- Needs Assessment data specific to each community.
- The community perspective on needs, strengths and priorities through the infant/toddler regions.
- National information provided by HomVEE about favorable outcomes for each model.

All communities consistently described high needs among families. Data suggest that between 2 and 11 percent of eligible families receive evidence-based home visiting services statewide. High needs and gaps in home visiting services for families are evident in each of the semi-finalist communities. The range of risk factors in this top tier of at-risk communities spanned the full spectrum at very high levels, so it was decided that the capacity in the community to implement the model and the readiness of the model to serve families and achieve results expected in the MIECHV program would be primary in the final selection.

Next, the counties submitted their written Community Capacity Assessment to Implement the EBHV Model. *See Attachment E: “Community Program Capacity Assessment to Implement the EBHV Model”* These were reviewed to determine the readiness and organizational capacity to:

- Recruit and retain the target population, identified both in the MIECHV guidance and specific populations identified by the communities as highest need.
- Engage with model developer for technical assistance and support.
- Recruit, train, and retain staff and supervisors.
- Monitor, assess, and support implementation with fidelity and ongoing quality assurance.
- Evaluate service delivery and collect and use data for continuous quality improvement.

Models also provided a snapshot of the services needed to address the needs identified in the community by sustaining or expanding current services.

In Step 3, the cross agency partners expressed commitment to building a “portfolio” approach to support the success of families with children prenatal to age 5, support a home visiting system to meet the federally mandated benchmarks, achieve results, and leverage future public and private funding. Key consideration in building a portfolio with the highest risk communities and EBHV models includes: use of multiple models, access technical assistance available from national model developers, ensure model and program ability to meet data and benchmark requirements, and build geographic diversity. The following four communities and two evidence-based home visiting models were selected for the first year of the MIECHV funding and announced on April 29, 2011.

Table 6: Washington State’s MIECHV Program Target Communities and Associated EBHV Model for Implementation

| COMMUNITY | MODEL | HIGHLIGHTS: COMMUNITY CAPACITY AND MATCH OF MODEL TO NEEDS |
|------------------|-------|---|
| 1: Yakima County | NFP | <ul style="list-style-type: none"> • Uses additional quality assurance methods. • Enhances the NFP model with a Mental Health Consultant to address mental health issues with clients. • Has an existing partnership with the Yakama Tribal Nation, which has demonstrated success. • Strong capacity to implement EBHV in Yakima—community-wide experience and commitment; coordination of implementing agencies. • Strong data collection capacity |
| | PAT | <ul style="list-style-type: none"> • Enhances the PAT model through use of books. • Collaboration between 3 organizations to implement PAT. • Considered strong in quality assurance. • As noted above, strong capacity to implement EBHV in Yakima and strong data collection capacity. Willingness to engage in increasing model specific data development. |

| | | |
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| 2: Pierce County – Council Districts 2, 4, 5, and 6 | NFP | <ul style="list-style-type: none"> • Highest need community identified in DOH Needs Assessment. • High number of military families identified by community will receive services. • Strong outreach strategies. • Enhances the NFP model with: use of a tool to assess depression; additional items for parents; and ACES information collection. |
| 3: Snohomish County – North Everett | NFP | <ul style="list-style-type: none"> • Strong quality assurance methods. • Enhances the NFP model with: <ul style="list-style-type: none"> • Training in infant mental health and early childhood development • Video feedback for home visitors • Has capacity to ramp up quickly and to add trained nurse home visitors. • Good match between NFP and the infant/toddler region needs • Can target Hispanic population through bilingual staffing and success with Hispanic population elsewhere in the county. |
| 4: King County - South | NFP | <ul style="list-style-type: none"> • Ability to reach target population specified for this Sub county area. • Historical high quality implementation. • Cultural competence is an organizational strength. • Enhances the NFP model with distribution of hormonal contraceptive as part of RCT. |

Washington’s Experience Implementing Selected Models

Washington plans to implement two evidence-based models in FY 2010 through the MIECHV funding. These include: Nurse-Family Partnership and Parents as Teachers. Both models have been offered in Washington for many years, and communities participating in competitive grant-making have consistently sought funding for sustainability, expansion, and program start ups with each of these models.

Washington has invested in development of a home visiting system that this federal program is intended to enhance and complement. The long history of this development began more than 10 years ago with state support for a Nurse-Family Partnership program in Chelan and Douglas counties through the state’s Title II CAPTA agency, Council for Children and Families (CCF). In subsequent years, CCF continued to provide funding to various evidence- and research-based home visiting programs including NFP and PAT programs as part of its capacity-building grants program. Simultaneously, Thrive by Five Washington—the state’s public/private partnership for early learning—invested in evidence-based, research-based and promising home visiting practices in two demonstration communities. These demonstration communities were connected to the CCF portfolio.

As the research became more familiar, public will for funding evidence-based programs grew. Evidence-based home visiting became a top priority among early learning advocates and stakeholders as a strategy to improve outcomes for children and families considered at highest

risk. In the 2007-09 biennium, the Legislature allocated state funding to CCF to develop and support a portfolio of evidence-based home visiting (EBHV) services. The intent of this funding was to expand and encourage the use of specific evidence-based, voluntary home visitation programs to support healthy child development, improve the quality of parent-child interactions, promote school readiness, and ultimately prevent child abuse and neglect. CCF implemented a request for proposal process and entered into contracts with community-based programs with the intent of contract renewal for a minimum of five years. Shortly thereafter, CCF contracted with Washington State University Area Health Education Center to develop and implement a formative and descriptive program evaluation of these home visiting efforts.

CCF's work has been foundational in developing relationships with communities, working with model developers and undertaking evaluation focused on continuous quality improvement. Washington also funds other research-based and promising practices models with state and private dollars. As the state develops a coordinated system of home visiting, we seek opportunities to build home visiting services that communities desire and that are shown to be effective. One of the primary goals articulated as part of the updated state plan is to increase availability and access to high-quality home visiting services throughout our state. The MIECHV program provides an opportunity to fund programs in our highest risk communities and achieve results for children and families.

The 2010 Legislature created a Home Visiting Services Account (HVSA) to align and leverage public funding with matching private funding to increase the number of families being served and support infrastructure development to ensure high-quality services. The HVSA—administered through a partnership between DEL and Thrive by Five Washington—also has invested in a portfolio of home visiting programs including NFP and PAT programs. As of July 2011, all state funding for home visiting has been transferred to DEL. DEL is leveraging this state funding by depositing it into the HVSA so that these public dollars are matched with private funding.

Approach to Home Visiting Quality Assurance and Fidelity of Service Delivery

The state will adopt an “implementation science” (Fixsen et al., 2005) framework to supplement the established protocols for assessing fidelity in PAT and NFP replication sites. Implementation science is discussed in greater detail in Section 5.

Implementation science focuses on staff and organizational readiness, organizational capacity to deliver the services, understanding of the characteristics and needs of clients, and a commitment to information-driven continuous quality improvement that can significantly increase the success of evidence-based practices.

The state will use each model's established fidelity standards. Fidelity will be assessed with respect to both reproducing each program's implementation conditions (process fidelity) and performance quality (performance fidelity). These existing standards address professional qualifications and training, minimum agency practices (including staff-client ratios and supervisory requirements), minimum service dose, service goals (such as health screens and service linkage), and delivery of approved curricula.

Adopting implementation science principles helps address several limitations that a sole focus on model fidelity introduces to this work, including:

- Fidelity standards are model-specific and development of the state plan will benefit from a common assessment framework in which to assess service delivery and fidelity to the model.
- The level of assessment detail between the two models is not consistent: NFP has far more extensive standards than PAT. Implementation science can provide a research-based approach to examining performance across the two models using a common framework. Elements of the two models' fidelity measures can then provide data.
- Fidelity to the models' performance expectations is critical but describes service specific performance while implementation science addresses the client, agency, staff, and contextual assets and barriers that can determine the success of any evidence-based practice.

As a result, our plan is to integrate the established model-specific fidelity indicators in a broader assessment of program implementation and client response.

In addition to attention to the quality and nature of services and the service providers, understanding the characteristics of the families enrolled in care will provide critical information determining both the course of service delivery and the potential benefits. Diverse cultural needs and differing levels of family risk for health and social problems are the two principal individual domains that may impact on home visiting benefits. Participant characteristics have been established as significant moderators of evidence-based practices. In home visiting, variable program benefit has principally been associated with families from marginalized communities, maternal depression and the presence of domestic violence.

Gomby's 2005 review of the research for home visiting emphasized several factors influenced by individual family differences as moderators of program success including: rapport and success in establishing family engagement, "cultural consonance" of programs from diverse backgrounds, and the quality of family motivation in the home visits as well as follow through on developmental tasks arising from the home visits. Evaluation information in Washington supports that families entering home visiting may have high levels of needs including behavioral health, homeless risk, and significant social marginalization. Through examination of progress of groups of families based on race and ethnicity as well as based on family risk characteristics, we will specifically address participant need and background as major potential factors affecting both program implementation and program benefit.

Implementation science explicitly builds on systems theory and provides a mechanism for addressing service success within the community, agency, and within the public policy context that drive the state's expansion of evidence-based home visiting.

Sustainability at the local level and development of the state's public policy for home visiting depends on a cycle of communication. Practice informs decisions, and practice is influenced by community and other stakeholders' needs. As a result, Washington's approach to service quality and fidelity explicitly calls out the process of bi-directional communication from the program level to decision-makers and the national model developers.

Figure 5 describes the principal elements of the Washington service implementation and fidelity development cycle of improvement. More specifics on continuous quality improvement efforts will be discussed in Section 7.

Quality Improvement

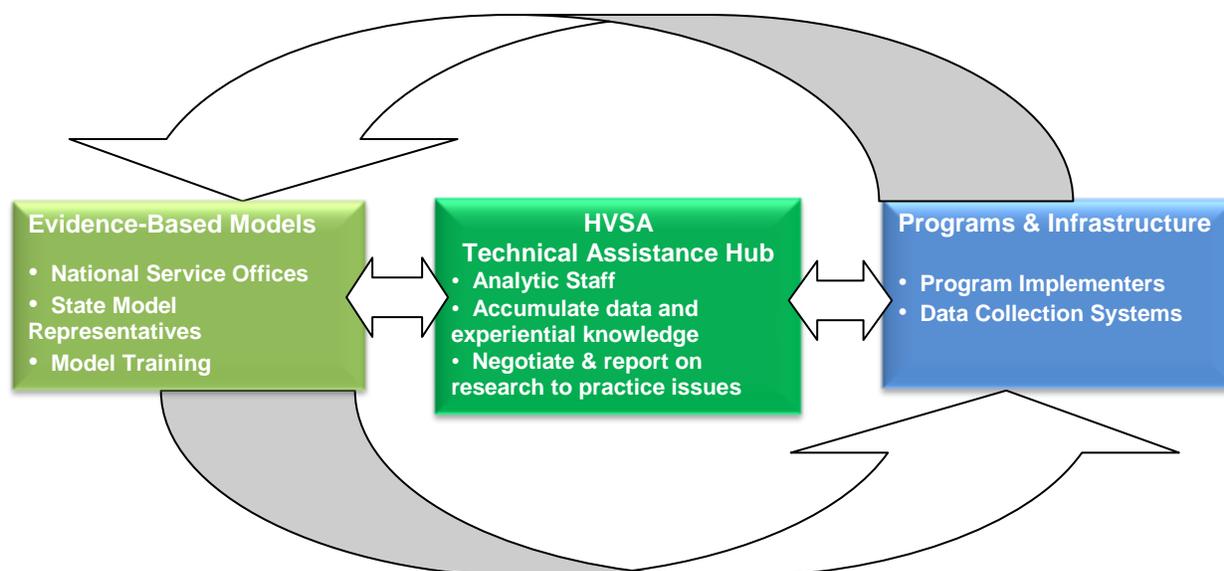


Figure 5: Addressing Fidelity and Program Quality Improvement in a System of Continuous Quality Improvement

Adapted from Fixsen et al., 2005

Identifying and Addressing Anticipated Challenges and Risks of Selected Models

Existing evaluation work in Washington suggests several common issues that characterize agency experiences implementing both NFP and PAT home visiting models. We will systematically assess these issues as a common review for developing training and technical assistance plans.

- **Participant attrition:** We have found widely varying success across programs in participant dropout. In some PAT and NFP programs, attrition can be very high, particularly in the first year. This finding suggests that staff training, specific family engagement strategies, and possibly differing levels of risks in participant populations will need be monitored and incorporated into training and technical assistance plans.
- **Staff turnover:** We also have found that agencies differ significantly in the stability of their work forces. We will place a priority in agency and staff assessments to identify and address barriers to staff tenure.
- **Introduction of enhancements to the core model:** We have found that it is common across local home visiting models to introduce additional services and to address distinct populations as local communities match home visiting to local needs. Such enhancements are well-recognized as both a characteristic of most evidence-based practices and a potential threat to the fidelity of the specific model. In our experience, enhancements often reflect the identified needs of families and the demands of the multiple funders

supporting local programs. Regardless, we will systematically assess for the presence and impact of local adaptations/enhancements on program delivery, participant experience, and program benefits.

- ***Family risk level and complexity:*** We have found that in many local home visiting programs, home visiting now addresses a highly distressed and vulnerable group of families. By design, the Washington home visiting program will be serving highly complex communities. Behavioral health, social isolation, and violence risk are common themes. We will work with programs to assess initial risk using common needs assessment and then monitor the effects of family risk on staff adjustment, program attrition, program fidelity and program impact.
- ***Cultural diversity:*** Cultural acceptability and congruence has only begun to be addressed in the home visiting literature. While NFP has been formally assessed in an African-American population, NFP has not been tested in other cultural and racial groups. PAT research addressing cultural acceptability and congruence is not presently available. By design, Washington will deliver home visiting services in highly diverse communities representing a range of cultures. As a result, we will assess and develop training and technical assistance plans to address cultural engagement, appropriate adaptations, and service impact in the two models.
- ***Community and agency differences:*** Because of the explicit identification of high-risk communities, both NFP and PAT will be implemented in communities with varying levels of community identity, acceptance of professional services, and access to professional resources. Within communities, implementing agencies also range from well-supported public agencies to smaller nonprofits. As a result, we will assess and as needed develop training and technical assistance to address distinct community and agency differences.

PAT challenges, risks, and anticipated technical assistance needs

Principal challenges associated with PAT arise from the active evolution in practice standards and changing information needs introduced by this federal funding. PAT's national office is actively addressing development needs but at this time the guidance, particularly as it relates to benchmarks and constructs, is still evolving. As a result, the team anticipates there will need to be a process of development and modification for both some program performance expectations but more significantly the assessment and information systems processes identified as critical to continuous quality improvement and policy development.

PAT provides guidance on minimum service goals but within the model supports a range of services in part based on the program's determination of client need. As a result, service dose and service type (individual visits, group programs, use of other community supports) may vary significantly and still be within program parameters. This variability is accepted as inherent in the model but the variability in experiences can potentially make a definition of services and identification of program and client needs a more variable and complex process.

PAT home visitors have varying levels of experience and training. We anticipate training and technical assistance needs will vary based on specific needs of staff.

NFP challenges, risks, and anticipated technical assistance needs.

The placement of NFP programs in public health agencies provides common characteristics across NFP programs. However, it is anticipated that there are some local program and staff preparation differences that can be addressed through training and technical assistance.

Although public health provides a strong foundation for NFP implementation, public health funding in Washington has been severely curtailed over the past decade. Even with the secure funding represented in these federal funds, the parent organizations implementing NFP are facing severe and continuing demands on maintaining services at current levels.

The NFP program has a detailed and systematic approach to assessment and fidelity. By contrast, NFP's complex existing system is likely to be placed under stress as we accommodate the expanded assessment demands of the federal requirements. Washington's team is confident in the goodwill from the national NFP office in working through these implementation issues with a mutually acceptable plan of action.

References:

- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231). Available at <http://nirn.fmhi.usf.edu>.
- Gomby, D. (2005). Home visitation in 2005: Outcomes for children and parents (Working Paper No. 7). Washington, DC: Invest in Kids Working Group.

Section 4: Implementation Plan for State Home Visiting Program

This section provides a plan for the implementation of Washington’s home visiting program, including a description of how the state will provide ongoing monitoring of the quality implementation of the NFP model and/or the PAT model at the community, agency and participant level.

The approach in Washington is based on developing individual implementation plans customized to the community based on their level of capacity at the onset of this grant. The next section describes the community engagement process, followed by summaries of the initial implementation plans for each of the four communities selected.

Community Planning and Engagement

The Washington team used a diverse cross-section of stakeholders in the development of the state home visiting plan. State-level leadership is provided through a coalition of state agencies and a statewide Home Visiting Advisory Group. At the local level, Washington’s HV team conducted planning conversations with each community to understand their needs, assess their capacity to implement a HV model, and develop implementation plans for their work. As a result of these engagements, each of the four communities selected developed detailed implementation plans complete with staffing structures, logic models, and quality assurance process. *See Attachment F: “Implementation Plan Proposal for Selected Communities”*

State Level Planning and Engagement

The groundwork for engaging communities, organizations, state agencies and key stakeholders began in June 2010. At the request of the Governor, a cross-agency governance structure was established. The heads of the Department of Health (DOH), the Department of Early Learning (DEL), the Department of Social and Health Services (DSHS) and the Council for Children and Families (CCF) serve as decision-making members, and designated directors from each of the four agencies and Thrive by Five Washington (a private-public partner) recommend strategic direction as part of a related Partnership Group. Additionally a Home Visiting Advisory Group engages local program staff, model representatives, consumers, funders, and early learning system stakeholders in the development of the updated state home visiting plan. Members represent the following organizations/affiliation:

- Department of Health
- Department of Early Learning
- Council for Children and Families
- Department of Social and Health Services
- Thrive by Five Washington
- Open Arms Perinatal Services
- Parents as Teachers, State Lead
- Parent Child Home Program, State Lead
- Nurse Family Partnership, Region Manager
- Washington Dental Foundation
- Yakima Valley Memorial Hospital
- Children’s Home Society

United Ways of Washington
Neighborhood House
Ready by Five Yakima
Jamestown S’Kallam Tribe
Tulalip Tribal Council
King County Children and Family Commission
Seattle King Department of Public Health
St James Family Center
Fight Crime: Invest in Kids Washington

As part of the community/model selection process, Washington engaged local communities in significant dialogue to better understand the needs in their local communities and the capacity of the evidence-based models to implement with fidelity. The initial selection of at-risk communities, described in Section 1, prioritized a subgroup of seven communities based on their at-risk ranking (using the HV Needs Assessment) and the presence of model(s) that meets the criteria for evidence-based according to MIECHV in the community. In the second stage of the selection, the communities selected were invited to participate in Community Needs and Community Capacity Assessment process to identify community strengths, needs and priorities.

Engaging At-Risk Communities in Regional Planning Conversations

Local birth-to-3 planning entities (infant/toddler regions), provided specific information about community strengths, risks and priorities. An explanation of these infant/toddler regions, and a summary of the comments they provided, are included for each of the targeted at-risk communities in Section 1.

Engaging Communities to Assess Capacity to Implement the Evidence-Based Home Visiting Model with Fidelity

Fidelity is, “... the degree to which a program as implemented corresponds with the program as described” (2005 National Implementation Resource Network). Research supports that implementation with fidelity is correlated with better model specific results and outcomes. Implementation with fidelity includes approaches and tools to assess the degree to which the program is being implemented as described (from January 9, 2008, National Implementation Research Network webinar “Bringing the Message Home: The Role of Fidelity in Quality Improvement efforts.) Therefore, to work towards EBHV model specific outcomes, EBHV models and programs implementing these models must routinely assess their capacity to implement with fidelity.

Washington engaged in a process of assessment of region/community capacity to implement the EBHV model with fidelity. The Washington team developed the “Community Program(s) Capacity Assessment to Implement the EBHV Model” (Capacity Assessment). *See Attachment E: “Community Program Capacity Assessment to Implement the EBHV Model”*

Model representatives from the EBHV programs worked with the seven semi finalist at-risk communities (please see Section 1, for selection of MIECHV Communities). If more than one organization in the community was implementing the same model, they worked together to communicate their capacity to implement the EBHV model with fidelity. Technical assistance was provided to the communities and the model leads to assist in this process. *See Attachment G: “Community Program(s) Capacity Assessment Technical Assistance Q & A”* The Capacity

Assessments provided an initial “self report” from model representatives and semi-finalist communities identifying resources available to implement the EBHV model with fidelity.

A template helped the review of community needs information provided by the infant/toddler regions and the Community Capacity Assessment. Reviewers then provide an overall “HIGH,” “MEDIUM” or “LOW” ranking for recommendation of final selection of regions/counties. *See Attachment H: “Community Need and Capacity Assessment Review”*

Selected Region(s)/County(s) and EBHV Models

Based on the results of the assessment process described above, the following four communities and two evidence-based home visiting models were selected for funding in the first year of the MIECHV program.

Region/County, Lead Agency, EBHV Model, and Projected Number of Families

| Region/County | Lead Agency | EBHV Model | Projected Number of Families |
|--|--|--------------------------|-------------------------------------|
| 1. Yakima County (NFP) | Yakima Valley Memorial Hospital | Nurse Family Partnership | 10-12 families |
| 2. Yakima County (PAT) | Parent Trust for Washington Children | Parents as Teachers | 25 families |
| 3. Pierce County - Council Districts: 2, 4, 5, 6 | Tacoma-Pierce County Health Department | Nurse Family Partnership | 25 families |
| 4. Snohomish County - North Everett | Snohomish Health District | Nurse Family Partnership | 25 families |
| 5. King County - South: American Indian/Alaska Native, African American women | Seattle King County Department of Public Health, dba Public Health Seattle-King County | Nurse Family Partnership | 50 families |

Implementation Plan Development

Next, communities were directly involved with implementation planning. For each community and model selected for funding, a baseline “Implementation Plan” (IP) was required. We adapted questions from the FRIENDS National Resource Center’s Tool for Critical Discussion (Discussion Tool), with some enhancement based on information required in the SIR.

The following information was gathered for each region/county and EBHV model.

1. EBHV Model, Selected Community/Region, Organization(s) Information
2. Assurances of Voluntary Participation and Prioritization of Participants
3. Funding Requirements for Services Supported with MIECHV Funding
4. Existing Resources
5. Participant Outreach, Engagement, Assessments and Timeline to Reach Maximum Caseload
6. National EBHV Model Developer, Technical Assistance and Support
7. Staff Recruitment, Training and Retention
8. Clinical Supervision and Reflective Practice
9. Monitoring, Assessing and Supporting Implementation with Fidelity and Ongoing Quality Assurance

- 10. Evaluation, Data Management and Ongoing Continuous Quality Improvement
- 11. MIECHV Implementation Plan Proposal Budget
- 12. MIECHV Draft Logic Model—Resources, Activities and Outputs Only

The process was similar to the Capacity Assessments process previously discussed. The EBHV model representative coordinated program(s) in the selected region/county implementing the EBHV model and provided model specific technical assistance. Each selected community/region implementing the EBHV model and the EBHV model representative were also provided technical assistance by Thrive by Five Washington to complete implementation plans. *See Attachment H: “MIECHV Implementation Plan Final”*

Region/County Baseline Implementation Plans

Implementation science is the specific area of practice research addressing how to successfully translate the promise of evidence-based programs into reliable high-impact program delivery. Reviews of home visiting’s current practices identify challenges to dissemination of evidence-based programs in routine practice. Such dissemination challenges are common across all evidence-based practice fields, and NFP and PAT programs are no exception.

This initial process of implementation planning with communities validated that communities and EBHV models have varying levels of capacity to implement with ‘fidelity.’ The following pages provide details regarding the state-level implementation of the program and the implementation of the NFP and PAT models at the community, agency and participant levels for each of communities/regions selected. The information presented was compiled from the comprehensive implementation plans provided from each of the four selected communities in *Attachment F: “Implementation Plan Proposal for Selected Communities”* These individualized plans will be used to begin the CQI process. (See Section 7 for details regarding implementation of CQI and provision of technical assistance.)

| | Lead Agency: | EBHV Model: | Families Served: |
|-------------------------------|---------------------------------|--------------------|-------------------------|
| 1. Yakima County (NFP) | Yakima Valley Memorial Hospital | NFP | 10-12 families |

A. Staffing and Supervision Plan for Implementation

NFP Yakima Implementing Programs

- .10 NFP Nurse Supervisor (bilingual in Spanish).4 NFP Public Health Nurse (bilingual in Spanish)
- Certified Lactation Consultant (IBCLC)
- NFP Administrative Support

WA State Positions Assisting Yakima NFP

- Thrive by Five Washington
- Washington State University Area Health Education Center

NFP State Positions Assisting Yakima NFP

- NFP Washington State Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program.
- NFP Washington State Nurse Consultant provides technical assistance around clinical and implementation issues (not yet in place in Washington)
- NFP Washington State Consortium

National Assistance

- NFP NSO Program Consultant in Program Quality

Recruitment and Hiring

NFP standards require that nurses have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, nurses must have completed the NFP training. It is helpful if candidates have prior experience providing home visiting services to at-risk pregnant women and new mothers and have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. Yakima NFP requires that a minimum of 50 percent of the staff be bilingual/bicultural nurses to deliver the program in the client's preferred language, as well as to meet the needs of the client's family. The program has adequate bilingual/bicultural staff, and has been successful in recruiting qualified bilingual staff. The nurse supervisor is bilingual, and is able to complete supervised joint visits in Spanish, ensuring the quality of the entire program and performance evaluation for individual nurses. All NFP staff complete initial and regular cultural competency training to help them meet the needs of the diverse client population. Yakima has one certified lactation consultant on the team.

Although recruitment of experienced nurses with bilingual/bicultural skills has been and remains a challenge, both agencies support local educational programs and efforts to bring more local individuals into nursing programs.

Staff Retention

Yakima NFP has maintained a low level of staff turnover. The program uses the National Implementation Research Network (NIRN) stages of implementation to perform organizational self assessment and identify opportunities for improvement in staff selection, training, coaching, and performance assessment. Based on the high level of mental health needs of clients, and the need to support nursing staff as they work with high-need clients and families, the program has developed and integrated a successful mental health consultant model, which has undoubtedly contributed to client, nurse and supervisor retention.

Plan for NFP Clinical Supervision & Reflective Practice

The NFP NSO model elements state: Nursing supervisors must provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-on-one clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

The Yakima County NFP maintains the NFP NSO expectation for nurse supervisor-to-staff ratio of no more than eight nurse home visitors per supervisor. The Yakima County NFP supervisor

provides the required activities for nurse supervision including weekly hour-long one-to-one reflective supervision, program development, referral management and other administrative tasks. The Yakima County NFP nurse supervisor also plans and leads monthly case conference and team meetings, as well as completes field supervision (joint home visits) quarterly with each nurse, using the NFP Visit Implementation Scale.

The YCNFP nurse supervisor provides this supervision. The frequency and duration of reflective supervision are weekly one-hour sessions with each nurse. Case conference and team meetings occur weekly for 2.5 hours. Joint home visits for field supervision occur at least three times per year for each nurse.

Fidelity Monitoring & Quality Assurance Through the National Model Developer:

NFP Yakima collects data and enters into ETO and engages in a CQI process for clinical practice. Data are used to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which nurse home visitors and supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both supervisors and nurse home visitors will review and utilize their program data in conjunction with the NSO nurse consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional Evaluation Efforts:

- **Council for Children and Families (CCF) State Funded EBHV Participatory Evaluation with Washington State University Area Health Education Center (WSU AHEC):**

WSU AHEC is currently conducting the evaluator for the CCF evidence-based home visiting portfolio of programs. Yakima Valley Memorial Hospital NFP is participating in evaluation of home visiting programs through CCF/WSU participatory evaluation. The CCF evaluation work specifically addresses the program impact and process of quality improvement in 11 programs, in six communities, implementing four home visiting models.

The CCF effort served as a critical test program for understanding the challenges and benefits of home visiting as a prevention and early intervention strategy for increasing numbers of Washington's most at-risk children and families. The lessons learned through the collaborative implementation and evaluation of the portfolio approach is vital to our state as we continue to build from this foundation.

The evaluation thus far demonstrates that CCF-supported evidence-based home visiting programs are well-established and successful community services that are reaching their intended clientele. Consistent with the published home visiting literature, local programs face a variety of staff, client, and resource challenges that are significant impacts on program focus, implementation fidelity, and potentially on program benefits. The evaluation supports the conclusion that all programs are working to deliver their model with rigor and attention to the model's standards but that success in our efforts requires

continued vigilance on implementation with fidelity and continuous quality improvement practices at the agency level.

B. Training and Curricula

NFP Training

The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Supervisors are required to attend an annual education session in Denver. Team meeting guidance is also supplied to supervisors so they can provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules on demand.

The NHV and supervisor have received training and are certified in NCAST. Each nurse has completed cultural competency training, and bilingual staff have demonstrated competency to deliver the service in Spanish.

Timeline for Obtaining Curricula

Yakima County has already secured the required training curricula for the program and has established a strong collaborative relationship with the NFP NSO to implement the *Nurse Family Partnership Visit to Visit Guidelines* curricula. The Yakima team has also secured curricula to present trainings on the *Partners in Parenting Education* (PIPE) curricula.

C. Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach Plan to Reach the At-Risk Yakima Population Identified by the NFP Program

All services will be provided on a voluntary basis. In Yakima County the NFP nurse supervisor disseminates program services and referral information to local community resources that come in contact with and /or serve low-income women. All of these groups serve Hispanic, Native American, and white low-income first time moms. Included in current outreach efforts are: family practice providers, obstetrical providers, family physician groups, local residency program, all local First Steps providers, which include Maternity Support Services and WIC. This outreach occurs on a regular basis, at least quarterly. Monthly contact is made with local First Steps providers. Efforts are made to make a face-to-face contact with medical providers each year. Yakima County NFP has a strong relationship with Indian Health Services, both through the medical clinic, where one of the nurse practitioners refers clients monthly, and the public health nursing office, who also refer clients on a regular basis. The Nurse Supervisor has scheduled a meeting with the Indian Health Services WIC Registered dietician, which will occur in June or July of this year.

The Nurse Supervisor or one of the PHN’s attend the monthly Perinatal Task Force meeting, with opportunity for brief updates at each meeting (community meeting with providers who serve pregnant and parenting families). The NFP nurse supervisor attends the Yakima Valley Farm Workers Clinic Community Health Services (Yakima Lincoln Avenue site nurses,

registered dietitians, and maternity case managers) weekly staffing meetings, where they discuss new pregnant clients who are receiving prenatal care at YVFWC clinics. The first-time moms are staffed with the CHS team and the referral given to NFP. The nurse supervisor also meets with the CHS nursing supervisor at the Toppenish YVFWC office to discuss referral coordination. These activities with YVFWC target primarily the Hispanic population, and Spanish speaking clients, but their clinics serve all at-risk populations targeted for Yakima County.

Outreach efforts are also directed at other organizations who come in contact with young women including: Catholic Family Services (family and child therapy services); local high school nurses and counselors; pregnancy testing clinics, alternative high school programs, domestic violence shelter, homeless teen shelter; and local community centers who offer services to youth. These contacts are made on a rotating basis, but occur at least annually. Outreach efforts are reinforced by the public health nurse when coordination occurs around enrollment, and when situations arise where personal contact is necessary. These relationships in the community are invaluable.

Plan for Recruitment and Engagement of the “At-Risk” Population Identified

The Nurse Supervisor will continue the efforts listed above, with increased attention to maintaining and building the relationships with Indian Health Services staff and Yakima Valley Farm Workers Clinic by continuing the above strategies, as well as widening the scope of people we interact with in their respective organizations. The NFP National Service Office provides great support in the way of outreach materials for community providers as well as potentially eligible clients. The program takes advantage of these materials, making sure there are ample supplies at all of the community locations listed. The NFP program works diligently to make sure all community providers and potential referral sources have up-to-date information about services and how to contact them. Providers at these agencies will inform potential clients of the existence of and services provided by the NFP program and ask their permission to send in a referral. Additionally, the NFP program supervisor is available to talk by phone to potential clients to describe the program and learn about family needs. If a client is referred by a trusted source and face-to-face contact can occur in a confidential setting at the client’s convenience, there is a higher enrollment rate. The program continues to identify additional strategies to reach out to the highest risk populations, homeless and mobile clients, and clients who have not yet informed their families or support systems of their pregnancies.

Plan for Individualized Assessments of Enrolled Participant Families

The following is a list of individualized assessments of enrolled participants in NFP services in Yakima:

NFP data collection forms including:

| | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools:

NCAST (Nursing Child Assessment Satellite Training) feeding scale
NCAST (Nursing Child Assessment Satellite Training) teaching scale

NCAST Difficult Life Circumstances
NCAST Community Life Skills Scale
Ages & Stages Questionnaire
Ages & Stages Social Emotional Questionnaire
Center for Epidemiologic Studies Depression Scale (CES-D)
Edinburgh Postnatal Depression Scale

Plan for Referrals to Services

Individual assessments are conducted with clients and their children according to NFP visit guidelines and data collection schedules. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings. If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available, will offer information and support, and refer to Children’s Village for a complete developmental assessment.

Estimated Timeline to Reach Maximum Caseload

Yakima County NFP would estimate that we would reach full caseload of 10 to 12 additional clients in four to five months. If start date is October 1, 2011, and two to three new clients enrolled per month, full caseload would be attained by January or February 2012.

Attrition Rate of Participants and Plan for Minimizing Attrition

The average rate of attrition for program participants in Yakima NFP is:

| | |
|------------------|-------|
| Pregnancy Phase: | 9.8% |
| Infancy Phase: | 22.0% |
| Toddler Phase: | 16.7% |

An improvement plan is in place for minimizing attrition rates based on the data received from NFP NSO, and the ETO system. This allows for thoughtful and purposeful reflection on root causes of attrition challenges. The team has noted improvement plans for increasing the ratio of completed to expected visits also have a positive impact on reduction of attrition rates. These improvement plans include enrollment strategies, focused attention to weekly visits postpartum, and using Partners in Parenting Education activities, to keep clients engaged in the visits. Yakima County NFP nurses have noted that with young teen clients, spending more time in

activities which teach the mom how to “play and learn” with her baby keeps them engaged and decrease attrition. The team has also identified incorporating Motivational Interviewing techniques into home visits, which may further decrease attrition rates. New client-centered visit guidelines introduced in the last 18 months, which increases client choice in the topic areas covered at home visits, may decrease in attrition over time. The nurses report increased client satisfaction with the new “facilitators,” or discussion handouts. The new handouts/facilitators provide increased opportunity for open-ended questions, which then continues to build the trusting relationship between the nurse and client.

D. Operational Plan for Coordination between Local Home Visiting Program and other Social Service and Health Agencies

For a detailed response to this question, please see “Plan for Coordination Among Existing Programs and Resources,” and “Local Capacity to Integrate Home Visiting Services into an Early Childhood System” under “1. Yakima County” in Section 1.

| | | | |
|-------------------------------|--|--|--|
| 2. Yakima County (PAT) | Lead Agency: Parent Trust for Washington Children | EBHV Model: Parents as Teachers | Families Served: 25 families |
|-------------------------------|--|--|--|

A. Staffing and Supervision Plan for Implementation

PAT Yakima Implementing Programs

- .5 FTE PAT Supervisor
- 1 FTE parent educator

WA State Positions Assisting PAT Yakima

- Thrive by Five Washington
- Washington State University Area Health Education Center

PAT State Assisting PAT Yakima

- The *WA PAT State Leader* provides technical assistance and training on a part-time basis for the 28 PAT programs in WA)

National Assistance

- National PAT provides guidelines and requirements for model fidelity and quality implementation.

Staff Recruitment

National Parents as Teachers recommends that parent educators have at least a bachelor’s degree or four-year degree in early childhood or a related field. However, it is also acceptable for parent educators to have a two-year degree or 60 college hours in early childhood or a related field. Supervised experience working with young children and/or parents is also recommended. *This is part of the new Essential Requirements for Affiliates.*

All three PAT programs in Yakima have existing staff to implement the federal project. All PAT staff in the three PAT sites in Yakima must complete all necessary model specific training/re-training by December 8, 2011, to meet national PAT requirements to be eligible for MIECHV funding. All PAT required trainings should be completed by October 1, 2011, for the Yakima PAT programs participating in the MIECHV program.

Subcontractors: The PAT programs in Yakima may use subcontractors to provide hearing screenings that will be required according to the new *Essential Requirements*. Hearing checks are no longer acceptable. The hearing screening must now be performed either by otoacoustic emissions (OAE) or pure tone audiometry. Given the cost of these required tools, PAT sites will consider partnering with Early Head Start health care providers, Kids Screen, school nurses or other appropriate organizations to coordinate and obtain hearing screening for enrolled children.

Staff Retention

Competitive wage and benefit packages, performance based annual wage increases, ongoing professional development opportunities and a true passion for their work assures low staff turnover.

Plan for PAT Clinical Supervision & Reflective Practice

The PAT supervisor directs, coordinates, supports, and evaluates the on-the-job performance of parent educators. A combination of education, work experience and effective interpersonal and communication skills is critical for the supervisor as well. For the supervisor, a college degree or beyond in early childhood education, elementary education, behavioral or social sciences or a related field is recommended. He or she must also successfully complete the *Model Implementation Training*, and it is strongly recommended to complete the Foundational Training. In addition, the supervisor must demonstrate the ability to work with adults and young children.

PAT guidelines state a maximum of 12 parent educators can be assigned to each full-time supervisor. It is essential that each month, parent educators participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings.

Yakima Parents as Teachers (PAT) programs are meeting and exceeding the requirements of the model. Supervisors meet with parent educators on a weekly basis (60 to 90 minute meetings), and most parent educators also take part in agency-wide weekly staff meetings. Supervisors observe home visits quarterly and also attend at least one group meeting quarterly. Meetings are used to review caseloads, monitor family documentation, and assist the parent educator with any issues or challenges that may be happening. Currently the three PAT programs have a total of 1.5 FTE supervisors supervising 7 FTE parent educators.

Fidelity Monitoring and Quality Assurance Through the National Model Developer

National PAT provides guidelines and requirements for model fidelity and quality that establish a comprehensive blueprint for quality implementation of PAT. The *Quality Assurance Guidelines* and *Essential Requirements* represent the programmatic elements necessary for model fidelity and will be used to guide the development and growth of a PAT affiliate and the completion of an *Affiliate Plan*. Affiliates annually report data on service delivery, program implementation, and compliance with the model replication requirements through the *Affiliate Performance Report*, a web-based reporting system. Timely reporting requires that the *Report* be

completed by July 31. All state PAT programs submit their report to the *WA PAT State Leader* who verifies its completeness and then submits to the national center.

PAT fidelity tracking and quality: Ongoing affiliation with PAT requires regular program self-assessment. To assist with this, National Parents as Teachers has developed a self-assessment process and tools. Every four years, affiliates must engage in an expanded program assessment, incorporating additional data, stakeholder input and documentation review to support the findings of their annual assessment.

Additional monitoring, assessing and supporting implementation with fidelity to the chosen model and maintaining quality assurance: PAT Yakima sites are currently being provided in additional support for implementation with fidelity to the PAT model. Aligning the work for PAT implementation with fidelity will be part of the focus for the data benchmark work we are proceeding with in Washington. The following additional support is currently being provided to Yakima PAT programs:

PAT Implementation in WA CQI: The HVSA is currently working with a consultant to facilitate conversations with all PAT programs in Washington assessing current strengths and challenges of PAT home visiting model implementation in Washington. The purpose of these conversations is to identify and propose approaches for PAT model specific technical assistance to help ensure consistent quality implementation and continuous quality improvement.

Conversations also are being held with key stakeholders to help frame an approach. Key players in the state include:

- Funders of PAT programs, including Thrive by Five Washington and CCF
- WSU, the overall evaluator of home visiting programs in the state
- Organizations implementing PAT that are currently being funded by Thrive, the CCF, as well as others participating in the Home Visiting Coalition (e.g., Children’s Home Society)
- The PAT model representatives and national office

A proposed continuous quality improvement strategy for strengthening PAT quality implementation in Washington will be completed by July 2011.

B. Training and Curricula

Training

New as of January 1, 2011: Parent educators and supervisors certified prior to January 1, 2011, who are with an existing program, must attend *PAT Foundational Training* and a *Model Implementation* re-training (Supervisors are only required to attend the Model Implementation, but *strongly* advised to complete Foundational Training as well). Also, to satisfy requirements for affiliate status, all parent educators must complete training in the Ages and Stages 3– both developmental and social emotional Questionnaires (ASQ-3); the Edinburgh Post Natal Depression Screening; and a Family Assessment Screening tool (LSP recommended by national). *New PAT programs must complete and receive approval for the affiliate plan by the WA PAT State Leader before any training is scheduled.*

All parent educators and supervisors must complete 40 hours of PAT certification training before implementing PAT. Certified parent educators must also complete in-service professional development hours annually to maintain their certification. The training focuses on replicating the PAT model with fidelity. Demonstrating accountability, evaluation and outcomes are themes woven throughout.

Training and Ongoing Professional Development Activities Provided by the Implementing Organizations

CPR trainings, personal safety, *Promoting First Relationships*, *Creative Curriculum*, and other relevant skill-building in-service workshops are provided by Parent Trust for Washington Children, Thrive, Catholic Family and Child Services, Educational School District 105 and other local agencies.

Initial and Ongoing Training and Professional Development

Through the national PAT, as well as through the *WA PAT State Office*, Parents as Teachers offers several resources that provide guidance for those implementing the model:

- PAT *Foundational Training* and a *Model Implementation* re-training (Supervisors are only required to attend the Model Implementation, but *strongly* advised to complete Foundational Training as well)
- To satisfy requirements for affiliate status, all parent educators must complete training in the Ages and Stages 3– both developmental and social emotional Questionnaires (ASQ-3); the Edinburgh Post Natal Depression Screening; and a Family Assessment Screening tool (LSP recommended by national).
- Technical assistance supporting initial implementation, including development and approval of the initial *Affiliate Plan*. It is designed as a logic model, linking inputs, activities, outputs and outcomes for families.
- Technical assistance around monitoring, assessing and supporting implementation with fidelity to the model and maintaining quality assurance - *Quality Assurance Guidelines*.
- Technical assistance regarding meeting the *Essential Requirements* (identified as best practices to ensure model fidelity).

Initial and Ongoing Technical Assistance and Support Provided to Yakima PAT

The *WA PAT State Leader*, who is part time, for 28 PAT programs in WA provides technical assistance to monitor compliance with PAT *Essential Requirements* and promote continuous quality improvement. The *WA PAT State Leader* provides technical assistance to each program site through phone/email support and training and individual site visits. The *WA PAT State Leader* provides monthly training calls with all WA State PAT programs. Trainings include updates regarding curriculum, state home visiting news and advocacy, news from PAT national office, and any upcoming training opportunities. An eight hour state-wide PAT training will be held yearly during the federal project. This training will include a variety of professional development opportunities; technical support for assessment tools being used, evaluation, data

management; showcase state-wide resources that are available for enhancements to PAT curriculum; and time for program networking.

The *WA PAT State Leader* is in contact with national office via phone and email. PAT national webinars are scheduled with State Leaders every three months. The *WA PAT State Leader* is also required to attend an annual national conference to receive ongoing training.

Timeline for Obtaining Curricula

Parent Trust for Washington Children has already secured the needed supply of *PAT approved Foundational/Model Curriculum* for Yakima programs implementing with the MIECHV funding.

C. Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach Plan to Reach the At-Risk Yakima Population Identified by the PAT Programs Include:

- All services will be provided on a voluntary basis.
- All families on each program's wait list will be called and screened for appropriateness, according to PAT model specifics and requirements of the federal funding project.
- PAT Supervisors and/or parent educators will participate in monthly meetings for joint coordination and project support with *WA PAT State Leader*. This meeting is in addition to the monthly state-wide meeting for all PAT programs.
- PAT Program Managers and/or Supervisors will participate in ongoing consortium and initiatives' monthly meetings to increase awareness and referrals.
- EBHV Yakima programs will work together to create a brochure/flyer for distribution to local medical providers, WIC, schools and other family service providers that will identify target populations and provide information about services available (Model leads will coordinate this effort).
- In lower Yakima Valley, YVFC PAT will continue to connect with all lower valley school districts through their *Readiness to Learn* program.

Recruitment and Engagement Plan for the "At-Risk" Population Identified

It is the policy of PAT to provide services in a culturally competent manner. In Yakima County, staff are bilingual in English and Spanish and have an understanding of the cultural beliefs and differences of the Hispanic and Native American groups they are serving. Educators use a flexible schedule to work around the migrant family's work schedule, including some evenings and weekends. All three PAT programs are currently recruiting and engaging "at-risk" families by hiring and maintaining high-quality and culturally competent staff, and collaborating with key consortiums and initiatives.

Plan for Individualized Assessments of Enrolled Participant Families

During the initial home visit, the PAT parent educator and the mother and/or father complete an enrollment agreement, which includes demographics and household information, family size, source of income, living situation, level of education for mother and/or father, cultural considerations, transportation, and access to resources. During the first few visits, the parent

educator is able to develop a more thorough assessment of the family—ethnic, cultural, and special needs, and areas of concern in the family’s life. The assessment is used to individualize services by adapting each home visit to meet the needs of parents and children within their family systems. Ongoing assessment of the family’s strengths and needs, as well as the infant/toddler’s developmental progress, occurs as part of each home visit and is recorded in the PAT *Personal Visit Record*. The Universal Risk Assessment (URA) is currently also being used by CFCS PAT. **New PAT Affiliate *Essential Requirements* mandate that all parent educators complete and document a family-centered assessment and family-centered goals with each family that they serve. All three PAT sites will begin using an evidence-based assessment tool approved by national PAT and selected by the *Evaluation/Benchmark Team for this project.***

Plan for Referrals to Services

Currently, services are indicated by enrollment information, scores from the URA, and other screening scores. These currently include assessment scores from formal health, vision, hearing, home safety and developmental and social emotional tools. Parent educators maintain active collaboration with all community resources to complement and extend PAT services. Referrals are documented on the *Personal Visit Record* of each family and re-visited at the next home visit to see if referral services were accessed. Parent educators also assist families overcome any barriers to access.

Timeline to Reach Maximum Caseload

Yakima County PAT estimates reaching a full caseload of 25 additional clients within six months from start date of grant.

** This timeline is estimated with the assumption that PAT sites will have completed PAT model specific re-training and training for all other Affiliate status requirements before October 1.*

National PAT requires that any PAT program that is included in the State Implementation Plan meet all Affiliate status requirements by December 8, 2011, but new families to be included in the federal project cannot receive required PAT components until all training is completed.

Attrition Rate and Plan for Minimizing Attrition

For the Yakima programs, the average rate of attrition is 10 to 12 percent annually. Current attrition rates are extremely low, considering the migrant population that is served. This includes families who move out of the area, and families who can no longer be located.

To provide service to parents who work certain months in the fields, the plan is to increase availability for evening and/or weekend visits for those families, make phone contacts with parents during the months when they are working in the fields, and provide visits with enrolled children at relative caregivers. For families showing disengagement behavior, parent educators attempt to reengage them in a three-part process that includes a drop-in personal visit, phone contact, and then a letter with a possible termination date if no re-engagement is made. As stated above, after a family has exited, a new family will be enrolled from the waiting list and/or recruited from a variety of referral services to maintain a full caseload.

D. Operational Plan for Coordination between Local Home Visiting Program and other Social Service and Health Agencies

For a detailed response to this question, please see “Plan for Coordination Among Existing Programs and Resources,” and “Local Capacity to Integrate Home Visiting Services into an Early Childhood System” under “1. Yakima County” in Section 1.

| | | | |
|---|---|--|--|
| 3. Pierce County - Council Districts: 2, 4, 5, 6 | Lead Agency: Tacoma-Pierce County Health Department | EBHV Model: Nurse Family Partnership | Families Served: 25 families |
|---|---|--|--|

A. Staffing and Supervision Plan for Implementation

NFP Pierce County Implementing Program

- 1.0 FTE Public Health Nurses
- .125 NFP Supervisor
- .125 Administrative Support

WA State Positions Assisting NFP Pierce County

- Thrive by Five Washington
- Washington State University Area Health Education Center

NFP State Positions Assisting NFP Pierce County

- NFP Washington State Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program.
- NFP Washington State Nurse Consultant provides technical assistance around clinical and implementation issues (not yet in place in Washington)
- NFP Washington State Consortium

National Assistance

- NFP NSO Program Consultant in Program Quality

Staff Recruitment

Per NFP and Tacoma Pierce County Health Department (TPCHD) standards, nurses must have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, Public Health Nurses (PHN’s) must have completed the NFP training. Successful candidates must have prior experience providing home visiting services to at-risk pregnant women and new mothers. They must have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. They must have a strong grounding in infant and child development, promotion of breast feeding, and health promotion. Bilingual skills in Spanish or Pacific Islander languages would be beneficial. They must pass a law enforcement background check.

Although there is a robust NFP program with 6.5 FTE public health nurses and 1.2 NFP Nurse Supervisors providing NFP services now, TPCHD will be hiring an additional nurse with the MIECHV dollars. Additionally, another .5 – 1.0 FTE nurse will be added to the NFP Team. The goal is to be at 8.0 FTE or more by October 2011.

The MIECHV-funded NFP nursing position will be posted on the employment section of the Health Department website, using the standard hiring process for all positions at the Health Department. The posting will occur when the contract is in place. The Board of Health (BOH) must approve the additional FTE before it can be posted. Presumably, that agreement will occur by the end of August 2011, and the FTE can be approved by the BOH at the September 7 meeting. The posting would occur immediately following that meeting.

Once the applicants have been screened for eligibility, and the top ten candidates have been screened by our Human Resources Department, an interview panel of two NFP Nurses and two NFP Nursing Supervisors will interview the candidates. They will select finalist(s) for a second interview by the Division Director and the Program Manager, who will make a final hiring decision.

Note: There are four public health home visiting nurses currently on staff eligible to apply. There are many other public health nurses on staff who may also apply.

Timeline for obtaining all necessary training for new staff to implement NFP: The NFP public health nurse will complete Unit 1 of the training on-line and read NFP-provided materials. Unit 2 is provided in Denver and is available the weeks of Sept 12, Oct 17 and Nov. 14. TPCHD would prefer to employ the nurse in time to attend the September 12 training. However, typical staff hiring can take two months for the full process. If the contract is signed later than expected, Unit 2 training will occur during the week of Nov. 14. Once Unit 2 is completed, Unit 3 is completed on site and further training is provided through reflective supervision, online training, and participation in weekly NFP Team meetings.

Staff Retention

There are a variety of elements that assist with retention. The staff that provides the NFP program has a vested interest and commitment to the program, and the families they serve. Another factor is a flexible work schedule and shifts. TPCHD provides biannual retreats to promote team building and positive staff reinforcement. The NFP program provides weekly reflective supervision for ongoing positive reinforcement and staff building. Additionally, many staff members at our site are long time employees and are vested in their retirement. Staff report the ability to take leave when desired is also a benefit.

A quote from one of the NFP NHV's in regards to retention. "I work with a group of women with a great deal of experience that I respect. Our supervisor leads in such a way I feel fulfilled while having fun at work."

Plan for NFP Clinical Supervision and Reflective Practice

NFP Model element 14 refers to required supervision provided to NHV's. This includes weekly hourly reflective supervision, weekly case conference/team meetings, and quarterly joint home visits.

Reflective supervision consists of a weekly 60 minute one-to one session between the nurse and supervisor. During this time the NHV and supervisor reflect on a nurse's work, including management of caseload, quality assurance of program implementation, and clinical competence.

Case conferences and team meetings are dedicated to administrative needs, program implementation, team building, joint review of cases, and the review of ETO reports and problem solve, identify solutions, and support professional growth. The 90-minute team

meetings and case conferences alternate weekly so there is one meeting per week on Wednesdays.

Joint home visits with the supervisor and nurse take place on a quarterly basis. The supervisor makes a visit with each nurse to at least one client and additional visits on an as-needed basis at the nurse's request or if the supervisor has concerns. The objective is to adhere to the quality assurance of program implementation and clinical competence.

Reflective supervision is provided at the site by the two NFP supervisors. The current ratio is 1:6 and 1:1 with room for additional NHV's for each supervisor. Reflection is regularly scheduled on a weekly basis. Reflective supervision is scheduled for one hour but can be extended if needed. Supervisors also maintain an open door policy so staff can debrief as needed.

Fidelity Monitoring & Quality Assurance Through the National Model Developer:

Data are collected, entered into ETO system, and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which Nurse Home Visitors and Supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision sessions. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both Supervisors and Nurse Home Visitors will review and utilize their program data in conjunction with the NSO Nurse Consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional Evaluation Efforts:

Council for Children & Families (CCF) State Funded EBHV Participatory Evaluation with Washington State University Area Health Education Center (WSU AHEC):

WSU AHEC is currently conducting the evaluation for the CCF evidence-based home visiting portfolio of programs. Tacoma Pierce County Health Department (TPCHD) NFP is participating in evaluation of home visiting programs through CCF/WSU participatory evaluation. The CCF evaluation work specifically addresses the program impact and process of quality improvement in 11 programs, in six communities, implementing four home visiting models.

The CCF effort served as a critical test program for understanding the challenges and benefits of home visiting as a prevention and early intervention strategy for increasing numbers of Washington's most at-risk children and families. The lessons learned through the collaborative implementation and evaluation of the portfolio approach is vital to our state as we continue to build from this foundation.

The evaluation thus far demonstrates that CCF- supported evidence-based home visiting programs are well-established and successful community services that are reaching their intended clientele. Consistent with the published home visiting literature, local programs face a variety of staff, client, and resource challenges that are significant impacts on program focus, implementation fidelity, and potentially on program benefits. The evaluation supports the conclusion that all programs are working to deliver their model with rigor and attention to the model's standards but that success in our efforts requires continued vigilance on implementation with fidelity and continuous quality improvement practices at the agency level. TPCHD is also engaging the HVSA evaluation also overseen by WSU AHEC.

Tacoma Pierce County Health Department NFP Evaluation

In addition to submitting all required data to the NFP ETO national database, and participating in WSU AHEC evaluation, TPCHD tracks all services and outcomes through two internal databases within the organization: the Nightingale Notes (using the Omaha System) and a Maternal Child Health database. Within the Health Department, the NFP program has been responsible, over the last four years, of documenting recommended child immunizations. The NFP supervisor reviews data from ETO quarterly. These data reflect whether fidelity markers were/were not met, i.e. gestational age at enrollment, client is first time mother, voluntary enrollment. The results are reviewed with the NFP team for fidelity. Through our CCF and Thrive grants we are currently participating in program evaluation with WSU.

The most recent quality improvement project evaluated the time of referral to first contact with client. The objective was to make first contact within 10 days. TPCHD NFP was able to meet the objective after program adjustments, and has sustained above 90% of families receiving first contact within 10 days in all but one quarter. This quality improvement marker is monitored on an ongoing basis in the Nightingale Notes charting system.

B. Training and Curricula

Staff Training:

NFP Training: The NFP National Service Office (NSO) requires the following initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approximately 4 days), Unit 3: onsite “distance learning”. On an annual basis, supervisors are required to attend a supervisor’s education session in Denver. Team meeting education modules are supplied by the NSO for supervisors to provide ongoing topics of continuing education during their monthly team meetings. The NSO also offers on-line learning modules on an as needed basis.

Implementing organization additional training: Trainings provided at our site include: an annual NCAST reliability training by one of our NFP NHV’s certified as an NCAST instructor. TPCHD can also provide ASQ training to new staff. Additional trainings offered on-site include: Advanced Partners in Parenting Education (PIPE), Culture of Poverty, Breastfeeding and Adverse Childhood Experiences (ACEs). Professional development is available on an as desired and as needed basis, including on-line training opportunities. Monthly continuing education training is offered through webinars at team meetings.

Timeline for Obtaining Curricula

TPCHD has already secured the required training curricula for the program and has established a strong collaborative relationship with the NFP NSO to implement the *Nurse Family Partnership Visit to Visit Guidelines* curricula. The curriculum for implementation of the NFP program includes:

- *NFP Visit to Visit Guidelines*
- *PIPE*
- *NCAST (Nursing Child Assessment Satellite Training) feeding scale*
- *NCAST (Nursing Child Assessment Satellite Training) teaching scale*
- *Ages & Stages Questionnaire*

- *Ages & Stages Social Emotional Questionnaire*
- *Center for Epidemiologic Studies Depression Scale (CES-D)*

C. Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach Plan to Reach the “At-Risk” Population Identified by the NFP Program

All services will be provided on a voluntary basis. The Tacoma-Pierce County Health Department NFP Program reaches out to organizations that have contact with and/or serve high-risk, low-income women. Included in current outreach efforts are all Public Health, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving at-risk low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Family Support Centers, TANF community service offices, and other home visiting programs. Outreach is usually timed to be most relevant based on the services each agency provides and on the availability of openings on our NFP nursing caseloads. Outreach to schools generally happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Our NFP supervisors regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Recruitment and Engagement of the Identified “At-risk” Population

The State Home Visiting Needs Assessment showed four of the seven County Council Districts in Pierce County in the top 10 communities at highest risk compared to the statewide average. The Tacoma-Pierce County Health Department has placed a high priority on conducting outreach to high-risk pregnant women in Council Districts 2, 4, 5 and 6 by allocating discretionary dollars to outreach. Currently two full time social workers from those communities are assigned to outreach. They work closely with medical providers, especially family practice and OB/GYN clinics, WIC sites, Community Healthcare, and the three maternity hospitals in the County (all three located within the target area). This team will be in all the secondary schools regularly, working closely with school nurses and counselors to identify eligible minority pregnant teens. They will also identify community sites where likely clients congregate, i.e. TANF CSO offices, laundromats, parks, community centers, etc. Both social workers are African American and have lived and worked in the target communities most of their lives. A Caucasian social worker will be joining them in August, and another African American community organizational specialist will join the team by September 2011.

Plan for Individualized Assessments of Enrolled Participant Families Conducted:

Following is a list of individualized assessments of enrolled participant in NFP services:

NFP data collection forms including:

- | | |
|---------------------------------|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |

Client Discharge Form Demographics Update Form
Use of Government & Community Services Form

Standardized Assessment Tools:

NCAST (Nursing Child Assessment Satellite Training) feeding scale
NCAST (Nursing Child Assessment Satellite Training) teaching scale
Ages & Stages Questionnaire
Ages & Stages Social Emotional Questionnaire
Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for Referral to Services according to Assessments

Individual assessments are conducted with the client and their child according to NFP visit guidelines and data collection scales. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

If a client scores high on the depression screen the nurse will discuss the results with the client and encourage a referral to behavioral health services with consent of the client. If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local our local child reach or child find program for further evaluation and follow up.

Estimated Timeline to Reach Maximum Caseload

Once the PHN has received the NFP training enrolment of clients begins. The NFP goal is to enroll an average of four families per month with the objective to achieve case load by nine months.

Attrition Rate and Plan for Minimizing Attrition

The average rate of attrition for program participants in TPCHD:

| | |
|------------------|-------|
| Pregnancy phase: | 5.4% |
| Infancy phase: | 20.5% |
| Toddler phase: | 16.4% |

TPCHD staff has been made aware of our attrition data and the NFP objective. The program is currently above NFP objective in the infancy and toddler phase of program. We have completed the NFP module, “client retention” and begun to discuss ideas to increase client retention. There was a discussion about the rationale for attrition when clients return to school or work (an NFP goal). In upcoming meetings the team will review a previous training provided by JoAnne Solchany, author of “Promoting Maternal Mental Health during Pregnancy,” in the training “Reaching the Most Difficult to Reach Families.” Meeting this NFP objective is on our annual evaluation plan from NFP.

D. Operational Plan for Coordination between Local Home Visiting Program and other Social Service and Health Agencies

For a detailed response to this question, please see “Plan for Coordination Among Existing Programs and Resources,” and “Local Capacity to Integrate Home Visiting Services into an Early Childhood System” under “3. Pierce County” in Section 1.

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|--|--|--|--|
| 4. Snohomish County – North Everett | Lead Agency: Snohomish Health District | EBHV Model: Nurse Family Partnership | Families Served: 25 families |
|--|--|--|--|

A. Staffing and Supervision Plan for Implementation

NFP Snohomish County – North Everett Implementing Program

- 1.0 FTE Public Health Nurse (with additional position hired by year 2)
- .125 NFP Supervisor
- .1 Administrative Support

WA State Positions Assisting NFP Snohomish County – North Everett

- Thrive by Five Washington
- Washington State University Area Health Education Center

NFP State Positions Assisting NFP Snohomish County – North Everett

- NFP Washington State Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program.
- NFP Washington State Nurse Consultant provides technical assistance around clinical and implementation issues (not yet in place in Washington)
- NFP Washington State Consortium

National Assistance

- NFP NSO Program Consultant in Program Quality

Staff Recruitment

The NFP NSO model elements require Nurse Home Visitors and Nursing Supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing. They must have a current WA State nursing license and prior to taking NFP clients; they must have completed the NFP training.

The Snohomish Health Department (SHD) currently has 5 NFP trained nurses on staff for a total of 2.8 FTE. One of the current nurses is bilingual in Spanish and is a lactation consultant. Another nurse has a bachelor degree in social work. All five of the nurses have additional training and experience in NCAST, special health care needs, and early intervention. One nurse is trained in Promoting First Relationships. These trainings support skills needed by staff to serve the at-risk community in Snohomish County. There are two additional trained nurses who were laid off in January 2011, and one who retired as a result of the budget crisis. It is the intention of SHD to rehire the full-time bilingual Spanish speaking nurse to serve the North Everett community with this funding. Once the award is received, she could be rehired and initiate service delivery immediately, because of her previous experience and training in NFP and in this community.

Staff Retention

The ongoing reflective supervision and support in continuing education are great strengths that support nurse retention at our agency. Interest in parent child health and improving the trajectories or enrolled families also impacts retention at the agency. Compensation packages, including salaries and benefits are competitive. Parent child health and mental health experience amongst the nursing staff range from seven to 21 years of service.

Plan for NFP Clinical Supervision & Reflective Practice

The NFP NSO model elements state: Nursing supervisors must provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

The Snohomish County NFP supervisor provides weekly reflective supervision with the nursing staff. Reflective supervision is provided for one hour weekly for each nurse. The weekly team meetings, ranging from 60-90 minutes, support the individual reflective process and team reflective process. The nurses use additional reflective supervision as needed for case consultation with the supervisor and with their NFP team members, one on one, or as a team.

Fidelity Monitoring & Quality Assurance through the National Model Developer:

Data are collected, entered into ETO and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which nurse home visitors and supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both supervisors and nurse home visitors will review and use their program data in conjunction with the NSO nurse consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional Evaluation Efforts:

Snohomish NFP: In addition to data collection system within NFP at the NSO, Snohomish County also utilizes the “Insight” software system for data collection, tracking and quality assurance. Snohomish uses the Insight system and the Omaha system to monitor Knowledge, Behavior and Status (KBS) of the clients. KBS ratings and outcomes are monitored for identified problems; caretaking parenting, pregnancy, postpartum, and growth and development at program entry, interim, and closure. Charting, tracking, noting measurement tools, and cross referencing specific indicators to risk factors such as mental health and substance use have been useful for monitoring and evaluating outcomes. For monitoring caseload activities and tracking identified problems and outcomes, measures such as the Center for Epidemiology Studies-Depression (CESD), Parenting Stress Index (PSI), Ages & Stages Questionnaire (ASQ) and Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) has been helpful.

Snohomish County Quality and Fidelity Challenges and Strategies to Address: The largest challenge to fidelity for SHD has been related to funding uncertainty. For the past three funding years, the program has been proposed for elimination and/or reduction. This has been disruptive to the NFP program, the agency and the community. In January the program was reduced from 5.3 FTE of nursing to 2.8 FTE of nursing due to cuts in local and private funding levels. The proposed strategy for this challenge is to obtain additional funding streams such as this federal funding opportunity, to diversify the funding portfolio, and to rebuild, sustain and expand the program in this high need community. Additionally, another challenge for this agency has been staff maternity leave. SHD experienced 10 deliveries of babies in a course of 10 years amongst NFP staff, resulting in some challenges for implementation with fidelity.

B. Training and Curricula

Staff Training

NFP Training: The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning,” Unit 2: face-to-face session in Denver (approximately four days), Unit 3: onsite “distance learning,” and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or training in another dyadic measurement tool (currently in development). Annually, supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

Implementing Organization Additional Training: All of the nurses have completed the required NFP training. SHD provides quarterly parent child health trainings and bi-annual all staff and community health trainings. Three of the nurses attended an early intervention and infant mental health training this year. The staff receives additional training in mental health and substance abuse, special health care needs, breastfeeding, NCAST, and Adverse Childhood Experiences (ACES) work.

Timeline for Obtaining Curricula

Snohomish Health Department has already secured the needed supply of curricula to implement the NFP program. Curricula include:

- Nurse-Family Partnership Visit to Visit Guidelines
- Partners in Parenting Education
- NCAST (Nursing Child Assessment Satellite Training) Feeding scale
- NCAST Teaching scale
- Ages & Stages questionnaire
- Ages & Stages Social Emotional questionnaire
- Center for Epidemiology Studies Depression Scale (CES-D)

C. Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the NFP program

All services will be provided on a voluntary basis. Currently in Snohomish County the NFP program reaches out to organizations that come in contact with and/or serve young, low-income women. Included in current outreach efforts are all of SHD, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving young low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Youth and Family Serving agencies, TANF community service offices, and other home visiting programs. Outreach occurs on a regular basis and is reinforced when coordination happens around referrals to NFP for services. Outreach is usually timed to be most relevant based on the services each agency provides. Outreach to schools generally happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Program supervisors regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Recruitment and Engagement of the “At-Risk” Population Identified

The NFP National Service Office (NSO) provides outreach materials for community providers an potentially eligible clients. SHD takes advantage of these materials, making sure there are ample supplies at key community locations listed above. The NFP program works diligently to make sure that all community providers and potential referral sources have up to date information about our services and how to contact us. Providers at these agencies inform potential clients about services provided by the NFP program, they ask their permission to send in a referral to NFP. Our referral form includes sections on whether the contact information is confidential, if the client has been informed of the referral, and if it is okay to contact the client at the telephone numbers listed. This ensures that NFP staff will not be making inappropriate contact with the clients, their families or support network, and will not risk the confidentiality of the client. Additionally, the NFP program supervisor is available to talk with phone to any potential clients and let them know more about the program and ensure that ongoing communication meets the client need. At the clinics where the NFP teams are located, if an eligible client is identified, staff will often page the NFP provider, facilitating an “in the moment” contact. This helps demystify the program to a potential client. Our experience shows if a client is referred by a trusted source and face-to-face contact occurs in a confidential setting

at the client's convenience, the enrollment rate is high. The program continues to identify additional strategies to reach out to the highest risk populations, those exiting juvenile detention, homeless and mobile clients, and clients who have not yet informed their families or support systems of their pregnancies.

Plan for Individualized Assessments of Enrolled Participant Families Conducted:

NFP data collection forms including:

| | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools:

NCAST (Nursing Child Assessment Satellite Training) feeding scale
NCAST (Nursing Child Assessment Satellite Training) teaching scale
Ages & Stages Questionnaire
Ages & Stages Social Emotional Questionnaire
Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for Referral to Services According to Individual Assessments

Individual assessments are conducted with the client and their children according to NFP visit guidelines and data collection scales. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was "measuring," what "normal" limits are, why the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive, the nurse will refer to available community resources like the Washington State "Quit Line." If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client's ongoing risk, and assist the client in developing a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local Birth to Three Neurodevelopment Center for a complete developmental assessment.

Estimated Timeline to Reach Maximum Caseload

Because of the intention to rehire a previously trained NFP nurse of SHD, the estimated time to reach maximum caseload would be six to seven months as compared to the typical nine months. She could take on three to four families per month from the first date of hire, because she was serving families in the pregnancy and infancy period prior to the reduction in force and she does not need to be retrained.

Attrition Rate and Plan for Minimizing Attrition

The average rate of attrition for program participants in Snohomish NFP:

| | |
|------------------|--------|
| Pregnancy phase: | 11.0% |
| Infancy phase: | 26.1 % |
| Toddler phase: | 18.6% |

SHD will use the ETO caseload reports, client activity, and nursing visit reports to engage in conversations with the nurses during reflective supervision regarding caseload activities. We will use team meetings to share successes in maintaining difficult to engage families. We will review client retention education module to support the fidelity of the model. We will also continue to build incentives into the program to support client retention.

D. Operational Plan for Coordination between Local Home Visiting Program and other Social Service and Health Agencies

For a detailed response to this question, please see “Plan for Coordination Among Existing Programs and Resources,” and “Local Capacity to Integrate Home Visiting Services into an Early Childhood System” under “4. Snohomish County – North Everett” in Section 1.

| | | | |
|---|--|---|--|
| 5. King County - South: American Indian/Alaska Native African American women | Lead Agency: Seattle King County Department of Public Health | EBHV Model: Nurse Family Partnership | Families Served: 50 families |
|---|--|---|--|

A. Staffing and Supervision Plan for Implementation

NFP King County South Implementing Program

- 2.0 FTE Public Health Nurse
- .25 NFP Supervisor
- .25 Administrative Support
- Additional Public Health Staff to be hired in year 1.

WA State Positions Assisting NFP King County South

- Thrive by Five Washington
- Washington State University Area Health Education Center

NFP State Positions Assisting NFP King County South

- NFP Washington State Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program.
- NFP Washington State Nurse Consultant provides technical assistance around clinical and implementation issues (not yet in place in Washington)
- NFP Washington State Consortium

National Assistance

- NFP NSO Program Consultant in Program Quality

Staff Recruitment and Hiring

NFP standards require that nurses have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, nurses must have completed the NFP training. It is helpful if candidates have prior experience providing home visiting services to at-risk pregnant women and new mothers and have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. For South King County hiring there will not be a need to recruit bilingual staff since the target populations are African American and Native American communities.

There are currently two teams, comprised of 11 nurses providing NFP services to eligible clients living in South King County. Capacity for these teams is supported with other funding sources, requiring recruitment and hiring of additional staff to reach the expanded “at-risk” populations supported by the MIECHV funds.

In order to meet the expanded “at-risk” populations supported by the MIECHV funds, Public Health Seattle-King County will need to recall or hire two additional Public Health Nurses. Public Health Seattle-King County staff is currently scheduled for lay-off due to anticipated State budget reductions. If staff are laid off at the end of June 2011, current contracts place them in a “layoff/recall” pool for a period of two years. Once the new positions are approved for hiring, NFP supervisors will post the position, and human resources will refer any eligible candidates from the layoff/recall pool. Eligible staff in layoff/recall has first rights to any open positions for which they are qualified. If no eligible candidates are identified in the layoff/recall pool, the positions will be posted on the King County website for 10 calendar days. Eligible applicants will be referred to hiring supervisors and interviews of selected candidates scheduled. Incorporating the required posting time, scheduling of interviews, reference checks and transition time for currently employed candidates, we would anticipate six to eight weeks to hire staff.

Staff Retention

Staff satisfaction with providing NFP services is the best retention mechanism. Public Health Seattle-King County has had almost no staff turnover in the teams serving South King County. One nurse retired and one nurse moved to an NFP supervisor opening in an adjacent county. To quote a current NFP nurse in King County: “This is the hardest I have ever worked, but the most satisfied I have ever been.” Model supported weekly reflective supervision, one hour each week for each nurse with the NFP supervisor also plays a large role in retention of staff. The regular and prioritized time with the supervisor provides the opportunity to debrief and obtain support around the work of intensively engaging with clients facing many challenges in their lives. In addition, weekly team meetings develop communication, collaboration and support among the team of nurses, supervisor and support staff. Administrative staff support positions for the two

South County NFP teams have had no turnover in the last 10 years. These team members value to work that the NFP program is doing and are committed in their roles to ensure team success.

Plan for NFP Clinical Supervision and Reflective Practice

The NFP NSO model elements state: Nursing supervisors must provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

Public Health Seattle-King County currently employs 3 Nurse-Family Partnership nursing supervisors. All three have been fully trained in the NFP program and supervise according to NFP guidelines: One hour each week with each nurse and her supervisor for reflective supervision, one 90 minute team meeting each week which includes case conferencing as well as practice support, and regularly supervised joint home visits to observe the nurses delivering NFP services in client homes. The current number of supervisors on staff is adequate to cover required supervision for a total of 19 nurses across three teams once the new MIECHV staff are in place.

Fidelity monitoring & Quality Assurance through the National Model Developer:

Data are collected, entered into ETO and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which nurse home visitors and supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both supervisors and nurse home visitors will review and use their program data in conjunction with the NSO nurse consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional Evaluation Efforts

Public Health Seattle-King County also has several agency-specific program monitoring tools related to staff productivity and timeliness of documentation that are used by NFP program supervisors to ensure that staff are meeting program expectations. A collaborative process is used to identify individual and/or program strengths, opportunities for improvement, and to problem-solve ways to most consistently meet staff and program goals. Fidelity to Nurse-Family Partnership criteria for enrollment, frequency and duration of visits, and program and visit content is adhered to in order to ensure the highest chances of replicating the short- and long-term outcomes achieved in the NFP research studies. King County NFP teams have demonstrated the ability to consistently collect required data and meet program objectives and outcomes.

B. Training and Curricula

Staff Training

NFP Training: The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning,” Unit 2: face-to-face session in Denver (approximately four days), Unit 3: onsite “distance learning,” and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

Implementing Organization additional training: All PHSKC NFP staff attends all required NFP training. In addition, staff participates in agency sponsored trainings on motivational interviewing, breastfeeding, and reflective practice updates. Many of these trainings are offered during quarterly trainings for PHSKC staff.

Timeline for Obtaining All Necessary Training for New Staff to Implement NFP

Once the NFP public health nurse has begun work, she will complete Unit 1 of the training on-line and by reading NFP-provided materials. Unit 2 is provided in Denver and is available the weeks of September 12, October 17 and November 14. Once Unit 2 is completed, Unit 3 is completed on site and further training is provided through reflective supervision, online training, and participation in weekly NFP Team meetings.

Timeline for Obtaining Curricula

Public Health Seattle-King County secured the required training curricula for the program and has established a strong collaborative relationship with the NFP NSO to implement the *Nurse-Family Partnership Visit to Visit Guidelines* curricula. The program will also use the *Partners in Parenting Education (PIPE)* curriculum to train staff directly engaged with parents.

Other curricula to support implementation of the program include:

- *NCAST (Nursing Child Assessment Satellite Training) feeding scale*
- *NCAST (Nursing Child Assessment Satellite Training) teaching scale*
- *Ages & Stages Questionnaire*
- *Ages & Stages Social Emotional Questionnaire*
- *Center for Epidemiologic Studies Depression Scale (CES-D)*

C. Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach Plan to Reach the “At-Risk” Population Identified by the NFP Program Include:

All services will be provided on a voluntary basis. Currently in South King County, Public Health Seattle-King County NFP programs reach out to organizations that come in contact with and/or serve young, low-income women. Included in current outreach efforts are all Public Health, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving young low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Youth and Family Serving agencies, TANF

community service offices, and other home visiting programs. Outreach occurs on a regular basis and is reinforced when coordination happens around referrals to NFP for services. Outreach is usually timed to be most relevant based on the services each agency provides. Outreach to schools generally happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Program supervisors regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Plan for Recruitment and Engagement the “At-Risk” Population Identified

The NFP National Service Office provides outreach materials for community providers and potentially eligible clients. Public Health Seattle-King County takes advantage of these materials, making sure there are ample supplies at key community locations listed above. The NFP program works diligently to make sure that all community providers and potential referral sources have up to date information about our services and how to contact us. In this way providers have the information needed to inform clients about our services. Providers at these agencies will inform potential clients about services provided by the NFP program and ask their permission to send in a referral. Our referral form includes sections on whether the contact information is confidential, if the client has been informed of the referral and if it is okay to contact the client at the telephone numbers listed. This ensures that NFP staff will not be making inappropriate contact with the clients, their families or support network, and will not risk the confidentiality of the client. Additionally, the NFP program supervisor is available to talk by phone to any potential clients and let them know more about the program and ensure that ongoing communication meets the client need. At the clinics where the NFP teams are located, if an eligible client is identified, staff will often page the NFP provider, facilitating an “in the moment” contact. This helps demystify the program to a potential client. Our experience shows if a client is referred by a trusted source and face-to-face contact occurs in a confidential setting at the client’s convenience, the enrollment rate is high. The program continues to identify additional strategies to reach out to the highest risk populations, those exiting juvenile detention, homeless and mobile clients, and clients who have not yet informed their families or support systems of their pregnancies.

Plan for Individualized Assessments of Enrolled Participant Families Conducted:

Following is a list of individualized assessments of enrolled participant in NFP services:

NFP data collection forms including:

| | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools

NCAST (Nursing Child Assessment Satellite Training) Feeding scale

NCAST (Nursing Child Assessment Satellite Training) Teaching scale
Ages & Stages Questionnaire
Ages & Stages Social Emotional Questionnaire
Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for Referral to Services According to Assessments:

Individual assessments are conducted with clients and their children according to NFP visit guidelines and data collection schedules. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions raised by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

For example, if a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local Birth to Three Neurodevelopment Center for a complete developmental assessment. In the fashion described, anytime a need is identified as a result of an assessment or screening, the results are discussed with the client and a referral to available resources is offered.

Estimated Timeline to Reach Maximum Caseload

The experience of implementing NFP over the last 12 years in King County has shown that enrolling three to four clients per month is the most successful pace for NFP nurses to build their caseload. In this fashion, we would expect the two full-time nurses supported by the MIECHV funding to reach full caseload in approximately six to eight months. Attention is also paid to staggering the due dates of enrolled client per team member in an attempt to avoid an overload of births in any given week or month.

Attrition Rate and Plan for Minimizing Attrition

The average rate of attrition for program participants in King County NFP is:

| | |
|------------------|-------|
| Pregnancy phase: | 7.2% |
| Infancy phase: | 21.4% |
| Toddler phase: | 16.5% |

NFP data shows that King County teams have very low attrition rates during the pregnancy phase, highest rates of attrition during the infancy phase, decreasing by 5% in the toddler phase. Based on this the focus on minimizing attrition should be on the infancy phase, a difficult time to

keep clients engaged when they are returning to work and school. Working with our team data we can identify the times that clients are most likely to be lost to follow up, identifying reasons that clients are leaving. Developing strategies to engage clients around these reasons in advance of, or early in the infancy period might lead to different methods of support and/or flexibility around visit schedules and location should help to decrease the likelihood that clients will leave the program.

D. Operational Plan for Coordination between Local Home Visiting Program and other Social Service and Health Agencies

For a detailed response to this question, please see “Plan for Coordination Among Existing Programs and Resources,” and “Local Capacity to Integrate Home Visiting Services into an Early Childhood System” under “5. King County – South” in Section 1.

Lessons Learned from Development of Implementation Plans in Selected Communities

There is a need to increase capacity of EBHV model support in Washington and community program implementing capacity. This will provide Washington with a CQI technical assistance strategy for consistent quality implementation. (Please see Section 7: Plan for Continuous Quality Improvement and Section 8: Technical Assistance Needs for additional details of State Plan to support implementation).

NFP National Capacity to Support Implementation

The NFP National Service Office (NSO) is an important resource to Washington’s programs implementing NFP. The intent of NFP NSO is to provide program implementation support; education for nurse home visitors and nurse supervisors and ongoing clinical support; reporting and quality improvement systems and support; federal policy and program financing support; and marketing and community outreach resources. State NFP programs can also access two regional representatives for ongoing technical assistance and support assigned by the National Service Office, an NFP program developer and a NFP nurse consultant.

NFP supports two regional representatives for ongoing technical assistance. The NFP program developer’s role is to help Washington EBHV programs secure funding for long-term sustainability and program expansion. This is a regional position and the current developer covers 14 states implementing NFP. The nurse consultant provides technical assistance on clinical and implementation issues. This is also a regional position and this person covers 14 states. With 11 NFP programs in Washington, the need for support of quality implementation exceeds the current capacity of the state support structure. This will be addressed as part of the MIECHV program grant activity.

PAT National Capacity to Support Implementation

Through the national PAT Office, as well as through the Washington State PAT Office, there are also resources to support implementation of Parents as Teachers. The National Office of Parents as Teachers (PAT) sets direction for the PAT model, the training and curriculum offerings, and the advocacy and research agendas at the national level. The national PAT Office provides technical assistance supporting initial implementation, including development and approval of

the initial *Affiliate Plan*; monitoring, assessing and supporting implementation with fidelity to the model; and maintaining quality assurance.

The Washington State PAT Office is organized to develop, support and sustain high-quality PAT Affiliates within the state. The WA PAT State Office is home of the PAT State Leader. There are 28 PAT programs in Washington, supported by the national office and a half time PAT State Leader. The ongoing need for support in quality implementation exceeds the current capacity of the state support structure. This will be enhanced as part of the Washington work over the next two to five years. Ongoing conversations are under way about how to best structure the additional support in Washington.

Model Specific Support for Quality Implementation Gap

Although each EBHV model has fidelity requirements, they are not always clearly understood, operationalized or attainable for programs implementing at the community level or in supported in broader systems development at the state level. Although both PAT and NFP models provide quality implementation guidance, access to the model specific technical assistance available from both national and WA EBHV model representatives is limited due to high demand. We relied heavily on the state EBHV model representatives (Regional NFP Program Developer and PAT State Leader) to coordinate the Implementation Plan in the communities and provide a direct link the emerging National office updates (meeting data benchmarks, fidelity and quality implementation). This work was instrumental in creating baseline implementation plans with the selected communities. In order to continue supporting quality implementation at the community level we plan to increase model specific support from state national model representatives. The specifics of the proposed increase in support will be negotiated over the next several months.

Washington's Approach to Developing Policy and Setting Standards for the State HV Program

The Challenge

Increased public and private investment in home visiting shifts both the Washington state-level policy approach and the performance context for local community organizations delivering home visiting services. Historically Washington has used community practice to inform policy development in home visiting. Implementation science for quality home visiting implementation presents approaches and standards that require increased accountability. New financing opportunities capitalize on this exciting research, requiring a rigorous approach to data collection, standards and policy.

Developing policy that balances community practice with accountability is the challenge that Washington will address. Integrating community practice with the rigor of implementation science will be an iterative process in Washington, resulting in public policy that reflects integrity on all levels.

History of Community Driven Evidence-based Practice Improvement and Policy Development

Historically, Washington's development of EBHV policy has been driven from community practice and research. As with many states, communities in Washington have delivered evidence based, research based and promising practice home visiting services to families in need for years.

With a long history of supporting community based programs with CBCAP dollars, the Council for Children & Families Washington (CCF) recognized home visiting as a key strategy to prevent child abuse and neglect. In 2006-2007, CCF convened a Research Advisory Committee and conducted an EBHV literature and research review, resulting in the development of a matrix of approved home visiting models. The matrix identified key characteristics of each model, and ranked the model in terms of the level of evidence supported by the research. During this same period, CCF conducted grassroots outreach and assessment of community interest and needs, which provided direction and “buy-in” at the community level.

CCF built political momentum as a result of the above for home visiting that could be demonstrated to the Legislature. And in 2007, the Legislature funded evidence and research-based voluntary home visiting programs and required the development of a coordinated plan for home visiting. In 2008 the Washington State Home Visiting Coalition (HV Coalition) was convened and has played a critical role in preserving and expanding funding for EBHV in Washington.

With targeted state dollars for funding of home visiting programs, more resources were available to communities. With this opportunity came challenges, including:

- Distributing money to communities for HV services did not automatically produce expected outcomes.
- Implementation challenges at the local level.
- Local program lacked the capacity to implement with fidelity, manage the program, effectively collect data, and implement a culture of continuous quality improvement.

Washington State’s Home Visiting Services Account (HVSA)

The 2010 Legislature created the Home Visiting Services Account (HVSA), which is administered by DEL and Thrive by Five Washington. The purpose of the HVSA is to:

- Fund home visiting services.
- Develop, administer and maintain infrastructure: training, evaluation, and quality improvement necessary to develop and support quality implementation of home visiting programs.

State Assurance to Comply with Maintenance of Effort Requirement

Washington will comply with the legislative requirement of maintenance of effort (MOE) funding. The state general fund investment as of March 23, 2010 will serve as the baseline for meeting MOE for this program. *Baseline and FY 2010 figures are included in the Budget Narrative, Attachment M: “Budget”*

Next Steps to Integrating Evidence-Based Practice Improvement and Evidence-Based Policy Development

The opportunity for significant increases in public funding of home visiting shifts the performance conditions for agencies delivering home visiting models. Agency experience in delivering home visiting services acts as a demonstration project for expansion to whole communities or even more broadly. Evidence-based policy is intended to be a rigorous approach to drive government priorities and resource use, drawing on careful data collection, experimentation, and quantitative and qualitative analysis. In evidence-based practice, the focus of effort is to benefit the child and family. Evidence-based policy addresses the needs of

communities and helps to prioritize effective investment of scarce resources. The goal is to balance these two approaches to demonstrate gains for families and build the capacities of communities to more effectively provide services.

As states adopt performance accountability standards, current HV model practices will have to change to meet these public policy needs. Our goal in this work plan is to balance high-quality information about evidence-based practice with high quality information to guide policy decision-making.

The home visiting field is adapting their existing performance standards and measures from an internal set of solutions to increasing public accountability. Inevitably, there are gaps between what programs currently do and this expanded demand for information. From the public policy perspective, we have to answer several questions about system development:

- What is the initial capacity of programs and models to provide information and what is needed to produce high quality data?
- Given the challenges in taking evidence-based practice to scale, what are the training and infrastructure needs of the agencies comprising the emerging system?
- How can we best deliver continuing evaluation and quality improvement efforts to improve practice, increase participant outcomes, and produce the information necessary to document services' processes and services' outcomes?
- Are the home-visiting services being provided to the at-risk population? Are the services for the at-risk population meeting expectations regarding adequate dosage, participation, completion of services and acceptable levels of attrition?
- How sustainable is the system of home visiting in Washington? Is the state, local and federal infrastructure flexible, well-integrated and developed enough to continue to support a diverse, statewide home visiting system in Washington through ongoing fiscal, staffing, and programmatic changes?

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

In this section, we first describe our approach to evaluation in Washington, the guidelines and assumptions that underlie our approach, the questions that frame our data collection and analysis, and lessons learned from existing home visiting evaluation in Washington. Next we describe our state plan for evaluation including assessing our performance in meeting the legislatively-mandated benchmarks. In this plan, we propose that benchmark assessment and CQI represent an integrated set of activities. Our state plan includes an initial six-month rapid development process to position Washington State to address the comprehensive set of constructs in the six benchmark areas identified in the SIR for the state home visiting plan. Following the initial build-out, we will begin collecting baseline data through the end of Year 1. Years 2-3 will involve continued data collection, analysis, and reporting to local programs, model representatives, state agency partners, and our federal funders. During this time, we plan to transition our data warehouse from Washington State University to a state level data system, and to pursue the acquisition of administrative data. Years 4-5 will involve ongoing data collection, analysis and reporting, and will add in efforts to move to a web-based reporting system.

Washington State Approach to Evaluation

Assumptions and Guiding Principles

In developing the plans for the MIECHV implementation and data/benchmark work, several guiding principles will inform the work. These include::

- Integrating evidence based practice improvement and evidence based policy development
- Using an implementation science framework and building a sustainable system
- Use of participatory research principles
- Exploring potential outcomes

Integrating Evidence-Based Practice Improvement and Evidence-Based Policy Development

The Affordable Care Act funding of home visiting supports evidence-based practices with an underlying goal of promoting system development. In essence, agency experience in delivering home visiting services acts as a demonstration project for expansion to whole communities or even more broadly. As states and communities expand home visiting, additional data collection, analysis, and continuous quality improvement will play a critical role in informing policy decisions.

There are gaps between what programs currently do and this expanded demand for information. Evidence-based policy decisions that address state and community priorities, scarce resources, and applicability of evidence-based practices to different populations is needed. Managing both the success of specific programs and the development of the publicly funded system of home visiting in Washington State requires related but distinct development steps. Distinguishing between evidence based practice and the demands of evidence based policy can help guide how we define the needed infrastructure for home visiting to scale-up with success.

Using an Implementation Science Framework and Building a Sustainable System

Implementation science is the specific area of practice research addressing how to translate successfully the promise of evidence based programs into reliable high impact program delivery. Among its key findings, implementation science identifies the following factors as key to establishing and managing evidence-based practices:

- organizational readiness and commitment
- broad community support
- staff capacity and development
- effective program supervisory practices
- attention to local individual client population differences
- maintenance of service dose and quality
- ability of agencies and staff to use information to guide practice

We will collect this information and use implementation science principles to support the overall MIECHV benchmark evaluation and the use of information in our CQI efforts. This is aligned with the SIR requirement that sufficient information is collected to provide meaningful capacity to assess program outcomes and provide analysis to guide continuous quality improvement efforts.

Exploring Potential Outcomes

The goals of the Affordable Care Act present a new challenge for home visiting programs such as NFP and PAT. Neither program has been proven to impact all of the required benchmark areas. Using the HOMVEE review conclusions as a reference, PAT has evidence of effects for positive child development, school readiness and positive parenting practices; NFP has evidence of effects for positive child development, school readiness, child and maternal health, family self-sufficiency, and reduced child maltreatment risk. As we address the full range of benchmark constructs, we recognize that in some important areas we are testing the potential benefit of these home visiting programs on new dimensions. As a result, distinguishing in the benchmarks between ‘demonstrated’ and ‘potential’ areas of program impact may help us understand how progress on the multiple constructs will occur in Washington’s efforts. This distinction is important because the expansion to test ‘potential’ areas of impact results in the two home visiting programs addressing outcomes that have not previously been part of their practice. We will rigorously collect information to explore these ‘potential’ outcomes, and the factors that may contribute to improvements, but do not assume we will show improvements in these areas.

Use of Participatory Research Principles

The federal home visiting funds introduce significant changes in current home visiting data collection practices, and significant development work with models and local programs will be required. We will align this development work with existing practices and emerging recommendations of the national model developers to the extent possible given the federal performance guidelines. Because minimizing burden on staff and families and the delivery of the models with fidelity are essential to success of the programs, coordination of assessment efforts with national model requirements is an explicit priority in this plan. However, Washington is responsible for meeting the federal performance requirements and must reserve the authority to determine appropriate assessment practices. As a result, we identify an active coordination discussion with the models’ representatives as part of this benchmark assessment.

We will use participatory research principles in the design and implementation of this benchmark data process. Model representatives, local program leadership, consumer representatives, and other key stakeholders will be used in an advisory capacity through a Data Steering Committee that serves as part of the overall MIECHV governance structure. Critical to the development of this benchmark data system is integration of data analysis with local program and state system continuous quality improvement.

Washington is operating on the assumption that benchmark assessment has to be integrated into the home visitors' contacts with the family if the data system is to support continuous quality improvement and be sustainable over time. Managing this design and development step early is essential to maintain the integrity of the NFP and PAT models as evidence-based practices. Data collection is not a neutral process and the potential time demands and shifts in relationships between home visitors and families needs to be managed to assure the integrity of the home visiting models. Given the pace of implementation of MIECHV, these conversations with the national models and local programs are underway but not complete. As a result, completing the design of the data collection system requires continued consultation with the models and providers to build a system that supports the delivery of the evidence based interventions and addresses the capacity needs of local programs.

Questions to Address

As Washington progresses in implementing evidence-based home visiting models as part of our statewide strategy to strengthen our comprehensive early childhood system of care, we plan to measure how well we are meeting what Washington needs to know to be successful.

Specifically, these activities are designed to address whether program outcomes and quality are improving over time, whether they are meeting the needs of children and families in high-risk communities, and whether the communities can sustain these programs organizationally and financially. The activities also integrate our efforts to conduct continuous quality improvement with our overarching goal of building an information system to address local, state and federal needs, including the measurement of long term outcomes. We have identified several questions that will drive our assessment of the implementation and our evaluation activities.

Some of these questions relate to continuous quality improvement of evidence-based home visiting model implementation:

- Are the models across communities being implemented with fidelity to model-specific standards?
- Are the models across communities acceptable and accessible? What local enhancements are needed to increase community acceptability and accessibility? Are enhancements needed to develop more culturally sensitive practices?
- Are the models across communities sustainable both organizationally and financially? What local enhancements are needed to improve sustainability?

Additional questions pertain to building an integrated home visiting and data collection system across models which meets the requirements of the Supplemental Information Request. These include:

- Are the models following implementation standards?
- Are the models across communities collecting and using data to evaluate client progress and support quality improvement over time?

- Are the home-visiting services being provided to the at-risk population? Are the services for the at-risk population meeting expectations regarding adequate dosage, participation, completion of services and acceptable levels of attrition?

Still other questions address the anticipated long term benchmarks and constructs identified in the Supplemental Information Request:

- Are the models across communities making a difference in the lives of families and children? Are programs able to conduct adequate and appropriate screening and referral as identified in the Supplemental Information Request? How has the need for services changed over time? Are communities able to meet the need for services?
- Are the models (within communities and across communities) positively impacting:
 - Maternal and Newborn Health
 - Child Injury, Child Abuse, Neglect or Maltreatment
 - Improvements in School Readiness and Achievement
 - Domestic Violence
 - Family Economic Self Sufficiency
 - Coordination and Referrals to Resources
- How sustainable is the system of home visiting in Washington? Is the state, local and federal infrastructure flexible, well-integrated and developed enough to continue to support a diverse, statewide home visiting system in Washington through ongoing fiscal, staffing, and programmatic changes?

History of Home Visiting and Its Evaluation in Washington

As is the case for most states, Washington has invested in development of a home visiting system that this federal program is intended to enhance and complement. Notably, for the past four years, state funding has been invested in a portfolio of home visiting programs including NFP and PAT programs through our Children’s Trust/CBCAP agency (the Council for Children & Families, CCF) and more recently the state Home Visiting Services Account (HVSA) managed by Thrive by Five Washington. As part of this work plan, we will align and expand on the evaluation methods and CQI practices of the CCF and HVSA work. Evaluators from Washington State University Area Health Education Center (WSU) responsible for the evaluation of these two existing portfolios of EBHV programs will also be the lead for the MIECHV benchmark evaluation program and will coordinate with the Technical Assistance Hub and Washington State Department of Health staff. WSU will be contracted with through the HVSA.

Until recently, Washington’s home visiting efforts have been a mix of largely locally initiated efforts with a range of program models. PAT and NFP have been the two most common models with 28 PAT and 10 NFP programs currently in operation in the state. Typically, these programs developed because of local funding efforts to address local needs. Model representatives and national offices have as a result had a significant influence in Washington because they helped provide common venues and collegial support systems across these local efforts.

Beginning in 2007, Washington made a five-year investment in supporting 11 of these existing programs in an evidence-based home visiting demonstration initiative managed through the CCF. As part of this initial state investment, CCF supported a formative and descriptive program evaluation of these home visiting efforts. Concurrently, Washington made a significant

investment in early learning and child development with creation of the cabinet level Department of Early Learning and creation of the public-private partnership entity, Thrive by Five Washington, to serve as major policy and implementation structures to address young children and their families. The CCF efforts are now merging into the Thrive by Five Washington which has the responsibility for implementing a Home Visiting Services Account, developed as a public-private funding and implementation vehicle in partnership with the Department of Early Learning to expand the adoption of evidence based home visiting.

Consistent with the general home visiting literature (e.g., Daro, 2006, 2009; Gomby, 2007), several findings from the evaluation of home visiting in Washington State inform the present work. These findings include:

- Implementation agencies vary significantly in capacity
 - Variability in the maturity and readiness of the agency implementing the model
 - Distinctive population characteristics and needs that may impact program success
 - Frequent challenges with recruitment and retention
 - Agency level practice and capacity needs
 - Practitioner differences and development needs
 - Variable practices across agencies in continuous quality improvement practices.
- Home visiting models vary significantly with respect to
 - Use of non-equivalent definitions of participant demographics and service encounters
 - Detail of fidelity assessment
 - Integrated information system structures to guide program implementation and assessment of participant benefit.
 - Specific practices supporting use of program benefit to describe child and family progress during and after the delivery of services
 - Scope and formality of practices supportive of continuous quality improvement.

As a result, even within the same model, local program variation and client characteristics result in a variety of factors that need to be understood and incorporated into assessment of benchmark progress and program success. Specific to the assessment efforts in this work plan, we have a range of readiness across models and of programs within models. Identifying and addressing this variability provides a framework for the current work plan.

Washington's adoption of NFP and PAT as the two home visiting models creates several challenges for development of the common state MIECHV data system:

- The two models differ greatly in the level of development and content of existing data strategies embedded in practice.
 - NFP has an extensive mandatory data collection process but it does not fully meet the MIECHV benchmark data requirements.
 - PAT collects a modest set of data
- To date neither model has released full information about its recommendations for how states and local programs are to address the benchmark constructs, although both models are actively engaged in pulling materials together.

- Both national model offices are taking development approaches that are model-specific and not likely to be easily reconciled in support of a comparable data reporting strategy across the two models in the Washington MIECHV system.
- The two models vary greatly in data collection, data reporting, and data use.
 - NFP has uniform model requirements for data collection, but access to and use of the information in program delivery and program improvement varies significantly across local programs
 - PAT national office has not until recently imposed significant standard requirements for data reporting, or supported adoption of an extensive mandatory data reporting and data repository system, so variability across local programs is pronounced. The emergence of the MIECHV requirements is now being incorporated into PAT national guidance but this work is incomplete. As a result, local PAT programs have varied greatly in terms of data collection and use based primarily on local capacity and the value placed on client and program information.
- A state data repository model does not exist for either NFP or PAT. Program data is either held by the local programs or by the national model. As a result, we will need to develop a common data archive or warehouse to receive, organize, analyze and report the MIECHV required data.

As part of the MIECHV evaluation and CQI plan, we identify the need for local program development in evaluation and data use on the following dimensions to reach a common level of data literacy and data use across and within the two models:

- Adoption of more comprehensive assessment in PAT programs,
- Design, adoption, and use of electronic data management principally in PAT programs,
- Staff training in collection and use of assessment tools in PAT programs, and
- Data interpretation and use training in PAT and NFP programs to guide quality improvement in individual client care and program development
- Creation of common minimum performance, skills, and data use expectations in local programs
- Standardization of data collection follow-up periods while families are enrolled in programs.

Recently released NFP and PAT national office statements about their proposed approaches to the MIECHV benchmarks demonstrate that for both models there are gaps in the capacity of current practices to meet the full set of constructs required. Even if we wholly adopted current NFP practices for assessment, additional data collection and reporting structures would be required. The need is greater in PAT where the MIECHV will require a very significant expansion of assessment and data reporting for PAT home visitors. As a result, there is significant design work and preparation of local programs and local staff to meet the assessment and evaluation requirement of the MIECHV benchmarks.

We welcome the emerging guidance provided by the national model offices for MIECHV data collection, but Washington will have to retain the responsibility to assure that assessment of each MIECHV construct meets standards as reliable, valid, and sensitive measures. For example,

despite the range and standardization of NFP's current data collection protocols, no independent research has been done to document the psychometric value (reliability, validity, and sensitivity) of the assessment protocols (personal communication with NFP NSO). As a result, we plan six months of development and design work with both PAT and NFP. This work is certain to result in expanded data collection requirements. While we will attempt to minimize these additional requirements, reaching an agreement on needed development will have to occur through negotiations in the first six months of Year 1. In this design work, we will structure the work around the following objectives:

- Wherever possible, build on existing assessment and data management practices to meet MIECHV benchmark requirements
- When needed, supplement existing practices with efficient, acceptable, and sensitive assessments to be completed by home visitors
- Wherever possible, use data sharing agreements with national model offices and local programs to receive and manage data collection
- When needed, work with local programs for enhanced data collection and reporting
- Assess local program capacity and develop quality improvement and training/technical assistance plans to implement standardized minimum data collection, data reporting, and data use performance expectations
- Establish a data warehouse for Washington's PAT and NFP programs and enrolled families.

Washington State Data Plan

Roles and Responsibilities

We have established a collaborative approach to support the development of an integrated home visiting data collection system which meets the requirements of the Supplemental Information Request. This approach extends the collaborative cross-agency planning structure in Washington created to develop the Washington State Home Visiting Plan. The approach includes the creation of a statewide Maternal Infant and Early Childhood Home Visiting Data Committee with cross agency representation to provide consultation and assistance regarding evaluation and CQI activities. The work of this committee will be guided by the values articulated in the Plan's Goals and Objectives: to place the needs of Washington families and children foremost in ensuring that high quality home visiting services are available and accessible, to build local capacity to collect and use data to inform and improve culturally competent evidence-based practices, to integrate home visiting with other early childhood data systems, and to develop strategies that build sustainability. The committee will be comprised of representatives from three state agencies to include: the Department of Early Learning, the Department of Health, and the Department of Social and Health Services; the HVSA implementation agency: Thrive by Five Washington, as well as representatives of other early learning and education data systems. Committee members will represent a broad array of disciplines and will bring widespread expertise in data collection, data analysis and reporting, evaluation, quality improvement, measurement, and assessment of education, social and health outcomes. The Committee will provide recommendations to the Partnership Group and the Executive Team of partner state agencies to guide the development of the statewide data collection system.

Day to day evaluation and CQI activities will be undertaken by analytic staff who have advanced training in research and evaluation methods and design, social work, psychology, and epidemiology. The activities include:

- developing/refining data collection tools
- training local program staff to collect, report and interpret data from clients
- adapting the data system to meet local, state and federal data needs
- building a data warehouse and system of data transfer
- ensuring data quality
- analyzing the data
- providing data to programs
- coaching program staff to use their own data for CQI and program development

The data warehouse will initially be developed at the Washington State University Area Health Education Center. Once the data collection framework and tools are well established and the data collection system is fully functioning, the data warehouse will begin to be transitioned to Washington State. Part of the reason for this is to pave the way for including state administrative data in the data warehouse, as well as taking the system from initial implementation to longer term sustainability, and potential expansion.

Benchmark Plan Requirements

Proposed Measures and Definition of Improvement

Proposed measures to collect for Benchmark Constructs are included in the table provided in *Attachment J: “Washington State Proposed Measures to meet Legislatively-mandated Benchmarks.”* The table summarizes the following items:

- the current status of the two models NFP and PAT with respect to measuring the benchmarks and constructs
- the measures Washington proposes to collect as examples of the federal constructs
- definitions of improvement for proposed measures

The variability in data collection and reporting across these two models is apparent by the color codes and gives an indication of the work involved in developing a unified data collection and reporting system. In the columns showing NFP and PAT tools, white indicates the model is currently collecting data on this construct. Gray indicates elements and tools the model proposes to collect and pink indicates a gap that we will address. The columns to the left of the tools indicate whether the model has been shown to improve that benchmark in the research literature, or whether the benchmark is a potential outcome and an area of exploration. As discussed above, many of the benchmarks areas are exploratory for PAT and some are for NFP. In addition, PAT does not currently collect data on most of the benchmarks and constructs.

The four columns on the far right of the table indicate the process and outcome elements we propose to measure, and how we define improvement for these indicators. We plan to use the first six months of Year 1 to develop a unified system to collect all of the process indicators identified on the table as well as to collect the outcome indicators for the constructs that don't have a process indicator identified (e.g., prenatal care). We will also put in place the data collection system to measure the outcome indicators, but many of these will require several months of ongoing follow up before we will have data to populate the database. We will only

report one of these elements annually to our federal partners, but we are not yet sure which we will report initially. Over the five year funding cycle, we will transition our reporting to track improvements in outcomes. Improvements in process indicators generally refer to an increase in the percent of home visiting clients screened for the specific construct. Improvements in outcome indicators refer to either increases in the percent of clients screened who received needed services, or a decrease in an adverse health outcome such as repeat pregnancy or rate of ER visits. In our identification of elements to track for the benchmark constructs, we focused on screening measures and receipt of services as these link most closely to our goals for home visiting services. Our goals are to identify issues that put families at risk for adverse health, child abuse and neglect, decreased literacy, or decreased self-sufficiency, and ensure that families receive needed services to support them and decrease their risk. We have not provided detailed definitions of the process and outcome indicators as we cannot define these until we have agreement with the models regarding the tools they will use to track these elements and the time frame for assessing them. This will be determined during the first three months of Year 1. By the fourth month of Year 1, we will compile a list of the indicators with more precise definitions, identified data sources, and timing of data collection.

Because the federal home visiting funds introduce significant changes in current home visiting data collection practices, significant development work with models and local programs will be required. We will use the first six months of Year 1 to transition fully to the complete benchmark assessment methodology, to design and deliver necessary training to staff, and to create the required data system infrastructure to implement equivalent data systems for Nurse Family Partnership (NFP) and Parents as Teachers (PAT). By the mid-point of Year 1, we will have a completely operational data collection system embedded in the funded local MIECHV programs with ability to document baseline status and track change on all six benchmarks' constructs. The intent is to support a stable data system capable of sensitively documenting progress of children and families in subsequent years. We assure that data collection on all benchmark constructs will begin with the first enrolled MIECHV families but that collection of information will need to be over a more extended 'baseline' period as we complete the design and implementation of the full state MIECHV data management system.

Plan for Demographic and Service Utilization Data

For purposes of the benchmark assessment, implementation science identifies key agency, staff, and client characteristics that serve as mediators of program implementation and program impact. In addition, service dose and service delivery characteristics may vary widely across programs and participants with direct effects on program benchmark results. We will collect information to address core elements about program practices, services, and client characteristics which when associated with MIECHV benchmark measures can help explain program benefits for children and families. The following table provides examples of program domains and elements to be assessed. This is a list of minimum elements for data collection and we expect we will add other elements based on the development. Many of the data elements required are embedded in existing PAT and NFP program practices but other elements will need to be developed as part of this work plan. Our intent is to collect data from existing program and client records through data sharing agreement when possible and to develop new data collection protocols to collect data from all families receiving services, as needed.

Table 7: Implementation science and service delivery mediators to be assessed

| Agency Practices | Staff | Supervision | Services |
|---|---|--|---|
| Staff: Client ratios | Education levels | Frequency/duration | Actual/Intended service dose |
| Years of experience with the model | Years of service | Supervisory ratios | Home visitor turnover (y/n) |
| Client demographic information: e.g., race, age, education, income | Years of model delivery | Supervisor years experience | Model fidelity measures at the family level |
| Client risk information: e.g., pregnancy status, history of child abuse, hx of substance use, developmental delay in children, armed forces employees | Continuing education hours in the model | Supervisor training | Retention/attrition |
| | Training in data use and interpretation for COI | Training in reflective supervisory practices | |

Anticipated Barriers or Challenges

Initial Implementation, Design and Establishment of Data Collection System

With the formal release of implementation funds, we will immediately enter into a six month period to complete the full common assessment protocol to address all benchmark standards. This first six months will involve a series of assessment objectives:

- Agreement by local programs to comply with all conditions for assessment of the benchmark constructs will be a condition for receiving the federal funding.
- Complete training on human subjects protection for all analytic staff.
- Immediately begin limited data collection with existing program elements for demographics, service utilization, and some limited baseline assessments common to the two models.
- Develop data sharing agreements that permit us to have access to the information based on the stage of development in the overall benchmark assessment process through Year 1. Data sharing agreements will address confidentiality and security measures to be taken to protect privacy of data and secure data transfer.
- Rapidly assess easily-agreed-to adoption of common assessment practices in Months 1-3 as programs gear up for expanded service delivery under MIECHV.
- Establish benchmark constructs where one model has an established assessment practice but the other does not:
 - Establish known psychometric characteristics and acceptability of the assessment question or tool.
 - If current practice is acceptable, establish agreement for the model without an existing assessment to adopt the current practice of the other model.
 - If the practice is not acceptable, negotiate the adoption of an alternative tool to be adopted as a new practice by both models.
- If neither model is assessing a construct:

- Identify psychometrically valid and reliable assessment protocols for adoption by both models.
- Negotiate agreement with models regarding new assessment practices (see additional detail below)
- Establish national model and local program data sharing agreements to have existing and pending data provided to a common data warehouse. De-identified individual level client data will be shared.
- Assess capacity and needs for staff training and data collection/data management and human subjects protection in each participating agency by the end of Month 3 in Year 1. By the end of Month 4, have technical assistance and training plans established for each provider. By the end of Month 6 in Year 1, have completed initial training and data capacity to start full data collection of all benchmark constructs in each program.
- Complete human subjects protection plan and submit proposal to the Washington State Institutional Review Board (in coordination with the Washington State University IRB) for implementing the new protocol by month five of Year 1.
- With human subjects' approval, collect additional information on families enrolled in the first six months of program operation to address new constructs added to existing NFP and PAT practices.
- Move to full implementation in the collection of all construct information in Month 7 of Year 1.

The Washington approach to the MIECHV evaluation is centered on data collection and reporting by the individual home visitor. As a result, the training and capacity of the individual home visitor and the agency supporting them will define the selection of assessment tools and inform our implementation. A critical reason for why we are proposing this time-limited development stage leading to full implementation is that line staff and supervisors need to be engaged in determining feasibility, acceptability, and sustainability of the enhanced assessment practices. With selection of the communities and the models, we now need to assure their participation in this design process. Without their informed agreement, we would risk proposing a system that could not be effectively implemented. While we wish to support a collaborative and shared development of the full benchmark assessment process, Washington will impose solutions if consensual agreements cannot be achieved. We assure that a fully operational benchmark assessment system will be in place by the beginning of Month 7 of Year 1.

As the first families are enrolled in this six month period, programs presently collect a limited amount of information we know we will use based on existing practices:

- Demographic data
- Service utilization data
- The Ages and Stages Questionnaire data

These common practices will permit a core set of data that is currently collected and can be shared for benchmark assessment. Because of start-up (contract completion, new staff hiring, staff training in model practices), there will be a short lag from funding release to the enrollment of the first families in local programs. During this start-up period, we will complete negotiations for potential common data collection that can be implemented universally across models and programs. An example of this early likely agreement is the Edinburgh Postnatal Depression Scale that already is in use by most NFP programs or proposed by the PAT national office for

universal use by PAT programs. PAT's adoption of domestic violence screening questions used by NFP may be a second example. As a result, there will be an immediate core of information either based on existing practices or easily adopted tools that will be collected on all families.

A more complex discussion will address new assessment practices for one or both of the models. Our duals goals are:

- build from existing practices when possible
- collect comparable information across the two models

New assessment practices will be decided by negotiated agreement and may entail:

- adoption of some NFP assessment practices by PAT sites.
- NFP agreeing to permit use of some tools they consider copyrighted assessments
- adopt of additional common data collection tools

Advantages to the programs of negotiating shared assessment practices include:

- PAT may be able to take advantage of NFP's tested and efficient assessments
- NFP would not have to change their current practice

In a parallel process to assessment tool selection, we will conduct program specific assessment of staff and organizational capacity needed to move to the expanded assessment and data reporting responsibilities required by the MIECHV benchmark evaluation:

- State Analytic Staff - CQI Technical Assistance and Data Collection & Data Management teams conduct capacity assessment using the adapted FRIENDS Discussion Tool
- Develop specific one year technical assistance and training plans in consultation with programs, and update annually
- All home visitors trained in data collection protocols, standard methods of introducing assessments, and follow-up with families who have prematurely left the program.
- Reassessment and re-training every six months as well as training of all newly hired home visitors as part of CQI
- Conduct process evaluations of training and technical assistance
- Study evaluators will perform data quality reviews monthly and will summarize findings in quarterly reports. Reports will be used to develop or modify data training to address data quality concerns.

Proposed Data Collection and Analysis Plan

Data collection process and content will proceed as follows:

- Data collected by home visitors in their individual caseload
- All clients funded with these federal dollars will be assessed for the benchmark and construct assessment. There will be no sampling of subjects.
- Collection during home visit sessions,
 - following model's existing schedules of assessment
 - conducted every six months following baseline while the family is active in the program if there is no standard schedule

- Baseline information completed within the first four home visits unless model practices or the age or developmental stage of the participant dictates an alternate baseline point.
- Within each family an “identified child”, generally the youngest child at the time of services, will be the focus of child-specific assessments
- Within each family a “primary caregiver” will be the focus of caregiver assessments. Typically this will be the biological mother of the identified child.
- Data collection until the end of the program model planned schedule of services.
- Permission to re-contact families after program dropout will be requested upon enrollment.
 - Re-contact to collect follow-up information would occur on the same schedule as enrolled families.
 - Re-contact is a significant change in current practice but essential to avoid introducing selection bias into the evaluation.

Data Safety, Data Sharing and Data Transfer

- Data sharing agreements will be developed to capitalize on existing electronic client records
- Home visiting staff will be trained in data collection, use, interpretation and maintaining data confidentiality and security.
- Complete training on human subjects protection for all analytic staff. Existing systems will be supplemented with easy-to-use data entry tools for collecting information not included in model or program electronic record systems
- Additional tools will be designed in Microsoft Access to collect client-level data in years 1-3.
- In years 4-5 secure web-based data collection systems will be assessed and implemented if feasible
- Only de-identified data will be shared to comply with HIPPA/FERPA requirements. Local programs will retain a ‘link file’ with a unique study identifier tied to the identifiable personal information for each family and family member who is the focus of assessment information.
- Secure transfer of information will be by encrypted CD or flash drive at least every calendar quarter
- Washington State University evaluation staff will merge data into a data warehouse that will be continuously updated.
- Monthly data quality reviews will be performed

Analysis and reporting

- Quarterly performance reports will be developed to address whether the models are being implemented with fidelity, following implementation standards and serving the at-risk population
- Quarterly performance reports will be used to update training and technical assistance
- Every six months, performance summaries will be developed for programs, communities, models and the state overall MIECHV effort. These reports will summarize the enrolled population and services provided.

- Annually, benchmarks and constructs will be analyzed and results summarized in the report to the Secretary.
- Benchmark and construct analysis will be performed at the program, model and state level. We will assess the change in scale scores and the percent change over time.
- Analyses of annual cohorts in six-month intervals will enable us to use interrupted time series analyses to look at overall program improvement over time.
- Annual cohort and model-specific analyses will track baseline to follow-up change using linear and logistic regression analyses with agency and service factors included as predictors of program change for families.
- Every six months qualitative interviews will be held with all programs using the FRIENDS Discussion Tool with supplemental questions to identify and address:
 - Acceptability
 - Accessibility
 - Cultural competency
 - Sustainability in funded communities
 - Challenges and barriers
 - Lessons learned
 - Changes in need for services
 - Community ability to meet service need
 - Community changes

A principal purpose of these qualitative process interviews is to assess how sustainable the system of home visiting is in Washington, to determine whether the local and state infrastructure is flexible enough to support a diverse home visiting system through environmental changes, and to identify implementation lessons that supplement the benchmark evaluation data to inform the evidence based policy decisions of the state in its management of MIECHV and its assessment of how and when to support expansion of home visiting in Washington.

Following the initial build-out, we will begin collecting baseline data through the end of Year 1. The initial data transfer to WSU will begin in the third quarter of Year 1. We will encourage monthly data transfer for a few months to ensure we identify any start-up issues with data collection and transfer as soon as possible and provide sufficient technical assistance to programs. We will begin monitoring data quality immediately and will provide the initial quarterly performance reports to programs by the end of the tenth month of Year 1. Initial performance summaries and the annual report will be completed at the end of Year 1.

During Years 2-3 we plan to:

- continue data collection and analysis, and develop performance reports, performance summaries and annual report as described above
- continue review of the CQI data, benchmark data and program performance reports to identify challenges
- continue to collaborate with programs and model representatives to identify solutions and develop any needed enhancements or adjustments to improve implementation and data collection
- draft guidelines for standard data collection, reporting and analysis across models
- continue to provide training and technical assistance to program staff

- identify long term goals for using home visiting data in Washington and develop any additional performance measures to meet the needs of Washington State
- modify elements to address benchmark constructs as needed
- modify data collection system and/or analyses as needed to address newly identified benchmark constructs or additional performance measures
- explore administrative data availability, structure, and content and feasibility of linkage to home visiting program data
- explore feasibility of linking home visiting data to other early childhood data systems
- develop plans to meet confidentiality and security requirements for administrative data sharing
- design state agency data warehouse to include administrative data linked to home visiting program data
- obtain IRB approval to transfer data warehouse from WSU to state agency
- update data sharing agreements with models and local programs to enable data transfer from WSU to state agency
- establish state agency data warehouse
- review data and reports from program implementation through the end of year 3, including change analyses to develop report on benchmarks and constructs showing improvement in at least 4 benchmark areas

During Years 4-5 we plan to:

- continue data collection and analysis, and develop performance reports, performance summaries and annual report as described above
- continue review of the CQI data, benchmark data and program performance reports to identify challenges
- continue to collaborate with programs and model representatives to identify solutions and develop any needed enhancements or adjustments to improve implementation and data collection
- continue to provide training and technical assistance to program staff
- modify elements to address benchmark constructs as needed
- modify data collection system and/or analyses as needed to address newly identified benchmark constructs or additional performance measures
- develop report to assess policy level questions regarding home visiting system, its ability to meet the needs of children and families, and the sustainability of services
- obtain IRB approval to transfer and link administrative data with program level home visiting data
- develop data sharing agreement to obtain administrative data
- develop protocol for linking home visiting records to administrative databases
- identify business use requirements for web-based data reporting system
- build web-based reporting system
- train program staff on web-based reporting
- begin web-based reporting
- incorporate administrative data analysis into analysis of home visiting program data

- review data and reports from program implementation through the end of year 5, including change analyses to develop report on benchmarks and constructs showing improvement in at least four benchmark areas

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Section 6: Plan for Administration of the State Home Visiting Program

Administrative Structure to Support the MIECHV Program

Lead Agency

Governor Chris Gregoire designated the Washington State Department of Early Learning (DEL) to lead in the planning and implementation of the MIECHV Program. As the first governor's cabinet-level agency in the nation solely focused on early learning, DEL brings visibility, focus, and results for young children and their families. As the lead agency, DEL will provide fiscal and management oversight of the MIECHV funding.

The Washington State Department of Health (DOH), the State's Title V agency, was designated as lead for the Needs Assessment process, and is the current HRSA grantee. The Lead Agency role will shift at the beginning of FY 2011 from DOH to DEL. DOH will remain an active collaborative partner as the program moves forward providing leadership in child and maternal health, and in data and epidemiology capacity.

Home Visiting Services Account and the Administration of Home Visiting Programs

In 2010, the Legislature created a Home Visiting Services Account (HVSA) to align and leverage public funding with private matching funding to increase the number of families being served, and to support the infrastructure necessary for implementing quality services. The HVSA supports programming that aims to: reduce child abuse and neglect; and improve school readiness through evidence based, research-based and promising practices home visiting services. The HVSA is codified in statute and resides officially with the state treasurer.

DEL is the designated public agency lead for the HVSA. Thrive by Five Washington is the public-private partnership designated in the HVSA statute to manage and administer home visiting including: competitive grant making; direct service implementation; infrastructure (technical assistance); evaluation, and engaging an advisory committee. Additionally, Thrive by Five Washington is the designated partner to raise the private dollars needed for matching the public dollars in the HVSA.

Washington has made a decision to administer the federal MIECHV funding through the HVSA so that we continue to:

- Build a home visiting system in a set strategic direction.
- Leverage and align funding in that set strategic direction.
- Expand services.
- Build infrastructure necessary for high-quality services.

DEL, as the HVSA designated public agency lead, will oversee the MIECHV funding. Thrive will administer, manage and implement the MIECHV funding in accordance with DEL's oversight and the state federal plan. Effective July 1, 2011, Thrive will also manage all state-funded home visiting programs and the private home visiting programs funded through the HVSA.

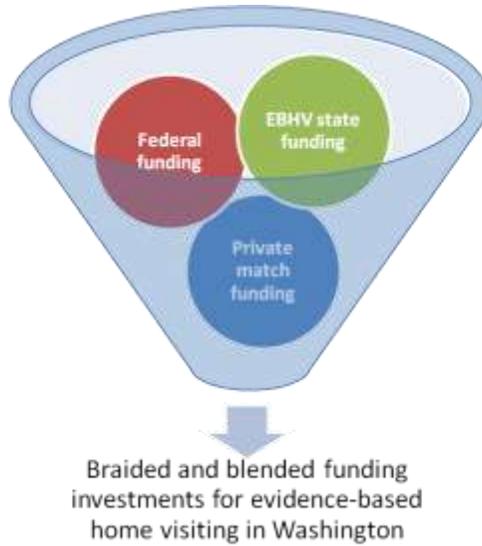


Figure 6: Home Visiting Services Account

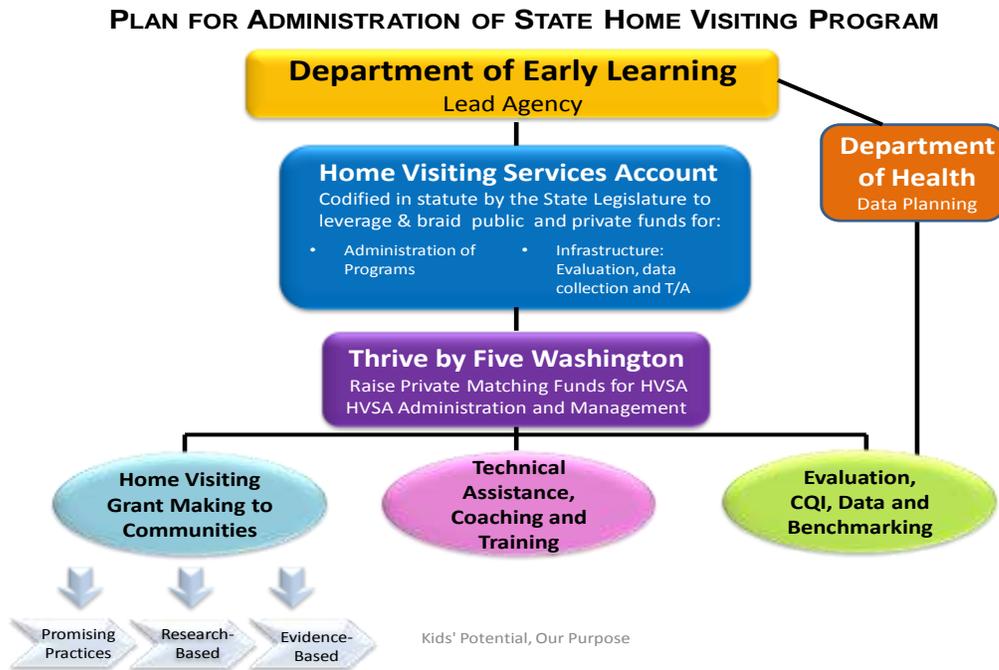


Figure 7: Plan for Administration of State Home Visiting Program

Cross Agency Governance Structure for Planning and Coordination: Collaborative Partners

The following list summarizes the membership and purpose of key groups and individuals involved in the planning and development of Washington State Home Visiting system. *See Attachment A: "WA State Home Visiting Planning Structure"*

Cross Agency Governance Structure, to be renamed the Home Visiting Executive Team

Membership: DEL Director Dr. Bette Hyde, DOH Secretary Mary Selecky, DSHS Secretary Susan Dreyfus, Council for Children and Families Interim Executive Director Chris Jamieson

Purpose: At the request of the Governor, this group leads the development of an evidence-based home visiting system and has final decision-making authority concerning the needs assessment and WA Home Visiting Plan. CAGS decisions include: what key indicators and other factors will be used in the needs assessment, final identification of which communities are at the highest risk, high-level decisions on resource allocation, defining "evidence-based" and ensuring a coordination plan for home visiting in Washington. As appropriate, the CAGS may delegate some decision-making authority to the Partnership Group. This structure will be called the Home Visiting Executive Team starting in July 2011.

Partnership Group

Membership: *DEL:* Kelli Bohanon, Judy King. *DOH:* Riley Peters, Kathy Chapman. *DSHS:* Amy Astle-Raaen. *CCF:* Maria Gehl. *Thrive by Five WA:* Sangree Froelicher, Nancy Gagliano.

Purpose: Appointed by the CAGS, the Partnership Group recommends strategic direction regarding the Home Visiting Program (examples are: final decisions regarding the needs assessment, key components of the Washington Home Visiting Plan, resource allocation, etc.); identifies an advisory committee; defines purpose and leads agenda setting for advisory committee; determines overall stakeholder engagement; prepares and presents decisions for CAGS; etc.

Advisory Committee

Membership: Members of existing Home Visiting Services Account Committee and WA Home Visiting Coalition and others as determined by the Partnership Group.

Purpose: The Advisory Committee provides support and input to the development of the home visiting plan. Specifically, the committee will advise the Partnership Group regarding: decisions related to how the needs assessment will inform the planning process (including the identification of "at-risk" communities where home visiting programs will be implemented as a priority); core components of the Washington Home Visiting Plan (examples are: funding, models, best practices, infrastructure development, etc.)

Members represent the following organizations/affiliation:

- Department of Health
- Department of Early Learning
- Council for Children and Families
- Department of Social and Health Services
- Thrive by Five Washington
- Open Arms Perinatal Services
- Parents as Teachers, State Lead
- Parent Child Home Program, State Lead

Nurse Family Partnership, Region Manager
Washington Dental Foundation
Yakima Valley Memorial Hospital
Children's Home Society
United Ways of Washington
Neighborhood House
Ready by Five Yakima
Jamestown S'Kallam Tribe
Tulalip Tribal Council
King County Children and Family Commission
Seattle King Department of Public Health
St James Family Center
Fight Crime: Invest in Kids

Management Plan for MIECHV Funding at State and Local Levels

An overall plan describing who will be **responsible** for success and how the program will be implemented.

Key Personnel, Position Descriptions, Functions and Resumes.

See Attachment K: "Resumes for Key Administrative Staff"

DEL Position Descriptions:

1. Kelli Bohanon, Assistant Director for Partnerships and Collaborations. This position reports to the DEL Deputy Director, and directs the work of a team of 25 professional staff members. The position is responsible for developing systems that establish a comprehensive and connected early learning system for children statewide; developing strategic partnerships with public education and private sector partners; focusing on school readiness; and strengthening collaboration across DEL programs and with other public sector agencies to align resources, and develop shared responsibility and streamline work to benefit children and families. The position oversees the home visiting work at DEL.
2. Judy King, Parent and Caregiver Engagement Administrator. This position reports to the Assistant Director for Partnerships and Collaboration, and is responsible for establishing new programs and maintaining current partnership efforts in statewide parent and family support efforts. The position leads the home visiting initiative and systems development within the department and in collaboration with statewide partners. The position provides leadership in bringing parent and caregiver involvement to development of policies and programs. The administrator is responsible for project oversight, policy development, program management, parent leadership efforts, and broad based collaborations which assist parents and caregivers with resources and supports. The position integrates research findings into programs, policies and procedures in the agency.

Thrive by Five Washington Position Descriptions:

3. Sangree Froelicher, Deputy Director. The overarching responsibility of the Deputy Director is to directly assist and support the CEO of Thrive by Five Washington in all aspects of her job, including administration, finance, communications, programs, fund development, new initiatives, strategic and operational planning, community relations, staff development and board coordination.
4. Nancy Gagliano, Director of Home Visiting. This position contributes to the overall mission of Thrive by Five Washington by directing and overseeing home visiting systems building, funding, grant-making, evaluation, technical assistance and reporting.

Department of Health Position Descriptions:

5. Riley Peters, Director of Child and Maternal Health. This position provides vision, direction and oversight of the Office of Child and Maternal Health including Maternal Infant Health, Child and Adolescent Health, Immunization Program CHILD Profile, Children with Special Health Care Needs, MCH Assessment, and Genetics. Responsible for interpreting national policy, overseeing multiple grants and funding streams, managing complicated intergovernmental agreements, and working with statewide constituencies.
6. Cathy Wasserman, Epidemiologist. Propose, plan and direct epidemiologic investigations exploring the causes of morbidity and mortality among the Maternal Child Health population in Washington. Analyze and interpret health status and health service information for use in policy development and decision making.

Washington State University Position Descriptions:

7. Christopher Blodgett, Associate Scientist. Director of the Area Health Education Center and Child and Family Research Unit, Washington State University. This unit addresses services and public policy for high risk children and families and community health outcomes.
8. Myah Houghton, Research Associate. Evidence Based Home Visiting Portfolio Evaluation that provides support and assistance with data management, analysis, interpretation, and reporting for continuous quality improvement.

Meeting Legislative Requirements

For detailed information about the local efforts to support competent staffing, quality supervision, implementation capacity, referral networks and monitoring for fidelity, see Section 4: Implementation Plan for Proposed Home Visiting Program.

For the overall statewide approach to fidelity implementation, see Section 5: Plan for Meeting Legislatively-Mandated Benchmarks, and Section 7: Plan for Continuous Quality Improvement.

Coordination of Referral, Assessments and Intakes in Communities with Multiple HV Models

Yakima County is the only county implementing more than one model as part of the MIECHV Program. Local coordination efforts are underway between NFP and PAT. For more information, see Section 1: Identifying our Target at-risk Communities, Yakima County, Sub sections:

D: Existing Mechanisms for Screening and Referral

E: Referral Resources Currently Available and Needed in the Future, and Plan for Coordination Among Existing Programs and Resources

Identification of Related State or Local Evaluation Efforts

Each MIECHV selected community has various levels of involvement with local and/or state evaluation efforts of home visiting. See Section 4: Implementation Plan for State Home Visiting Program, Region/County Baseline Implementation Plans, and Additional Evaluation Efforts.

Coordination with Existing State Early Childhood Plans

Washington's efforts to align efforts and develop a comprehensive system to support children prenatal to age 8 are articulated in the state's 10-year Early Learning Plan. As part of the development of the Updated State Plan for Home Visiting the partners reviewed details in the Early Learning Plan to identify potential linkages, as well as reviewed the work identified in the State Advisory Council Plan and the State Early Childhood Comprehensive Systems Plan. The close connections between the various plans demonstrate the state's commitment to align, coordinate and integrate systems and services to support the healthy development of children and families.

The integration of home visiting work with other key early learning work is further explained in Section 2: State Home Visiting Goal and Objectives. Several key efforts identified include: Universal Developmental Screening, Media Campaign for Parents, State Advisory Council development, Connections to High Quality Early Learning Services, and Strengthening Families.

Section 7: Plan for Continuous Quality Improvement

Washington's Perspective of Continuous Quality Improvement

The goal of CQI in Washington Home Visiting Plan is to continuously improve performance of the home visiting system and home visiting programs by using metrics.

CQI helps programs pursue delivery of reliable, consistent results. CQI requires commitment to being a learning organization, addressing variability, using data-driven decision making and responding to community need while maintaining fidelity to core components of evidence-based models. CQI includes promoting an organizational culture of quality through attitude, transparency, valuing data, commitment to process, honoring existing culture and achieving outcome performance.

Continuous Quality Improvement

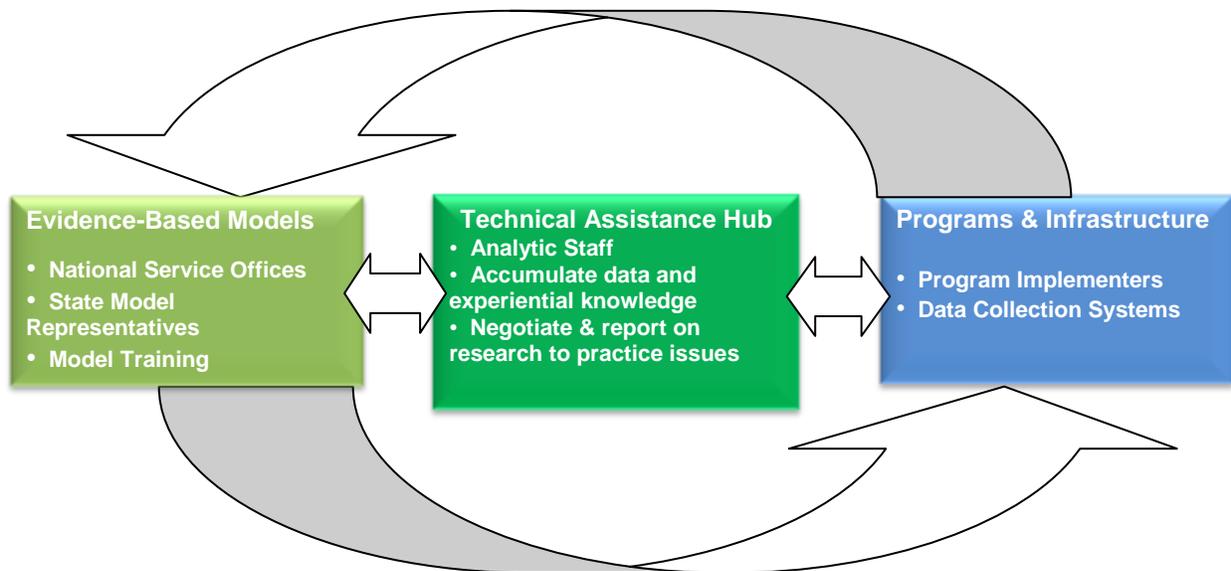


Figure 8: The Continuous Quality Improvement Cycle for the State HV Implementation.

At the program level CQI is expected to achieve the following:

- Empowerment of home visitors and program administrators to seek information about their own practices through the provision of regular reports that summarize performance on a variety of indicators associated with their processes and outcomes.
- A means for community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups.
- Implementation of EBHV models with fidelity to core components of the model and detecting and addressing model drift
- Quality implementation, not just minimum requirements.

- Effective monitoring and measuring of implementation and outcomes.
- A means to discern effectiveness problems from implementation problems and guides ways to address them.
- Mechanisms to ensure adaptations and enhancements to EBHV programs are systematic and effective.
- Reflective analysis and data sharing for program development, identifying key components of effective interventions, and contributing to general meta-level learning.
- Field building information through sharing lessons learned on both implementation and outcome achievement at the program and model levels and identifying training and TA needs.
- Program-level adjustments to correct implementation challenges, improve outcome performance and respond to community needs including strengthening referral networks and the service continuum.

The Importance of CQI

Implementation research and our experiences in Washington show us that what a model's research says will be effective and what actually happens in the field can differ. Implementation research has demonstrated several key findings that have implications for the dissemination and replication of evidence-based programs and practices related to this gap. Several reasons have been documented:

- The knowledge base in the field regarding implementation is lacking.
- Programs have not been clearly informed about the breadth of resources and capacity required to implement evidence-based programs.
- Implementation of evidence-based programs often does not adhere to fidelity and/or monitor for effect.

The research suggests that there are several factors that can positively impact implementation and address these gaps including providing assistance to organizations over time to help them implement a program with fidelity and support them in achieving positive effects.

Child and family differences influence program success in home visiting. Addressing these participant differences is a major source of variability in program effectiveness across interventions and critical to address in understanding system development needs. The ability to replicate evidence-based benefits is often challenged by local variations in family characteristics and need. Home visiting models organically adapt to population differences as well as new research findings.

National model developers recognize this varied set of demands and continue to refine and adapt the original evidence-based strategies based on this field experience. Each EBHV model has fidelity requirements, but they are not always clearly understood or attainable for programs implementing at the community level. When we recognize these requirements, and identify gaps in meeting these requirements, we can address the technical assistance needed at the organizational and/or model level so that programs build capacity to move along the fidelity continuum in implementation.

Finally, a systems perspective is critical to successful implementation of EBHV. The quality of service provided by individual staff depends on the quality of organizational implementation in adopting, adapting, and managing services. As home visiting becomes part of the continuum of care, the quality of supports and resources available will depend significantly on how our efforts are organized to support this quality.

Washington's CQI Plan

Using implementation science principles, our CQI approach focuses on development supports in the following areas to address the identified gap between research and practice:

A. Program Level Development: Performance enhancement at the program and model level, including program accountability, support and evaluation development and increase model specific implementation supports and technical assistance.

B. System Level Development: Development and maintenance, including infrastructure to provide on-going capacity building technical assistance

A. Program Level Development

A Technical Assistance (TA) Hub will coordinate support for all local EBHV programs. This TA Hub will support and oversee model specific and community level training and coaching to ensure quality implementation, adherence to fidelity, and the development CQI processes. The TA Hub, housed at Thrive by Five Washington, will also provide Systems Level Development, described later in this section.

The following components are proposed to develop and support CQI at the program level:

1. **TA to Programs:** Provide TA to programs through one-on-one coaching (site visits, training, report feedback, additional contact as needed) and training to:
 - Support increased/improved agency capacity to engage in CQI by:
 - Enhancing organizational leadership skills to support adoption of CQI practices
 - Developing/enhancing information management systems and use of data in quality improvement
 - Building administrative supports to collect and use data
 - Improving the ability to measure and monitor process and program outcomes
 - Increase/improve agency capacity to implement EBHV with quality and fidelity by:
 - Improving staff training and retention
 - Building supervisory capacity and skills
 - Ensuring a focus on fidelity and performance
 - Increasing capacity to engage families
 - Improving understanding of program theory and its link to program activities

Key Activities:

Activities in the first 6-12 months of grant period:

Activity 1: Develop community/program level MIECHV Logic Model (LM) and tool to:

1. Understand “What Is ”: captures core model component and illuminates unique community/program characteristics and/or enhancements/adaptations
2. Maintain implementation focus: programs stay on track and resist temptations for “model” drift.
3. Align reporting for programs implementing the same EBHV models:
 - Core model components and data benchmarks alignment.
 - Program specific content populating some of the categories, but common activity categories, process outcomes (fidelity) and constructs and benchmarks will be included in the logic model.
4. Standardize reporting: LM will be used as a template for a portion of the quarterly and year end reporting. The LM provides a method for charting progress - tracking what is happening and what is not, where expectations are being met or exceeded, etc.

Activity 2: Review Capacity Assessment and develop technical assistance plans.

Using Implementation Plans submitted and FRIENDS National Resource Center’s Tool for Critical Discussion (Discussion Tool), assess each region/county EBHV model program(s) existing level of capacity to implement their EBHV model with fidelity.

- Identify common areas for technical assistance strategies across programs implanting the same model and across models
- Develop individual program level technical assistance plan
- Prioritize TA Plans and implement based on needs

Activity 3: Develop program level reporting and CQI feedback including the following:

- Quarterly Reporting – demographics, activities, outputs (dosage – frequency and duration), process indicators
- Annual reporting – all quarterly reporting components and required performance indicators
- Feedback on all reports back to communities for reflection and CQI

2. **State Model Representative Support:** Model specific support will be available to the two selected models to ensure strong implementation and fidelity. The State Model Representatives will provide model specific technical assistance around clinical and implementation issues to programs.

For NFP, the NFP State Nurse Consultant will provide these services, and for PAT, the PAT State Leader will provide the services.

- The NFP State Nurse Consultant will:
 - Provide support for fidelity implementation of the evidence-based model
 - Support program adherence to model specific reporting and certification requirements

- Coordinate ongoing NFP training and technical assistance for nurses and supervisors
 - Convene monthly supervisory meetings to:
 - Support programs utilization of data for reflective practice
 - Focus on the implementation needs of the agencies in Washington which includes state specific contextual knowledge and statewide implementation challenges
 - Gain support through the NFP Washington State Consortium, which meets in person 1-2 times per year.
 - Interface with NFP NSO, Washington State TA Hub, and WA NFP programs
 - The PAT State Leader will:
 - Provide technical assistance supporting initial implementation, including development and approval of the initial *Affiliate Plan*.
 - Provide technical assistance on monitoring, assessing and supporting implementation with fidelity to the model and maintaining quality assurance - *Quality Assurance Guidelines*.
 - Provide the *Affiliate Performance Report*, a web-based reporting system. All WA State PAT programs submit their Report to the *WA PAT State Leader* who verifies its completeness and then submits to the national center.
 - Offer technical assistance regarding meeting the *Essential Requirements* (identified as best practices to ensure model fidelity).
 - Provide monthly training calls with PAT programs
 - Interface with PAT National, WA State TA Hub, and WA PAT programs
3. **National Office Support:** The National Offices of the selected EBHV Models will engage in activities to support the success of local programs, state model representative support, and overall system development.

The Nurse-Family Partnership National Service Office will provide the following:

- NFP National Staff Training

Washington's programs implementing the NFP model work closely with the NFP National Service Office to meet the requirements for initial and ongoing training and professional development. All new NFP Nurses are required to complete an NFP Core Education covering the fundamentals of the NFP model and the Partners in Parenting Education (PIPE) curriculum to be used directly with clients. Official printed Core Education and PIPE materials are available through the NSO. The 6-month training includes a minimum of 30 hours of self-study, 4 days of training at the national office, and additional online curriculum.

Requirements are completed in accordance with the following structure:

- *NFP Nursing Practice Unit 1:* 30 hours of self-study, covers 13 chapters that provide foundational information about NFP model and the NFP approach to working with low-income, first-time mothers and the PIPE workbook.

- *NFP Nursing Practice Unit 2*: 4 day in-person training at the national office, provides interactive participant involvement to build skills, integrate information, and deepen knowledge around the NFP model and use of the NCAST assessment tools.
- *NFP Nursing Practice Unit 3*: 3 online sessions completed over a 6-months period, addresses early emotional development, fidelity and model elements, and motivational interviewing.

Initial training of supervisors requires an additional 3 supervisory education units including online sessions, a 3-day, in-person training, and an annual in-person Supervisor and Nurse Consultant Education training.

In addition to the initial training requirements, NFP NSO requires the following ongoing training for NFP professionals:

- Ages & Stages Questionnaire
- NCAST training or another dyadic measurement tool (currently in development)
- NFP National Technical Assistance
 - For newly hired supervisors individual calls are scheduled weekly, biweekly, or monthly and continue for approximately a year.
 - Individual site visits are conducted on at an annual basis.
 - Completion of annual plans using program data to identify quality improvement efforts to be undertaken during that year with the Regional Nurse Consultant.
 - Regional Program Developer and the Regional Nurse Consultant support available upon requested by the site.
- NFP National Data Management, Fidelity and CQI
 - All programs enter data into the Efforts to Outcomes (ETO) system.
 - Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

The National Office of Parents as Teachers will provide the following:

- PAT National Training
 - The 40 hour training will be provided for parent educators and supervisors to meet certification requirement before implementing the program.
 - Certified parent educators must also complete in-service professional development hours annually to maintain their certification.
 - *PAT Foundational Training* and a *Model Implementation* re-training (Supervisors are only required to attend the Model Implementation, but *strongly* advised to complete Foundational Training as well) to satisfy requirements for Affiliate status. All parent educators must complete training in the Ages and Stages 3– both developmental and social emotional Questionnaires (ASQ-3); the Edinburgh Post Natal Depression Screening; and a Family Assessment Screening tool (LSP recommended by national). PAT offers a variety of professional development trainings as well as an

annual conference to help parent educators meet this requirement. Parent educators may opt to participate in local early learning trainings to satisfy some of the PAT requirements.

- PAT National Technical Assistance
 - Support initial implementation, including, the development and approval of the initial Affiliate Plan.
 - *Quality Assurance Guidelines* - monitoring, assessing and supporting implementation with fidelity to the model and maintaining quality assurance - *Essential Requirements* support
- PAT National Data Management, Fidelity and CQI
 - Currently *Visit Tracker* is national Parents as Teachers recommended data management system. (Not all programs in Washington use Visit Tracker.)
 - The *Quality Assurance Guidelines* and *Essential Requirements* represent the programmatic elements necessary for model fidelity and should be used to guide the development and growth of a PAT affiliate and the completion of an *Affiliate Plan*.
 - Affiliates annually report data on service delivery, program implementation, and compliance with the model replication requirements through the *Affiliate Performance Report*, a web-based reporting system. All WA State PAT programs submit their Report to the *WA PAT State Leader* who verifies its completeness and then submits to the national center.

B. Systems Level Development

The Technical Assistance (TA) Hub, that provides Program Level Development discussed above, will also support the proposed Systems Level Development. This work, overseen by Thrive by Five Washington, will support the overall state's home visiting efforts including:

- Integrating knowledge from implementation research to support programs achieving quality implementation with fidelity and demonstrated outcome achievement. Accumulate data and experiential knowledge to engage in CQI at a systems level, contribute to field building.
- Reporting on research to practice issues.
- Promoting alignment of home visiting funding, policy and practice.

Key Activities:

Activities in the first 6-12 months of grant period:

Activity 1: Develop staffing and structure for statewide Technical Assistance Hub.

Activity 2: Engage model representatives, programs and stakeholders in collaborative efforts to identify and propose approaches quality implementation and continuous quality improvement.

Activity 3: In coordination with the National Equity Project, provide technical support to grantees to improve cultural appropriateness of their EBHV program.

Activity 4: Engage consultants from the National Equity Project and national and state model representatives to analyze national models and develop culturally competent adaptations.

- Plan for community development activities for programs serving rural, isolated and tribal communities.
 - Outreach and engagement with rural communities in need of services.
 - Provide external consultants to support communities in developing a plan for implementation of home visiting.
- Plan for Promising Program development:
 - Provide technical assistance to assist programs in identifying core components of their model, monitoring implementation, developing data and evaluation capacity, and improving their financial management.

Section 8: Technical Assistance Needs

State System Needs

Washington has a long history of implementing evidence-based home visiting programs as well as providing technical assistance to grantees for capacity-building and CQI. We have identified several key challenges or opportunities that we plan to address through the MIECHV Program with expert technical assistance. These include:

- Developing a sustainable system to meet the range of technical assistance needs in communities.
- Developing sustainable services in rural, isolated and tribal communities.
- Building a strong data system to support CQI and accountability.
- Building linkages between home visiting and universal developmental screening initiative.

Developing a Sustainable System to Meet the Range of Technical Assistance Needs in Communities

Our proposal addresses these factors by creating a system level Technical Assistance Hub. We have drawn heavily on the implementation research and understand the critical nature of providing this type of support. We are most interested in approaches to support services and systems across communities and models. We anticipate a great need for coaches/trainers who are experts in utilizing CQI for program development. These staff will need a deep knowledge of both CQI processes and implementation science. They also must be skilled at relationship-based professional development to effectively support grantees in building these skills. We plan to develop a team to provide the technical assistance to all Washington home visiting programs in a coordinated, responsive and cohesive manner. Our request for technical assistance is related to supporting this structural element of our system. Figure 7 in Section 7 outlines the role of Technical Assistance in Continuous Quality Improvement for the HV Program. We would like to engage experts from the implementation science field to support us in further developing this system.

Developing Sustainable Services in Rural, Isolated and Tribal Communities

We also request assistance in developing services in rural, isolated and tribal communities. Our community selection/model matching process identified high need geographic communities with no existing EBHV services. In FY 2011, we plan to explore outreach and engagement activities in these communities to identify the best methods for supporting their local efforts in planning for home visiting services and developing linkages with existing supports and services for families. With significant barriers to establishing sustainable services in some of these isolated areas, we request technical assistance to support our efforts. Relationship-building and the development of trust will be critical to our success. Dialogue in communities with families and trusted agencies will be a primary focus of this longer term process.

Through the Home Visiting Needs Assessment, we have also have identified high risk among American Indian/Native Alaskan populations. The American Indian Health Commission, in their

Maternal Infant Health Strategic Plan, identified specific needs and opportunities for collaborative work in supporting AI/AN pregnant women and infants. Preliminary conversations have begun, and in FY 2011 we plan to explore strategies to expand and improve maternal infant health services through increasing our collaborative work. As a state with several American Indian Home Visiting programs selected as part of the tribal MIECHV funding, technical assistance could help us better understand approaches that have been successful across the country with meeting the needs of AI/AN families in a culturally competent manner, and how funding through the Affordable Care Act can help us better meet those needs through home visiting.

Building a Strong Data System to Support CQI and Accountability

Washington will continue active involvement in the national dialogue about performance management and the data/benchmarks requirements of this grant. There is much work happening at the local level, state level, and at the model level to understand the best approach to this work. Washington requests ongoing technical assistance as we fine-tune our measures, develop cooperative agreements, try out processes on the ground level, and identify ways to enhance our ability to improve program performance and report on successes.

Building Linkages Between Home Visiting and Universal Developmental Screening Initiative

As a Help Me Grow National Replication Grant recipient Washington is interested in learning how other states have linked home visiting to universal screening. Technical assistance would be helpful to explore opportunities to build linkages at the state and local level so that families entering a door for developmental screening can be connected to home visiting, and home visiting programs offer robust screening and referrals as part of model implementation.

Section 9: Reporting Requirements

Washington will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the home visiting program. This report will contain descriptions of:

Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period
- Barriers to progress and strategies taken to overcome these barriers
- Updates or revisions to goals and objectives in the Updated State Plan
- Updates or changes to the Home Visiting State Plan logic model
- Washington's efforts to contribute to a comprehensive high-quality early childhood system, using the Updated State Plan's logic model.

Promising Program Update

- Evaluation of any implemented promising programs
- Copies of reports from local evaluation of promising programs and other evaluation of the overall home visiting program

Implementation in Targeted At-Risk Communities

For each Targeted At-Risk Community:

- Community engagement
- Work with and technical assistance from national model developer
- Procurement of curricula and other materials
- Training and professional development activities
- Staff recruitment, hiring, and retention
- Participant recruitment and retention
- Program caseload
- Coordination between home visiting programs and other existing programs and resources
- Challenges to maintaining quality and fidelity for the home visiting program and proposed response

Legislatively Mandated Benchmarks

For each benchmark area data collection efforts, including data collected, definition of improvement, data sources for measures, barriers and challenges and steps taken to resolve them.

Continuous Quality Improvement

| | |
|---------------------------|--------------------------------------|
| Administration of Program | Organizational Chart Updates |
| Key Personnel Updates | Supervision strategies |
| New Policy updates | Referral and service network support |
| Staff training efforts | |

Attachments

Attachment A: WA State Home Visiting Planning Structure

Attachment B: WA Map of Geographic Risk and EBHV Programs

Attachment C: WA Map of Infant Toddler Regions

Attachment D: WA Map of MIECHV Communities FY 2010

Attachment E: Community Program Capacity Assessment to Implement the EBHV Model

Attachment F: Implementation Plan Proposal for Selected Communities

Attachment G: Community Program(s) Capacity Assessment Technical Assistance Q & A

Attachment H: Community Need and Capacity Assessment Review

Attachment I: MIECHV Communities' Implementation Plans

Attachment J: Washington State Proposed Measures to Meet Legislatively-Mandated Benchmarks

Attachment K: Resumes for Key Administrative Staff (removed from this version)

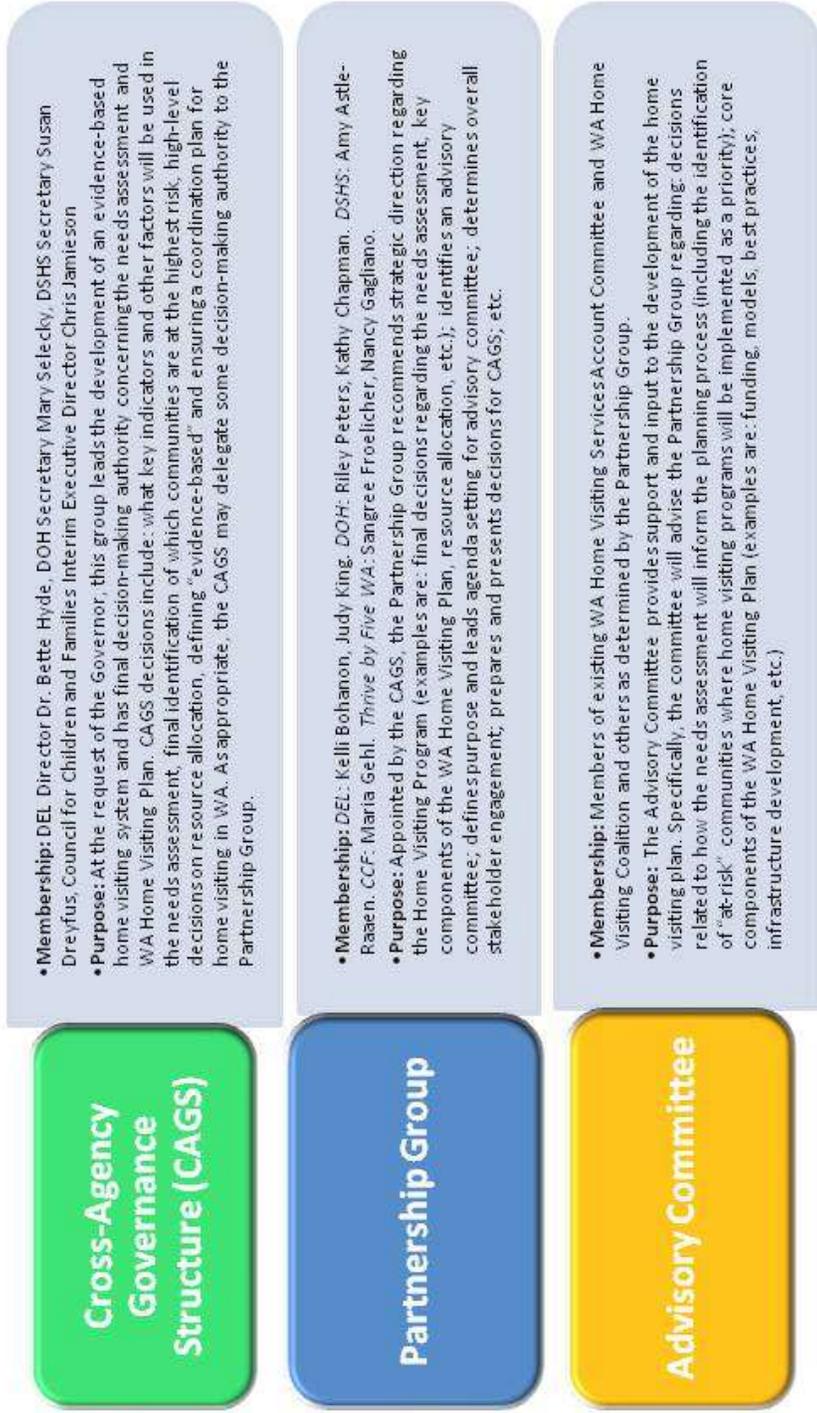
Attachment L: Letters of Concurrence (removed from this version)

Attachment M: Budget

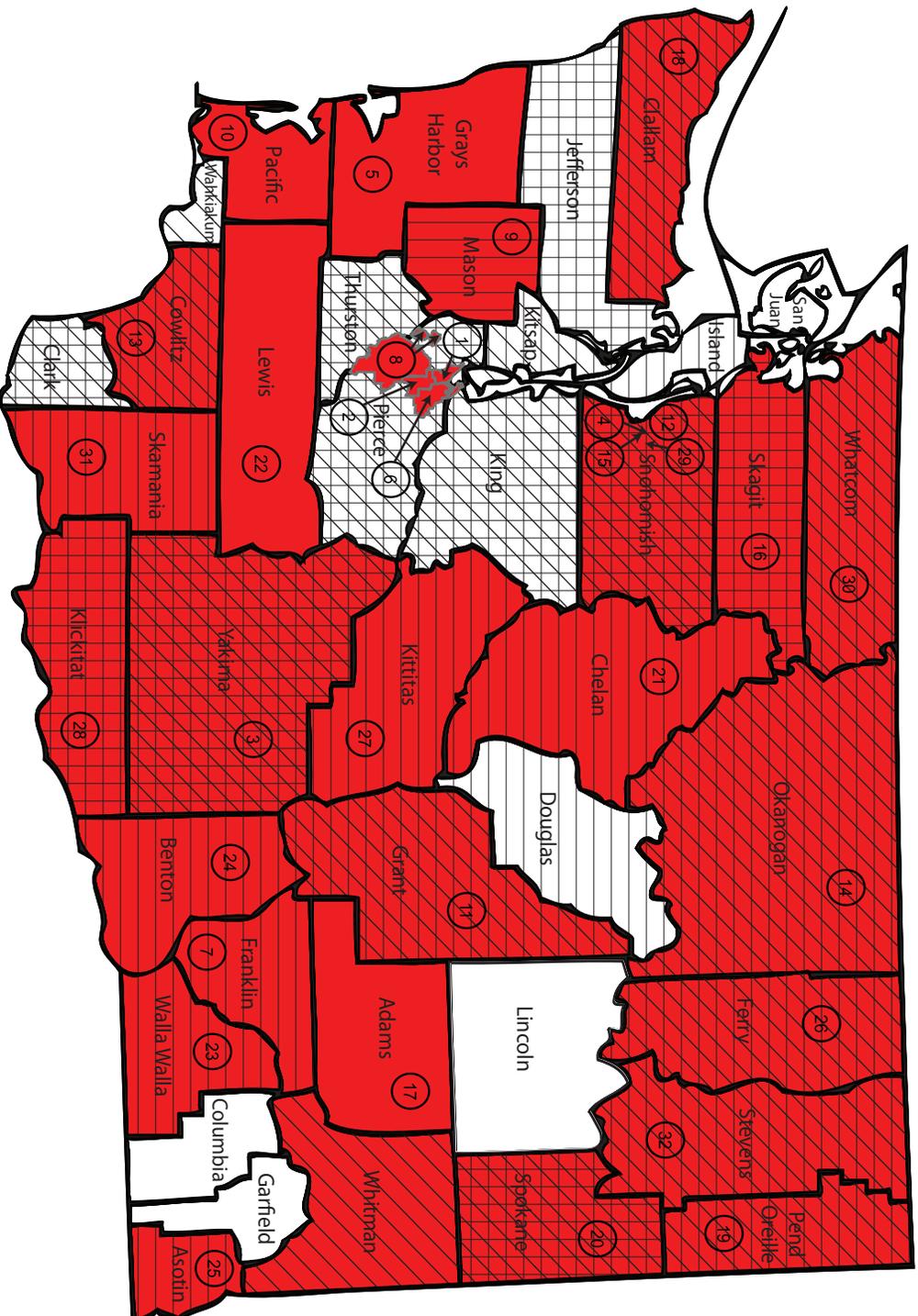
Attachment A: WA State Home Visiting Planning Structure

Washington State Home Visiting Planning Structure

This document summarizes the membership and purpose of key groups and individuals involved in the development of the WA Home Visiting Plan. It is not an exhaustive list of all elements involved. The WA Home Visiting Plan is being created in response to the opportunity for federal funding for home visiting through the Patient Protection and Affordable Care Act of 2010 (Health Care Reform, Act H.R. 3590). In Washington, Governor Gregoire designated the Department of Health (DOH) to lead the development of the home visiting needs assessment and has directed the Department of Early Learning (DEL) to lead the home visiting planning process (that will result in the submission of a WA Home Visiting Plan).



Attachment B: WA Map of Geographic Risk and EBHV Programs



Early Head Start



Nurse-Family Partnership

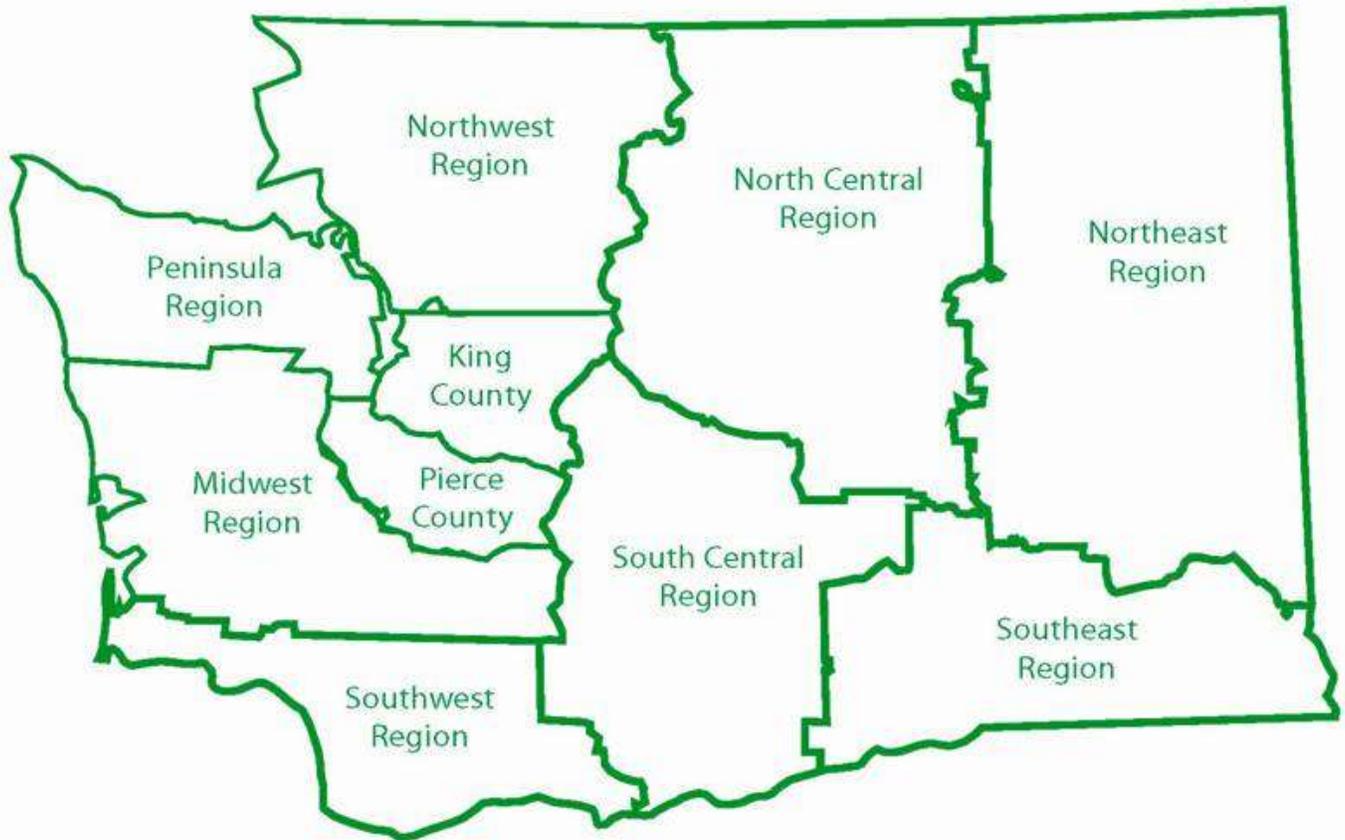


Parents as Teachers

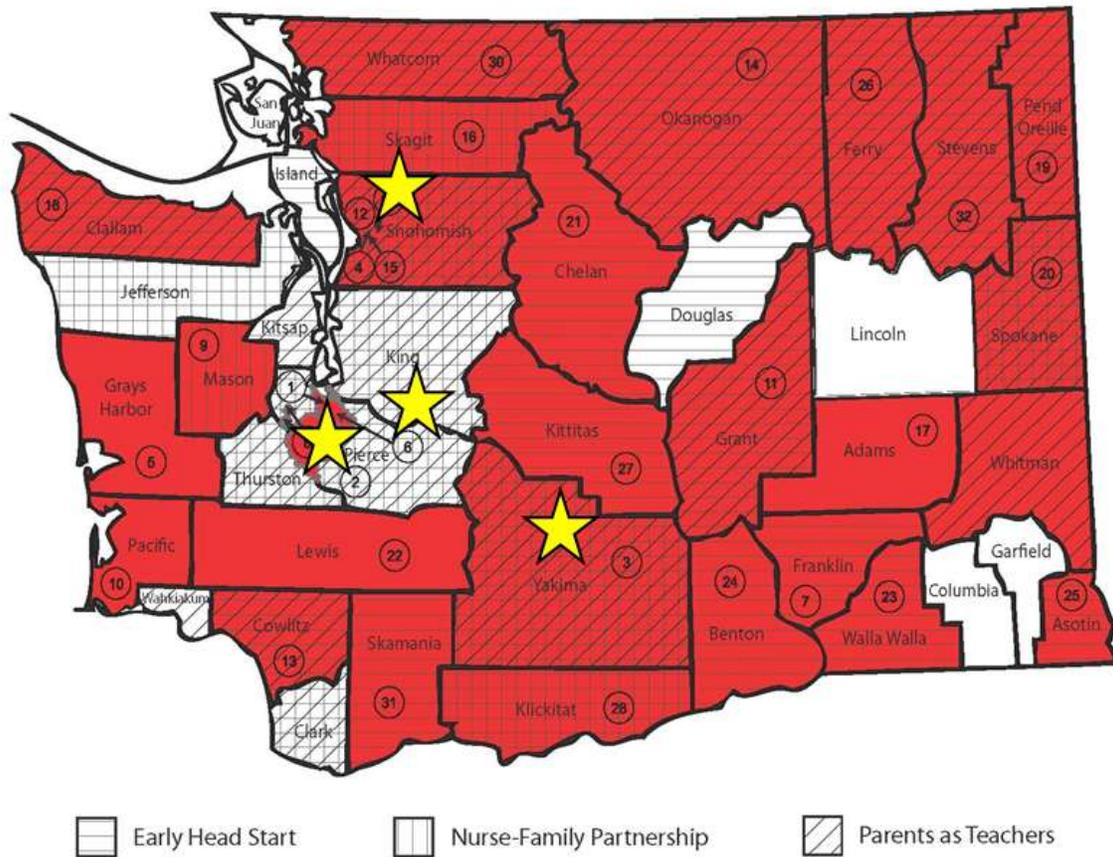
The following 32 geographic areas in Washington state were identified as at-risk compared to the state. These at-risk areas are listed as follows in the order of the summary risk score they received.

1. Pierce County-City Council District 4
2. Pierce County-City Council District 5
3. Yakima County
4. Snohomish County-North Everett
5. Grays Harbor County
6. Pierce County-City Council District 2
7. Franklin County
8. Pierce County-City Council District 6
9. Mason County
10. Pacific County
11. Grant County
12. Snohomish County-Marysville-Tulalip
13. Cowlitz County
14. Okanogan County
15. Snohomish County-South Everett
16. Skagit County
17. Adams County
18. Clallam County
19. Pend Oreille County
20. Spokane County
21. Chelan County
22. Lewis County
23. Walla Walla County
24. Benton County
25. Asotin County
26. Ferry County
27. Kittitas County
28. Klickitat County
29. Snohomish - Lake Stevens
30. Whatcom
31. Skamania
32. Stevens

Attachment C: WA Map of Infant Toddler Regions



Attachment D: WA Map of MIECHV Communities FY 2010



The following 32 geographic areas in Washington state were identified as at-risk compared to the state. These at-risk areas are listed as follows in the order of the summary risk score they received.

- | | |
|--|----------------------------|
| 1. Pierce County-City Council District 4 | 17. Adams County |
| 2. Pierce County-City Council District 5 | 18. Clallam County |
| 3. Yakima County | 19. Pend Oreille County |
| 4. Snohomish County-North Everett | 20. Spokane County |
| 5. Grays Harbor County | 21. Chelan County |
| 6. Pierce County-City Council District 2 | 22. Lewis County |
| 7. Franklin County | 23. Walla Walla County |
| 8. Pierce County-City Council District 6 | 24. Benton County |
| 9. Mason County | 25. Asotin County |
| 10. Pacific County | 26. Ferry County |
| 11. Grant County | 27. Kittitas County |
| 12. Snohomish County-Marysville-Tulalip | 28. Klickitat County |
| 13. Cowlitz County | 29. Snohomish-Lake Stevens |
| 14. Okanogan County | 30. Whatcom |
| 15. Snohomish County-South Everett | 31. Skamania |
| 16. Skagit County | 32. Stevens |

Attachment E: Community Program Capacity Assessment to Implement the EBHV Model

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
Community's Program(s) Capacity Assessment to Implement the EBHV Model**

Overview Community's Program(s) Capacity Assessment to Implement the EBHV Model

When we think about a community's capacity to implement an EBHV model, we are referring to the resources available to the program(s) that are implementing the EBHV model with fidelity. Fidelity is, "... the degree to which a program as implemented corresponds with the program as described" (Fixen, Naoom, Blase, Friedman & Wallace, 2005 National Implementation Resource Network). Research supports implementation with fidelity is correlated with better model specific results and outcomes. Depending on the EBHV model, there are approaches and tools to assess the degree to which the program is being implemented as described. Some common components of fidelity measures are:

- Target Population
- Use of the Program Components and Materials
- Proper Settings
- Staff Qualifications
- Staff training and supervision
- Dosage/Exposure
- Number and length of sessions/contacts
- Number of families per worker
- Quality of Program Delivery (e.g. competence of practitioners)

Therefore, in order to work towards EBHV model specific outcomes, EBHV models and programs implementing an EBHV model must routinely assess their capacity to implement with fidelity. This is why a capacity assessment is so helpful. By responding to the Community Program(s) Capacity Assessment questions, a general assessment of resources available to implement the EBHV model with fidelity can be considered.

Please note, the assessment of community program(s) capacity to implement the EBHV model is just one of multiple factors that will be used to decide final community and model selection awarded for the first round of funding by the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program funding.

Overview of Funding Focus for Year One:

1. **Funded programs will be in at-risk communities, defined by the DOH Home Visiting Needs Assessment, that have existing evidence based home visiting models.**

The following seven communities, identified through the Washington State DOH Needs Assessment with high risk based on geography or race/ethnicity and that currently provide evidence based home visiting, will be considered for funding:

- Pierce County –Council Districts 2, 4, 5 and 6
- Yakima County
- Snohomish County –North Everett
- Franklin County
- Mason County
- Grant County
- South King County – included based on high numbers of Medicaid births to American Indian/Alaska Native and African American women.

EBHV Models: Three EBHV models, approved in the federal guidance and currently operating in these communities, will be considered:

- Early Head Start – Home Based Option;
 - Nurse-Family Partnership; and/or
 - Parents as Teachers.
- Home visiting services must be provided to populations identified as being high risk in the Washington State DOH Home Visiting Needs Assessment. Communities must also prioritize participants identified in the Supplemental Information Request (SIR) for the MIECHV Program. These include participants that:
 - Have low incomes;
 - Are pregnant women who have not attained age 21;
 - Have a history of child abuse or neglect or have had interactions with child welfare services;
 - Have a history of substance abuse or need substance abuse treatment;
 - Are users of tobacco products in the home;
 - Have, or have children with, low student achievement;
 - Have children with developmental delays or disabilities;
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.
 - Existing programs implementing the EBHV model can expand to increase the number of families being served and/or support the critical sustainability of current level of services whose non-state funding is in jeopardy. There will be no new evidence based home visiting programs or start ups funded in this initial round.

Directions for Community Program Capacity Assessment to Implement the EBHV Model

1. Three EBHV models are asked to provide Community Capacity Assessments:
 - Early Head Start – home based
 - Nurse Family Partnership
 - Parents as Teachers
2. Community Program(s) Capacity Assessments will be from the following seven communities identified through the Washington State DOH Needs Assessment with high risk based on geography or race/ethnicity **and are currently implementing an evidence based home visiting model approved in the federal guidance :**
 - a. Pierce County –Council Districts 2, 4, 5 and 6
 - b. Yakima County
 - c. Snohomish County –North Everett
 - d. Franklin County
 - e. Mason County
 - f. Grant County
 - g. South King County – included based on high numbers of Medicaid births to American Indian/Alaska Native and African American women.
3. Three WA model representatives are in charge of coordinating and **submitting ONE Community Program Capacity Assessment for all the EBHV program(s) in a semifinalist community.**
 - The three WA model representatives for each of the models are:

| EBHV Model | EBHV Model Representative | Email |
|-------------------------------|---------------------------|---|
| Early Head Start – home based | Jennifer Jennings-Shaffer | jennifer.jennings-shaffer@del.wa.gov |
| Nurse Family Partnership | Kristen Rogers | kristen.rogers@nursefamilypartnership.org |
| Parents As Teachers | Linda Clark | lclark@parenttrust.org |

4. EBHV Model, Semifinalist Communities & Existing Organizations Providing the EBHV Program(s)

Early Head Start – Home Based

| Geographic Area | Organization(s) Providing EHS – Home Based Program |
|---|--|
| 1) Pierce: Council Districts 2,4,5 and 6 | 1a) Puget Sound Educational Service District |
| 2) Yakima | 2a) Enterprise for Progress in the Community 2b) Washington State Migrant Council |
| 3) Snohomish – North Everett | 3a) Snohomish County Head Start |
| 4) Franklin | 3b) See Tulalip Tribe |
| 5) Grant | 4a) Benton/Franklin Head Start |
| 6) South King – included based on high numbers of Medicaid births to American Indian/Alaska Native and African American Women | 5a) Family Services of Grant County 6a) Children’s Home Society of Washington 6b) Denise Louie Education Center 6c) First AME 6d) Neighborhood House 6e) See United Indians |

Nurse Family Partnership

| Geographic Area | Organization(s) Providing NFP |
|--|--|
| 1) Pierce: Council Districts 2,4,5, and 6 | 1a) Tacoma-Pierce County Health Department |
| 2) Yakima | 2a) Yakima Valley Memorial Hospital |
| | 2b) Yakima Valley Farm Workers Clinic |
| 3) Snohomish – North Everett | 3a) Snohomish Health District |
| 4) Mason | 4a) Mason County Health Department |
| 5) South King- included based on high numbers of Medicaid births to American Indian/Alaska Native and African American Women | 5a) Public Health: Seattle & King County |

Parents as Teachers

| Geographic Area | Organization(s) Providing PAT |
|---|--|
| 1) Pierce: Council Districts 2,4,5and 6 | 1a) Heroes at Home (scheduled to close 9/10) |
| 2) Yakima | 2a) Catholic Family & Child Services (Ready by Five) |
| | 2b) Yakima Valley Farm Workers Clinic (Project LAUNCH) |
| | 2c) Parent Trust for Washington Children |
| 3) Snohomish-North Everett | 3a) See Tulalip Tribe |
| 4) Grant | 4a) Family Services of Grant County |
| 5) South King - included based on high numbers of Medicaid births to American Indian/Alaska Native and African American Women | 5a) Children’s Home Society Healthy Start (Friends of Youth) |

Frequently Asked Questions:

Guidelines for Completing the Community Program(s) Capacity Assessment to Implement the EBHV Model and Technical Assistance Available

- **DUE DATE: MONDAY, APRIL 11 TH, 2011 - 2:00 PM**
- **There will be no exceptions to this deadline.** Any Community Program(s) Capacity Assessment received after 2:00 PM on Monday, April 11th, 2011 will not be considered.
- **Model Representatives must submit only ONE Community Program Capacity Assessment Summary per semifinalist community for all of the EBHV program(s) in that community. Please EMAIL two (2) electronic copies, one in WORD and in PDF to:** Michelle Low, Thrive by Five Washington, at michelle@thrivebyfivewa.org & Judy King, Department of Early Learning, at judy.king@del.wa.gov. Please be sure to save the document as follows: CountyModelNameModelRepInitialsDate. For example: OceanCountyXYZModelNG4/11/11.
- Use standard font type Times New Roman, 11 point, with one inch margins. Number all pages. Please use headings to identify each section.
- Technical assistance opportunities are available as follows:

EBHV Model Representatives can schedule a **one hour** technical assistance (TA) call, with Thrive by Five Washington, for each semifinalist community implementing the EBHV model they represent. The EBHV Model Representative can coordinate with the organization(s) in that community to be on the TA call with the Model Representative and arrange for a number for all parties to call in on. Thrive by Five Washington will contact the EBHV Model Representative at the number requested at the time the technical assistance call is scheduled. Thrive by Five Washington will not be taking individual calls from the organizations implementing the model in the semi-finalist community. Please contact Michelle Low, Project Support Coordinator, at Thrive by Five WA via email michelle@thrivebyfivewa.org or phone 206.621.5572 to schedule a time. Michelle will schedule all one hour TA calls based on availability on the following dates and times:

- Thursday, March 31, 2011: 2:00pm-5:00pm
- Friday, April 1, 2011: 1:00pm-4:00pm
- Monday, April 4, 2011: 1:00pm-4:00pm
- Tuesday, April 5th: 12:00pm-2:00pm
- Wednesday, April 6, 2011: 3:00pm-5:00pm

Once the TA call is scheduled, Michelle Low will ask that you send your questions to Michelle 24 hours in advance of your call so we can best be prepared to answer your questions during the call. All Q & A will be posted to the HVSA website by the following day close of business.

- **Sections, Maximum Total Pages Allowed:** Below are the sections for a complete Community Capacity Assessment. **Maximum total pages allowed for a Community Capacity Assessment is 11. Each section also has a maximum page limit allotted. Any Community Capacity Assessment that exceeds the 11 page limit, and/or exceeds page limit(s) for any of the sections will not be considered.** Please ensure the following categories of information, in this order and within the corresponding page limits, are included.

Community's Program(s) Capacity Assessment Sections & Page Limits for Each Section

| Capacity Assessment Sections | Maximum Pages |
|-------------------------------------|----------------------|
|-------------------------------------|----------------------|

| | |
|---|----------------|
| | Allowed |
| Community/Organization(s) Information | 2 |
| Participant Assessments and Priority Given to Eligible Participants | 1 |
| National EBHV Model Developer, Technical Assistance & Support | 1 |
| Staff Recruitment, Training & Retention | 1 |
| Clinical Supervision and Reflective Practice | 1 |
| Monitoring, Assessing & Supporting Implementation with Fidelity and Ongoing Quality Assurance | 1 |
| Evaluation, Data Management & Ongoing Continuous Quality Improvement | 2 |
| Funding | 1 |
| Approval by the EBHV Model Developer | 1 |
| Total Pages Allowed | 11 |

**Affordable Care Act Maternal, Infant and Early Childhood
 Home Visiting Program
 Supplemental Information Request of the Updated State Plan
 Community's Program(s) Capacity Assessment to Implement the EBHV Model**

| Community/Organization(s) Information | | | |
|---|---|--|--|
| Submission Date: _____ | EBHV Model State Representative Submitting the Assessment: _____ | | |
| Evidence Based Home Visiting Model: | <input type="checkbox"/> Early Head Start – home based <input type="checkbox"/> Parents as Teachers <input type="checkbox"/> Nurse Family Partnership | | |
| Identify the Semi-Finalist community according to: | DOH Needs Assessment: _____ Ranked as: _____ | | |

| | | | |
|--|--|--|----------------------|
| Identify the at risk population(s) identified in the WA State DOH Needs Assessment for the Semi-Finalist community: | <input type="checkbox"/> Hispanic <input type="checkbox"/>Non-Hispanic Blacks <input type="checkbox"/> Non-Hispanic Pacific Islanders <input type="checkbox"/>Non-Hispanic Asian <input type="checkbox"/> Non Hispanic American Indian/Alaska Natives <input type="checkbox"/>Non-Hispanic Multiple Races <input type="checkbox"/> White | | |
| Numbers (#'s) served currently by program(s) implementing the EBHV model: | # of CHILDREN | # OF PARENTS/ADULTSADULT CAREGIVERS | # OF FAMILIES |
| What is the number of <u>additional</u> families that could be served through expansion, without duplication of services in your community, by the EBHV model | # of FAMILIES | | |
| Organizations Currently Implementing EBHV Model | | | |
| Organization(s), Address | | | |
| Organization(s) Address | | | |

Community’s Program(s) Capacity Assessment to Implement the EBHV Model

Please respond to the following questions.

Participant Assessments and Priority Given to Eligible Participants

(Page limit- 1)

1. Are individualized assessments of participant families conducted?
 - a. If, yes –please describe how services are provided in accordance with those individual assessments.
2. How does the program(s) assure services are provided on a voluntary basis?
3. Please check if priority is given to serve eligible participants who:
 - Have low incomes
 - Are pregnant women who are under 21

- Have a history of child abuse and neglect or have had interactions with child welfare services
- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home
- Have, or have children with, low student achievement
- Have children with developmental delays or disabilities
- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States

National EBHV Model Developer, Technical Assistance & Support

(Page limit - 1)

4. Please briefly describe how program(s) in this community work with the national model developer.
5. Do the programs in your community receive regular ongoing technical assistance from a national developer and/or a representative of the EBHV model?
 - a. If, yes – describe what technical assistance and support that is provided by the national developer and/or representative of the EBHV model. What is the frequency, duration of the support available?

Staff Recruitment, Training & Retention

(Page limit - 1)

Staff Recruitment:

6. What qualifications (e.g., degrees, credentials or experience) are needed for the program(s) staff to implement the EBHV model?
7. What unique skills are needed among staff (i.e. bilingual staff) to implement the EBHV program(s) in your community?
8. How many staff are currently hired to implement the EBHV program(s) in your community?
9. Are there enough individuals at the organizations and/or in your community with the necessary qualifications to successfully maintain and/or expand the EBHV program in your community?

Staff Training

10. What initial and ongoing training is provided by the national model developer?
11. What initial and ongoing professional development activities are provided by your local agencies/community?
12. Is existing staff currently trained in the EBHV they model?

Staff Retention

13. What mechanisms are in place to retain staff in the program(s)?

Clinical Supervision & Reflective Practice

(Page limit- 1)

14. What are the EBHV model's requirements for staff supervision? Describe program(s) understanding of the model's supervision requirements and how each meets these requirements.

15. Are there currently individuals on staff/in your community who are providing this supervision? What is the frequency, duration of the supervision provided?

Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

(Page limit- 1)

16. How does the EBHV program(s) participate in fidelity monitoring and/or quality assurance through the national model developer?
17. Does the EBHV program(s) conduct fidelity tracking or quality assurance on its own? If yes, please describe.
18. Please describe all enhancements that are currently being made by the EBHV program(s). Enhancements are any additional activities above the core model components.
19. What is the average rate of attrition for program participants?
20. Provide the average dosage of services provided to families (frequency and duration).

Evaluation, Data Management and Ongoing Continuous Quality Improvement

(Page limit- 2)

21. Please respond to the following questions on how program(s) collects, maintain and uses any data collected for the EBHV model:
- a. Assessment/Masurement Tools:
Assessment/Measurement tools are what we use to capture information on whether or not an indicator has been achieved, and to what degree. Some EBHV models use standardized evaluation tools such as written instruments that contain questions about the indicators you are tracking. Some programs implementing EBHV models use a standardized tool and/or other tools to capture information.
- Please include the following for **each** Measurement Tool used by Program:
- The name of Measurement Tool
 - Developed by:
 - Frequency administered
- b. Does the EBHV model have a database that program(s) implementing the EBHV model are using? If yes, what database does the EBHV model use? Are the programs implementing the EBHV model in this community using this database?
- c. If there is no existing national model database, how do the EBHV program(s) in your community track the data; is there another database system that is used?
- d. Are there modifications needed to the program(s) database(s) to help track and report on the data collected?
- e. Who is responsible for collecting the data in the program(s)?
- f. Who is responsible for data input in the program(s)?
- g. Who analyzes and reports the data in the program(s)?
- h. How is the data used once analyzed in the program(s)?

Funding

(Page limit- 1)

22. What is the total existing level of funding program(s) received for the EBHV model services that are currently being provided?
23. Please list all funding sources. Please provide **non-state funding** that will not be continued in the coming fiscal year and the number of families served with the non-state funding.
24. Based on the information you provided for questions 22 & 23, what level of funding are program(s) seeking for this coming fiscal year to sustain existing services?
25. How many families are served annually by the program(s)?
26. How many families will be served with sustaining funding as is?

Approval by the EBHV model Developer to Implement the EBHV Model

(Page limit- 1)

27. Based on your knowledge of the EBHV model developer requirements, will all or some of the program(s) likely be approved by the EBHV model developer to implement the EBHV model?
 - a. Please list the names of the organization(s) in this community that you believe would be approved by the EBHV Model Developer to implement the EBHV model.
 - b. Please provide the names of the organizations that you believe would not be approved and a brief reason as to why they would not be approved at this point.

Attachment F: Implementation Plan Proposal for Selected Communities

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
Implementation Plan Proposal for Selected Communities**

Overview of Implement Plans for Selected Communities

For Communities/Models selected for funding an “Implementation Plan” (IP) is required. The IP will build off of the Community Program(s) Capacity Assessments, gathering additional information regarding implementation planning, data collection, meeting the legislatively mandated benchmarks, and continuous quality improvement. The process is similar to the Capacity Assessments process just completed. Once again, the EBHV Model Representative is in charge of coordinating and submitting one IP Proposal for each selected county/region implementing the EBHV model. **The IP must be completed by Monday, May 16th at 2:00 pm.** These county/region Implementation Plans will be submitted in early June as part of Washington’s Updated State Plan.

Guidelines for Completing the County/Region EBHV Model Implementation Plan Proposal and Technical Assistance Available

1. The following four communities and two evidence-based home visiting models have been selected for funding in the first year of a five year federal grant through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

Region/County, EBHV Model, MIECHV Funding Level and Projected Number of Families

| Region/County | Evidence-Based Home Visiting Model | Proposed Funding Level – Year One | Projected Number of Families |
|---|------------------------------------|-----------------------------------|------------------------------|
| Pierce County: County Council Districts: 2, 4, 5 and 6 | Nurse Family Partnership | \$145,000 | 25 families |
| Snohomish County: North Everett | Nurse Family Partnership | \$123,000 | 25 families |
| Yakima County | Nurse Family Partnership | \$63,000 | 10-12 families |
| Yakima County | Parents as Teachers | \$71,000 | 25 families |
| South King County: American Indian/Alaska Native and African American women | Nurse Family Partnership | \$250,000 | 50 families |

2. **Two WA model representatives are in charge of coordinating and submitting ONE IP for the program(s) implementing the EBHV model in the selected county/region.** Only programs that were included in the Capacity Assessment submission are eligible. The two WA model representatives are:

| EBHV Model | EBHV Model Representative | Email |
|--------------------------|---------------------------|---|
| Nurse Family Partnership | Kristen Rogers | kristen.rogers@nursefamilypartnership.org |
| Parents As Teachers | Linda Clark | lclark@parenttrust.org |

3. DUE DATE: MONDAY, MAY 16TH, 2011 - 2:00 PM

4. There will be no exceptions to this deadline. Any IP received after 2:00 PM on MONDAY, MAY 16th, 2011 will not be included for first year MIECHV funding and submitted with the MIECHV Washington State Plan.
5. **Model Representatives must submit only ONE Implementation Plan Proposal per selected county/region for all of the EBHV program(s) in that community. Please EMAIL two (2) electronic copies, one in WORD and in PDF** to: Michelle Low, Thrive by Five Washington, at michelle@thrivebyfivewa.org & Judy King, Department of Early Learning, at judy.king@del.wa.gov. Please be sure to save the document as follows: CountyModelNameModelRepInitialsDate. For example: OceanCountyXYZModelNG5/16/11.
6. If more than one organization will be implementing the EBHV model in the selected County/Region a lead Fiscal Sponsor from one of the organizations must be identified in the IP Proposal.
7. Use standard font type Times New Roman, 11 point, with one inch margins. Number all pages. Please use headings to identify each section.
8. Technical assistance opportunities are available as follows:

EBHV Model Representatives can schedule a 1.5 hour IP technical assistance (TA) calls, with Thrive by Five Washington, for each selected community/region implementing the EBHV model they represent. The EBHV Model Representative will coordinate with the organization(s) in that county/region to be on the TA call. The Model Representative will arrange for a number for all parties to call in on. Thrive by Five Washington will call into the number provided at the time the technical assistance call is scheduled. Thrive by Five Washington will not be taking individual calls from the organizations implementing the model in the selected county/region outside of these scheduled calls. If additional information is needed once the IP are submitted on May 16th, individual organizations will be contacted for follow up. Please contact Michelle Low, Project Support Coordinator, at Thrive by Five WA via email michelle@thrivebyfivewa.org or phone 206.621.5572 to schedule a time. Michelle will schedule all 1.5 hour TA calls based on availability on the following dates and times:

- Monday, May 9, 2011: 12:00pm-1:30pm
- Monday, May 9, 2011: 3:00pm-4:30pm
- Tuesday, May 10, 2011: 11:30pm-1:00pm
- Tuesday, May 10, 2011: 1:30pm-3:00pm
- Tuesday, May 10, 2011: 3:30pm-5:00pm

Once the TA call is scheduled, Michelle Low will ask that you send your questions to Michelle 24 hours in advance of your call so we can best be prepared to answer your questions during the call.

9. Sections, Recommended Maximum Total Pages Allowed:
Below are the sections for a complete Implementation Plan. **Maximum total pages allowed for an Implementation Plan is 22. An IP that is shorter than 22 pages is fine. Each section also has a maximum page limit allotted.** Please ensure the following categories of information, in this order and within the corresponding page limits, are included.

Implementation Plan Proposal & Page Limits for Each Section

| Implementation Plan Sections | Maximum Pages Allowed |
|---|-----------------------|
| EBHV Model, Selected Community/Region, Organization(s) Information | 2 |
| Funding Requirements for Services Supported with MIECHV Funding | 1 |
| Existing Resources | 2 |
| Participant Outreach, Engagement, Assessments and Timeline to Reach Maximum Caseload | 2 |
| National EBHV Model Developer, Technical Assistance & Support | 2 |
| Staff Recruitment, Training & Retention | 2 |
| Clinical Supervision and Reflective Practice | 2 |
| Monitoring, Assessing & Supporting Implementation with Fidelity and Ongoing Quality Assurance | 3 |
| Evaluation, Data Management & Ongoing Continuous Quality Improvement | 2 |
| MIECHV Implementation Plan Proposal Budget | 2 |
| MIECHV Draft Logic Model | 2 |
| Total Pages Allowed | 22 |

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
Implementation Plan**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|---|--|---|---|
| Evidence Based Home Visiting Model: <input type="checkbox"/> NFP <input type="checkbox"/> PAT EBHV State Rep Name: _____ EBHV State Rep: Ph: Email: | Selected Region/County: _____ | Funding Level in Year One _____ | To Serve # Families : _____ # Children: _____ # Parents/Caregivers: _____ |
| Identified “at risk” population to target in selected region/community | <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Pacific Islanders <input type="checkbox"/> Non Hispanic American Indian/Alaska Natives <input type="checkbox"/> White <input type="checkbox"/> Non-Hispc Blacks <input type="checkbox"/> N-Hispanic Asan <input type="checkbox"/> Non-Hispanic Multiple Races | | |
| FISCAL SPONSOR | | | |
| Organization Name | | | |
| Organizations Mailing Address | | | |
| Organization Physical Address | | | |
| Federal Tax ID #: | | | |
| Chief Executive Name & Title | | | |
| Chief Executive’s Email | | | |
| EBHV Manager Name & Title: | | | |
| EBHV Manager’s Email | | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |
| Additional Organization(s) Name & Address | | | |

| | |
|--|--|
| | |
|--|--|

Implementation Plan

Please respond to the following questions. Please note, some of the Community Program(s) Capacity Assessment Summary questions are asked again, please provide the same responses provided in the Capacity Assessment if the question is exactly the same. Some questions asked in the Capacity Assessment have been expanded and require additional information from the base question that was asked. Questions that are the same and/ or similar to the Capacity Assessment questions are highlighted in **yellow for your convenience. Please read each question carefully and add to the response when more detailed information is requested. Lastly, some of the questions are new and therefore will require written responses that have not been asked previously.**

Funding Requirements for Services Supported with MIECHV Funding

(Page limit- 1)

Selected counties/regions must comply with the following for families served with MIECHV funding (please check all to indicate intent to comply):

- Services are provided on a voluntary basis
 - Priority is given to serve eligible participants who:
 - Have low incomes
 - Are pregnant women who are under 21
 - Have a history of child abuse and neglect or have had interactions with child welfare services
 - Have a history of substance abuse or need substance abuse treatment
 - Are users of tobacco products in the home
 - Have, or have children with, low student achievement
 - Have children with developmental delays or disabilities
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including
 - such families that have members of the armed forces who have multiple deployments outside of the United States
 - As a requirement of the federal MIECHV Program funding, data must be collected on ALL constructs for the 6 benchmarks identified in the MIECHV Program guidance. To participate in this funding opportunity you agree to collect data at the family level to meet the federal requirements. Specific data collection requirements for county/regions and EBHV models selected will be developed over the next 3-4 month in partnership with state and national model leads. You will be asked to work in a participatory process with the Washington data/benchmarks staff to build processes that work for you at the local level and the model level.
- We agree to participate in the process to collect data as required by the federal MIECHV funding.
- We are unable to participate at this time. We understand that this disqualifies us for the first year of federal MIECHV funding. Please consider us in the subsequent rounds of funding.

Existing Resources

(Page limit- 2)

28. List all existing NFP, PAT and EHS (home based) home visiting programs, currently operating or discontinued since March 23, 2010, in the selected county/region, please identify:
 - b. The EBHV model, the home visiting programs/organizations implementing
 - c. Any home visiting initiatives in the community/region
29. Describe all existing mechanisms for screening, identifying and referring families and children to home visiting programs in the community (i.e.: centralized intake system at the local community level).
30. Describe the plan for coordination among the existing home visiting programs in the county/region.
31. What referral resources are currently available to support families residing in the county/region? (Specifically health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education and other social and health services.)
32. What referral resources are needed in the future to support families residing in the county/region that are not currently available?
33. Describe any community plan for coordination among existing resources in the county/region.

Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

(Page limit- 2)

34. Present the outreach plan to reach the “at risk” population identified. In the outreach plan identify: the organizations, institutions, other groups, and/or individuals that will be engaged; the frequency, duration and outreach approach that will be used for each over the next twelve months.
35. Describe the process and unique strategies that will be used in order to effectively recruit and engage the “at risk” population identified.
36. Are individualized assessments of enrolled participant families conducted?
37. If, yes –please describe how referral to services are provided in accordance with those individual assessments.
38. Provide an estimated timeline to reach maximum caseload.

National EBHV Model Developer, Technical Assistance & Support

(Page limit - 2)

39. Present a plan for working with the EBHV national model developer and/or regional/state representative from the EBHV model. Please include frequency and duration of the support available:
 - a. Initial and ongoing training and professional development
 - b. Initial and ongoing technical assistance and support provided

Staff Recruitment, Training & Retention

(Page limit – 2)

Staff Training:

40. Restate the initial and ongoing staff training provided by the national model developer.
41. List all initial and ongoing professional development activities provided by the implementing organization(s).

Staff Recruitment:

42. What qualifications (e.g., degrees, credentials or experience) and skills (i.e.: bilingual) are needed for the program(s) staff to implement the EBHV model in the selected county/region to reach the “at risk” population?
43. Are there staff currently hired to implement the EBHV program(s) in the MIECHV targeted county/region to reach the “at risk” population?
 - a. If, no—please describe the recruitment plan and the timeline for recruiting and hiring staff.
 - b. What is the timeline for obtaining all necessary training for new staff to implement the EBHV model?
44. Will subcontractors used?
 - a. If yes, please describe the plan for recruitment of subcontractor organizations.

Staff Retention

45. What mechanisms are in place to retain all staff in the program(s)?

Clinical Supervision & Reflective Practice

(Page limit- 2)

46. What are the EBHV model’s requirements for staff supervision? Describe program(s) understanding of the model’s supervision requirements and how each meets these requirements.
47. Are there currently individuals on staff/in your community who are providing this supervision? What is the frequency, duration of the supervision provided?
 - a. If, no—please describe the recruitment plan and the timeline for recruiting and hiring supervision.

Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

(Page limit- 3)

48. How does the EBHV program(s) participate in fidelity monitoring and/or quality assurance through the national model developer?
49. What additional monitoring, assessing and supporting implementation with fidelity to the chosen model and maintaining quality assurance does the EBHV program participate in (i.e.: **if participating in the Council for Children and Families (CCF) technical assistance and participatory evaluation work with WSU please describe**)?
50. Does the EBHV program(s) conduct any fidelity tracking or quality assurance on its own? If yes, please describe.
51. Please describe 2-3 challenges to maintain quality and fidelity when implementing in the selected county/region. What are the proposed strategies to address these challenges?
52. Please describe all enhancements that are currently being made by the EBHV program(s). Enhancements are defined here as any additional activities above the core model components.
53. What is the average rate of attrition for program participants?
54. Describe the improvement plan for minimizing attrition rates for participants enrolled in the program.
55. Provide the average dosage of services provided to families (frequency and duration).

Evaluation, Data Management and Ongoing Continuous Quality Improvement

(Page limit- 3)

56. Please respond to the following questions on how program(s) collects, maintain and uses any data collected for the EBHV model:

i. Assessment/Measurement Tools:

Assessment/Measurement tools are what we use to capture information on whether or not an indicator has been achieved, and to what degree. Some EBHV models use standardized evaluation tools such as written instruments that contain questions about the indicators you are tracking. Some programs implementing EBHV models use a standardized tool and/or other tools to capture information.

Please include the following for **each** Measurement Tool used by Program:

- The name of Measurement Tool
- Developed by:
- Frequency administered

j. Does the EBHV model have a database that program(s) implementing the EBHV model are using? If yes, what database does the EBHV model use? Are the programs implementing the EBHV model in this community using this database?

k. Are there modifications needed to the program(s) database(s) to help track and report on the legislatively mandated benchmarks? If yes, please provide a description of how the National Model will address modifications and the timeline.

l. If there is no existing national model database, how do the EBHV program(s) in your community track the data; is there another database system that is used?

m. Who is responsible for collecting the data in the program(s)?

n. Who is responsible for data input in the program(s)?

o. Who analyzes and reports the data in the program(s)?

p. How is the data used once analyzed in the program(s)?

MIECHV Implementation Plan Proposal Budget

(Page Limit - 2)

- Please use the [“MIECHV Implementation Plan Proposal Budget”](#) template provided detailing your proposed year-one budget. A MIECHV budget should be created for County/Region, EBHV Model Funding Level only.
- Do not include pending funds
- If you indicate in-kind income, please note the source of this income on the form and provide a letter of agreement in the attachment section of the application that verifies this contribution. The source of in-kind is always from an organization outside of the applicant agency. Do not include unpaid volunteers as in-kind.
- Match: Please include additional dollars that will match the MIECHV funding to support the number of families.
- Please include actual indirect expenses (contracted professional services, occupancy or other indirect) that support the MIECHV funding level for the number of families that will be served.

MIECHV Implementation Plan Draft Logic Model

(Page Limit - 2)

- Please use the [“MIECHV Implementation Plan Draft Logic Model”](#) template provided. **A MIECHV draft logic model is only for MIECHV supported services and not for an organization entire EBHV program.**
- Note: **if implementing programs are currently utilizing a Council for Children & Families (CCF) or a Home Visiting Services Account (HVSA) Logic Model please align MIECHV logic model.**
- **Fill in Resources, Activities and Outputs column only.**
- At this time Do NOT fill in Fidelity, Constructs and Benchmarks – follow up on this will be done after submission of IP on May 13th.

Attachment G: Community Program(s) Capacity Assessment Technical Assistance Q and A

**Affordable Care Act Maternal, Infant & Early Childhood Home Visiting Program
Supplemental Information Request of the Updated State Plan
Community Program(s) Capacity Assessment to Implement the EBHV Model
Questions & Answers to Technical Assistance Calls**

Technical assistance available for Community Program(s) Capacity Assessment to Implement the EBHV Model

EBHV Model Representatives can schedule a **one hour** technical assistance (TA) call with Thrive by Five WA for each semifinalist community implementing the EBHV model they represent. The EBHV Model Representative can coordinate with the organization(s) in that community to be on the TA call with the Model Representative and arrange for a number for all parties to call in on. Thrive by Five WA will contact the EBHV Model Representative at the number requested at the time the TA call is scheduled. Thrive by Five WA will not be taking individual calls from the organizations implementing the model in the semifinalist community.

Please contact Michelle Low, Project Support Coordinator at Thrive by Five WA, via email at michelle@thrivebyfivewa.org or phone at 206-621-5572 to schedule a TA call. Michelle will schedule all one hour TA calls based on availability on the following dates and times:

- ❖ Thursday, March 31, 2011: 2:00pm-5:00pm
- ❖ Friday, April 1, 2011: 1:00pm-4:00pm
- ❖ Monday, April 4, 2011: 1:00pm-4:00pm
- ❖ Tuesday, April 5, 2011: 12:00pm-2:00pm
- ❖ Wednesday, April 6, 2011: 3:00pm-5:00pm

All questions and answers from each TA call will be posted on the Thrive by Five WA website at http://www.thrivebyfivewa.org/HVSA_TA_Q&A.html by close of business the following day.

- 1) PSESD has raised the point that they have a site in White Center which should fall under the South King umbrella. This didn't pop up in the DOH assessment (I suspect it just got missed) – what does this mean for them?

The tables on pages 3 & 4 of the Capacity Assessment titled “EBHV Model, Semifinalist Communities & Existing Organizations Providing the EBHV Program(s)” were compiled based on the information in the DOH Needs Assessment. These are the only organizations that model representatives will be contacting to help complete the capacity assessment for this initial round of funding.

- 2) The Capacity Assessment Section starts with 2 pages worth devoted to Community Engagement....are there additional questions associated with community engagement: we don't see them specifically listed in the Assessment.

On page 5 of the Capacity Assessment, “Sections, Maximum Total Pages Allowed”, there is an error in the “Community’s Program(s) Capacity Assessment Sections & Page Limits for Each Section” chart. Under the Capacity Assessment column, the first row should read “Community /Organization(s) Information”, not “Community Engagement in Implementation of the EBHV

Model”. The “Community /Organization(s) Information” template is found on page 6. There is a maximum of two pages allotted for the “Community/Organization Information” section. Please see correction below:

Community’s Program(s) Capacity Assessment Sections & Page Limits for Each Section

| Capacity Assessment Sections | Maximum Pages Allowed |
|---|-----------------------|
| Community /Organization(s) Information | 2 |
| Participant Assessments and Priority Given to Eligible Participants | 1 |
| National EBHV Model Developer, Technical Assistance & Support | 1 |
| Staff Recruitment, Training & Retention | 1 |
| Clinical Supervision and Reflective Practice | 1 |
| Monitoring, Assessing & Supporting Implementation with Fidelity and Ongoing Quality Assurance | 1 |
| Evaluation, Data Management & Ongoing Continuous Quality Improvement | 2 |
| Funding | 1 |
| Approval by the EBHV Model Developer | 1 |
| Total Pages Allowed | 11 |

- 3) Can you please explain question #4 on page 7: “Please briefly describe how program(s) in this community work with the national model developer”.

This question is an opportunity to explain if and how the program(s) communicates and receives support from the national model developer or the national office of the EBHV model. An example of this could be a national conference, monthly check-in meetings with a professional from the national office to discuss implementation, a yearly site visit conducted by the National office, etc.

- 4) Can you please clarify question #16, on page 8: “How does the EBHV program(s) participate in fidelity monitoring and or quality assurance through the national model developer?”

Depending on the EBHV model you are implementing, there may be approaches and tools to assess the degree to which the program is being implemented as described, with fidelity. Please contact the national model office for clarification regarding specifics standards for fidelity and quality assurance.

- 5) Can you please clarify, question #27, page 9: “Based on your knowledge of the EBHV model developer requirements, will all or some of the program(s) likely be approved by the EBHV model developer to implement the EBHV model?”

The EBHV model representative will be submitting the capacity assessment. The EBHV model representative is knowledgeable about the standards the national model requires to be considered a program that would be approved, or in good standing, for the requirements of the federal funding.

- 6) On pages 5-6, there are no directions for the “Community Engagement in Implementation of the EBHV Model” section.

On page 2 of the Capacity Assessment, “Sections, Maximum Total Pages Allowed”, there is an error in the “Community’s Program(s) Capacity Assessment Sections & Page Limits for Each Section” chart. Under the Capacity Assessment column, the first row should read “Community /Organization(s) Information”, not “Community Engagement in Implementation of the EBHV Model”. “Community /Organization(s) Information” is found on page 3 and is the template that should be filled out (there is a maximum of two pages allotted for the “Community/Organization Information” section. Please see correction below:

Community’s Program(s) Capacity Assessment Sections & Page Limits for Each Section

| Capacity Assessment Sections | Maximum Pages Allowed |
|---|-----------------------|
| Community /Organization(s) Information | 2 |
| Participant Assessments and Priority Given to Eligible Participants | 1 |
| National EBHV Model Developer, Technical Assistance & Support | 1 |
| Staff Recruitment, Training & Retention | 1 |
| Clinical Supervision and Reflective Practice | 1 |
| Monitoring, Assessing & Supporting Implementation with Fidelity and Ongoing Quality Assurance | 1 |
| Evaluation, Data Management & Ongoing Continuous Quality Improvement | 2 |
| Funding | 1 |
| Approval by the EBHV Model Developer | 1 |

- 7) On page 6, “Numbers (#’s) served currently by program(s) implementing the EBHV model - of # of Children, # of Parents/Adults Caregivers # of Families served” If we are serving 200 families (consisting of mother and infant) do we reflect 200 children, 200 parents and 200 families?

Please provide the appropriate numbers in each category. If there are 200 families total, you can further define the make-up of a family, the number of parents/caregivers and the number of children. There may be more than 200 parents if the EBHV model serves more than 1 adult in the home visit. There may be less than 200 children if the EBHV model is providing services to expecting parents.

- 8) Do we count county-wide NFP caseload or only South King County caseload?

The programs that are being considered for the initial round of federal funding must be in one of the seven semifinalist communities noted on page 2 of the Capacity Assessment. South King County is included as one of the seven communities being considered for funding based on high numbers of Medicaid births to American Indian/Alaska Native and African American women. Providing the county-wide NFP caseload could be helpful to set the context of the program in the county. Also provide what portion of the countywide caseload serves the designated area and the specific populations (American Indian/Alaska Native and African American women in South King County).

- 9) **Additional families eligible for service:** Is this only for South King County region or the entire county?

Only for South King County serving American Indian/Alaska Native and African American women.

- 10) On page 7, Question #1, “Are individualized assessments of participant families conducted? If yes, please provide how services are provided in accordance with those individual assessments?” Are you asking this relative to screening in eligible families or as part of the initial visits once referrals to service have “screened in”?

This question specifically asks about assessments of participant families, or how the “screening-in” process is conducted. If there is an assessment, “screening-in” this should be explained.

- 11) On page 9, Questions #23-4, when you reference “coming fiscal year”, are you referring to July 1, 2011-June 30, 2012?

Please consider a 12-month funding period. The Updated State Plan will be submitted by June 8, 2011. After receiving approval by HRSA, funding can begin. The intention would be to fund July 1, 2011-June 30, 2012.

- 12) On page 9, Question #23, “Please list all funding sources. Please provide non-state funding that will not be continued in the coming fiscal year and the number of families served with the non-state funding.” What about funding for Medicaid First Steps, since there is state funding that is allocated and we have concerns reductions in the Medicaid First Steps funding stream.

List all funding sources first. The state funding that should NOT be included is state EBHV funding (CCF and/or HVSA funding). Include local grant as well as Medicaid First Steps funding that will not be continued in the coming fiscal year and the number of families served.

- 13) On page 6 of Capacity Assessment, under Identify Semifinalist Community according to DOH Needs Assessment, how should we (Pierce County) fill this out for our 3 council districts? What page in the DOH Needs Assessment shows the rankings of the communities?

Model reps should look at DOH Needs Assessment, Appendix B, Table B-5, starting on page 98 to complete this section.

- 14) Page 6, “What is the number of additional families that could be served through expansion...” Do you want total number of people served by EBHV program?

For the Capacity Assessment being completed, model reps should put the number of additional families, without duplication of services that could be served in the semifinalist community.

- 15) Page 7, Question #7 “What unique skills are required among staff to implement the EBHV program(s) in your community”? Do you mean current staff or what would be needed for an expansion?

If there are differences between the two, then please clarify that in your response.

- 16) Page 8, Question #12, is the existing staff currently trained in the EBHV model. Is this as straightforward as it sounds?

Please clarify if existing staff has been trained or certified in the EBHV model.

- 17) On page 8, Question #13 “What mechanisms are in place to retain staff in the program?” Is there something in particular you’re looking for regarding staff retention?

This question is an opportunity to specify if there are any steps being taken in your organization to retain staff.

- 18) Page 8, Question #18 “Please describe all enhancements that are currently being made to the EBHV program.” Is there anything specific you’re looking for?

For the Capacity Assessment, please consider enhancements as any additional activities/trainings/staffing/supervision/etc. above the core EBHV model components. An example would be if the community has high mental health needs and the EBHV program has enhanced the model by having a mental health consultant.

- 19) Can we expand our services to reach populations we are not currently serving within their identified at-risk communities?

Yes, expanding services to populations identified in the DOH Needs Assessment within the identified community would be appropriate.

- 20) What is the distinction between Page 8, Question # 16 “How does the EBHV program participate in fidelity monitoring and/or quality assurance through the national model developer?” and Question #17 “Does the EBHV program conduct fidelity tracking or quality assurance on its own?”

Question #16 refers to how the program is participating in national model fidelity monitoring and quality assurance requirements. Question #17 refers to anything beyond the national model requirements that the local program is doing to track fidelity and quality assurance on its own.

- 21) On page 6, “Identify the semifinalist community according to the DOH Needs Assessment and Ranked As...”

Model reps should look at DOH Needs Assessment, Appendix B, Table B-5 (page 98).

- 22) On page 6, “Community/Organization(s) Information” section, please clarify the following - clarification of South King County’s geographic boundaries

Please refer to the DOH Needs Assessment for clarification of the geographic boundaries for South King County. Please note, South King County was selected as a semifinalist community due to high Medicaid births to Alaska Native/Native American and African-American women. Please make sure to complete the Capacity Assessment with this targeted population in mind.

- Numbers served currently are only for families in the target area?

The programs that are being considered for the initial round of federal funding must be in one of the seven semifinalist communities noted on page 2 of the Capacity Assessment. South King County is included as one of the seven communities being considered for funding based on high numbers of Medicaid births to American Indian/Alaska Native and African American women. Providing the county-wide PAT caseload could be helpful to set the context of the program in the county. Also provide what portion of the countywide caseload currently serves the designated area and the specific populations (American Indian/Alaska Native and African American women in South King County). When responding to “the number of additional families that could be served through expansion...” only include additional American Indian/Alaska Native and African American women in South King County.

- Is it OK to use a range when answering “number of additional families served”?

Yes. It is fine to provide a range, a narrow range would be recommended.

- 23) On page 8, “Monitoring, Assessing and Supporting Implementation” section, what do you consider “enhancements”? Please give an example.

Please refer to http://www.thrivebyfivewa.org/hvsa_TA_Q&A.html April 1, 2011 Q & A, question #18.

- 24) On page 9, Question #22, “What is the total existing level of funding program(s) received for the EBHV model services that are currently being provided?” Are you asking for just the funding that is designated for target area services or total organizational funding?

Provide the total existing funding for the program. Then clarify the amount of that total funding that is used for Alaska Native/Native American and African-American women in South King County.

- 25) On page 9, Question #24, “What level of funding are program(s) seeking for this coming fiscal year to sustain existing services?” Is this specifically asking about the federal initiative of from any funding source?

This question refers to the amount of funding needed in order to sustain existing levels of services. The number will be calculated based on the responses provided to question #22 and question #23.

- 26) Can you clarify Questions #25 (How many families are served annually by the program(s)?) and #26 (How many families will be served with sustaining funding as is?) on page 9?

The answer to #25 is how many families are currently being served by the program. The answer to #26 is if the funding remains exactly as it is moving forward, will there be any increases to the numbers of families served? Some programs may be able to increase the numbers of families that can be served with no additional funding, if they are not currently at full caseload capacity.

- 27) Please provide an overview of the scope of the project – please explain the sections of the Capacity Assessment sections on page 5.

Please refer to the DEL website <http://www.del.wa.gov/development/visiting/plan.aspx> for an overview of Affordable Care Act Maternal, Infant & Early Childhood Home Visiting Program Supplemental Information Request of the Updated State Plan for Washington State.

- 28) What do services look like? Do we only serve families, children and areas we are currently providing services or do we expand into underserved and/or un-served areas?

We recommend that you respond to the questions that are asked, some of the questions ask about existing services while others ask about expansion. Please read the questions carefully.

- 29) On page 6, “Numbers of children/families/parents served...”EHS is not funded by children, but by slots. How do we fill this out?

Please provide the number of children that are currently receiving EHS- home based services.

- 30) On page 6, Community/Organization Information section, is the EHS Combination model considered “home visiting”?

The EHS - home-based option is eligible for this funding stream and not the combination option.

- 30) What other factors will be used to decide the final community and model selection that will be awarded in addition to the community capacity assessment? What is the timing of the additional information and proposal, what does that include?

Please refer to the DEL website <http://www.del.wa.gov/development/visiting/plan.aspx> for an overview of Affordable Care Act Maternal, Infant & Early Childhood Home Visiting Program Supplemental Information Request of the Updated State Plan for Washington.

- 31) On page 6, Community/Organization Information section, “Identify the semifinalist community according to DOH Needs Assessment and Ranked As...” how should we fill in these blanks?

Model reps should refer to the DOH Needs Assessment, starting on page 98, Appendix B, Table B-5.

- 32) On page 7, Question #4 “Briefly describe how programs in this community work with the national model developer...” Is the Office of Head Start the national model developer? If not, who is? Do we work with the Regional Office in Seattle?

Whatever is the correct term for Early Head Start, please use this. It is most important to list where EHS-home based receives support for their programs.

- 33) Page 9, Question #24 “What level of funding are programs seeking for this coming fiscal year to sustain existing services?” Is this referring to ARRA expansion funding?

Question #22 asks for the existing level of funding for EBHV services currently provided, your budget for this year. Question #23 first asks to list all the existing funding sources for this year. Question #23 then asks for any anticipated reductions for the coming fiscal year – listing any reductions that are non-state EBHV dollars. Based on responses to Questions #22 and Questions#23, Question #24 can be answered – what level of funding will be needed to sustain existing services.

- 34) On page 9, Question #26, “How many families will be served with sustaining funding as is?” Is there a preference to increase the number of families being served or is it to sustain current services whose federal funding is currently unknown? Also, please clarify “with sustaining funding as is?” Are you referring to only the ARRA funding? Do you count families, funded slots, or cumulative families or individual served?

Please refer to http://www.thrivebyfivewa.org/hvsa_TA_Q&A.html April 5, 2011 Q & A, question #26.

- 35) Is there a non-federal share requirement and if so, at what percentage?

The Capacity Assessment does not ask for non-federal share requirements.

- 36) On page 9, Question #27, “Based on your knowledge of the EBHV model developer requirements, will all or some of the programs likely be approved by the EBHV model developer to implement the EBHV model?” If the EBHV model developer is the Head Start Office, should we answer based on our prospects for ongoing funding for the Head Start/EHS programs? Should we answer based on our most recent program review? Should our answer be based solely on how well we comply with EHS Performance Standards and not our guess on availability of funds to sustain the ARRA expansion?

Please refer to http://www.thrivebyfivewa.org/hvsa_TA_Q&A.html April 1, 2011 Q & A, question #5.

****There is no Question #37 – Numbering Error****

- 38) On page 9, Funding section, Question #24, can you provide more guidance on how to talk about the shortfall from other funding streams, or how that fits with the overall plan?

Start with Question #22, provide the total funding (budget) for the EBHV model program(s) in the community. Moving on to Question #23, there are two parts to answer: first list all the current funding sources for the EBHV program(s) in the community; second provide all non-state EBHV funding (grants, federal funding, local funding) for the EBHV model program(s) in the community that will **not** be carried forward in the coming fiscal year. The answers provided in Questions #22 & #23, will inform the answer to Question #24 – what is the dollar amount needed in the coming fiscal year to sustain existing levels of service.

- 39) The DOH Needs Assessment has Yakima Valley Farm Workers Clinic and Yakima Valley Memorial Hospital listed as two separate organizations in Yakima implementing NFP, but in Yakima both organizations are considered the Yakima Valley Nurse Family Partnership (YVNFPP) program.

The guidelines on page 4 state that each EBHV model representative must submit only one Community's Program(s) Capacity Assessment per semi-finalist community for all the EBHV model programs in that community. Therefore presenting the one capacity assessment for the YVNFPP program is appropriate.

- 40) On page 7, question # 1 "Are individualized assessments of participants families conducted?" - a discussion on the number of assessment/measurement tools could be lengthy, this information could best be delivered in a table format.

This question is not in regards to assessment/measurement tools, but about initial assessments or a "screening-in" process in order to determine eligibility for the EBHV model and appropriate fit of the EBHV model services to the families needs. If there is an assessment process that is conducted, please describe.

- 41) On page 6, Community/Organization Information section, for Target Population, are we to use the information from the WA HV Needs Assessment? We have a percentage in each category except African American. We have less than 1% Asian. Should all boxes be checked except African American?

Refer to your needs assessment and check only the populations identified in the WA State DOH Needs Assessment that were identified as the most high-needs in your community.

- 42) Why is there no logic model request? Indicators?

There is no logic model requirement for the capacity assessment. Model representatives are asked on page 8, question #21 (a) to provide the following for each assessment/measurement tool:

- Name of the Measurement tool
- Developed by:
- Frequency administered

- 43) Since there are multiple sites in this community, do you want information included for each site under each question?

The guidelines on page 4 state that each EBHV model representative must submit only one Community's Program(s) Capacity Assessment per semi-finalist community for all the EBHV model programs in that community. Responses to each question should consolidating the information for all programs implementing the EBHV model.

- 44) On page 6, Community/Organization Information section, do you want a breakdown of numbers served for each program or just overall for total community?

Please see response to question #43 above.

Also, I presume it is OK to not be planning to expand but just sustain existing program?

We recommend that you respond to the questions that are asked, some of the questions ask about existing services while others ask about expansion. Please read the questions carefully.

- 45) On page 7, Participant Assessments, Question #3 regarding priorities served. Do you want the answers to be a combination of all sites?

Yes.

Attachment H: Community Need and Capacity Assessment Review

Semi-Finalist Community:

DOH Needs Assessment Ranking:

Identified “at risk” populations in DOH Needs Assessment:

- | | |
|--|--|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non-Hispanic Blacks |
| <input type="checkbox"/> Non-Hispanic Pacific Islanders | <input type="checkbox"/> Non-Hispanic Asian |
| <input type="checkbox"/> Non Hispanic American Indian/Alaska Natives | <input type="checkbox"/> Non-Hispanic Multiple Races |
| <input type="checkbox"/> White | |

Infant Toddler Themes:

PAT Programs:

- (core components)
- Enhancements (list):
- Assessments? Yes: No
- Average Dosage of Services: Frequency: Duration:
- Attrition rate:
- Current # of families:
- Additional # Families Expansion:
- Funding Request to Sustain: \$

PAT OVERALL CAPACITY TO IMPLEMENT: High Medium Low

| | | | | |
|--|--|---|--|---|
| <p>Priorities</p> <p>Participants:</p> <p><input type="checkbox"/> low incomes</p> <p><input type="checkbox"/> preg under 21</p> <p><input type="checkbox"/> HX CAN or CW</p> <p><input type="checkbox"/> HX SA or need SA TX</p> <p><input type="checkbox"/> tobacco</p> <p><input type="checkbox"/> low stud achvmt</p> <p><input type="checkbox"/> DD delays or disabilities</p> <p><input type="checkbox"/> armed forces, deployment</p> | <p>National PAT Developer Involvement/TA:</p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Medium</p> <p><input type="checkbox"/> Low</p> <p>Degree of Fidelity Monitoring through PAT National:</p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Medium</p> <p><input type="checkbox"/> Low</p> <p>Additional Fidelity Tracking & CQI:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Staff Recruitment:</p> <p>Unique Skills?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Current staff Qualified #:</p> <p>Enough Qualified?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Staff Training Model Initial?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Staff Currently Trained?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Model Ongoing training?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prof Development Initial?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prof Development Ongoing?</p> <p><input type="checkbox"/> Yes: <input type="checkbox"/> No</p> <p>Staff Retention:</p> <p>Mechanisms for staff retention?</p> <p><input type="checkbox"/> Yes: <input type="checkbox"/> No:</p> | <p>Clinical Supervision/ Reflective Practice Requirements for Staff Supervision?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequency:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p>Duration:</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>PAT program(s) meeting Supervision requirements?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Actual Supervision Provided:</p> <p>Frequency:</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>Duration:</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> | <p>Evaluation: Assessment/Measurement Tools: (List)</p> <p>Databases: EBHV Model Database</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identify EBHV Model database:</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> <p>Are programs using:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is another database used?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identify other database:</p> <p>Are modifications Needed?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Identified Data Collection, input & analysis Capacity:</p> <p><input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p>CQI with Data</p> <p><input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> |
|--|--|---|--|---|

NFP Programs:

(core components)

- **Enhancements (list):**
- **Assessments?** Yes: No
- **Average Dosage of Services: Frequency:**
- **Attrition rate:**
- **Current # of families:**
- **Additional # Families Expansion:**
- **Funding Request to Sustain: \$**

Duration:

NFP OVERALL CAPACITY TO IMPLEMENT: High Medium Low

| | | | | |
|--|---|---|--|---|
| <p><u>Priorities</u></p> <p><u>Participants:</u></p> <p><input type="checkbox"/> low incomes</p> <p><input type="checkbox"/> preg under 21</p> <p><input type="checkbox"/> HX CAN or CW</p> <p><input type="checkbox"/> HX SA or need SA TX</p> <p><input type="checkbox"/> tobacco</p> <p><input type="checkbox"/> low stud achvmt</p> <p><input type="checkbox"/> DD delays or disabilities</p> <p><input type="checkbox"/> armed forces, deployment</p> | <p><u>National NFP Developer Involvement/TA:</u></p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Medium</p> <p><input type="checkbox"/> Low</p> <p><u>Degree of Fidelity Monitoring through NFP National:</u></p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Medium</p> <p><input type="checkbox"/> Low</p> <p><u>Additional Fidelity Tracking & CQI:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p><u>Staff Recruitment:</u></p> <p>Unique Skills?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Current Staff Qualified #:</u></p> <p><u>Enough Qualified?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Staff Training</u></p> <p>Model Initial?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Staff Currently Trained?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Model Ongoing training?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Prof Development Initial?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Prof Development Ongoing?</u></p> <p><input type="checkbox"/> Yes: <input type="checkbox"/> No</p> <p><u>Staff Retention:</u></p> <p>Mechanisms for staff retention?</p> <p><input type="checkbox"/> Yes: <input type="checkbox"/> No:</p> | <p><u>Clinical Supervision/ Reflective Practice Requirements for Staff Supervision?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequency:</p> <p>Duration:</p> <p><u>NFP program(s) meeting Supervision requirements?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Actual Supervision Provided:</u></p> <p>Frequency:</p> <div data-bbox="878 1236 1192 1381" style="border: 1px solid black; height: 69px; width: 193px;"></div> <p>Duration:</p> <div data-bbox="878 1509 1208 1669" style="border: 1px solid black; height: 76px; width: 204px;"></div> | <p><u>Evaluation:</u></p> <p><u>Assessment/Measurement Tools: (List)</u></p> <p><u>Databases:</u></p> <p><u>EBHV Model Database</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Identify EBHV Model database:</u></p> <div data-bbox="1252 1039 1503 1150" style="border: 1px solid black; height: 53px; width: 155px;"></div> <p><u>Are programs using:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Is another database used?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Identify other database:</u></p> <p><u>Are modifications Needed?</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Identified Data Collection, input & analysis Capacity:</u></p> <p><input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p><u>CQI with Data</u></p> <p><input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> |
|--|---|---|--|---|

Attachment I: MIECHV Communities' Implementation Plans

Region/County, Lead Agency, EBHV Model, and Projected Number of Families

| Region/County | Lead Agency | EBHV Model | Projected Number of Families |
|--|--|--------------------------|-------------------------------------|
| 1. Yakima County | Yakima Valley Memorial Hospital and Yakima Valley Farm Workers | Nurse Family Partnership | 10-12 families |
| 2. Yakima County | Parent Trust for Washington Children | Parents as Teachers | 25 families |
| 3. Pierce County - County Council Districts 2, 4, 5, 6 | Tacoma-Pierce County Health Department | Nurse Family Partnership | 25 families |
| 4. Snohomish County - North Everett | Snohomish Health District | Nurse Family Partnership | 25 families |
| 5. King County - South: American Indian/Alaska Native, African American women | Seattle King County Department of Public Health, dba Public Health Seattle-King County | Nurse Family Partnership | 50 families |

**Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program
 Supplemental Information Request of the Updated State Plan
 Yakima County NFP Implementation Plan
 Community, Agency, Participant Level**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|---|--|---|--|
| Evidence Based Home Visiting Model: <input checked="" type="checkbox"/> NFP <input type="checkbox"/> PAT EBHV State Rep Name: <u>Kristen Rogers</u> EBHV State Rep: Ph: 253-441-0292 Email: Kristen.Rogers@nursefamilypartnership.org | Selected Region/County: <u>Yakima County</u> | Funding Level in Year One <u>\$63,000</u> | To Serve # Families : <u>10</u> # Children: <u>10</u>(once children are born) # Parents/Caregivers: <u>10</u> |
| Identified “at-risk” population to target in selected region/community | <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Pacific Islanders <input checked="" type="checkbox"/> NH American Indian/Alaska Natives <input checked="" type="checkbox"/> White <input type="checkbox"/> Non-Hisp Blacks <input type="checkbox"/> N-Hispanic Asian <input type="checkbox"/> Non-Hispanic Multiple Races | | |
| FISCAL SPONSOR | | | |
| Organization Name | Yakima Valley Memorial Hospital | | |
| Organizations Mailing Address | 2811 Tieton Drive Yakima WA 98902 | | |
| Organization Physical Address | 2811 Tieton Drive Yakima WA 98902 | | |
| Federal Tax ID #: | 91-056-7263 | | |
| Chief Executive Name & Title | Rick Linneweh, YVMH CEO | | |
| Chief Executive’s Email | Rick.Linneweh@yvmh.org | | |
| EBHV Manager Name & Title: | Marilyn VanOostrum RN, BSN NFP Nurse Supervisor | | |
| EBHV Manager’s Email | Marilyn.vanoostrum@yvmh.org | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |
| Additional Organization(s) Name & Address | Yakima Valley Farm Workers Clinic 518 West First Avenue Post Office Box 190 Toppenish WA 98948 | | |

Yakima County NFP Implementation Plan

Assurance – Voluntary Services & Priority Given to Serve Eligible Participants who:

Yakima County NFP Programs assure:

- Services are provided on a voluntary basis

Yakima County NFP Programs assure:

Priority is given to serve eligible participants who:

- Have low incomes
- Are pregnant women who are under 21
- Have a history of child abuse and neglect or have had interactions with child welfare services
- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home
- Have, or have children with, low student achievement
- Have children with developmental delays or disabilities

Please note: we do assess and make referrals for developmental delays and disabilities and provide appropriate services as warranted, but we do not enroll families after the child is born and thus do not prioritize families with delays/disabilities in our enrollment process.

- Participants are in families that include individuals, who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States.

Existing Home Visiting Services in Yakima County (please see Section 1)

Existing Mechanisms for Screening in Yakima County (Please see Section 1)

Referral Resources currently available and needed in the future in Yakima County (Please see Section 1)

Coordination Among Existing Programs and Resources in Yakima County (Please see Section 1)

Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the NFP programs include:

In Yakima County the NFP Nurse Supervisor disseminates program services and referral information to local community resources that come in contact with and /or serve low-income women. All of these groups serve Hispanic, Native American, and White low-income first time moms. Included in current outreach efforts are: family practice providers, obstetrical providers, family physician groups, local residency program, all local First Steps providers, which include Maternity Support Services and WIC. This outreach occurs on a regular basis, at least quarterly. Monthly contact is made with local First Steps providers. Efforts are made to make a face-to-face contact with medical providers each year. Yakima County NFP has a strong relationship with Indian Health Services, both through the medical clinic, where one of the nurse practitioners refers clients monthly, and the public health nursing office, who also refer clients on a regular basis. The Nurse Supervisor has scheduled a meeting with the Indian Health Services WIC Registered dietician, which will occur in June-July of this year.

The Nurse Supervisor or one of the PHN’s attend the monthly Perinatal Task Force meeting, with opportunity for brief updates at each meeting (community meeting with providers who serve pregnant

and parenting families). The NFP Nurse Supervisor attends the Yakima Valley Farm Workers Clinic Community Health Services (Yakima Lincoln Avenue site nurses, registered dietitians, and maternity case managers) weekly staffing meetings, where they discuss new pregnant clients who are receiving prenatal care at YVFWC clinics. The first time moms are staffed with the CHS team and the referral given to NFP. The Nurse Supervisor also meets with the CHS Nursing Supervisor at the Toppenish YVFWC office to discuss referral coordination. These activities with YVFWC target primarily the Hispanic population, and Spanish speaking clients, but their clinics serve all at-risk populations targeted for Yakima County.

Outreach efforts are also directed at other organizations who come in contact with young women including: Catholic Family Services (family and child therapy services); local high school nurses and counselors; pregnancy testing clinics, alternative high school programs, domestic violence shelter, homeless teen shelter; and local community centers who offer services to youth. These contacts are made on a rotating basis, but occur at least annually. Outreach efforts are reinforced by the public health nurse when coordination occurs around enrollment, and when situations arise where personal contact is necessary. These relationships in the community are invaluable.

Plan for Recruitment and engagement of the “at-risk” population identified.

The Nurse Supervisor will continue the efforts listed above, with increased attention to maintaining and building the relationships with Indian Health Services staff and Yakima Valley Farm Workers Clinic by continuing the above strategies, as well as widening the scope of people we interact with in their respective organizations. The NFP National Service Office provides great support in the way of outreach materials for community providers as well as potentially eligible clients. We take advantage of these materials, making sure there are ample supplies at all of the community locations listed in #7. The NFP program works diligently to make sure that all community providers and potential referral sources have up to date information about our services and how to contact us. In this way providers have the information needed to inform clients about our services. Providers at these agencies will inform potential clients of the existence of and services provided by the NFP program and ask their permission to send in a referral. Additionally, the NFP program supervisor is available to talk by phone to any potential clients and let them know more about the program and ensure that ongoing communication meets the client need. Our experience to date tells us that if a client is referred by a trusted source and face-to-face contact can occur in a confidential setting at the client’s convenience, we have a higher enrollment rate. We continue to try to identify additional strategies to reach out to the highest risk populations, homeless and mobile clients and clients who have not yet informed their families or support systems of their pregnancies.

Plan for individualized assessments of enrolled participant families conducted:

The following is a list of individualized assessments of enrolled participants in NFP services in Yakima:

NFP data collection forms including:

- | | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools:

NCAST (Nursing Child Assessment Satellite Training) feeding scale

NCAST (Nursing Child Assessment Satellite Training) teaching scale
NCAST Difficult Life Circumstances
NCAST Community Life Skills Scale
Ages & Stages Questionnaire
Ages & Stages Social Emotional Questionnaire
Center for Epidemiologic Studies Depression Scale (CES-D)
Edinburgh Postnatal Depression Scale

Plan for Referrals to Services:

Individual assessments are conducted with clients and their children according to NFP visit guidelines and data collection schedules. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings. If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available, will offer information and support, and refer to Children’s Village for a complete developmental assessment.

Estimated timeline to reach maximum caseload:

Yakima County NFP would estimate that we would reach full caseload of 10 additional clients in 4-5 months. If start date is October 1, 2011, and 2-3 new clients enrolled per month, full caseload would be attained by January or February 2012.

Plan for Working with National, Regional/State EBHV Model Developer/Representative, Technical Assistance & Support

The NFP NSO requires initial training for all new staff:

- Unit 1: onsite “distance learning”,
- Unit 2: face-to-face session in Denver, CO (approx. 4 days), and
- Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit.
- PIPE, a full parenting curriculum, is imbedded in the initial education sessions.
- Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development).

Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

All of the sites in Washington state work with a Program Developer and a Nurse Consultant assigned to the state by the NFP National Service Office. The Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program and the Nurse Consultant provides technical assistance around clinical and implementation issues. In addition, each site has a contractual relationship with the NFP NSO and the 18 model elements that must be adhered to ensure fidelity to the model are included in each contract.

The NFP NSO provides training and support services to ensure that the model is precisely replicated in Yakima County, leading to improved outcomes for both mothers and children. Yakima County NFP adheres to all key elements of the Nurse-Family Partnership model.

Each site participates in monthly 90-minute conference calls, has individual site calls, participates in individual site visits at least annually, and completes an annual plan that encompasses program data to dictate the quality improvement efforts to be undertaken during that year with the Nurse Consultant. With new sites and newly hired supervisors, individual calls are scheduled weekly, biweekly or monthly and continue for approximately a year. In addition, both the Developer and the Nurse Consultant are available to respond to emergent issues as needed and requested by the site. This technical assistance is available to sites for the life of the program.

The NFP NSO is an important and accessible resource to the Yakima County NFP, providing program implementation support; education for nurse home visitors and nurse supervisor and ongoing clinical support; reporting and quality improvement systems and support; federal policy and program financing support; and marketing and community outreach resources.

Yakima County NFP also receives support through the NFP Washington State Consortium, which meets in person 1-2 times per year. The NFP NSO Program Consultant in Program Quality has met with sites to assure Nurse Supervisors' understanding of data collection and reporting, increase their knowledge and practice in analyzing reports to improve practice, and to promote their understanding of how it correlates with outcome data.

The NFP NSO provides multiple publications to ensure implementing agencies are able to provide services with quality and fidelity to the model. These publications include: NFP Visit by Visit Guidelines and Facilitators for each program phase, monthly NSO Communications, marketing materials, NFP Data Collection Forms and Data Collection Manual, Team Educational Modules, NFP Competency Model of Professional Growth (competency statements and critical elements), NFP Core Education Workbooks and on-line education, NFP Model Elements, NFP Implementation Logic Model, and the NFP Theory of Change Logic Model.

Plan for Staff Training, Recruitment & Retention

Staff Training

NFP Training: The NFP NSO requires initial training for all new staff: Unit 1: onsite "distance learning", Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite "distance learning", and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

Implementing Organization additional Training Provided: The NHV and supervisor have received training and are certified in NCAST. Each nurse has completed cultural competency training, and bilingual staff have demonstrated competency to deliver the service in Spanish.

Staff Recruitment

NFP standards require that nurses have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, nurses must have completed the NFP training. It is helpful if candidates have prior experience providing home visiting services to at-risk pregnant women and new mothers and have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. Yakima NFP requires that a minimum of 50% of the staff be bilingual/bicultural nurses to deliver the program in the client's preferred language, as well as to meet the needs of the client's family. We have adequate bilingual/bicultural staff, and have been successful in recruiting qualified bilingual staff. The Nurse Supervisor is bilingual, and is able to complete supervised joint visits in Spanish, assuring the quality of the entire program and performance evaluation for individual nurses. All NFP staff complete initial and regular cultural competency training to help them meet the needs of the diverse client population. Yakima has one certified lactation consultant (IBCLC) on the team.

There are currently enough staff at our two agencies to successfully sustain Yakima County NFP. Although recruitment of experienced nurses with bilingual/bicultural skills has been and remains a challenge, both agencies support local educational programs and efforts to bring more local individuals into nursing programs.

Staff Retention

Yakima NFP has maintained a low level of staff turnover. We utilize the National Implementation Research Network (NIRN) stages of implementation to perform organizational self assessment and identify opportunities for improvement in staff selection, training, coaching, and performance assessment. Based on the high level of mental health needs of clients, and the need to support nursing staff as they work with high need clients and families, we have developed and integrated a successful Mental Health Consultant model, which has undoubtedly contributed to client, nurse and supervisor retention.

Plan for NFP Clinical Supervision & Reflective Practice

The NFP NSO model elements state: Nursing Supervisors must provide Nurse Home Visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the Nurse Home Visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

The Yakima County NFP maintains the NFP NSO expectation for nurse supervisor-to-staff ratio of no more than 8 nurse home visitors per supervisor. The Yakima County NFP supervisor provides the required activities for nurse supervision including weekly hour-long one-to-one reflective supervision, program development, referral management and other administrative tasks. The Yakima County NFP Nurse Supervisor also plans and leads monthly case conference and team meetings, as well as completes field supervision (joint home visits) quarterly with each nurse, using the NFP Visit Implementation Scale.

YCNFP Nurse Supervisor provides this supervision. The frequency and duration of reflective supervision are weekly one hour sessions with each nurse, excluding vacations and illness. Case

Conference and Team Meetings occur weekly for 2.5 hours, with the only exception being major holidays and illness. Joint home visits for field supervision occur at least 3 times per year for each nurse.

Plan for Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

Fidelity monitoring and/or quality assurance through the national model developer:

NFP Yakima collects data and enters into ETO and engages in a CQI process for clinical practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which Nurse Home Visitors and Supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both Supervisors and Nurse Home Visitors will review and utilize their program data in conjunction with the NSO Nurse Consultant. Information from the ETO reports are incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional monitoring, assessing and supporting implementation with fidelity to the chosen model and maintaining quality assurance:

Council for Children & Families (CCF) State Funded EBHV Participatory Evaluation with Washington State University Area Health Education Center (WSU AHEC):

WSU AHEC is currently conducting the evaluator for the Council for Children & Families Evidence Based Home Visiting portfolio of programs. Yakima Valley Memorial Hospital NFP is participating in evaluation of home visiting programs through CCF/WSU participatory evaluation. The CCF evaluation work specifically addresses the program impact and process of quality improvement in 11 programs, in six communities, implementing four home visiting models.

The CCF effort served as a critical test program for understanding the challenges and benefits of home visiting as a prevention and early intervention strategy for increasing numbers of Washington's most at-risk children and families. The lessons learned through the collaborative implementation and evaluation of the portfolio approach is vital to our state as we continue to build from this foundation.

The evaluation thus far demonstrates that CCF-supported evidence based home visiting programs are well-established and successful community services that are reaching their intended clientele.

Consistent with the published home visiting literature, local programs face a variety of staff, client, and resource challenges that are significant impacts on program focus, implementation fidelity, and potentially on program benefits. The evaluation supports the conclusion that all programs are working to deliver their model with rigor and attention to the model's standards but that success in our efforts requires continued vigilance on implementation with fidelity and continuous quality improvement practices at the agency level.

Yakima NFP Local Evaluation:

Yakima County NFP maintains a local evaluation structure provided by YVFWC. Local evaluation activities includes maintenance of a small local database, development of reporting systems that will combine local and NSO-collected data, data analysis, maintenance of an Interagency Evaluation Advisory Team that meets semi-annually, support for various funder-required reports and IRB-related activities, and support for sustainability planning. The smaller local database includes information and measures not tracked by the NFP ETO system, such as client funding source, and DLC (Difficult Life Circumstances) and NCAST Teaching scores. Additionally, the local evaluation structure supports the

Yakima County NFP as it has incorporated the implementation drivers and stages of implementation model developed by the National Implementation Research Network (NIRN) into its continuous improvement activities. The Yakima County supervisor and local evaluators have attended NIRN trainings, and now conduct a collaborative annual program self-evaluation to rate each implementation driver along the stages of implementation. This self-evaluation leads to program-level performance improvement activities that continue to institutionalize organizational support for the local program within the two partner organizations.

Yakima NFP Quality and Fidelity Challenges and Strategies to address

The challenges to meeting quality and fidelity in Yakima include: enrollment by 16 weeks gestation and meeting the completed-to-expected visit ratio in pregnancy and infancy. In Yakima County enrolling 60% of clients by 16 weeks gestation and meeting the completed-to-expected visit ratio in the pregnancy and infancy phase is a challenge. The proposed strategy to address these challenges includes continuing to educate and inform referral sources about offering, and referring early to, Nurse-Family Partnership, as well as continuing to be thoughtful in how we offer the program to potential clients in the first encounter, which would motivate them to make their decision regarding enrollment. For the percentage of visits completed in pregnancy and infancy phases, the Yakima County NFP team of nurses and nurse supervisor will continue to review the data/reports received from the NFP NSO and reflect on potential causes and strategic planning to address the challenge.

The identified “at-risk” population identified in Yakima County is highly mobile, and are usually homeless by definition due to “couch-surfing.” Most of the Native American clients have texting only on their cell phones, if they have working cell phones at all. All of the “at-risk” groups represented have frequent phone number changes, or do not have minutes at the end of the month for calling. The Yakima County NFP team will continue to address engagement during these phases, and have already addressed this in a local performance improvement plan. This plan included increased focus on weekly visits in the early postpartum period, and strategies to make the program more meaningful to the client during the Infancy phase. This included a focus on using Partners in Parenting Education activities, which engage the mother and the baby in learning activities together, and offering information about infant cues during the last weeks of pregnancy (versus introducing in the first weeks of the baby’s life). These interventions are affected by Home Visitor Safety policies adopted by county agencies, which include phone or text confirmation of home visit, prior to going to the visit. This is due to the potential of harm to the home visitor, if the client is not at her home and other family members or friends may be there, who may put the nurse’s safety in jeopardy. The nurse discusses visit policies with the client when she enrolls, including home visitor safety. This scenario is a problem, but also an opportunity. Following a cancelled visit, nurses report clients sharing with them that a family member with strong gang affiliation or unstable mental illness was at the home at the time of the visit, reflecting the strong trusting relationship between nurse and client.

The Yakima NFP team has also focused on the content of home visits during the Infancy phase, specifically percentage of time spent on the Maternal Role. The nurses understand that meeting the NFP Objective of 45-50% will have a positive impact on the clients’ engagement and retention, as well as meet quality and fidelity goals. Additionally, the local evaluation structure supports the Yakima County NFP as it has incorporated the implementation drivers and stages of implementation model developed by the National Implementation Research Network (NIRN) into its continuous improvement activities. The Yakima County supervisor and local evaluators have attended NIRN trainings, and now conduct a collaborative annual program self-evaluation to rate each implementation driver along the stages of implementation. This self-evaluation leads to program-level performance improvement activities that continue to institutionalize organizational support for the local program within the two partner organizations.

Attrition Rate for Participants & Plan for Minimizing Attrition

The average rate of attrition for program participants in Yakima NFP is:

Pregnancy Phase: 9.8%
Infancy Phase: 22.0%
Toddler Phase: 16.7%

Plan for minimizing attrition rates

The improvement plan in place for minimizing attrition rates is based on reviewing the data received from NFP NSO, and the ETO system as a team, and thoughtfully and purposefully reflecting on root causes, and then form the improvement plan to address attrition. The team has noted that many of the same improvement plans for completed to expected visit ratio, also have a positive impact on attrition rates. These improvement plans listed in question #24 include enrollment strategies, focused attention to weekly visits postpartum, and utilizing Partners in Parenting Education activities, to keep clients engaged in the visits. Yakima County NFP nurses have noted that with young teen clients, that spending more time in activities which teach the mom how to “play and learn” with her baby, also keep them engaged and decrease attrition. The team has also identified working individually and as a group on increasing their skills in Motivational Interviewing, and how to best incorporate the techniques into home visits, which they believe will decrease attrition rates. The introduction of new client-centered visit to visit guidelines over the last 18 months, which increases client choice in the topic areas covered at home visits, we believe will relate to a decrease in attrition over time. The nurses’ report increased client satisfaction with the new “facilitators”, or discussion handouts. The nurses also report that the new handouts/facilitators have more opportunity for open-ended questions, which then continues to build the trusting relationship between the nurse and client.

Existing Yakima County Measurement Tools, Data Management & Ongoing Continuous Quality Improvement

Current Measurement tools being used by NFP Yakima:

Assessment/Measurement Tools:

| Measurement tool | Developed by | Frequency administered |
|--|--|---|
| NFP data collection forms including: <ul style="list-style-type: none"> • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter Form • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Government & Community Services • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report | NFP National Service Office | Collected per NFP schedule multiple times over program phases |
| NCAST (Nursing Child Assessment Satellite Training) feeding scale | <ul style="list-style-type: none"> ▪ NCAST AVE ▪ University of Washington | <ul style="list-style-type: none"> ▪ Completed at 6-8 weeks postpartum ▪ Repeated when child is 12 months |
| NCAST (Nursing Child Assessment Satellite Training) teaching scale | <ul style="list-style-type: none"> ▪ NCAST AVE ▪ University of Washington | Completed when child is 7 months repeated when child is 13 months |
| Ages & Stages Questionnaire | Early intervention program, University of Oregon | Childs age of 4 months, 10 months, 14 months, 20 months |
| Ages & Stages Social Emotional Questionnaire | Early intervention program, University of Oregon | Childs age of 6 months, 12 months, 18 months, 24 months |
| Edinburgh Postnatal Depression Scale | J.L. Cox, et al. | Completed at intake and repeated at 6 weeks postpartum |
| NCAST (Nursing Child Assessment Satellite Training) CLSS | <ul style="list-style-type: none"> ▪ NCAST AVE ▪ University of Washington | At intake and child 24 months |
| NCAST (Nursing Child Assessment Satellite Training) DLC (Difficult Life Circumstances) | <ul style="list-style-type: none"> ▪ NCAST AVE ▪ University of Washington | At intake |
| Relationship Quality Form | Selected questions from Section F: Relationship Quality - Study of Community Family Life Questionnaire, Feb 2007 Sponsored by ACF, HHS Prepared by RTI International and The Urban Institute | At intake and child 24 months (ACF clients only) |
| HOME Assessment | Bettye Caldwell | At child 12 and 24 months |

YCNFP nurse home visitors collect data directly from the client on NFP Data Collection Forms, as well as any other local data collection tools. YCNFP has a dedicated support staff to the program, providing 20 hours per week to NFP data input and team support. 2 other support staff members, including the Operations Supervisor, are trained in data entry and NFP support as well. YVMH and YVFWC maintain a HIPAA-compliant data sharing agreement, and YVFWC clerical staff input data for the smaller local database. The YCNFP Nurse Supervisor analyzes and reviews the quarterly data reports with the nurses as a team, and together they problem solve any areas of concern. The ongoing process of learning from both clients and program data systems has identified areas that need improvement. The YCNFP Nurse Supervisor also reviews data, including performance outcomes with the NSO Nurse Consultant. The Nurse Supervisor, along with YVFWC Evaluation staff support, reports on the data to funders and the community. The YCNFP Nurse Supervisor and staff review the data on a quarterly basis during team meetings and reflective supervision sessions, and decide upon performance improvement measures to focus on. The YCNFP Nurse Supervisor utilizes the Children's Village Report Card, which is a local performance improvement tool for all of the services provided at Children's Village. 3 outcomes are chosen annually, with specific goals for each outcome, along with a plan for improvement.

Data Management Systems:

The NFP NSO requires all programs to enter data into the Efforts to Outcomes (ETO) system – formerly the Clinical Information System (CIS). All programs in Washington are currently entering data into the ETO system on a regular basis. In addition to the ETO system, Yakima County NFP maintains a local evaluation structure provided by YVFWC. The local database includes information and measures not tracked by the NFP ETO system, such as client funding source, and DLC (Difficult Life Circumstances) and NCAST Teaching scores.

Future Data Collection

Data collection that will be used for the Yakima PAT programs is included in Section 5: Plan for Meeting Legislatively Mandated Benchmarks.

MIECHV Logic Model

Lead Organization Name: **Yakima Valley Memorial Hospital and Yakima Valley Farm Workers**

Clinic/Yakima County Nurse Family Partnership

Evidence Based Home Visiting Model: Nurse Family Partnership (NFP)

Date (Month/Year): May 2011

| RESOURCES | ACTIVITIES (include core model components and any enhancements/adaptations) | OUTPUTS Provided outputs for each relevant activity that coincide with the MIECHV funding only, in the selected county/region for the targeted population | LEGISLATIVELY MANDATED BENCHMARKS (SEE SECTION 5 – PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS) |
|--|--|---|---|
| <p>Target Population: Hispanic, Non-Hispanic American Indian, and White first time low-income mothers</p> <p>Target Geographic Area: Yakima County</p> <p>Staffing: Public Health Nurses NFP Nurse Supervisor NFP Administrative Support</p> <p>EBHV Curriculum used and any additional: Nurse Family Partnership Visit to Visit Guidelines Partners in Parenting Education (PIPE)</p> <p>Assessment & Evaluation Tools: NFP data collection forms including: Home Visit Encounter Form Infant Birth Form Alternative Encounter Form Infant Health Care Form Maternal Health Assessment Form Demographics Form Demographics Update Form Client Discharge Form Health Habits Form Relationships Form Use of Govt & Community Services Form Profile of Program Staff Visit Implementation Scale Supervision Progress Report</p> | <p>Staffing 1) Maintain NFP Team at full capacity and low nurse turnover.</p> <p>Training 2) NFP nurses will receive ongoing local training in collaboration with NFP National Service Office (NSO), as needed.</p> <p>Home Visits 3) Provide home visits for first-time, low-income Hispanic, American Indian and White mothers in Yakima County.</p> <p>Supervision 4) Nurse Supervisor will conduct Reflective Supervision with 1 Public Health Nurse</p> <p>Mental Health Consultation 5) Mental Health Consultant meets regularly with NFP Public Health Nurse and attends case conference regularly</p> | <p>Staffing 1) MIECHV NFP program staff will be: .40 FTE Public Health Nurse .10 NFP Nurse Supervisor</p> <p>Training 2) NFP PHN will complete on-going Efforts to Outcomes (ETO) training online and locally, as needed with collaboration with the NFP NSO. Supervisor will attend required NFP NSO Supervisor Annual Education NFP PHN will complete Motivational Interviewing educational modules as released by NFP NSO.</p> <p>Home Visits 3) 10 clients will receive home visit according to NFP guidelines</p> <p>Supervision 4) 44 Weekly reflective supervision sessions annually with supervisor for 60 minutes each.</p> <p>Mental Health Consultation 5) 12 monthly, up to two hour</p> | |

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|--|--|---|--|
| <p>NCAST (Nursing Child Assessment Satellite Training) Feeding scale NCAST Teaching scale Ages & Stages Questionnaire Ages & Stages Social Emotional Questionnaire Center for Epidemiologic Studies Depression Scale (CES-D) Edinburgh Postnatal Depression Scale NCAST CLSS (Community Life Skills Scale) NCAST DLC (Difficult Life Circumstances)</p> <p>Funding: MIECHV funding, WA State Maternity Support Services (MSS)</p> <p>Data System: NFP Efforts to Outcomes (ETO) and local evaluation structure provided by YVFWC</p> | | <p>consultations with PHN annually. Mental Health Consultant will attend 12 monthly case conferences annually, 2 hours each.</p> | |
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**Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program
Supplemental Information Request of the Updated State Plan**

**Yakima County PAT Implementation Plan
Community, Agency, Participant Level**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|--|--|---|---|
| Evidence Based Home Visiting Model: <input type="checkbox"/> NFP <input checked="" type="checkbox"/> PAT EBHV State Rep Name: <u>Linda Clark</u> EBHV State Rep: Ph: 206-233-0156 ext 288 Cell: 360-481-1572 Email: lclark@parenttrust.org | Selected Region/County: <u>Yakima County</u> | Funding Level in Year One <u>\$71,000</u> | To Serve # Families : <u>25</u> # Children: _____ # Parents/Caregivers: _____ |
| Identified “at-risk” population to target in selected region/community | <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Pacific Islanders <input checked="" type="checkbox"/> Non Hispanic American Indian/Alaska Natives <i>(not in first year)</i> <input type="checkbox"/> White | | |
| FISCAL SPONSOR | | | |
| Organization Name | Parent Trust for Washington Children | | |
| Organizations Mailing Address | 2200 Rainier Avenue South Seattle, WA 98144 | | |
| Organization Physical Address | Same as above | | |
| Federal Tax ID #: | 91-1036940 | | |
| Chief Executive Name & Title | Jack Edgerton, Executive Director | | |
| Chief Executive’s Email | jedgerton@parenttrust.org | | |
| EBHV Manager Name & Title: | Linda Clark, Parents as Teachers Coordinator/WA State Leader | | |
| EBHV Manager’s Email | lclark@parenttrust.org | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |

| | |
|--|---|
| Additional Organization(s) Name & Address | <p>Catholic Family & Child Services – PAT Yakima Catholic Charities 5301 Tieton Drive, Ste. C Yakima, WA 98908</p> <p>NCAC Readiness to Learn/Yakima Valley Farmworkers Clinic PO Box 831 706 Rentschler Lane Toppenish, WA 98948</p> <p><i>Site address for Parents as Teachers Yakima PAT is:</i> 15 North Naches Ave. #15 Yakima, WA 98901</p> |
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Yakima County PAT Implementation Plan

Assurance - Voluntary Services & Priority Given to Serve Eligible Participants who:

Yakima County PAT programs assure:

- Services are provided on a voluntary basis

Yakima County PAT programs assure:

Priority is given to serve eligible participants who:

- Have low incomes
- Are pregnant women who are under 21
- Have a history of child abuse and neglect or have had interactions with child welfare services
- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home – (to be developed)
- Have, or have children with, low student achievement – (to be developed)
- Have children with developmental delays or disabilities – (to be developed)
- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States – (to be developed)

Existing Home Visiting Services in Yakima County (please see Section 1)

Existing Mechanisms for Screening in Yakima County (Please see Section 1)

Referral Resources currently available and needed in the future in Yakima County (Please see Section 1)

Coordination Among Existing Programs and Resources in Yakima County (Please see Section 1)

Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the PAT programs include:

- All families on each program’s “Wait List” will be called and screened for appropriateness, according to PAT Model specifics and requirements of the federal funding project.
- PAT Supervisors and/or Parent Educators will participate in monthly meetings for joint coordination and project support with *WA PAT State Leader*. This meeting is in addition to the monthly state-wide meeting for all PAT programs.
- PAT Program Managers and/or Supervisors will participate in ongoing consortium and initiatives’ monthly meetings (#6) to increase awareness and referrals.
- EBHV Yakima programs will work together to create a brochure/flyer for distribution at local medical providers, WIC, schools and other family service providers that will identify target populations and services available (Model leads will coordinate this effort).
- In lower Yakima Valley, YVFC PAT will continue to connect with all lower valley school districts through their *Readiness to Learn* program.

Recruitment and engagement plan for the “at-risk” population identified.

It is the policy of Parents as Teachers to work and provide services in a culturally competent manner. In Yakima County, staff are bilingual in English and Spanish and has an understanding of the cultural beliefs and differences of the Hispanic and Native American populations that they are serving. Educators also have a flexible schedule to work around the migrant family’s work schedule, even when this may mean working some evenings and weekends. All three PAT programs are currently recruiting and engaging “at-risk” families through the effectiveness of hiring and maintaining quality and culturally competent staff and collaborating with those consortiums and initiatives that are listed in #6.

Plan for Individualized assessments of enrolled participant families:

During the initial home visit, the PAT Parent Educator and the mother and/or father complete an enrollment agreement, which is signed by all present. The agreement includes demographics and household information, family size, source of income, living situation, level of education for mother and/or father, cultural considerations, transportation, and access to resources. During the first few visits, the Parent Educator is able to develop a more thorough assessment of the family – ethnic, cultural, and special needs, and problems and areas of concern in the family’s life. The assessment is used to individualize services by adapting each home visit to meet the needs of parents and children within their family systems. Ongoing assessment of the family’s strengths and needs, as well as the infant/toddler’s developmental progress, occurs as part of each home visit and is recorded in the PAT *Personal Visit Record*. The Universal Risk Assessment (URA) is currently also being used by CFCS PAT. New PAT Affiliate *Essential Requirements* mandate that all Parent Educators complete and document a family-centered assessment and family-centered goals with each family that they serve. All three PAT sites will begin using an evidence-based assessment tool approved by national PAT and selected by the *Evaluation/Benchmark Team for this project*.

Plan for Referrals to Services:

Services are indicated by enrollment information, scores from the URA, and other screening scores. These currently include assessment scores from formal health, vision, hearing, home safety and developmental and social emotional tools. The initial formal screening (hearing, vision, developmental, and the health record) must take place within 90 days of enrollment for each child and completed at a minimum annually. Parent Educators maintain active collaboration with all community resources to complement and extend PAT services. Referrals are documented on the *Personal Visit Record* of each family and re-visited at the next home visit to see if referral services were accessed. Parent Educators also assist families overcome any barriers to access.

Timeline to reach maximum caseload:

- Catholic Family & Child Services PAT: Caseload of 7 families will be reached within three months.
- Parent Trust for WA Children PAT: Caseload of 19 families will be reached within six months.
- Yakima Valley Farmworkers Clinic PAT: not applicable for first funding year

* *This timeline is estimated with expectations that all three PAT sites will have completed PAT model specific re-training and training for all other Affiliate status requirements before October 1st. National PAT requires that any PAT program that is included in the State Implementation Plan meet all Affiliate status requirements by December 8, 2011, but new families to be included in the federal project cannot receive required PAT components until all training is completed.*

Plan for Working with National, Regional/State EBHV Model Developer/Representative, Technical Assistance & Support

National Parents as Teachers (PAT) sets direction for the PAT model, the training and curriculum offerings, the advocacy and research agendas at the national level, and the national office itself. A key function of the Parents as Teachers national office is to develop, support and sustain high quality *Parents as Teachers (PAT) State Offices*. The purpose of the *PAT State Office* is to develop, support and sustain high quality PAT Affiliates. The *PAT State Office* is home for the *PAT State Leader*.

National PAT has been collecting PAT programs' evidence-based information and evidence-informed practices over the years and has carefully monitored trends in the field. The majority of PAT programs across the United States now target their work toward families who are vulnerable due to low income and/or other stressors. The 2011 new Parents as Teachers *Foundational and Model Implementation* curriculum and training focuses on evidence-based practices, family well-being factors, parent-child activity pages, parent educator tool kit, intentional reflection, parent educator core competencies, strengthening families protective factors, parent goal setting, and an enhanced prenatal section. The new curriculum is a good fit for addressing the needs of many targeted at-risk populations and incorporates the *Strengthening Families™ Protective Factors*.

Initial and Ongoing Training and Professional Development

Through the national PAT, as well as through the *WA PAT State Office*, Parents as Teachers offers several key resources that provide comprehensive guidance for those implementing the model:

- Technical assistance supporting initial implementation, including development and approval of the initial *Affiliate Plan*. It is designed as a logic model, linking inputs, activities, outputs and outcomes for families.
- Technical assistance around monitoring, assessing and supporting implementation with fidelity to the model and maintaining quality assurance - *Quality Assurance Guidelines*.
- Technical assistance regarding meeting the *Essential Requirements* (identified as best practices to ensure model fidelity).
- *Ongoing Professional Development*: PAT offers a variety of professional development trainings as well as an annual conference to help Parent Educators meet this requirement. Parent Educators may participate in a variety of local early learning trainings to also satisfy the PAT requirement.

Initial and Ongoing Technical Assistance and Support Provided

Across the stages of Parents as Teachers implementation, technical assistance addresses two vital aspects of model fidelity: structural fidelity and process fidelity. The *WA PAT State Leader* provides technical assistance that is delivered through two main categories of work: monitoring compliance with the *PAT Essential Requirements* and promoting continuous quality improvement. The *WA PAT State Leader* provides all training and technical assistance to each program site through phone/email support and training and individual site visits. The *WA PAT State Leader* provides monthly training calls with all WA State PAT programs. Trainings include updates regarding curriculum, state home visiting news and advocacy, news from PAT national office, and any upcoming training opportunities. An eight hour state-wide PAT training will be held yearly during the federal project. This training will include a variety of professional development opportunities; technical support for assessment tools being used, evaluation, data management; showcase state-wide resources that are available for enhancements to PAT curriculum; and time for program networking.

The *WA PAT State Leader* is in constant contact with national office via phone and email. PAT national webinars are scheduled with State Leaders every three months. The *WA PAT State Leader* is also required to attend an annual national conference to receive ongoing training.

Plan for Staff Training, Recruitment, & Retention

Staff Training:

PAT Training: All Parent Educators and Supervisors must complete 40 hours of PAT certification training before implementing PAT. Certified Parent Educators must also complete in-service professional development hours annually to maintain their certification. The training explains how to successfully replicate the PAT model with fidelity. Demonstrating accountability, evaluation and outcomes are themes woven throughout.

***New as of January 1, 2011:** Parent Educators and Supervisors certified prior to January 1, 2011, who are with an existing program, must attend *PAT Foundational Training* and a *Model Implementation* re-training (Supervisors are only required to attend the *Model Implementation*, but *strongly* advised to complete *Foundational Training* as well). Also, to satisfy requirements for Affiliate status, all Parent Educators must complete training in the *Ages and Stages 3–* both developmental and social emotional Questionnaires (ASQ-3); the

Edinburgh Post Natal Depression Screening; and a Family Assessment Screening tool (LSP recommended by national). *New PAT programs must complete and receive approval for the Affiliate plan by the WA PAT State Leader before any training is scheduled.*

Training and ongoing professional development activities provided by the implementing organizations: CPR trainings, personal safety, *Promoting First Relationships, Creative Curriculum*, and other relevant skill-building in-service workshops are provided by Parent Trust for WA Children, Thrive by Five, Catholic Family and Child Services, Educational School District 105 and other local agencies.

Staff Recruitment:

National Parents as Teachers recommends that Parent Educators have at least a bachelor's or four-year degree in early childhood or a related field. However it is also acceptable for Parent Educators to have a two-year degree or 60 college hours in early childhood or a related field. Supervised experience working with young children and/or parents is also recommended. *This is part of the new Essential Requirements for Affiliates.*

All three PAT programs have existing staff to implement the federal project. All PAT staff in the three PAT sites in Yakima must complete all necessary model specific training/re-training by December 8, 2011 to meet national PAT requirements to be eligible for MIECHV funding. As discussed previously, the timeline to have all PAT required trainings completed is October 1, 2011 so that recruitment and services to new families could begin.

Subcontractors: The PAT programs in Yakima may use subcontractors to provide hearing screenings that will be required according to the new *Essential Requirements*. Hearing checks are no longer acceptable. The hearing screening must now be performed either by otoacoustic emissions (OAE) or pure tone audiometry. Given the cost of these required tools, PAT sites will look into partnering with Early Head Start health care providers, Kids Screen, school nurses or other appropriate organizations to coordinate and obtain hearing screening for enrolled children, which could result in contracts with other agencies/organizations.

Staff Retention:

Competitive wage and benefit packages, performance based annual wage increases, ongoing professional development opportunities and a true passion for their work assures low staff turnover.

Plan for PAT Clinical Supervision & Reflective Practice

The Parents as Teachers (PAT) supervisor directs, coordinates, supports, and evaluates the on-the-job performance of Parent Educators. A combination of education, work experience and effective interpersonal and communication skills is critical for the supervisor as well. For the supervisor, a college degree or beyond in early childhood education, elementary education, behavioral or social sciences or a related field is recommended. He or she must also successfully complete the *Model Implementation Training*, and it is strongly recommended that the Foundational Training is also completed. In addition, the supervisor should have demonstrated the ability to work with adults and young children.

A maximum of 12 Parent Educators can be assigned to each Supervisor or mentor or lead Parent Educator regardless of whether the Parent Educators being supervised are full-time or part-time employees. The maximum number of supervisees is based on a full time Supervisor/mentor/lead

Parent Educator and should be less if the supervisor/mentor/lead Parent Educator is not full time. It is essential that each month, Parent Educators participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings. All Parents as Teachers (PAT) programs recognize these supervision requirements as one of the *Essential Requirements* required by PAT national to be a PAT Affiliate site. Part of the role of the WA *PAT State Leader* is to monitor that PAT affiliates are adhering to all *Essential Requirements*.

Yakima Parents as Teachers (PAT) programs are meeting and even exceeding the requirements of the model. Supervisors meet with parent educators on a weekly basis (60 to 90 minute meetings), and most Parent Educators also take part in agency-wide weekly staff meetings. Supervisors observe home visits quarterly and also attend at least one group meeting quarterly. Meetings are used to review caseloads, monitor family documentation, and assist the Parent Educator with any issues or challenges that may be happening. Currently between the three PAT programs, there are a total of 1.5 FTE Supervisors supervising 7FTE Parent Educators.

Plan for Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

National PAT provides guidelines and requirements for model fidelity and quality that establish a comprehensive blueprint for quality implementation of Parents as Teachers (PAT). The *Quality Assurance Guidelines* and *Essential Requirements* represent the programmatic elements necessary for model fidelity and should be used to guide the development and growth of a PAT affiliate and the completion of an *Affiliate Plan*. Affiliates annually report data on service delivery, program implementation, and compliance with the model replication requirements through the *Affiliate Performance Report*, a web-based reporting system. Timely reporting requires that the *Report* be completed by July 31. All WA State PAT programs submit their *Report* to the WA *PAT State Leader* who verifies its completeness and then submits to the national center.

PAT fidelity tracking and quality:

Ongoing affiliation with PAT requires regular program self-assessment. To assist with this, National Parents as Teachers has developed quality self-assessment process and tools. Every four years, Affiliates must engage in an expanded program assessment, incorporating additional data, stakeholder input and documentation review to support the findings of their annual assessment.

Additional monitoring, assessing and supporting implementation with fidelity to the chosen model and maintaining quality assurance:

PAT Yakima sites are currently being provided in additional support for Implementation with fidelity to the PAT model. Aligning the work for PAT implementation with fidelity will be part of the focus for the data benchmark work we are proceeding with in WA. The following additional support is currently being provided to Yakima PAT programs:

PAT Implementation in WA CQI:

The HVSA is currently working with Organizational Research Services (ORS) is to facilitate conversations with all PAT programs in Washington assessing current strengths and challenges of Parents as Teachers (PAT) home visiting model implementation in Washington State. The

purpose of these conversations is to identify and propose approaches for PAT model specific technical assistance for consistent quality implementation and continuous quality improvement.

As a PAT funder and a leader in the Washington State and National evidence-based home visiting expansion, the HVSA understands model-specific technical assistance is critical to quality implementation. Documentation of program implementation practices, enhancements programs are making, and challenges for implementation is the first step. Such documentation would support future targeting of additional technical assistance needed to support consistent, quality implementation across the state and nationally. ORS is facilitating conversations with key stakeholders that would help frame an approach which could be funded in the future. Various key players in the state include:

- Funders of PAT programs, including Thrive by Five WA and Council for Children and Families
- WSU, the overall evaluator of home visiting programs in the state (supported by Thrive)
- Organizations implementing PAT who are currently being funded by thrive by Five, the Council for Children & Families as well as others participating in the Home Visiting Coalition (e.g., Children's Home Society)
- The PAT model representatives and national office

A proposed continuous quality improvement strategy for strengthening PAT quality implementation in Washington will be completed by July 2011.

Council for Children & Families (CCF) State Funded EBHV Participatory Evaluation with Washington State University Area Health Education Center (WSU AHEC):

WSU AHEC is currently conducting the evaluator for the Council for Children & Families Evidence Based Home Visiting portfolio of programs. Yakima Valley Memorial Hospital NFP is participating in evaluation of home visiting programs through CCF/WSU participatory evaluation. The CCF evaluation work specifically addresses the program impact and process of quality improvement in 11 programs, in six communities, implementing four home visiting models.

The CCF effort served as a critical test program for understanding the challenges and benefits of home visiting as a prevention and early intervention strategy for increasing numbers of Washington's most at-risk children and families. The lessons learned through the collaborative implementation and evaluation of the portfolio approach is vital to our state as we continue to build from this foundation.

The evaluation thus far demonstrates that CCF- supported evidence based home visiting programs are well-established and successful community services that are reaching their intended clientele. Consistent with the published home visiting literature, local programs face a variety of staff, client, and resource challenges that are significant impacts on program focus, implementation fidelity, and potentially on program benefits. The evaluation supports the conclusion that all programs are working to deliver their model with rigor and attention to the model's standards but that success in our efforts requires continued vigilance on implementation with fidelity and continuous quality improvement practices at the agency level.

PAT programs describe the following challenges to maintain quality and fidelity when implementing in Yakima:

- PAT programs in Yakima and all others in WA State are challenged because of lack of designated funding to assure that all PAT Parent Educators and Supervisors are trained according to the national *Essential Requirements* that are required to achieve Affiliate status and provide quality and appropriate services to families in their communities.
- In the past, there has not been a designated or required PAT family assessment tool that is being used by PAT programs. To be included in the State Implementation Plan for MIECHV funding, PAT programs must be able to collect data for each construct in each federal benchmark area. New PAT *Essential Requirements* also mandate using a family assessment tool. In order to assure viable outcomes for the three PAT programs in Yakima and eventually across the State, there needs to be consensus for one assessment tool that will be used.
- Home visiting to the rural population of Yakima County in fidelity of the PAT model is challenged because of the distance that Parent Educators have to travel between visits and still meet the requirement of providing two visits each month to higher risk families. Along with distance, many of the enrolled families are migrant workers and are hard to reach during times when crops are ready.
- Another challenge that is not specific to Yakima but affects the quality and fidelity of all WA State PAT programs is that the *WA PAT State Leader* position is continually underfunded. This position is solely maintained by grants obtained by the State Office, which in WA State is a non-profit organization. Unlike other national models, there are not dollars designated from national PAT for the State Office or State Leader position, although the *WA PAT State Leader* is instrumental in monitoring the quality and fidelity of individual PAT programs.

Strategies to address these challenges:

- The *WA PAT State Leader* has been working with the State Planning Advisory Committee, Thrive by Five and the local Yakima sites to determine the amount of funding needed to complete all necessary training for Affiliate status. The short term ORS project will also lead to valuable information concerning PAT needs and challenges. The current strategy is that for Yakima PAT programs, HVSA and federal training dollars will be used to fully assist these three sites reach Affiliate status in the required time period to be included in the State Plan. **Long-term strategy:** *To assure that PAT programs across WA State have equal opportunities to achieve Affiliate status, a plan should also be implemented to designate state and federal training and capacity building dollars towards PAT programs and other EBHV programs that are in jeopardy of not being able to provide services in fidelity of their model due to lack of training.*
- The new PAT Essential Requirements require that one of four recommended family assessment tools be used for enrolled families (Life Skills Progression is

recommended by national). The project *Evaluation/Benchmark Team*¹ will be working with Yakima PAT programs to implement an assessment tool (or tools) that are approved by national and also have the ability to meet state and federal requirements. Training and ongoing technical assistance will be provided by both the *WA PAT State Leader* and the *Evaluation/Benchmark Team*. **Long-term strategy:** *Assessment tools selected to be used by Yakima PAT programs will also be implemented throughout the state in order to achieve state-wide outcomes.*

- Achieving model fidelity in rural communities and diverse populations requires Parent Educators who understand the cultural beliefs and differences of the Hispanic and Native American populations being served in Yakima and willing to work flexible hours to meet the needs of their enrolled families. With new PAT requirements regarding increased dosage of home visits to higher risk families, additional Parent Educators may need to be hired and trained in the second year of federal funding.
- Conversations are ongoing with State Planning Committee members and the *WA PAT State Office*. A budget with required duties of the *WA PAT State Leader* position has been forwarded to the Committee with the hope of finding a solution to sustain this position at a level to perform all necessary requirements to assure that all PAT programs receive needed PAT technical assistance, trainings, and support from the *State Office*.

Attrition & Plan for Minimizing Attrition

For the Yakima programs, the average rate of attrition is 10-12% annually. Current attrition rates are extremely low, considering the migrant population that is being served. This includes families who move out of the area, and families who can no longer be located. As families are exited from the program, new families are enrolled who are on the waiting list and/or recruited from a variety of referral services.

Plan for Minimizing Attrition

To provide service to parents who work certain months in the fields, a plan is to increase availability for evening and/or weekend visits for those families, make phone contacts with parents during the months when they are working in the fields, and doing visits with enrolled children at relative caregivers. Phone contacts and visits in relative caregiver homes would only be temporary while parents are not available for regular PAT home visits. For those families that are showing disengagement behavior, Parent Educators attempt to reengage them in a three-part process that includes a drop-in personal visit, phone contact, and then a letter with a possible termination date if no re-engagement is made. As stated above, after a family is exited, a new family will be enrolled from the waiting list and/or recruited from a variety of referral services so that a full caseload is maintained for the Parent Educator.

Existing Yakima Measurement Tools, Data Management & Ongoing Continuous Quality Improvement

Current measurement tools being used by Parents as Teachers in Yakima:

| Name of Measurement Tool | Developed by | Frequency Administered |
|---|---|--|
| Ages & Stages – Developmental, Second Edition* | University of Oregon, Dr. Diane Bricker | At specific age indicated by tool – can be done at each age interval (4, 6,8,10 months, etc.) |
| Ages & Stages – Social Emotional, Second Edition* | University of Oregon, Dr. Diane Bricker | At specific age indicated by tool – can be done at each age interval (4, 6,8,10 months, etc.) |
| Ages & Stages – Developmental, Third Edition (ASQ-3) | University of Oregon, Dr. Diane Bricker | At specific age indicated by tool – can be done at each age interval (4,6,8,10 months, etc.) <i>2 and 9 month has been added in third edition</i> |
| Ages & Stages– Social Emotional, Third Edition (ASQ-3) | University of Oregon, Dr. Diane Bricker | At specific age indicated by tool – can be done at each age interval (4, 6,8,10 months, etc.) <i>2 and 9 month has been added in third edition</i> |
| Survey of Parenting Practices- Parent Ladder (1-6 rating scale) | University of Idaho, Shaklee & Demerest | Initial assessment is 90 days to six months after enrollment and every six months thereafter |
| Adverse Childhood Experience Questionnaire (ACE) | Study by Robert F. Anda, MD, MS, and Vincent J. Felitti, MD | Initial assessment and six months after enrollment and six months thereafter. |

* *Programs using Second Edition will be trained and use Third Edition (New PAT Essential Requirement)*

Parent Educators collect the data in the program; Parent Educators and Supervisors share the responsibility for data input; and Supervisors, Programs Managers, and Evaluation Directors analyze and report on the data. Analyzed data is used to refer families to early intervention services if the child shows screening delays; to manage the program and monitor to assure model fidelity; to focus visits on parenting knowledge and skill in specific areas that the parent has not yet learned; reporting outcomes/goals met to funders; to report satisfaction of services by families; and to help identify gaps in service.

Future Data Collection:

Parents as Teachers National has provided a table that highlights how Parents as Teachers outcomes, as outlined in the 2011 PAT Logic Model, align with the Federal Home Visiting Initiative’s benchmarks (Table and Logic Model have been forwarded to Evaluation/Benchmark Team). The use of a family-centred assessment is an essential requirement for compliance with the PAT model as of January 2011. There are four recommended tools, including *Life Skills Progression (LSP)*, *Protective Factors Survey*, *Keys to Interactive Parenting Scale (KIPPS)*, and the *University of Idaho Survey of Parenting Practices (Parent Ladder)*. The *LSP* is the recommended tool. The *Edinburgh Post Natal Depression Scale* is also highlighted in the table

and is required for Affiliates, as of January 2011. *DOVE*, an evidence-based tool for domestic violence screening, prevention, and intervention is included in the new PAT Foundational Curriculum. Data collection that will be used for the Yakima PAT programs is included in Section 5: Plan for Meeting Legislatively Mandated Benchmarks.

Data Management System:

Currently Visit Tracker is national Parents as Teachers recommended data management system. This tool assists Parent Educators with regular reporting on implementation of PAT. Parent Educators have the capability to track family history and demographics, track screenings and referrals, assure health and immunizations are up to date, and track attendance at monthly group meetings. *Visit Tracker* also has a place to enter scores generated using PAT recommended outcomes measurement and screening tools. Family goals and how the goals are met are tracked in *Visit Tracker*. The PAT *Personal Visit Record* is recorded on *Visit Tracker* after each home visit. The *Personal Visit Record* documents family strengths and protective factors focused on in the visit, strength-based observations of parent-child interactions, and Development Centered Parenting Topics discussed (healthy births, attachment, discipline, health, nutrition, safety, sleep, transitions/routines). *DOVE* results are also recorded in the Personal Visit Record. All data from the *Personal Visit Records* that has been input into *Visit Tracker* can easily be pulled to run reports at anytime for an individual family or for the entire PAT program. Reports can also be broken down per Parent Educators and/or funding sources.

Parent Trust for WA Children is currently using *Visit Tracker*. Yakima Valley Farmworkers Clinic PAT program is examining the possibility of also purchasing *Visit Tracker*. Catholic Family and Child Services PAT are using the ETO database. Yakima Valley Farmworkers Clinic PAT is recording data by hand currently while the Project LAUNCH evaluation team (Spokane Child Research Center) is designing a database to be used by LAUNCH partners. Modifications will be needed for data collection for Yakima PAT programs. Please see Plan for meeting legislatively mandated benchmarks, Section 5, for specific plan for PAT.

MIECHV Logic Model

Lead Organization Name: Parent Trust for Washington Children
 Evidence Based Home Visiting Model: Parents as Teachers
 Date (Month/Year): 5/16/2011

| RESOURCES | ACTIVITIES (include core model components and any enhancements/adaptations) | OUTPUTS Provided outputs for each relevant activity that coincide with the MIECHV funding only, in the selected county/region for the targeted population | LEGISLATIVELY MANDATED BENCHMARKS (SEE SECTION 5 – PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS) |
|---|---|---|---|
| <p>Target Population:</p> <ul style="list-style-type: none"> Hispanic, Non-Hispanic American Indian Very low income; 25 higher risk families with children birth-3 <p>Target Geographic Area:</p> <p>Yakima County</p> <p>Staffing:</p> <p>2-.5FTE PAT Supervisor 7FTE</p> <p>EBHV Curriculum used and any additional:</p> <p>PAT approved Foundational/Model Curriculum</p> <p>Assessment & Evaluation Tools:</p> <p>Ages & Stages-3 Edinburgh Post Natal Depression Tool</p> <p>Funding:</p> <p>\$71,000 -MIECHV Initiative</p> <p>Data System:</p> <p>Visit Tracker Excel Spreadsheet ETO</p> | <p>1. Training All PAT Staff will complete all necessary training to achieve PAT Affiliate status. * New PAT Foundational/Model Curriculum; *ASQ-3 *Edinburgh Post Natal Depression Scale a *Family-centered assessment tool to be determined</p> <p>2. Affiliate Status 3 Yakima Sites will achieve Affiliate status</p> <p>3. Home Visits Voluntary home visits twice each month from enrollment up to 3 years of age using the model specific PAT curriculum.</p> <p>4. Group Activities Monthly voluntary group activities for families are offered for each PAT program. Examples of Group Topics include Summer safety for children. Literacy Night with child choosing a Page Ahead book, Discipline & Guidance, Guest Speakers, etc.</p> <p>5. Child Developmental and Health Screenings *Ages&Stages-developmental and social emotional screening *health records; formal hearing; informal vision, dental</p> <p>6. Referrals Referrals are made to community partners as listed in chart –question 4</p> | <p>1. 1.5FTE Supervisors and 7FTE Parent Educators from all 3 PAT programs will complete: *40hrs of Foundational/Model Training * 8 hrs each for ASQ-3, Edinburgh Post Natal Depression Scale; and a Family-Centered Assessment Tool</p> <p>2. All 3 Yakima PAT programs will complete all Essential Requirements and achieve Affiliate status by December 8, 2011</p> <p>3. 25 higher risk families will receive a minimum of two 1-1.5 hour visits each month,</p> <p>4. 25 enrolled families will have the opportunity to participate in monthly group activities provided by each PAT program, each group 1.5-2hrs each.</p> <p>5. All enrolled children will receive health, developmental, social emotional, vision, dental, hearing screenings (or contract with partner provider) within 90 days after enrollment and on an ongoing basis thereafter (given at interval of tool recommendation)</p> <p>6. Referrals to early intervention services are made when screenings or observations indicate delay or health problem.</p> | |

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
Pierce County Council Districts 2, 4, 5 & 6
NFP Implementation Plan
Community, Agency, Participant Level**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|---|---|--|--|
| Evidence Based Home Visiting Model: <input checked="" type="checkbox"/> NFP <input type="checkbox"/> PAT EBHV State Rep Name: <u>Kristen Rogers</u> EBHV State Rep: Ph: (253) 441-0292 Email: Kristen.rogers@nursefamilypartnership.org | Selected Region/County : <u>Pierce County Council Districts 2, 4, 5 & 6</u> | Funding Level in Year One <u>\$145,000</u> 0 | To Serve # Families : <u>25</u> # Children: <u>25</u> # Parents/Caregivers: <u>25</u> |
| Identified “at-risk” population to target in selected region/community | <input checked="" type="checkbox"/> Hispanic <input checked="" type="checkbox"/> Non-Hispanic Pacific Islanders <input checked="" type="checkbox"/> Non Hispanic American Indian/Alaska Natives <input type="checkbox"/> White <input checked="" type="checkbox"/> Non-Hisp Blacks <input type="checkbox"/> N-Hispanic Asian <input checked="" type="checkbox"/> Non-Hispanic Multiple Races <input checked="" type="checkbox"/> Military Families | | |
| FISCAL SPONSOR | | | |
| Organization Name | Tacoma-Pierce County Health Department | | |
| Organizations Mailing Address | 3629 South D Street, MS 1100491 Tacoma, WA 98418-6813 | | |
| Organization Physical Address | 3408 S. Union Ave. Tacoma, WA 98409 | | |
| Federal Tax ID #: | 91-1488160 | | |
| Chief Executive Name & Title | Anthony Chen, MD, MPH, Director of Health | | |
| Chief Executive’s Email | achen@tpchd.org | | |
| EBHV Manager Name & Title: | MerrieLynn Rice, RN, BSN, IBCLC NFP Supervisor | | |
| EBHV Manager’s Email | mrice@tpchd.org | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |

| | |
|--|-------------|
| Additional Organization(s) Name & Address | none |
|--|-------------|

Pierce County Council Districts 2, 4, 5 & 6: NFP Implementation Plan

Assurance – Voluntary Services & Priority Given to Serve Eligible Participants

Pierce County NFP Programs Assure:

- Services are provided on a voluntary basis

Priority is given to serve eligible participants who:

- Have low incomes
- Are pregnant women who are under 21
- Have a history of child abuse and neglect or have had interactions with child welfare services
- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home
- Have, or have children with, low student achievement
- Have children with developmental delays or disabilities

Please note: We assess and make referrals for developmental delays and disabilities and provide appropriate services as warranted, but we do not enroll families after the child is born and thus do not prioritize families with delays/disabilities in our enrollment process.

- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States

Please see Section 1 for the following information:

- **Existing Home Visiting Services**
- **Existing Mechanisms for Screening**
- **Referral Resources currently available and needed in the future**
- **Coordination Among Existing Programs and Resources**

Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the NFP program includes:

The Tacoma-Pierce County Health Department NFP Program reaches out to organizations which come in contact with and/or serve high-risk, low-income women. Included in current outreach efforts are all Public Health, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving at-risk low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Family Support Centers, TANF community service offices, and other home visiting programs. Outreach is usually timed to be most relevant based on the services each agency provides and on the availability of openings on

our NFP nursing caseloads. Outreach to schools generally happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Our NFP Supervisors regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Recruitment and Engagement of the Identified “At-risk” Population

Due to the results of the State Home Visiting Needs Assessment, naming four of our seven County Council Districts as being in the top 10 areas for risk to young children, the Tacoma-Pierce County Health Department has placed a high priority on conducting outreach to high-risk pregnant women in Council Districts 2, 4, 5 and 6 by allocating our state MAM dollars and our discretionary dollars to outreach. Currently two Social Workers from those communities are assigned, full time, to that work. They work closely with medical providers, especially family practice and OB/GYN clinics, WIC sites, Community Healthcare, and the three maternity hospitals in the County (all three located within the target area). This team will be in all the secondary schools regularly, working closely with school nurses and counselors to identify eligible minority pregnant teens (our top priority). They will also identify community sites where likely clients congregate, i.e. TANF CSO offices, Laundromats, parks, community centers, etc. Both Social Workers are African American and have lived and worked in the target communities most of their lives. A Caucasian Social Worker will be joining them in their efforts by August and another African American Community Organizational Specialist will join the team by September 2011.

Plan for individualized assessments of enrolled participant families conducted:

Following is a list of individualized assessments of enrolled participant in NFP services:

NFP data collection forms including:

| | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools:

- NCAST (Nursing Child Assessment Satellite Training) feeding scale
- NCAST (Nursing Child Assessment Satellite Training) teaching scale
- Ages & Stages Questionnaire
- Ages & Stages Social Emotional Questionnaire
- Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for referral to Services according to Assessments:

Individual assessments are conducted with client and their child according to NFP visit guidelines and data collection scales. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why

the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

If a client scores high on the depression screen the nurse will discuss the results with the client and encourage a referral to behavioral health services with consent of the client. If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local our local child reach or child find program for further evaluation and follow up.

Estimated timeline to reach maximum caseload.

Once the PHN has received the NFP training she can then begin to enroll clients into the program. NFP goal is an average of 4 families per month with the objective to achieve case load by 9 months.

Plan for Working with National, Regional/State EBHV Model Developer/Representative, Technical Assistance & Support

The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

All of the sites in Washington state work with a Program Developer and a Nurse Consultant assigned to the state by the NFP National Service Office. The Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program and the Nurse Consultant provides technical assistance around clinical and implementation issues. In addition, each site has a contractual relationship with the NFP NSO and the 18 model elements that must be adhered to ensure fidelity to the model are included in each contract.

Each site participates in monthly 90-minute conference calls, has individual site calls, participates in individual site visits at least annually, and completes an annual plan that

encompasses program data to dictate the quality improvement efforts to be undertaken during that year with the Nurse Consultant. With new sites and newly hired supervisors, individual calls are scheduled weekly, biweekly or monthly and continue for approximately a year. In addition, both the Developer and the Nurse Consultant are available to respond to emergent issues as needed and requested by the site. This technical assistance is available to sites for the life of the program.

The NFP NSO provides multiple publications to ensure implementing agencies are able to provide services with quality and fidelity to the model. These publications include: NFP Visit by Visit Guidelines and Facilitators for each program phase, monthly NSO Communications, marketing materials, NFP Data Collection Forms and Data Collection Manual, Team Educational Modules, NFP Competency Model of Professional Growth (competency statements and critical elements), NFP Core Education Workbooks and on-line education, NFP Model Elements, NFP Implementation Logic Model, and the NFP Theory of Change Logic Model.

Plan for Staff Training, Recruitment & Retention

Staff Training:

NFP Training: The NFP NSO requires the following initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approximately 4 days), Unit 3: onsite “distance learning”. On an annual basis, supervisors are required to attend a supervisor’s education session in Denver. Team meeting education modules are supplied by the NSO for supervisors to provide ongoing topics of continuing education during their monthly team meetings. The NSO also offers on-line learning modules on an as needed basis.

Implementing organization additional training: Trainings provided at our site are annual NCAST reliability training. One of our NFP NHV’s is a certified NCAST instruction. We also can provide ASQ training to new staff. We have hosted the following trainings on site, Advanced Partners in Parenting Education (PIPE) and the Culture of Poverty. Nurse have also attended Breastfeeding trainings, Adverse Childhood Experiences (ACEs) training in the community and other on-line trainings. Professional development is available on an as desired and as needed basis. We also provide monthly continuing education training through webinars at team meetings.

Staff Recruitment:

Per NFP and TPCHD standards, nurses must have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, PHN’s must have completed the NFP training. Successful candidates must have prior experience providing home visiting services to at-risk pregnant women and new mothers. They must have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. They must have a strong grounding in infant and child development, promotion of breast feeding, and health promotion. Bilingual skills in Spanish or Pacific Islander languages would be beneficial. They must pass a law enforcement background check.

Although we have a robust NFP program with 6.5 FTE public health nurses and 1.2 NFP Nurse Supervisors on staff providing NFP services now, we will be hiring an additional nurse with the MIECHV dollars. Additionally, we hope to add another .5 – 1.0 FTE nurse to our NFP Team in

the next few months as well. The goal is to be at 8.0 FTE or more by October 2011, if not sooner.

The MIECHV-funded NFP nursing position will be posted on the employment section of our Health Department website, using the standard hiring process we use for all positions at the Health Department. The posting will not occur until the contract has been agreed to, as we need Board of Health (BOH) approval of the additional FTE before it can be posted. Presumably, that agreement will occur by the end of August 2011, and the FTE can be approved by the BOH at their September 7th meeting. The posting would occur immediately following that meeting.

Once the applicants have been screened for eligibility, and the top ten candidates have been screened by our Human Resources Department, an interview panel of two NFP Nurses and our two NFP Nursing Supervisors will interview the candidates. They will select finalist(s) for a second interview by the Division Director and the Program Manager, who will make a final hiring decision.

Note: There are four public health home visiting nurses currently on staff who would be eligible to apply. There are many other public health nurses on staff who may also apply.

Timeline for obtaining all necessary training for new staff to implement NFP:

Once the NFP public health nurse has begun work, she will complete Unit 1 of the training on-line and by reading NFP-provided materials. Unit 2 is provided in Denver and is available the weeks of Sept 12, Oct 17 and Nov. 14. We would prefer to employ the nurse in time so that she can attend the September 12th training; however, hiring a new person usually takes two months from the beginning to the end of the process. If the contract is not signed until September, the new person may not start until the beginning of November, necessitating participating in Unit 2 training during the week of Nov. 14th. Once Unit 2 is completed, Unit 3 is completed on site and further training is provided through reflective supervision, on-line training, and participation in weekly NFP Team meetings.

Staff Retention

There are a variety of elements that assist with retention. The staff that provides the NFP program has a vested interest and commitment to the program, and the families they serve. Another factor is a flexible work schedule and shifts. We provide biannual retreats to promote team building and positive staff reinforcement. The NFP program has weekly reflective supervision built into the program which allows an opportunity for ongoing positive reinforcement and staff building. In addition many staff members at our site are long time employees and are vested in their retirement. Staff report the ability to take leave when desired is also a benefit.

A quote from one of the NFP NHV's in regards to retention. "I work with a group of women with a great deal of experience that I respect. Our supervisor leads in such a way I feel fulfilled while having fun at work."

Plan for NFP Clinical Supervision and Reflective Practice

NFP Model element 14 refers to required supervision provided to NHV's. This includes weekly hourly reflective supervision, weekly case conference/team meetings, and quarterly joint home visits.

Reflective supervision provides an opportunity between a nurse and supervisor weekly in one-to-one, one-hour session. During this time the NHV and supervisor will reflect on a nurse's work

including management of caseload and quality assurance of program implementation and clinical competence.

Case conferences and team meetings are dedicated to administrative purposes, program implementation issues, team building, along with joint review of cases, ETO reports and charts using reflection for the purposes of solution finding, problem solving, and professional growth. Team meetings and case conferences alternate weekly so there is one meeting of the team every week.

Joint home visits with supervisor and nurse take place every four months. The supervisor makes a visit with each nurse to at least one client and additional visits on an as-needed basis at the nurse's request or if the supervisor has concerns. Again the objective is to adhere to the quality assurance of program implementation and clinical competence.

Our site is committed to the importance of all model elements, including 14. We are aware that adhering to this model element is imperative to the success of the program. We provide the NFP required weekly 1:1 supervision for each NFP nurse. We also conduct the NFP-required weekly team meeting/case conferencing which last for 1.5 hours. The NFP supervisor conducts joint home visits quarterly with each nurse.

Reflective supervision is provided at our site by the 2 NFP supervisors. Current ratio is 1:6 and 1:1 with room for additional NHV's for each supervisor. Reflection is conducted weekly, and each staff member has a standing day and time. Reflective supervision is scheduled for one hour but may go over if the NHV desires.

We also conduct the NFP-required weekly team meeting/case conferencing. The team meetings are held Wednesday mornings and last 90 minutes. NFP supervisors also participate in quarterly joint home visits with each nurse. Supervisors also maintain an open door policy when not in reflection so staff can debrief after a visit as needed.

Plan for Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

Fidelity monitoring and/or quality assurance through the national model developer:

Data are collected, entered into ETO and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which Nurse Home Visitors and Supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both Supervisors and Nurse Home Visitors will review and utilize their program data in conjunction with the NSO Nurse Consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional fidelity tracking or quality assurance:

Additional monitoring, assessing and supporting implementation with fidelity to the chosen model and maintaining quality assurance:

Council for Children & Families (CCF) State Funded EBHV Participatory Evaluation with Washington State University Area Health Education Center (WSU AHEC):

WSU AHEC is currently conducting the evaluation for the Council for Children & Families Evidence Based Home Visiting portfolio of programs. Tacoma Pierce County Health Department (TPCHD) NFP is participating in evaluation of home visiting programs through CCF/WSU participatory evaluation. The CCF evaluation work specifically addresses the program impact and process of quality improvement in 11 programs, in six communities, implementing four home visiting models.

The CCF effort served as a critical test program for understanding the challenges and benefits of home visiting as a prevention and early intervention strategy for increasing numbers of Washington's most at-risk children and families. The lessons learned through the collaborative implementation and evaluation of the portfolio approach is vital to our state as we continue to build from this foundation.

The evaluation thus far demonstrates that CCF- supported evidence based home visiting programs are well-established and successful community services that are reaching their intended clientele. Consistent with the published home visiting literature, local programs face a variety of staff, client, and resource challenges that are significant impacts on program focus, implementation fidelity, and potentially on program benefits. The evaluation supports the conclusion that all programs are working to deliver their model with rigor and attention to the model's standards but that success in our efforts requires continued vigilance on implementation with fidelity and continuous quality improvement practices at the agency level. TPCHD is also engaging the HVSA evaluation also overseen by WSU AHEC.

Tacoma Pierce County Health Department NFP.

In addition to submitting all required data to the NFP ETO national database, and participating in WSU AHEC evaluation, TPCHD tracks all services and outcomes through two internal databases within our organization, Nightingale Notes (using the Omaha System) and our Maternal Child Health database. Within our Health Department, our NFP program has been responsible, over the last four years, of documenting how well our Health Department ensures that children receive the recommended immunizations. NFP supervisor reviews data from ETO quarterly. This data reflects if fidelity markers were/were not met, i.e. gestational age at enrollment, client is first time mother, voluntary enrollment. The results are then reviewed with the NFP team for fidelity. Through our CCF and Thrive grants we are currently participating in program evaluation with WSU.

Our most recent Quality Improvement project evaluated the time of referral to first contact with client. Our objective was 10 days, we were able to meet the objective after program adjustments, and we have sustained above 90% all but one quarter. We continue to monitor this quality improvement marker in our Nightingale Notes (NN) charting system.

Pierce County NFP Quality and Fidelity Challenges and Strategies to address

Challenges we have encountered are meeting the weekly supervision, and occasionally team meetings when the NFP supervisor is called for other public health emergencies. The Health Department's H1N1 work last winter required a lot of her time, making regular reflective supervision and occasionally team meetings a challenge. We manage this is by the NFP supervisor keeping an open door policy for the nurses to drop in when needed. We also

rescheduled reflection as soon as we know there will be a disruption in the schedule and we were able to adapt/plan ahead. TPCHD and NFP both place a high value and requirement on weekly Reflective Supervision.

Another fidelity element we adjusted is having enrolled one client that was not a first time mom. She actively sought out our program with multiple contacts and reported her previous pregnancy was the result of rape and the child was relinquished. After discussion with our NFP Nurse Consultant we decided to enroll the client. She remains actively enrolled and engaged in the program. This client is our only exception to the model element.

An additional challenge is client retention during the infancy and toddler phase of program. Please see the response in question 27.

Attrition & Plan for Minimizing Attrition

The average rate of attrition for program participants in TPCHD:

- Pregnancy phase: 5.4%
- Infancy phase: 20.5%
- Toddler phase: 16.4%

Plan for minimizing attrition rates:

Staff has been made aware of our attrition data and the NFP objective. They are aware we are above NFP objective in the infancy and toddler phase of program. We have completed the NFP module, “client retention” and begun to discuss ideas to increase client retention. There was discussion i.e. rational for attrition, clients returning to school or work (an NFP goal) and how we lose the client at that time. For a future meeting we plan to review a previous training provided by JoAnne Solchany, author of “Promoting Maternal Mental Health during Pregnancy”, training titled “Reaching the Most Difficult to Reach Families”. Meeting the NFP objective is on our annual evaluation plan from NFP.

Existing Pierce County Measurement Tools, Data Management & Ongoing Continuous Quality Improvement

Current Measurement tools being used by TPCHD:

| Measurement tool | Developed by | Frequency administered |
|---|--------------|--|
| NFP data collection forms including: <ul style="list-style-type: none"> • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter Form • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Government & Community Services | NFP | Collected per NFP schedule multiple times over program phase |

| | | |
|---|--|--|
| <ul style="list-style-type: none"> • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report | | |
| Omaha System, Knowledge, Behavior, Status rating | Karen S. Martin et al | Problems scored when opened with change in client status End of July End of December, When problem closed |
| NCAST (Nursing Child Assessment Satellite Training) feeding scale | NCAST AVE University of Washington | Completed at 6-8 weeks postpartum Repeated when child is 12 months |
| NCAST (Nursing Child Assessment Satellite Training) teaching scale | NCAST AVE University of Washington | Completed when child is 7 months repeated when child is 13 months |
| Ages & Stages Questionnaire | Early intervention program, University of Oregon | Childs age of 4 months, 10 months, 14 months, 20 months |
| Ages & Stages Social Emotional Questionnaire. | Early intervention program, University of Oregon | Childs age of 6 months, 12 months, 18 months, |
| Client Satisfaction Survey, Non-Standardized tools | 1-developed by TPCHD 2-developed by NFP and altered for our needs | 1-at 2 months postpartum 2-at child's first birthday Repeated at closing. |
| Center for Epidemiologic Studies Depression Scale (CES-D) | Center for Epidemiologic Studies | at intake, 36 weeks gestation, 4 weeks postpartum, 4-6 months postpartum and again at 12 months postpartum |
| Adverse Childhood Experiences (ACEs) | Robert F Anda, MD (CDC) | Collected at intake |

The nurse home visitors collect the data for the clients. Nursing supervisor collects data specific for the NHV's.

A Health Department Office Administrator is responsible for managing our database system. Her staff that works on our data includes an Office Assistant II, who enters the required client data into the NFP ETO system and an Office Assistant III, who enters client data into our MCH database. Nurses enter data into our Nightingale Notes charting platform/data collection system. Nursing supervisor is responsible for entering data into ETO specific to the NHV's. This includes data entry for new hires, team meetings and reflective supervision. NFP monitors data and conducts its own fidelity analysis process and reports to our NFP supervisor. Our NFP Supervisor conducts quarterly reviews of data reports to identify performance levels and program improvements. Our Office of Community Assessment provides technical support and higher-level data assessment as needed. Data that is provided in quarterly reports, is used to determine

fidelity adherence, is reported in our agency's Performance Measures, and is used for program evaluation with the NFP team for program correction.

Data Management Systems

The NFP NSO requires all programs to enter data into the Efforts to Outcomes (ETO) system – formerly the Clinical Information System (CIS). All programs in Washington are currently entering data into the ETO system on a regular basis. In addition to the ETO system, Yakima County NFP maintains a local evaluation structure provided by YVFWC. The local database includes information and measures not tracked by the NFP ETO system, such as client funding source, and DLC (Difficult Life Circumstances) and NCAST Teaching scores.

Future Data Collection

Data collection that will be used for the Yakima PAT programs is included in Section 5: Plan for Meeting Legislatively Mandated Benchmarks.

MIECHV Logic Model

Lead Organization Name: Tacoma-Pierce County Health Department
 Evidence Based Home Visiting Model: Nurse Family Partnership (NFP)
 Date (Month/Year): May 2011

| RESOURCES | ACTIVITIES (include core model components and any enhancements/adaptations) | OUTPUTS Provided outputs for each relevant activity that coincide with the MIECHV funding only, in the selected county/region for the targeted population | LEGISLATIVELY MANDATED BENCHMARKS (SEE SECTION 5 – PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS) |
|--|---|--|---|
| <p>Target Population: Hispanic, Non-Hispanic Pacific Islander, Non-Hispanic American Indian/Alaska Native, White, Non-Hispanic Black and Non-Hispanic Multiple Racial first time low income mothers.</p> <p>Target Geographic Area: Council Districts 2, 4, 5, 6</p> <p>Staffing: Public Health Nurses NFP Supervisor NFP Administrative Support</p> <p>EBHV Curriculum used and any additional: NFP Visit to Visit Guidelines PIPE</p> <p>Assessment & Evaluation Tools: NFP data collection forms including: Home Visit Encounter Form Infant Birth Form Alternative Encounter Form Infant Health Care Form Maternal Health Assessment Form Demographics Form Demographics Update Form Client Discharge Form</p> | <p>Staffing NFP 1) Hire additional Public Health Nurse to serve in NFP program</p> <p>Training 2) NFP nurse will complete all required NFP model training</p> <p>Home Visits 3) Provide home visits for first-time, low-income Hispanic, Non-Hispanic Pacific Islander, Non-Hispanic American Indian/Alaska Native, White, Non-Hispanic Black and Non-Hispanic Multiple Racial mothers living in council districts 2, 4, 5, and 6, at time of enrollment.</p> <p>Supervision 4) Nurse Supervisor will conduct Reflective Supervision with NFP PHN</p> <p>Enhancements:</p> <p>Adverse Childhood Experience Study: Once implemented at our site, score will be collected on each family enrolled into program at intake and repeated a second time during enrollment.</p> <p>Joseph H Easterday grant: Grant allows access to funds for items such as car seats, cribs through an application process by the client. Top range limit is \$500 per family. Fund is also used per incentives and gifts per NFP program guidelines</p> | <p>Staffing 1) MIECHV NFP program staff will be: 1.0 FTE Public Health Nurses .125 NFP Supervisor .125 Administrative Support</p> <p>Training 2) NFP PHN staff will complete distance, online learning and one session at NFP training center in Denver, Colorado to meet all NFP training. NFP staff will also complete on-going Efforts to Outcomes (ETO) training online as needed in collaboration with the NFP National Service Office (NSO). Supervisor will attend required NFP NSO Supervisor Annual Education NFP staff will participate in ongoing professional development offerings for nursing staff at Tacoma-Pierce County Health Department and additional trainings as required by NFP NSO.</p> <p>Home Visits 3) 25 clients will receive home visits according to NFP guidelines</p> <p>Supervision 4) PHN will receive weekly reflective supervision sessions with supervisor for 60 minutes each. PHN will participate in weekly 1.5 hour team meetings Supervisor will participate in Monthly WA state Supervisor NFP Calls</p> <p>Enhancements:</p> | |

| | | | |
|--|--|--|--|
| <p>Health Habits Form</p> <p>Relationships Form</p> <p>Use of Govt & Community Services Form</p> <p>Profile of Program Staff</p> <p>Visit Implementation Scale</p> <p>Supervision Progress Report</p> <p>NCAST (Nursing Child Assessment Satellite Training) feeding scale</p> <p>NCAST (Nursing Child Assessment Satellite Training) teaching scale</p> <p>Ages & Stages Questionnaire</p> <p>Ages & Stages Social Emotional Questionnaire</p> <p>Center for Epidemiologic Studies Depression Scale (CES-D)</p> <p>Funding: MIECHV funding, First Steps, Medicaid Admin. Match</p> <p>Data System: NFP ETO, TPCHD Nightingale Notes electronic documentation system, and MCH data base.</p> | | <p><u>Adverse Childhood Experience Study:</u> Collect information on the 25 families enrolled 2 times in service period</p> <p><u>Joseph H Easterday grant-</u></p> <p>NFP PHN will offer access to Easterday grant application to unwed NFP clients in council districts 2, 4, 5, & 6 on an as needed basis. Client will submit completed grant application for specific needs.</p> | |
|--|--|--|--|

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
Snohomish County – North Everett NFP Implementation Plan
Community, Agency, Participant Level**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|---|---|--|---|
| Evidence Based Home Visiting Model: <input checked="" type="checkbox"/> NFP <input type="checkbox"/> PAT EBHV State Rep Name: <u>Kristen Rogers</u> EBHV State Rep: Ph: 253.441.0292 Email: <u>Kristen.Rogers@nursefamilypartnership.org</u> | Selected Region/County: <u>Snohomish-North Everett</u> | Funding Level in Year One <u>\$123,000</u> | To Serve # Families : <u>25</u> # Children: <u>25</u> #Parents/Caregivers: <u>25</u> |
| Identified “at-risk” population to target in selected region/community | <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Pacific Islanders <input checked="" type="checkbox"/> Non Hispanic American <input type="checkbox"/> Indian/Alaska Natives <input type="checkbox"/> White <input type="checkbox"/> Non-Hispanic Blacks <input type="checkbox"/> N-Hispanic Asian <input type="checkbox"/> Non-Hispanic Multiple Races | | |
| FISCAL SPONSOR | | | |
| Organization Name | Snohomish Health District | | |
| Organizations Mailing Address | 3020 Rucker, Suite 203 Everett WA, 98201 | | |
| Organization Physical Address | same | | |
| Federal Tax ID #: | 91-1866899 | | |
| Chief Executive Name & Title | Dr. Gary Goldbaum, Health Officer | | |
| Chief Executive’s Email | ggoldbaum@shd.snohomish.wa.gov | | |
| EBHV Manager Name & Title: | Gina Veloni Program Manager | | |
| EBHV Manager’s Email | gveloni@shd.snohomish.wa.gov | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |

Snohomish County – North Everett NFP Implementation Plan

Assurance – Voluntary Services & Priority Given to Serve Eligible Participants who:

Snohomish County NFP Program Assures:

Services are provided on a voluntary basis

Priority is given to serve eligible participants who:

Have low incomes

Are pregnant women who are under 21

Have a history of child abuse and neglect or have had interactions with child welfare services

Have a history of substance abuse or need substance abuse treatment

Are users of tobacco products in the home

Have, or have children with, low student achievement

Have children with developmental delays or disabilities

Please note: we do assess and make referrals for developmental delays and disabilities and provide appropriate services as warranted, but we do not enroll families after the child is born and thus do not prioritize families with delays/disabilities in our enrollment process.

Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States

Please see Section 1 for the following information:

- **Existing Home Visiting Services**
- **Existing Mechanisms for Screening**
- **Referral Resources currently available and needed in the future**
- **Coordination Among Existing Programs and Resources**

Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the NFP program:

Currently in Snohomish County the NFP program reaches out to organizations that come in contact with and/or serve young, low-income women. Included in current outreach efforts are all of SHD, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving young low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Youth and Family Serving agencies, TANF community service offices, and other home visiting programs. Outreach occurs on a regular basis and is reinforced when coordination happens around referrals to NFP for services. Outreach is usually timed to be most relevant based on the services each agency provides. Outreach to schools generally

happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Program supervisors regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Recruitment and Engagement of the “at-risk” population identified:

The NFP National Service Office (NSO) provides great support in the way of outreach materials for community providers as well as potentially eligible clients. We take advantage of these materials, making sure there are ample supplies at all of the community locations listed above. The NFP program works diligently to make sure that all community providers and potential referral sources have up to date information about our services and how to contact us. Providers at these agencies will inform potential clients of the existence of and services provided by the NFP program and ask their permission to send in a referral. Our referral form includes sections on whether the contact information is confidential, if the client has been informed of the referral, and if it is okay to contact the client at the telephone numbers listed. This ensures that NFP staff will not be making inappropriate contact with the clients, their families or support network, and will not risk the confidentiality of the client. Additionally, the NFP program supervisor is available to talk with phone to any potential clients and let them know more about the program and ensure that ongoing communication meets the client need. At the clinics where the NFP teams are located, if an eligible client is identified, staff will often page for “any available NFP provider”, thus allowing for “in the moment” contact and demystifying the program as a whole. Our experience to date tells us that if a client is referred by a trusted source and face-to-face contact can occur in a confidential setting at the client’s convenience, we have a very high enrollment rate. We continue to try to identify additional strategies to reach out to the highest risk populations, those exiting juvenile detention, homeless and mobile clients and clients who have not yet informed their families or support systems of their pregnancies’.

Plan for individualized assessments of enrolled participant families conducted:

NFP data collection forms including:

- | | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
| Client Discharge Form | Demographics Update Form |
| Use of Government & Community Services Form | |

Standardized Assessment Tools:

- NCAST (Nursing Child Assessment Satellite Training) feeding scale
- NCAST (Nursing Child Assessment Satellite Training) teaching scale
- Ages & Stages Questionnaire
- Ages & Stages Social Emotional Questionnaire
- Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for referral to services according to individual assessments:

Individual assessments are conducted with client and their children according to NFP visit guidelines and data collection scales. If an assessment or screening is within normal limits, the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

If a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive, the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client in developing a safety plan for herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local Birth to Three Neurodevelopment Center for a complete developmental assessment.

Estimated timeline to reach maximum caseload.

Because of the intention to rehire a previously trained NFP nurse of SHD, the estimated time to reach maximum caseload would be 6-7 months as compared to the typical 9 months. She could take on 3-4 families per month from the first date of hire, because she was serving families in the pregnancy and infancy period prior to the reduction in force and she does not need to be retrained.

Plan for Working with National, Regional/State EBHV Model Developer/Representative, Technical Assistance & Support

The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

All of the sites in Washington state work with a Program Developer and a Nurse Consultant assigned to the state by the NFP National Service Office. The Program Developer assists with advocacy and sustainability efforts for existing sites and

expansion funding for the programs. The Nurse Consultant also provides technical assistance around clinical and implementation issues. In addition, each site has a contractual relationship with the NFP NSO ensuring the 18 model elements are adhered to supporting the fidelity of the model per contract.

Each site participates in monthly 90-minute conference calls, has individual site calls, participates in individual site visits at least annually, and completes an annual plan that encompasses program data to dictate the quality improvement efforts to be undertaken during that year with the Nurse Consultant. With new sites and newly hired supervisors, individual calls are scheduled weekly, biweekly or monthly and continue for approximately a year. In addition, both the Developer and the Nurse Consultant are available to respond to emergent issues as needed and as requested by the site. This technical assistance is available to sites for the life of the program.

The NFP NSO provides multiple publications to ensure implementing agencies are able to provide services with quality and fidelity to the model. These publications include: NFP Visit by Visit Guidelines and Facilitators for each program phase, monthly NSO Communications, marketing materials, NFP Data Collection Forms and Data Collection Manual, Team Educational Modules, NFP Competency Model of Professional Growth (competency statements and critical elements), NFP Core Education Workbooks and on-line education, NFP Model Elements, NFP Implementation Logic Model, and the NFP Theory of Change Logic Model.

Plan for Staff Training, Recruitment & Retention

Staff Training

NFP Training: The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually, supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

Implementing Organization Additional Training: All of the nurses completed the required NFP training. SHD provides quarterly parent child health trainings and bi-annual all staff and community health trainings. Three of the nurses attended an early intervention and IMH training this year. The staff receives additional training in mental health and substance abuse, special health care needs, breastfeeding, NCAST, and Adverse childhood experiences (ACES) work.

Staff Recruitment

The NFP NSO model elements state that Nurse Home Visitors and Nursing Supervisors must be registered professional nurses with a minimum of a Baccalaureate degree in nursing. They must have a current WA State nursing license and prior to taking NFP clients; they must have completed the NFP training.

SHD currently has 5 NFP trained nurses on staff for a total of 2.8 FTE. One of the current nurses is bilingual in Spanish and is a lactation consultant. Another nurse has a bachelor in social work. All five of the nurses have additional training and experience in NCAST, special health care needs, early intervention, and one with promoting first relationships. These are beneficial skills to serving the at-risk community in Snohomish County. There are two additional trained nurses who were laid off in January of 2011 and one who retired as a result of the budget crisis. It is the intention of SHD to rehire the full-time bilingual Spanish speaking nurse to serve the North Everett community with this funding. Once the award is received, she could be rehired and initiate service delivery immediately, because of her previous experience and training in NFP and in this community.

Staff Retention

The ongoing reflective supervision and support on continuing education are great strengths that support nurse retention at our agency. Interest in parent child health and their family's trajectories also impact retention at the agency. Regional County compensation including salaries and benefits are competitive. Parent child health and mental health experience amongst the nursing staff range from 21 years of service to 7 years of service.

Plan for NFP Clinical Supervision & Reflective Practice

The NFP NSO model elements state: Nursing Supervisors must provide Nurse Home Visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the Nurse Home Visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

The Snohomish County NFP supervisor provides weekly reflective supervision with the nursing staff. One hour of scheduled reflective supervision is scheduled weekly. The weekly team meetings, ranging between an hour and hour and half support the reflective process and individual and team reflective process. The nurses also utilize additional reflective supervision as needed for case consultation from the supervisor and, with their NFP team members, one on one and/or as a team. This reflective process builds on the nurses' ability to provide containment to the families they serve so they may be more emotionally available to their clients.

Plan for Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

Fidelity monitoring and/or quality assurance through the national model developer:

Data are collected, entered into ETO and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which Nurse Home Visitors and Supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can

be identified and an improvement process can be initiated. It is expected that both Supervisors and Nurse Home Visitors will review and utilize their program data in conjunction with the NSO Nurse Consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional fidelity tracking or quality assurance:

Snohomish NFP:

In addition to data collection system within NFP at the NSO, the previous Clinical Information System (CIS) and Efforts to Outcomes (ETO), Snohomish also utilizes the "Insight" software system for data collection, tracking and quality assurance. Snohomish utilizes the Insight system and its Omaha system to monitor Knowledge, Behavior and Status (KBS) of the clients. KBS ratings and outcomes are monitored for identified problems; caretaking parenting, pregnancy, postpartum, and growth and development at program entry, interim, and closure. Charting, tracking, noting measurement tools, and cross referencing specific indicators to risk factors such as mental health and substance use have been useful for monitoring and evaluating outcomes. Monitoring caseload activities and tracking identified problems and outcome measures such as the Center for Epidemiology Studies-Depression (CESD), Parenting Stress Index (PSI), Ages & Stages Questionnaire (ASQ) and Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) has been helpful in the Insight system as well.

Snohomish County Quality and Fidelity Challenges and Strategies to Address:

The largest challenge to fidelity for SHD has been related to funding uncertainty. For the past three funding years, the program has been proposed for elimination and/or reduction. This has been disruptive to the NFP program, the agency and the community. In January the program was reduced from 5.3 FTE of nursing to 2.8 FTE of nursing. The proposed strategy for this challenge is to obtain additional funding streams such as this federal funding opportunity, to diversify the funding portfolio and rebuild, sustain and expand the program in this high need community. Additionally, another challenge for this agency has been maternity leaves. SHD experienced 10 deliveries of babies in a course of 10 years amongst SHD NFP staffing. This may be a resolved issue given the current staffing, but it has been a challenge to the fidelity over the course of years within the agency.

Attrition & Plan for Minimizing Attrition

The average rate of attrition for program participants in Snohomish NFP:

| | |
|------------------|--------|
| Pregnancy phase: | 11.0% |
| Infancy phase: | 26.1 % |
| Toddler phase: | 18.6% |

Plan for minimizing attrition rates for participants enrolled in the program.

SHD will utilize the ETO caseload reports, client activity, and nursing visit reports to engage in conversations with the nurses during reflective supervision regarding caseload activities. We will utilize team meetings to share successes in maintaining difficult to engage families. We will review client retention education module to support the fidelity

of the model. We will also continue to build in incentives into the program to support client retention.

Existing Snohomish County Measurement Tools, Data Management & Ongoing Continuous Quality Improvement

Current Measurement tools being used by Snohomish County NFP:

| Measurement tool | Developed by | Frequency administered |
|--|--|--|
| NFP data collection forms including: <ul style="list-style-type: none"> • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter Form • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Government & Community Services • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report | NFP National Service Office | Collected per NFP schedule multiple times over program phases |
| NCAST (Nursing Child Assessment Satellite Training) feeding scale | NCAST AVE University of Washington | Completed at 6-8 weeks postpartum Repeated when child is 12 months |
| NCAST (Nursing Child Assessment Satellite Training) teaching scale | NCAST AVE University of Washington | Completed when child is 7 months repeated when child is 13 months |
| Ages & Stages Questionnaire | Early intervention program, University of Oregon | Childs age of 4 months, 10 months, 14 months, 20 months |
| Ages & Stages Social Emotional Questionnaire | Early intervention program, University of Oregon | Childs age of 6 months, 12 months, 18 months, 24 months |
| Edinburgh Postnatal Depression Scale | J.L. Cox, et al. | Completed at intake and repeated at 6 weeks postpartum |
| Center for Epidemiologic Studies Depression Scale (CES-D) | Center for Epidemiologic Studies | at intake, 36 weeks gestation, 4 weeks postpartum, 4-6 months postpartum and again at 12 months postpartum |

NFP staff and supervisors collect the data entered into these two data collection system. All data collected by NHVs is entered by NFP Administrative Support Staff. Ongoing

fidelity tracking and quality assurance is primarily supported by the NFP National Service Office through a series of quarterly and annual reports. These reports summarize and analyze the data provided to the NSO by Snohomish program staff. Quarterly reports are provided to Snohomish summarizing program implementation and outcome measures. These quarterly reports include local data and compare local outcomes to National NFP Program objectives, as well as comparisons of Snohomish performance to national and statewide performance data. Snohomish performance as documented in these reports is reviewed by supervisory staff and shared with the program's Nurse Home Visitors with discussion around program successes and opportunities for improvement.

Data Management Systems

The NFP NSO requires all programs to enter data into the Efforts to Outcomes (ETO) system – formerly the Clinical Information System (CIS). All programs in Washington are currently entering data into the ETO system on a regular basis. In addition to the ETO system, Yakima County NFP maintains a local evaluation structure provided by YVFWC. The local database includes information and measures not tracked by the NFP ETO system, such as client funding source, and DLC (Difficult Life Circumstances) and NCAST Teaching scores.

Future Data Collection

Data collection that will be used for the Yakima PAT programs is included in Section 5: Plan for Meeting Legislatively Mandated Benchmarks.

MIECHV Logic Model

Lead Organization Name: Snohomish Health District
 Evidence Based Home Visiting Model: Nurse-Family Partnership (NFP)
 Date (Month/Year): May 2011

| RESOURCES | ACTIVITIES <small>(include core model components and any enhancements/adaptations)</small> | OUTPUTS <small>Provided outputs for each relevant activity that coincide with the MIECHV funding only, in the selected county/region for the targeted population</small> | LEGISLATIVELY MANDATED BENCHMARKS <small>(SEE SECTION 5-PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS)</small> |
|---|--|--|--|
| <p>Target Population: Hispanic and non-Hispanic American Indian first time low-income mothers</p> <p>Target Geographic Area: Snohomish-North Everett</p> <p>Staffing: Public Health Nurse NFP Supervisor NFP Administrative Support</p> <p>EBHV Curriculum used and any additional:</p> <ul style="list-style-type: none"> • Nurse Family Partnership Visit to Visit Guidelines • Partners in Parenting Education <p>Assessment & Evaluation Tools:</p> <ul style="list-style-type: none"> • NFP data collection forms including: • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter Form • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Govt & Community Services | <p>Staffing Hire additional Public Health Nurse to serve in the NFP program</p> <p>Training NFP nurse will receive ongoing local training in collaboration with NFP National Service Office (NSO), as needed</p> <p>Home Visits Provide home visits for first-time, low-income Hispanic and non-Hispanic American Indian mothers living in North Everett, Snohomish County</p> <p>Supervision NFP supervisor will conduct Reflective</p> | <p>Staffing MIECHV NFP program staff will be: Public Health Nurse: 1 FTE Administrative Support: 0.1 FTE NFP Supervisor: 0.125 FTE</p> <p>Training NFP PHN will complete on-going Efforts to Outcomes (ETO) training online and locally, as needed in collaboration with the NFP NSO. Supervisor will attend required NFP NSO Supervisor Annual Education. NFP PHN will complete Motivational Interviewing education modules when released by NFP NSO</p> <p>Home Visits 20-25 clients will receive home visits according to NFP guidelines</p> <p>Supervision PHN will receive weekly reflective supervision sessions with supervisor</p> | |

| | | | |
|--|---|----------------------------|--|
| <p>Form</p> <ul style="list-style-type: none"> • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report <p>NCAST (Nursing Child Assessment Satellite Training) Feeding scale NCAST Teaching scale</p> <p>Ages & Stages questionnaire</p> <p>Ages & Stages Social Emotional questionnaire</p> <p>Center for Epidemiology Studies Depression Scale (CES-D)</p> <p>Funding: MIECHV funding</p> <p>Data System: Nurse-Family Partnership: Efforts to Outcomes and Insight electronic data system</p> | <p>Supervision with Public Health Nurse</p> | <p>for 60 minutes each</p> | |
|--|---|----------------------------|--|

**Affordable Care Act Maternal, Infant and Early Childhood
Home Visiting Program
Supplemental Information Request of the Updated State Plan
South King County NFP Implementation Plan
Community, Agency, Participant Level**

| EBHV Model/Selected Community/Organization(s) Information | | | |
|---|---|--|--|
| Evidence Based Home Visiting Model: <input checked="" type="checkbox"/> XNFP <input type="checkbox"/> PAT EBHV State Rep Name: <u>Kristen Rogers</u> EBHV State Rep: Ph: (253) 441-0292 Email: Kristen.Rogers@nurse familypartnership.org | Selected Region/County: <u>South King County</u> | Funding Level in Year One <u>\$250,000</u> | To Serve # Families : <u>50</u> # Children: <u>50</u> # Parents/Caregivers: <u>50</u> |
| Identified “at-risk” population to target in selected region/community | <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Pacific Islanders <input checked="" type="checkbox"/> Non Hispanic American Indian/Alaska Natives <input type="checkbox"/> White | | <input checked="" type="checkbox"/> Non-Hisp Blacks <input type="checkbox"/> N-Hispanic Asian <input type="checkbox"/> Non-Hispanic Multiple Races |
| FISCAL SPONSOR | | | |
| Organization Name | Seattle King County Department of Public Health, dba Public Health Seattle-King County | | |
| Organizations Mailing Address | 401 5 th Ave Suite 1300 Seattle, WA 98104 | | |
| Organization Physical Address | 401 5 th Ave Suite 1300 Seattle, WA 98104 | | |
| Federal Tax ID #: | 91-6001327 | | |
| Chief Executive Name & Title | David Fleming, MD Director and Health Officer | | |
| Chief Executive’s Email | david.fleming@kingcounty.gov | | |
| EBHV Manager Name & Title: | Lois Schipper Program Manager | | |
| EBHV Manager’s Email | lois.schipper@kingcounty.gov | | |
| Organization(s) that will implementing the EBHV Model in the Selected Community using the MIECHV funding <i>(please do not repeat information for fiscal agent if fiscal agent is implementing)</i> | | | |

South King County NFP Implementation Plan

Assurance – Voluntary Services & Priority Given to Serve Eligible Participants who:

South King County NFP Programs Assure:

Services are provided on a voluntary basis

Priority is given to serve eligible participants who:

Have low incomes

Are pregnant women who are under 21

Have a history of child abuse and neglect or have had interactions with child welfare services

Have a history of substance abuse or need substance abuse treatment

Are users of tobacco products in the home

Have, or have children with, low student achievement

Have children with developmental delays or disabilities

Please note: we do assess and make referrals for developmental delays and disabilities and provide appropriate services as warranted, but we do not enroll families after the child is born and thus do not prioritize families with delays/disabilities in our enrollment process.

Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have multiple deployments outside of the United States

Please see Section 1 for the following information:

- Existing Home Visiting Services
- Existing Mechanisms for Screening
- Referral Resources currently available and needed in the future
- Coordination Among Existing Programs and Resources

Plan for Participant Outreach, Engagement, Assessments & Timeline to Reach Maximum Caseload

Outreach plan to reach the “at-risk” population identified by the NFP program include:

Currently in South King County, Public Health Seattle-King County NFP programs reach out to organizations that come in contact with and/or serve young, low-income women. Included in current outreach efforts are all Public Health, First Steps and WIC (Women, Infant and Children) providers, and family planning, primary care, community clinic and obstetric programs serving young low income women. Additionally, outreach efforts are directed to counselors and school nursing staff at local middle and high schools including alternative programs, Youth and Family Serving agencies, TANF community service offices, and other home visiting programs.

Outreach occurs on a regular basis and is reinforced when coordination happens around referrals to NFP for services. Outreach is usually timed to be most relevant based on the services each agency provides. Outreach to schools generally happens each fall at the beginning of the school year, to remind returning staff and to reach out to new staff. For ongoing programs such as primary care, family planning and community clinics outreach happens more regularly, with the frequency often determined by the available capacity of the NFP program. Program supervisors

regularly communicate with community referral sources to ensure that they have up to date information, referral forms and current contact information for the NFP program.

Plan for recruitment and engagement the “at-risk” population identified.

The NFP National Service Office provides great support in the way of outreach materials for community providers as well as potentially eligible clients. We take advantage of these materials, making sure there are ample supplies at all of the community locations listed in #7. The NFP program works diligently to make sure that all community providers and potential referral sources have up to date information about our services and how to contact us. In this way providers have the information needed to inform clients about our services. Providers at these agencies will inform potential clients of the existence of and services provided by the NFP program and ask their permission to send in a referral. Our referral form includes sections on whether the contact information is confidential, if the client has been informed of the referral and if it is okay to contact the client at the telephone numbers listed. This ensures that NFP staff will not be making inappropriate contact with the clients, their families or support network, and will not risk the confidentiality of the client. Additionally, the NFP program supervisor is available to talk by phone to any potential clients and let them know more about the program and ensure that ongoing communication meets the client need. At the clinics where the NFP teams are located, if an eligible client is identified, staff will often page for “any available NFP provider”, thus allowing for “in the moment” contact and demystifying the program as a whole. Our experience to date tells us that if a client is referred by a trusted source and face-to-face contact can occur in a confidential setting at the client’s convenience, we have a very high enrollment rate. We continue to try to identify additional strategies to reach out to the highest risk populations: those exiting juvenile detention, homeless and mobile clients and clients who have not yet informed their families or support systems of their pregnancies.

Plan for individualized assessments of enrolled participant families conducted:

Following is a list of individualized assessments of enrolled participant in NFP services:

NFP data collection forms including:

- | | |
|---|----------------------------|
| Home Visit Encounter Form | Infant Birth Form |
| Health Habits Form | Alternative Encounter Form |
| Relationships Form | Infant Health Care Form |
| Maternal Health Assessment Form | Demographics Form |
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| Use of Government & Community Services Form | |

Standardized Assessment Tools

- NCAST (Nursing Child Assessment Satellite Training) Feeding scale
- NCAST (Nursing Child Assessment Satellite Training) Teaching scale
- Ages & Stages Questionnaire
- Ages & Stages Social Emotional Questionnaire
- Center for Epidemiologic Studies Depression Scale (CES-D)

Plan for Referral to Services according to Assessments:

Individual assessments are conducted with clients and their children according to NFP visit guidelines and data collection schedules. If an assessment or screening is within normal limits,

the results are shared with the client and any other service providers identified and consented to by the client. A description of what the assessment was “measuring,” what “normal” limits are, why the assessment is being conducted, and any questions raised by the client will be discussed. If assessment or screening results are not within normal limits, or indicate ongoing risk to the client or her child, the results are again discussed with the client, addressing all of the items above. In addition, the client will be offered referrals to community providers or resources to help address the assessment findings.

For example, if a client indicates on a health habits form that she is smoking during pregnancy the NFP nurse will discuss the risks of this habit with her, and ascertain her interest and desire to change this behavior. If the client is receptive the nurse will refer to available community resources like the Washington State “Quit Line.” If a client discloses intimate partner violence on the relationships form, the NFP nurse will discuss this with the client, ascertaining the client’s ongoing risk, and assist the client to develop a safety plan for the herself and her family. In addition, the nurse will offer information about, and referrals to community resources which may include confidential shelter, community advocate services and/or protection order programs. If a child screening such as ASQ or ASQ SE identifies that the child is in need of further assessment, the nurse in coordination with the client and primary care provider if available; will offer information and support, and refer to a local Birth to Three Neurodevelopment Center for a complete developmental assessment. In the fashion described, anytime a need is identified as a result of an assessment or screening, the results are discussed with the client and a referral to available resources is offered.

Estimated Timeline to reach maximum caseload

The experience of implementing NFP over the last 12 years in King County has shown us that enrolling 3-4 clients per month is the most successful pace for NFP nurses to build their caseload. In this fashion, we would expect the two full time nurses supported by the MIECHV funding to reach full caseload in approximately 6-8 months. Attention is also paid to staggering the due dates of enrolled client per team member in an attempt to avoid an overload of births in any given week or month.

Plan for Working with National, Regional/State EBHV Model Developer/Representative, Technical Assistance & Support

The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), and Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

All of the sites in Washington state work with a Program Developer and a Nurse Consultant assigned to the state by the NFP National Service Office. The Program Developer assists with advocacy and sustainability efforts for existing and expansion funding for the program and the Nurse Consultant provides technical assistance around clinical and implementation issues. In

addition, each site has a contractual relationship with the NFP NSO and the 18 model elements that must be adhered to ensure fidelity to the model are included in each contract.

The NFP NSO provides training and support services to ensure that the model is precisely replicated in King County, leading to improved outcomes for both mothers and children. King County NFP adheres to all key elements of the Nurse-Family Partnership model.

Each site participates in monthly 90-minute conference calls, has individual site calls, participates in individual site visits at least annually, and completes an annual plan that encompasses program data to dictate the quality improvement efforts to be undertaken during that year with the Nurse Consultant. With new sites and newly hired supervisors, individual calls are scheduled weekly, biweekly or monthly and continue for approximately a year. In addition, both the Developer and the Nurse Consultant are available to respond to emergent issues as needed and requested by the site. This technical assistance is available to sites for the life of the program.

The NFP NSO provides multiple publications to ensure implementing agencies are able to provide services with quality and fidelity to the model. These publications include: NFP Visit by Visit Guidelines and Facilitators for each program phase, monthly NSO Communications, marketing materials, NFP Data Collection Forms and Data Collection Manual, Team Educational Modules, NFP Competency Model of Professional Growth (competency statements and critical elements), NFP Core Education Workbooks and on-line education, NFP Model Elements, NFP Implementation Logic Model, and the NFP Theory of Change Logic Model.

Plan for Staff Training, Recruitment & Retention

Staff Training:

NFP Training: The NFP NSO requires initial training for all new staff: Unit 1: onsite “distance learning”, Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite “distance learning”, and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training or another dyadic measurement tool (currently in development). Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

Implementing Organization additional training: All PHSKC NFP staff attends all required NFP training. In addition, staff participates in agency sponsored trainings on motivational interviewing, breastfeeding, and reflective practice updates. Many of these trainings are offered during quarterly trainings for PHSKC staff.

Staff Recruitment:

NFP standards require that nurses have a BSN and have a current Washington State nursing license. Prior to taking NFP clients, nurses must have completed the NFP training. It is helpful if candidates have prior experience providing home visiting services to at-risk pregnant women and new mothers and have demonstrated an ability to create a trusting and supportive relationship with low-income women with multiple risk factors. For South King County hiring there will not

be a need to recruit bilingual staff since the target populations are African American and Native American communities.

There are currently 2 teams, comprised of 11 nurses providing NFP services to eligible clients living in South King County. Capacity for these teams is supported with other funding sources, requiring recruitment and hiring of additional staff to reach the expanded “at-risk” populations supported by the MIECHV funds.

In order to meet the expanded “at-risk” populations supported by the MIECHV funds, Public Health Seattle-King County will need to recall or hire two additional Public Health Nurses. Public Health Seattle-King County staff is currently scheduled for lay-off due to anticipated State budget reductions. If these staff are laid off at the end of June 2011, current contracts place them in a “layoff/recall” pool for a period of two years. Once the new positions are approved for hiring, NFP supervisors will post the position, and human resources will refer any eligible candidates from the layoff/recall pool. Eligible staff in layoff/recall has first rights to any open positions for which they are qualified. If no eligible candidates are identified in the layoff/recall pool, the positions will be posted on the King County website for 10 calendar days. Eligible applicants will be referred to hiring supervisors and interviews of selected candidates scheduled. Incorporating the required posting time, scheduling of interviews, reference checks and transition time for currently employed candidates, we would anticipate 6-8 weeks would be required to hire staff.

Timeline for obtaining all necessary training for new staff to implement NFP:

Once the NFP public health nurse has begun work, she will complete Unit 1 of the training on-line and by reading NFP-provided materials. Unit 2 is provided in Denver and is available the weeks of Sept 12, Oct 17 and Nov. 14. Once Unit 2 is completed, Unit 3 is completed on site and further training is provided through reflective supervision, on-line training, and participation in weekly NFP Team meetings.

Staff Retention

Staff satisfaction with providing NFP services is the best retention mechanism we have. We have had almost no staff turnover in the teams serving South King County. We have had one nurse retire and one move to an NFP supervisor opening in an adjacent county. To quote a current NFP nurse in King County: “This is the hardest I have ever worked, but the most satisfied I have ever been.” Model supported weekly reflective supervision, one hour each week for each nurse with the NFP supervisor also plays a large role in retention of staff. The regular and prioritized time with the supervisor provides the opportunity to debrief and obtain support around the work of intensively engaging with clients facing many challenges in their lives. In addition, weekly team meetings develop communication, collaboration and support among the team of nurses, supervisor and support staff. Administrative staff support positions for the two South County NFP teams have had no turnover in the last ten years. These team members value to work that the NFP program is doing and are committed in their roles to ensure team success.

Plan for NFP Clinical Supervision & Reflective Practice

The NFP NSO model elements state: Nursing Supervisors must provide Nurse Home Visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the Nurse Home Visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field

supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

Public Health Seattle-King County currently employs 3 Nurse-Family Partnership nursing supervisors. All 3 have been fully trained in the NFP program and supervise according to NFP guidelines: One hour each week with each nurse and her supervisor for reflective supervision, one 90 minute team meeting each week which includes case conferencing as well as practice support, and regularly supervised joint home visits to observe the nurses delivering NFP services in client homes. The current number of supervisors on staff is adequate to cover required supervision for a total of 19 nurses across three teams once the new MIECHV staff are in place.

Plan for Monitoring, Assessing and Supporting Implementation with Fidelity & Ongoing Quality Assurance

Fidelity monitoring and/or quality assurance through the national model developer:

Data are collected, entered into ETO and subsequently used to address practice. Data are utilized to guide improvements in program implementation and demonstrate fidelity. The ETO reports are tools with which Nurse Home Visitors and Supervisors assess and manage areas where systems, organizational, or operational changes are needed in order to enhance the overall quality of program operations and inform reflective supervision with each nurse. Through continuous monitoring, variance in performance outcomes can be identified and an improvement process can be initiated. It is expected that both Supervisors and Nurse Home Visitors will review and utilize their program data in conjunction with the NSO Nurse Consultant. Information from the ETO reports is incorporated into each site's annual plan to ensure fidelity and continuous quality improvement.

Additional fidelity tracking or quality assurance:

Public Health Seattle-King County also has several agency-specific program monitoring tools related to staff productivity and timeliness of documentation that are used by NFP program supervisors to ensure that staff are meeting program expectations. A collaborative process with individuals and or teams of program staff is used to identify individual and/or program strengths and opportunities for improvement and to problem-solve ways to most consistently meet staff and program goals. Fidelity to Nurse-Family Partnership criteria for enrollment, frequency and duration of visits and program and visit content is adhered to in order to ensure the highest chances of replicating the short- and long-term outcomes achieved in the NFP research studies. King County NFP teams have demonstrated the ability to consistently collect required data and meet program objectives and outcomes.

South King County NFP Quality and Fidelity Challenges and Strategies to address

Several challenges can be identified to maintaining ongoing quality and fidelity in implementing NFP. Several are identified in the table below, along with proposed strategies to address:

| Challenge | Proposed strategies to address |
|--|---|
| Reaching the benchmark of enrollment by 16 weeks gestation when serving clients with multiple challenges including denial of pregnancy, late entry to prenatal care and limited support among family regarding pregnancy | Continue to outreach to providers serving young low-income women, with a focus on how NFP can help to support clients in overcoming these challenges. Track methods that are successful in finding homeless and mobile clients referred for services. |
| Incorporating the new Efforts to Outcomes (ETO) data system into program and quality improvement efforts. | Take advantage of all offered learning and information sessions from the NFP National Service Office, communicate with other local and statewide NFP programs to problem solve and identify solutions and successes. |
| Finding time to develop, run and analyze program data to inform program improvements. | Consider setting aside one team meeting per month to learn more about ETO reporting capacity and to review data and consider program implications for improvement. |

Attrition & Plan for Minimizing Attrition

The average rate of attrition for program participants in King County NFP is:

| | |
|------------------|-------|
| Pregnancy phase: | 7.2% |
| Infancy phase: | 21.4% |
| Toddler phase: | 16.5% |

NFP data shows that King County teams have very low attrition rates during the pregnancy phase, highest rates of attrition during the infancy phase, decreasing by 5% in the toddler phase. Based on this the focus on minimizing attrition should be on the infancy phase, a difficult time to keep clients engaged when they are returning to work and school. Working with our team data we can identify the times that clients are most likely to be lost to follow up, identifying reasons that clients are leaving. Developing strategies to engage clients around these reasons in advance of, or early in the infancy period might lead to different methods of support and/or flexibility around visit schedules and location should help to decrease the likelihood that clients will leave the program.

Existing South King County Measurement Tools, Data Management & Ongoing Continuous Quality Improvement

Current Measurement tools being used by NFP South King County:

| Measurement tool | Developed by | Frequency administered |
|--|--|--|
| NFP data collection forms including: <ul style="list-style-type: none"> • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter Form • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Government & Community Services • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report | NFP National Service Office | Collected per NFP schedule multiple times over program phases |
| NCAST (Nursing Child Assessment Satellite Training) feeding scale | NCAST AVE University of Washington | Completed at 6-8 weeks postpartum Repeated when child is 12 months |
| NCAST (Nursing Child Assessment Satellite Training) teaching scale | NCAST AVE University of Washington | Completed when child is 7 months repeated when child is 13 months |
| Ages & Stages Questionnaire | Early intervention program, University of Oregon | Childs age of 4 months, 10 months, 14 months, 20 months |
| Ages & Stages Social Emotional Questionnaire | Early intervention program, University of Oregon | Childs age of 6 months, 12 months, 18 months, 24 months |
| Center for Epidemiologic Studies Depression Scale (CES-D) | Center for Epidemiologic Studies | at intake, 36 weeks gestation, 4 weeks postpartum, 4-6 months postpartum and again at 12 months postpartum |

NFP nurses collect all of the client data on mothers and infants. The supervisor collects and submits data on all new hires and on supervised visits. An administrative assistant does all data entry into the NFP ETO web based reporting system. Nurses' chart on their visits in an agency based online documentation system. The NFP NSO analyzes and reports on data entered into the national web based NFP reporting system. Reports are provided quarterly and annually to each NFP implementing agency. Local data is analyzed by the program supervisors. The NFP NSO

provides program benchmarks as well as national and state performance levels of other NFP programs. We use these guidelines to assess if we are meeting the benchmarks and to compare our performance to other NFP programs. If we are not meeting benchmarks or are lagging behind other NFP programs we discuss what the data is telling us and plan and implement some program quality improvement to correct the areas needing improvement.

Data Management Systems

The NFP NSO requires all programs to enter data into the Efforts to Outcomes (ETO) system – formerly the Clinical Information System (CIS). All programs in Washington are currently entering data into the ETO system on a regular basis.

Future Data Collection

Data collection that will be used for the Yakima PAT programs is included in Section 5: Plan for Meeting Legislatively Mandated Benchmarks.

MIECHV Logic Model

Lead Organization Name: Public Health Seattle-King County (PHSKC)
 Evidence Based Home Visiting Model: Nurse Family Partnership (NFP)
 Date (Month/Year): May 2011

| RESOURCES | ACTIVITIES (include core model components and any enhancements/adaptations) | OUTPUTS Provided outputs for each relevant activity that coincide with the MIECHV funding only, in the selected county/region for the targeted population | LEGISLATIVELY MANDATED BENCHMARKS |
|---|--|--|--|
| <p>Target Population: African American and Native American first time low-income mothers.</p> <p>Target Geographic Area: South King County</p> <p>Staffing: Public Health Nurses NFP Supervisor NFP Administrative Support</p> <p>EBHV Curriculum used and any additional: Nurse Family Partnership Visit to Visit Guidelines Partners in Parenting Education (PIPE)</p> <p>Assessment & Evaluation Tools - NFP data collection forms:</p> <ul style="list-style-type: none"> • Home Visit Encounter Form • Infant Birth Form • Alternative Encounter | <p>Staffing NFP 1) Hire additional Public Health staff to serve in NFP program</p> <p>Training 2) NFP nurses will complete required NFP model training</p> <p>Home Visits 3) Provide home visits for first-time, low-income African American and Native American mothers living in South King County at time of enrollment.</p> <p>Supervision 4) Nurse Supervisor will conduct Reflective Supervision with 2 Public Health Nurses</p> | <p>Staffing</p> <p>1) MIECHV NFP program staff:</p> <p>2.0 FTE Public Health Nurses</p> <p>.25 NFP Supervisor</p> <p>.25 Administrative Support</p> <p>Training</p> <p>2) NFP PHN staff will complete distance , online learning and two sessions at NFP training center in Denver , Colorado for initial NFP training. All NFP staff will also complete on-going Efforts to Outcomes (ETO) training online and locally, as needed in collaboration with the NFP NSO.</p> <p>Supervisor will attend required NFP NSO Supervisor Annual Education NFP staff will participate in</p> | <p>(SEE SECTION 5 – PLAN FOR MEETING LEGISLATIVELY MANDATED BENCHMARKS)</p> |

| | | | |
|---|---|--|--|
| <p>Form</p> <ul style="list-style-type: none"> • Infant Health Care Form • Maternal Health Assessment Form • Demographics Form • Demographics Update Form • Client Discharge Form • Health Habits Form • Relationships Form • Use of Govt & Community Services Form • Profile of Program Staff • Visit Implementation Scale • Supervision Progress Report <p>Other Curricula:</p> <ul style="list-style-type: none"> • NCAST (Nursing Child Assessment Satellite Training) feeding scale • NCAST (Nursing Child Assessment Satellite Training) teaching scale • Ages & Stages Questionnaire • Ages & Stages Social Emotional Questionnaire • Center for Epidemiologic Studies Depression Scale (CES-D) <p>Funding: MIECHV funding, WA state First Steps, Medicaid Administrative Match</p> <p>Data System: NFP Efforts to Outcomes and PHSKC TREC electronic documentation system.</p> | <p><u>NFP Reproductive Health Study</u></p> <p>5) Staff participate in NFP2 randomized study on delivery of hormonal contraception in the home</p> | <p>ongoing professional development offerings for nursing staff at Public Health Seattle-King County</p> <p><u>Home Visits</u></p> <p>3) 50 clients will receive home visits according to NFP guidelines</p> <p><u>Supervision</u></p> <p>4) PHNs will receive weekly reflective supervision sessions with supervisor for 60 minutes each.</p> <p><u>NFP Reproductive Health Study</u></p> <p>5) NFP PHNS will offer participation in NFP randomized study on delivery of hormonal contraception in the home, to all enrolled, eligible NFP clients at or before reaching 32 weeks gestation.</p> | |
|---|---|--|--|

Attachment J: Washington State Proposed Measures to Meet Legislatively-Mandated Benchmarks

| Federal Benchmark Area | Federal Constructs | NFP data (referenced from NFP NSO draft Guidance for Implementation and Quality of the NFP Program, April 2011) | | PAT data (referenced from National PAT draft document of How PAT Outcomes Align with Federal HIV Initiative Benchmarks, 3/4/2011) | | MIECHV Process Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Process Indicators | MIECHV Outcome Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Outcome Indicators | |
|------------------------------------|---|--|--|--|---------------------------------------|---|--|--|--|--|
| | | | | | | | | | | |
| Improved Maternal & Newborn Health | Prenatal Care | Demonstrated areas of NFP program impact | NFP Standard Interview | PAT recommends Life Skills Progression | Potential areas of PAT program impact | | | Average gestational age when women enrolled prenatally began prenatal care | Increase in the average gestational age when women enrolled prenatally began prenatal care | |
| | Parental use of alcohol, tobacco or illicit drugs | | NFP Standard Interview | | | % of mothers enrolled prenatally screened for tobacco use within three months of enrollment | Increase in the % of mothers enrolled prenatally screened for tobacco use within three months of enrollment | % of mothers enrolled prenatally who screened positive tobacco use at enrollment who decreased use by child's first birthday | Increase in the % of mothers enrolled prenatally who screened positive for tobacco use at enrollment and decreased their use by the child's first birthday | |
| | Preconception care | | NFP Standard Interview | | | % of mothers enrolled prenatally who were counselled about their ongoing health care needs within the first three months postpartum | Increase in the % of mothers enrolled prenatally counselled about their ongoing health care needs within the first three months postpartum | | | |
| | Inter-birth intervals | | NFP Standard Interview | | | % of mothers enrolled prenatally who are regularly screened for subsequent pregnancy | Increase in the % of mothers enrolled prenatally who are regularly screened for a subsequent pregnancy | Rate of subsequent pregnancy for each year cohort defined as the number of women enrolled prenatally with a subsequent pregnancy during enrollment divided by the number of person months of enrollment for all women enrolled prenatally in that cohort | Decrease in the rate of subsequent pregnancy during enrollment among women enrolled prenatally | |
| | Screening for maternal depressive symptoms | | Edinburgh Postnatal Depression Scale Screening (Optional for agencies) | | | PAT recommends Edinburgh Postnatal Depression Scale | % of mothers screened for depression within the first three months postpartum | Increase in the % of mothers enrolled prenatally who are screened for depression within the first three months postpartum | % of mothers enrolled prenatally who screened positive for depression postpartum who received follow up services | Increase in the % of mothers who screened positive for depression who received follow up services |
| | Breastfeeding | | NFP Standard Interview | | | PAT recommends Life Skills Progression | | | % of mothers enrolled prenatally who initiated breastfeeding at all | Increase in the % of mothers enrolled prenatally who initiated breastfeeding |
| | Well-child visits | | NFP Standard Interview | | | | % of families who were asked about well-child care for the index child at least monthly? | Increase in the % of families asked monthly about well-child care for their index child | Average number of well child visits in the first year defined as the number of well child visits in the first 12 months of life among index children whose families were enrolled prenatally divided by the number of index children enrolled at least 12 months | Increase in the average number of well child visits in the first year of life among index children born to women enrolled prenatally |
| | Maternal & child health insurance status | | NFP Standard Interview | | | | % of mothers enrolled prenatally who were screened regularly for health insurance coverage postpartum | Increase in the % of mothers screened regularly for health insurance coverage | % of mothers enrolled prenatally with health insurance at the index child's first birthday | Increase in the % of mothers enrolled prenatally who had health insurance coverage at their child's first birthday |
| | | | | | | | | | | |

| Federal Benchmark Area | Federal Constructs | NFP data (referenced from NFP NSO draft Guidance for Implementation and Quality of the NFP Program, April 2011) | PAT data (referenced from National PAT draft document of How PAT Outcomes Align with Federal HIV Initiative Benchmarks, 3/4/2011) | MIECHV Process Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Process Indicators | MIECHV Outcome Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Outcome Indicators |
|--|---|--|--|--|--|---|--|
| Child Abuse, Neglect, or Maltreatment & Reduction of Emergency Department Visits | Visits for children to the emergency department from all causes | Participant report. Child visits to emergency care, urgent care, or hospital for injury or ingestion* | PAT suggests Life Skills Progression, Protective Factors Survey, and PAT Personal Visit Record | % of families served who have child emergency department visits for injury/ingestion reported regularly (time frame to be developed with models)? | Increase in the % of families with regularly reported information on child ER visits for injury or ingestion | Annual rate of injury/ingestion ER visits among index children 0-2 - number of visits divided by index children 0-2 yrs * months enrollment | Decrease in the annual rate of injury or ingestion ER visits among index children 0-2 |
| | Visits of mothers to the emergency department from all causes | Data not currently collected* | | % of mothers served who have emergency department visits for any cause reported regularly? | Increase in the % of mothers with regularly reported ER visits | Annual rate of maternal ER visits - the number of maternal ER visits among women enrolled prenatally divided by the total number of women enrolled prenatally * months enrollment | Decrease in the annual rate of maternal ER visits |
| | Information provided or training of participants on prevention of child injuries topics such as safe sleeping, shaken baby syndrome, or traumatic brain injury, etc | Participant report. Recorded in individual client records, currently not collected in the data collection system* | | % of mothers enrolled prenatally receiving information or training on prevention of child injuries by end of index child's first year | Increase in the % of mothers enrolled prenatally who received information or training on prevention of child injuries by end of child's first year | | |
| | Incidence of child injuries requiring medical treatment | Participant report with comparisons to local & state child welfare data. Recorded in individual client records, currently not collected in the data collection system* | | % of primary caregivers who are screened regularly for injuries of household children that required medical treatment | Increase in the % of primary caregivers who are screened regularly for injuries among household children that required medical treatment | | |
| | Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated) | Referral to Child Protective Services (CPS): referral only, not whether case was substantiated. Participant report with comparisons to local & child welfare data | | % of primary caregivers who were regularly screened for parenting stress (parent-child relationship, resources to deal with stress) | Increase in the % of primary caregivers screened for parenting stress | | |
| | Reported substantiated maltreatment (substantiated/indicated /alternative response victim) for children in the program | Referral to Child Protective Services (CPS): referral only, not whether the case was substantiated. Interview with comparisons to local & child welfare data | | Number of steps to access state child welfare agency (CPS) data that have been accomplished: 1- identify confidentiality issues to be addressed 2-submit IRB application for data linkage 3-obtain IRB approval 4-complete data sharing agreement with CPS and communities 5-obtain initial datasets from CPS and communities 6-complete initial linkage 7-document linkage process and improvement identification 8-explore ongoing linkages 9-give data feedback to programs | Increase in the number of steps accomplished | % of families served with history of substantiated maltreatment at enrollment who have received services to address child abuse and neglect during enrollment | Increase in the % of families with a history of substantiated maltreatment at enrollment who received services |
| | First-time victims of maltreatment for children in the program | Referral to Child Protective Services (CPS): referral only, not whether the case was substantiated. Interview with comparisons to local & child welfare data | | Number of steps to access state child welfare agency (CPS) data that have been accomplished: 1- identify confidentiality issues to be addressed 2-submit IRB application for data linkage 3-obtain IRB approval 4-complete data sharing agreement with CPS and communities 5-obtain initial datasets from CPS and communities 6-complete initial linkage 7-document linkage process and improvement identification 8-explore ongoing linkages 9-give data feedback to programs | Increase in the number of steps accomplished | % of families served with reported substantiated maltreatment during enrollment who receive services to address child abuse and neglect | Increase in the % of families with newly identified substantiated maltreatment who received services |

| Federal Benchmark Area | Federal Constructs | NFP data (referenced from NFP NSO draft Guidance for Implementation and Quality of the NFP Program, April 2011) | PAT data (referenced from National PAT draft document of How PAT Outcomes Align with Federal HIV Initiative Benchmarks, 3/4/2011) | MIECHV Process Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Process Indicators | MIECHV Outcome Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Outcome Indicators |
|--|--|---|--|---|---|---|---|
| Improvements in School Readiness & Achievement | Parent support for children's learning & development (e.g., appropriate toys available; read & talk with child). | Ages and Stages Questionnaire (ASQ) using parent-report. Additional observation, parent-report, sample of child's work & ASQ score collected through parent report &/or nurse observation | PAT suggests ASQ and ASQ-SE; Keys to Interactive Parenting Scales-KIPS; Univ of Idaho Survey of Parenting Practices; Protective Factors Survey; and DECA | % of primary caregivers that have been assessed using the HOME inventory within three months of enrollment (or delivery for mothers enrolled prenatally) | Increase in the % of primary caregivers who received baseline assessments using the HOME inventory within three months of enrollment (or delivery for mothers enrolled prenatally) | % of primary caregivers who showed improvement from baseline to twelve months later in HOME inventory | Increase in the % of primary caregivers who showed improvement from baseline to twelve months later in HOME inventory |
| | Parent knowledge of child development & of their child's developmental progress | ASQ using parent-report. Additional observation, parent-report, sample of child's work & ASQ score collected through parent report &/or nurse observation | | % of primary caregivers who received baseline screening using the Protective Factors Survey within three months of enrollment (or delivery for mothers enrolled prenatally) | Increase in the % of primary caregivers who received baseline screening using the Protective Factors Survey within three months of enrollment (or delivery for mothers enrolled prenatally) | % of primary caregivers who showed improvement from baseline to twelve months later in child development/knowledge of parenting subscale of Protective Factors Survey | Increase in the % of primary caregivers who showed improvement in child development/knowledge of parenting subscale of Protective Factors Survey |
| | Parenting behaviors & parent-child relationships (eg discipline strategies, play interactions) | Interview, observation, and NCAS; not recorded in the data system* | | % of primary caregivers who received baseline screening using the Protective Factors Survey within three months of enrollment (or delivery for mothers enrolled prenatally) | Increase in the % of primary caregivers who received baseline screening using the Protective Factors Survey within three months of enrollment (or delivery for mothers enrolled prenatally) | % of primary caregivers who showed improvement from baseline to twelve months later in nurturing and attachment subscale of Protective Factors Survey | Increase in the % of primary caregivers who showed improvement in nurturing and attachment subscale of Protective Factors Survey |
| | Parent emotional well-being or parenting stress | Interview & observation | | % of primary caregivers who were screened for parenting stress (parent-child relationship, resources to deal with stress) | Increase in the % of primary caregivers screened for parenting stress | % of primary caregivers who report high levels of stress who receive resources to deal with stress and/or improve parent-child relationships | Increase in the % of caregivers with high levels of stress who report receiving resources to deal with stress or improve their parent/child relationships |
| | Child's communication, language & emergent literacy | Ages & Stages Questionnaire (ASQ), additional observation, parent-report and/or nurse observation | | % of families whose index child received a cognitive development screening (appropriate timing to be defined with models) | Increase in the % of families whose index child received a cognitive development screening | % of families who received follow up services when index child shows an area of concern on cognitive developmental screening | Increase in the % of families who receive services when the index child has shown an area of concern on cognitive developmental screening |
| | Child's general cognitive skills | Ages & Stages Questionnaire (ASQ), additional observation, parent-report and/or nurse observation | | % of families whose index child received a cognitive development screening (appropriate timing to be defined with models) | Increase in the % of families whose index child received a cognitive development screening | % of families who received follow up services when index child shows an area of concern on cognitive developmental screening | Increase in the % of families who receive services when the index child has shown an area of concern on cognitive developmental screening |
| | Child's positive approaches to learning including attention | Ages & Stages Questionnaire (ASQ), additional observation, parent-report and/or nurse observation | | % of families whose index child received a cognitive development screening (appropriate timing to be defined with models) | Increase in the % of families whose index child received a cognitive development screening | % of families who received follow up services when index child shows an area of concern on cognitive developmental screening | Increase in the % of families who receive services when the index child has shown an area of concern on cognitive developmental screening |
| | Child's social behavior, emotion regulation & emotional well-being | Ages & Stages Questionnaire (ASQ), additional observation, parent-report and/or nurse observation | | % of families whose index child received a social & emotional development screening (appropriate timing to be defined with models) | Increase in the % of families whose index child received a social & emotional development screening | % of families who received follow up services when index child shows an area of concern on social & emotional development screening | Increase in the % of families who receive services when the index child has shown an area of concern on social & emotional development screening |
| | Child's physical health & development | Direct assessment, but currently not reported* | | % of families whose index child received a physical development screening (appropriate timing to be defined with models) | Increase in the % of families whose index child received a physical development screening | % of families who received follow up services when index child shows an area of concern on physical developmental screening | Increase in the % of families who receive services when the index child has shown an area of concern on physical developmental screening |

| Federal Benchmark Area | Federal Constructs | NFP data (referenced from NFP NSO draft Guidance for Implementation and Quality of the NFP Program, April 2011) | PAT data (referenced from National PAT draft document of How PAT Outcomes Align with Federal HIV Initiative Benchmarks, 3/4/2011) | MIECHV Process Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Process Indicators | MIECHV Outcome Indicators to Track Starting Year 1 | Definition of Improvement for MIECHV Outcome Indicators |
|---|---|--|--|---|--|---|---|
| Domestic Violence | Screening for domestic violence | Maternal self report | PAT recommends collecting with DOVE tool, Life Skills Progression, and PAT Personal Visit Record | % of primary caregivers screened for domestic violence | Increase in the % of primary caregivers screened for domestic violence | | |
| | Referrals for domestic violence services for families with identified need. | NFP Standard Interview | Born to Learn Curriculum | % of primary caregivers screened for domestic violence who received referrals | Increase in the % of primary caregivers who screened positive for domestic violence who received services | | |
| | Safety plan completed for families with identified need. | Recorded in the client chart.* Interview. | PAT recommends collecting with DOVE tool, Life Skills Progression, and PAT Personal Visit Record | % of program home visiting staff who have been trained on the domestic violence resources and the development of a safety plan | Increase in the % of program home visiting staff who received training on domestic violence resources and the development of a safety plan | % of primary caregivers with identified need who have a documented safety plan | Increase in the % of primary caregivers who screened positive for domestic violence who have a documented safety plan |
| Family Economic Self-Sufficiency | Household income & benefits. | NFP Standard Interview Data Collection | Born to Learn Curriculum | | | % of families served who meet one or more priority eligibility areas (defined by SIR) upon enrollment | Increase in the % of families served who meet one or more priority eligibility areas upon enrollment |
| | Health insurance status. | Health Insurance Status* Interview. | PAT recommends collecting with Life Skills Progression, and PAT Personal Visit | % of mothers enrolled prenatally who were screened regularly for health insurance coverage postpartum | Increase in the % of mothers screened regularly for health insurance coverage | % of mothers enrolled prenatally with health insurance at the index child's first birthday | Increase in the % of mothers enrolled prenatally who had health insurance coverage at their child's first birthday |
| | Number of families identified for necessary services. | Direct measurement* | Born to Learn Curriculum | % of primary caregivers with identified service needs recorded by home visiting programs within three months of enrollment | Increase in the % of primary caregivers with identified service needs recorded in a standardized format | | |
| | Number of families that required services & received a referral to available community resources. | Completion of referrals is not currently collected.* Direct measurement. | | % of primary caregivers with identified service needs recorded by home visiting programs within three months of enrollment | Increase in the % of primary caregivers with identified needs with documented referrals to community agencies | % of primary caregivers given referrals with documented receipt of needed services | Increase in the overall number of primary caregivers who received referrals for services and received the needed services |
| Coordination & Referrals for Other Community Resources & Supports | MOUs or other formal agreements with other social service agencies in the community. | Direct measurement and agency administrative data. | PAT recommends Life Skills Progression; Protective Factors Survey, and the PAT Personal Visit Record | % of primary caregivers with identified referrals to community agencies recorded on the Personal Visit Record or Government and Community Services Form within three months of enrollment | Increase in the number of MOUs or other formal agreements with other social service agencies in the community | Number of social service agencies in the community with whom the home visiting program has a clear point of contact | Increase in the number of social service agencies in the community with whom the home visiting program has a clear point of contact |
| | Information sharing | * Direct measurement and agency administrative data. | | % of program staff who have received initial and periodic training on handling sensitive information | Increase in the number of program staff who have received initial and periodic updated training on handling sensitive information | | |
| | Number of completed referrals | Completion of referrals is not currently collected.* Direct measurement and agency administrative data. | | % of primary caregivers given referrals with documented receipt of needed services | Increase in the overall number of primary caregivers who received referrals for services and received the needed services | | |

* NFP NSO is adding these constructs to its reporting portfolio.

Color code scheme – white is data currently being collected, light gray is a proposed tool that is being collected but not reported currently, and light pink shows a topic that is not currently being collected by the model.

Light blue shows the measures we plan to report on initially, and our definition of improvement for these measures. As our program progresses, we hope to report on the outcome measures which are

Light yellow highlights every other Benchmark as some run onto multiple pages.

Attachment M: Budget

Budget Period**July 15, 2010 to September 30, 2012**

Overview: The Washington State Home Visiting Program is administered by a Cross Agency Governance Structure providing decision authority for expenditures, targeting, selection of home visiting model, and other major decisions. The Cross Agency Governance Structure consists of the following state agency partners: of the Department of Early Learning (DEL), the Department of Health (DOH), the Department of Social and Health Services (DSHS), and the Council for Children and Families (CCF).

Coordination of the Cross Agency Governance Structure and primary program planning will be the responsibility of DEL.

DOH will act as fiscal agent and have primary responsibility for conducting the Needs Assessment. The contracted cost below will span the entire project period. All other costs are expected to be incurred during the Needs Assessment phase (approximately 2 ½ months).

Personnel: DOH employed a needs assessment team consisting of three Health Service Consultants 3s, an Epidemiologist 3, and a Health Services Consultant 4 to complete the needs assessment. The needs assessment portion of the project period will require a higher level of effort from these staff than the remaining portion of the project. An additional Epidemiologist is funded for ongoing data and planning work.

| Salaries | Annual Salary | Needs Assessment And Planning | | |
|----------------------------------|----------------------|--------------------------------------|----------------------|----------------------|
| | | FTE | Time period | Funding |
| HSC3 (Tory Henderson) | 61,632 | 0.75 | 6/2010-9/2010 | 9,630 |
| HSC3 (Jenae Henry) | 54,504 | 1.00 | 6/2010-9/2010 | 11,355 |
| HSC3 (Marilyn Gisser) | 61,632 | 0.30 | 6/2010-9/2010 | 3,852 |
| HSC4 (Lowest Jefferson) | 63,192 | 0.25 | 6/2010-9/2010 | 3,291 |
| Epidemiologist 3 (Diane Pilkey) | 89,280 | 0.50 | 6/2010-9/2010 | 9,300 |
| Manager (Kathy Chapman) | 91,524 | 0.25 | 6/2010-9/2010 | 1,803 |
| HSC2 (Mary Kellington) | 51,864 | 0.05 | 6/2010-9/2010 | 540 |
| Secretary Senior (Marnie West) | 28,840 | 0.30 | 6/2010-9/2010 | 4,767 |
| Epidemiologist (Cathy Wasserman) | 89,280 | 0.50 | <u>7/2011-6/2012</u> | <u>44,640</u> |
| Total DOH Salaries | | | | <u>89,178</u> |

Fringe Benefits: specifically identified to each employee and charged as direct costs. Benefits are computed at 25.4% and consist of payroll taxes: social security and Medicaid, industrial insurance; and health insurance and retirement benefits.

22,651

Total Personnel Costs

111,829

Travel: Local ground transportation from Olympia, Washington to other locations in Washington, for DOH needs assessment planning team to meet with partners on a regular basis and with other groups as needed. DOH travel policies require that employees use state owned vehicles, if available. If a state owned vehicle is not available, DOH reimburses employees for mileage at the standard federal mileage rate (currently .50/per mile). This category also includes DOH meeting costs.

875

Supplies: Office supplies (costs are based historical MCH office wide averages)

404

Contractual Costs: Interagency agreement with Department of Early Learning (DEL).

DEL will coordinate a Cross Agency Governance Structure that will have decision authority for expenditures, targeting, selection of home visiting model, and other major decisions. The Cross Agency Governance Structure will consist of DOH, DEL, DSHS, and CCF.

DEL will coordinate program planning in conjunction with the Cross Agency Governance Structure. DEL will convene a Partnership Group that will advise the Cross Agency Governance Structure. The Partnership Group will consist of other state agencies, private organizations, and family and community representatives.

DEL will convene and coordinate expert panels and other workgroups as needed. These will have broad representation designed to promote input and expertise from academia, the community, home visiting programs, advocates, and families.

DEL will fulfill all programmatic requirements related to HRSA funding opportunity HRSA-10-275, excluding the Washington State Needs Assessment.

This interagency agreement will ensure that no more than \$500,000 in grant funds are spent prior to approval of Washington State Needs Assessment and updated State Plan for Home Visiting.

1,213,654

Other Costs: Based on historical MCH office wide averages (includes communications, rent, employee training and development, printing and data processing, GIS desktop licensing, and computer technical assistance).

8,255

Total Direct Charges

1,335,017

Indirect Charges, provisional indirect rate:

Contractual (1.2%)

14,564

Other (21.4%)

25,971

Total Indirect Charges

40,535

DOH Grand Total

1,375,552

Existing Resources and Other Sources of Support: Other sources of support within DOH include content experts in existing programs at DOH, including Maternal, Infant, Child, and Adolescent Health; and Maternal and Child Health Assessment. Staff in these areas will provide technical assistance and support to the Home Visiting Project Manager. DSHS, DEL, OSPI, CCF, and other partners will also likely contribute staff and resources to this project over and above those paid for through contract with DOH.

Contractual Costs for the Department of Early Learning

(All costs through June, 2012 unless noted)

| Salaries | Salary | FTE | Time Period | Funding |
|-----------------------------------|---------------|------------|--------------------|----------------|
| Program Manager (vacant) | 63,480 | 1.0 | 10/2010-11/2010 | 11,021 |
| Program Administrator (Judy King) | 76,008 | 1.0 | 12/2011 -6/2012 | 112,792 |
| Program Specialist 2 (vacant) | 42,588 | .5 | 7/2011-6/2012 | 21,294 |
| Total DEL Salaries | | | | 145,107 |

Fringe Benefits: Specifically identified to each employee and charged as direct costs. Consist of payroll taxes: social security and Medicaid, industrial insurance; and health insurance and retirement benefits. **42,274**

Travel: In-State Local ground transportation from Olympia to other locations in Washington for 2 employees to meet with partners on a regular basis and other groups as needed. DEL travel policies encourage employees to use state owned vehicles, if available. If a state owned vehicle is not available, DEL reimburses employees for mileage at the standard federal rate (currently .51 per mile). Based on FTE averages for 1.5 FTEs. **6,250**

Travel: Out of State

One 2 day PEW Home Visiting Symposium in Washington DC for 1 staff, February 2011. One 2-3 day grantee meeting in Washington DC for 2 staff.

Washington DC travel estimated at \$1800 per trip to include state airfare, ground transportation and per diem. This budget includes 3 trips @ \$1800 each. **5,400**

Other Costs: Includes phone, VPN, computer, staff development and printing (costs are based historical DEL office wide averages) **5,800**

Sub Contracts:

- Cedar River Group 66,300
Provides facilitation of Cross Agency Governance Structure, Partnership Group and public outreach. September 2010-September 2011
- Thrive by Five Washington 40,000
Home visiting planning project consultant. September 2010-June 2011
- Early Learning Fund/Home Visiting Services Account 902,523
To provide coordination and implementation support for the MIECHV program, including local grant oversight, program implementation, program and model specific TA, development of a TA hub, oversight on data/benchmarks/CQI work. **1,008,823**

Contract Grand Total **1,213,654**

Maintenance of Effort MOE Baseline

A Maintenance of Effort (MOE) requirement is a condition of eligibility for states to be eligible for the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program. To be eligible, states must provide assurance that MOE is established and maintained to represent State General Funds allocated for evidence-based home visiting as of March 23, 2010.

The following models are included in the federal definition of Evidence-Based Home Visiting:

- ✓ Early Head Start – home based options
- ✓ Family Check up
- ✓ Healthy Families America
- ✓ Healthy Steps
- ✓ Home Instruction Program for Preschool Youngsters (HIPPY)
- ✓ **Nurse Family Partnerships**
- ✓ **Parents as Teachers**

As of March 23, 2010 two EBHV models received State General funds in Washington State. These include: Nurse Family Partnership and Parents as Teachers. As of March 23, 2010 State General funds dedicated to evidence-based home visiting were allocated in the budget in the State CAPTA agency, the Council for Children and Families.

The MOE baseline for Washington is calculated at \$933,621. This amount reflects funding (SGF) in the Council for Children and Families budget as of March 23, 2010, funding the 2 identified evidence-based models.

| | |
|---|------------------|
| State FY 2010 budget for evidence-based, research-based and promising practices | \$1,171,000 |
| Contracts for <u>non</u> EBHV, according to federal definition | \$237,379 |
| Total allocation for EBHV, as of March 23, 2010 | \$933,621 |

MOE Assurance for State FY 2011 Funding for EBHV

State Fiscal Year 2011 funding for EBHV is allocated to the Council for Children and Families and to the Department of Early Learning to be invested in the Home Visiting Services Account.

The State General Fund investment in models identified in the federal definition of EBHV include: Parents as Teachers and Nurse Family Partnerships. This includes: \$569,883 at the Council for Children and Families and \$432,800 at Thrive by Five Washington, in the Home Visiting Services Account.

Total State General Fund EBHV State FY 2011 \$1,002, 683

Washington provides assurance that the MOE requirement has been met.

