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Section 1: Needs Assessment and Identification of Targeted 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. Counties were chosen as the initial definition for the geographic areas. However, the three largest counties—King, Pierce and Snohomish—were subdivided into their existing health planning areas, resulting in a total of 57 geographic communities for the needs assessment. Risk indicator data were also 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 measured for each of the 64 individual "communities" (57 geographic areas + seven race/ethnic communities). Ten of the indicators were required by the federal guidance for the mandated Home Visiting Needs Assessment. As allowed in that guidance, Washington added five additional indicators. Aggregate risk scores were compiled using the 15 indicators. The aggregate scores were compiled three different ways, each weighted the individual indicators differently so that no one indicator or group of indicators would drive the aggregate score. The individual and aggregate scores were then ranked to compare communities. American Indian/Alaska Natives had the highest risk scores of all geographic and racial/ethnic groups.

Of the 57 geographic communities, 32 were identified as high risk compared to the state average. Of the seven racial/ethnic communities, five were at higher risk than the state as a whole. Two racial/ethnic communities were identified as being a very high risk: Native American and African American. Because high-risk communities ultimately needed to be defined geographically, we cross-walked those communities with places populated with the highest numbers of Native American and African American births. This added five more communities to the high-risk list, bringing that number to 37 total. Those communities were then ranked by need.

We also conducted a capacity assessment of highest-risk communities to identify which of the communities were ready to implement. In Washington, the evidence-based models currently implemented include *Early Head Start Home-Based Option, Nurse-Family Partnership* and *Parents as Teachers.* Information was gathered from those communities already implementing evidence-based home visiting models to determine capacity to implement each model. Another consideration was ensuring representation from both Eastern and Western Washington in the initial community prioritization process.

Based on community need and capacity, we identified seven of the highest-risk communities (four counties) for the FFY10 Updated State Plan. Those communities were King County (South), Pierce County (Districts 2, 4, 5 and 6), Snohomish County (North Everett) and Yakima County. In FFY11, we will add two more communities to expand their current evidence-based home visiting programs: *Clallam* and *Pend Oreille* counties.

The following is a demographic summary of the two new counties compared to the state as a whole. A detailed description of need for these two communities follows.

AREA	2008 POP	WOMEN 1-44 YRS	BIRTHS	AGES 1-4	% MEDICAID	% MINORITY
State	6,587,600	1, 350,299	90,270	347,674	55%	24.8%
Clallam	69,202	10,276	648	2,759	64%	14.0%
Pend Oreille	12,801	2,051	129	542	75%	26.4%

CLALLAM COUNTY

Clallam County is a rural community, located on the western tip of Washington state and ranked higher than the state in six of the 15 indicator areas identified in the Home Visiting Needs Assessment, achieving a statewide ranking of #18 (of the 57 total). Based on the Home Visiting Needs Assessment, the highest risk factors for this community include: *unemployment, poverty, domestic violence, high school dropout rate, child maltreatment and substance use treatment utilization*. For specific indicator data, see the Washington State Home Visiting Needs Assessment, Appendix B: Data Report Information, Tables B-1 and B-3 (pp. 92-95).

Existing Home Visiting Services

In 2008, Clallam County had two evidence-based home visiting programs: *Early Head Start (Home Based)* and *Parents as Teachers (PAT)*. Additionally, they had other home visiting programs operating including: Parent-Child Assistance Program, Maternity Support Services and Infant Case Management, Early Support for Infants and Toddlers (IDEA Part-C), Early Family Support Services, and Children with Special Health Care Needs. Priority populations being served are teenage parents, Hispanic and Native American families. Another targeted group includes families of prisoners who are housed in the prison in Clallam County. However, it is estimated that only 11% of the eligible population is being reached.

Existing Mechanisms for Screening and Referral

Clallam County PAT will participate in the MIECHV program**.** Three organizations are implementing PAT programs in Clallam: First Steps Family Support Center (fiscal agent); Forks Hospital/West End Outreach and Quileute Tribal School. Clallam does not have a centralized intake system for home visiting. Existing mechanisms for referrals: First Steps, Primary Care Providers, WIC, tribal services, and other community resources.

Coordination among Existing Programs and Resources

One of the clear community strengths in this community is the history of collaborative relationships among local agencies. PAT programs currently work with the existing Early Head Start program and local social and health agencies. The PAT State Leader will work with the PAT programs to increase collaboration and schedule ongoing meetings and/or informational updates to the local community to increase quality services to families. The idea is to evolve this work to actually engage in joint planning for services that support child health, social-

emotional development, literacy development and link early learning to the K-12 system. A real strength is that local agency staff are bilingual in English and Spanish and understand the cultural beliefs and differences of the Hispanic and Native American populations being served.

Referral Resources Currently Available (noted with an "X") and Identified Gaps									
Names of Organizations	Health	Mental Health	Early Child Development	Substance Abuse	DV Prevention	Child Maltreatment Prevention	Child Welfare	Education	Other (Specify)
First Steps Family SC	X		X					X	MSS & Infant Case Management services
Clallam County HD	X						X		WIC, Immunizations
Olympic Medical	X		X					X	Childbirth classes, postpartum, breastfeeding consultation & support groups
Jamestown S'Klallam Chemical Dep Ctr				X					
Family Planning of Clallam County	X							X	Pregnancy & STD tests; emergency contraceptive, birth control & annuals
Dungeness Valley Health and Wellness	X								Free Clinic
OlyCap	X		X					X	Dental, EHS, HeadStart
Jamestown Family Dental	X								Jamestown Tribal Dental Clinic
Peninsula Mental Health		X			X				
Healthy Families of CC					X	X	X		
Serenity House									Emergency & transitional housing

Pend Oreille County

Pend Oreille County is in the northeastern corner of the state. Selkirk School District is 95 miles from Spokane and at least 45 miles from the nearest hospital or city with any community

services. School budget cuts caused the closure of its Head Start program and now threaten the potential closing of PAT. Pend Oreille County ranked higher than the state in 10 of the 15 indicator areas in the Home Visiting Needs Assessment, achieving a statewide ranking of #19. The highest risk factors for this community include: *preterm birth, infant mortality, unemployment (within the boundary of the school district there is a 21% unemployment rate), poverty, child maltreatment, high school illicit drug use, high school binge drinking, late or no prenatal care, teen pregnancy and low 3rd grade reading WASL scores*. 100% of PAT families served by Selkirk School District in Pend Oreille County are living below the poverty level. 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).

Existing Home Visiting Services

In 2008, Pend Oreille County had two evidence-based home visiting programs: *Early Head Start (Home Based)* and *Parents as Teachers (PAT)*. Additionally, they had other home visiting programs operating including: Maternity Support Services and Infant Case Management, Early Support for Infants and Toddlers (IDEA Part-C), Early Family Support Services, Early Intervention Program, and Children with Special Health Care Needs. School budget cuts caused the closure of its Head Start program this past year.

Existing Mechanisms for Screening and Referral

Selkirk School District is the only organization that provides a PAT program. Pend Oreille lacks a centralized intake system for home visiting. Referrals come from the school district, primary care providers, Selkirk Community Health Center and other family-serving organizations.

Coordination among Existing Programs and Resources

Selkirk PAT will coordinate with the local free medical and dental clinic, Community Health Clinic, and the resources available through the Selkirk School District. All other resources, including WIC, are located 45-60 miles away. The idea is to evolve this work to actually engage in joint planning for services that support child health, social-emotional development, literacy development and link early learning to the K-12.

Referral Resources Currently Available (noted with an "X") and Identified Gaps									
Names of Organizations	**Health**	**Mental Health**	**Early Child Development**	**Substance Abuse**	**DV Prevention**	**Child Maltreatment Prevention**	**Child Welfare**	**Education**	**Other (Specify)**
Selkirk CHC	X								Free Dental
NE Tri-County HD	X								
Selkirk School District			X					X	
Pend Oreille MH		X		X					
Pend Oreille County Health Department	X	X		X					

Integrate Home Visiting Services into a Statewide Early Childhood System

Each of the at-risk communities has engaged in 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 at the Department of Early Learning, and foster collaboration and planning through a variety of other early learning focused initiatives.

At the state level, Washington is in 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-tem, integrated governance and planning structure. 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.

List of At-risk Communities NOT being Served with MIECHV (due to funding limitations)		
Benton County	Snohomish County-South Everett	Asotin County
Franklin County	Skagit County	Ferry County
Mason County	Adams County	Kittitas County
Pacific County	Spokane County	Klickitat County
Grant County	Chelan County	Snohomish County-Lake Stevens
Snohomish County-Marysville	Lewis County	Whatcom County
Cowlitz County	Walla Walla County	Skamania County
Okanogan County		Stevens County

Section 2: State Home Visiting Program Goals and Objectives

The goals and objectives of Washington State's Home Visiting Program are based on strategies from Washington's 10-year ***Early Learning Plan*** (ELP) and the state's three-year ***Birth to Age 3 Plan***. These plans clearly identify how implementation of the Home Visiting Program will contribute to developing a comprehensive, high-quality early learning system that promotes maternal, infant, and early childhood health, safety and development and strong parent-child relationships. Washington's ELP provides a critical foundation for actionable strategies that offer a strong system-wide foundation that will make a positive difference in the lives of young children and their parents. The ELP also provides a framework for a comprehensive system of early learning across a spectrum of program and services to support children and families. The

ELP is organized as an inclusive framework that includes all stakeholders in the system: children, families and caregivers, communities, schools, educators and related systems.

Goals and Objectives

Washington's 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 State. 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 long term steps our system must take to continue building a comprehensive home visiting system, as well as contribute to the development of Washington's unified early learning system, as delineated in our ELP. See Attachment 1 for the logic model of our Home Visiting as a whole. In the short term for FY11, Washington will focus on a subset of those goals and objectives outlined in our State Plan for a Home Visiting Program. They are:

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 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.

Objective A

- Use the current home visiting planning structure to provide ongoing input and strategic direction in the development of the home visiting system (Early Learning Advisory Council, Home Visiting Advisory Committee, Home Visiting Partnership Group, and the Home Visiting Executive Team).

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 2-11% of all at-risk children and families are receiving these services. Through the U.S. Census and Washington Kids Count,[1] 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.

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.

[1] http://datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=WA

Objectives A, B and D:

- Make evidence-based, research-based and promising program models more widely available and accessible to local communities.
- Build capacity to increase access to home visiting services in rural, tribal and other underserved communities.
- Conduct culturally competent outreach to recruit and retain families in home visiting programs in underserved communities.

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 highly 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 are also underway 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, B and D:

- Increase the capacity to collect and analyze meaningful data at the program, model and systems levels for use in home visiting program improvement efforts.
- Support communities in using these data for continuous quality improvement and ongoing learning in their organizations.
- Build professional development opportunities, training, and technical assistance for specific models/programs to support quality implementation of home visiting services.

Section 3: Selection of Proposed HV Models and Meeting Community Needs

Below is information that we included in the FY10 State plan, with updates where needed with additions to the FY11 plan. Using a multiple-step process to identify communities and models for funding, six communities were selected based on the risk in each community and the capacity of the community to effectively implement a quality EBHV program. The selected communities and models are: *Yakima - NFP and PAT; Pierce County – Council Districts 2, 4, 5, and 6 – NFP; Snohomish County – North Everett – NFP; South King County – NFP; Clallam County – PAT; Pend Oreille – PAT*.

Understanding Community Needs through Regional Planning Conversations

For the FY10 State Plan, local birth-three planning entities, called "Infant-Toddler Regions," provided specific information about community strengths, risks and priorities. Development of

a regional 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, is underway in Washington. These regional entities were able provide a more in-depth look at community strengths, needs and characteristics of the populations from a neutral stance. For the FY11 plan we did not have the time to engage the Infant Toddler Regions, but, armed with ample data from the Needs Assessment, will target two additional rural high-needs counties in Washington: *Clallam County* and *Pend Oreille County*.

Assessing the Community Capacity to Implement Evidence-Based Home Visiting

All selected 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 assist 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

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 FY10 funding, the Partnership Group ("PG") 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 and national information provided by HomVEE about favorable outcomes for each model. For the two additional communities added in FY11, the PG reviewed information related to community needs from the Needs Assessment and strengths of national information by the HomeVEE.

Next, the counties submitted their written Community Capacity Assessment to Implement the EBVH 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 quality assurance.
- Evaluate service delivery and collect and use data for CQI.

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

The cross-agency partners expressed commitment to building a "portfolio" approach to support the success of families with children prenatal to age five, support a home visiting system to meet the federally mandated benchmarks, achieve results, and leverage future public and private funding. Key considerations in building a portfolio with the highest risk communities

and EBHV models includes: *use of multiple models, access to technical assistance available from national model developers, ensure model and program ability to meet data and benchmark requirements, and build geographic diversity*.

Washington's Experience Implementing Selected Models

Washington plans to implement two evidence-base models in FY11 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.

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. 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 & 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 ("Thrive"), the state's public/private partnership for early learning, invested in evidence-based, research-based and promising home visiting practices in two demonstration communities.

Early success and recognition contributed to greater public will to expand HV services. EBHV 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, CCF was allocated general fund dollars to develop and support a portfolio of EBHV services in Washington state. The goal 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 entered into contracts with community-based programs, as well as the Washington State University Area Health Education Center, to develop and implement a formative and descriptive program evaluation of these home visiting efforts.

The historical work done through the CCF has been foundational in developing relationships with communities, working with model developers and undertaking evaluation focused on continuous quality improvement. Washington also currently supports 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 community's desire and that are shown to be effective.

In 2010, the Washington State 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, managed by Thrive, has invested in a portfolio of HV programs including NFP and PAT programs. As of July 2011, all state funding for home visiting has been transferred to the DEL, which deposits it into the HVSA so that 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"[2] framework to supplement the established protocols for assessing fidelity in PAT and NFP replication sites. (Implementation science is discussed in greater detail in Section 7.)

For the present discussion, implementation science proposes that attention to staff and organizational readiness, ensuring staff and organizational capacity to deliver the service, understanding the characteristics and needs of clients, and a commitment to information-driven continuous quality improvement can significantly increase the potential for successful dissemination 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

[2] 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.

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, generally. In home visiting, variable program benefit has principally been associated with families from marginalized communities, maternal depression and the presence of domestic violence.[3] Gomby's[4] 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 state 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 public policy contexts 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 to have practice inform decisions but also for practice to be influenced by community and other stakeholders' needs. As a result, our approach to service quality and fidelity explicitly calls out the process of bidirectional communication from the program level to decision-makers and the national model developers. For more about Washington's approach to program assessment and support of model fidelity, please see Section 5: Data and Benchmarks and Section 7: Plan for CQI.

Identifying and Addressing Anticipated Challenges and Risks of Selected Models

Existing evaluation work in Washington State 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.

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[3] Howard, K.S., & Brooks-Gunn, J. (2009).The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect.*The Future of Children, 19 (2),* 119-146.

[4] Gomby, D. (2005). Home *visitation in 2005: Outcomes for children and parents (Working Paper No. 7)*. Washington, DC: Invest in Kids Working Group.

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.[5] 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 state home visiting programs 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 state 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 their guidance, particularly as it relates

[5] Backer, T. E. (2001).*Finding the Balance—Program Fidelity and Adaptation in Substance Abuse Prevention: A State-of-the Art Review*. Center for Substance Abuse Prevention, Rockville, MD.

to meeting data and benchmark requirements, 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 home visitors also represent a comparatively diverse group with respect to education and professional experience. PAT implementing agencies also are more likely to include a range of agencies in terms of experience and capacity. The team anticipates that a more complex and extensive training and technical assistance demand may as a result be needed.

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 note that the variability in experiences can make definition of services and identification of program and client needs a more variable and complex process potentially.

NFP Challenges, Risks, and Anticipated Technical Assistance Needs

Because of the placement of NFP programs in public health agencies, NFP program share much greater level of common characteristics than is so for PAT. However, it is anticipated that local program and staff preparation differences will occur and need to 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's comparatively more detailed and systematic approach to assessment and fidelity also introduces some meaningful challenges. PAT program potentially will use federal funding to address a number of valuable development tasks addressing assessment and information systems. 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 but the team also believes this is a legitimate challenge that will have to be managed to a mutually acceptable plan of action.

Section 4: Implementation Plan for State Home Visiting Program

We have learned in Washington that there are multiple levels of support necessary for quality implementation of evidence-based home visiting programs in communities. Implementation science has taught us that community readiness and capacity to implement evidence-based programs is critical for success. Additionally, home visiting models vary in clarity and

communication of fidelity elements and accessible support necessary for successful implementation.

This section provides a plan for the implementation of Washington state's Home Visiting Program that builds from the FY10 plan. This plan includes a description of how the State will provide ongoing monitoring and continuous quality improvement for quality implementation of the models in six high-risk selected regions/counties. This plan also includes our work with national model developers, how our state will support training and professional development and the staffing plan for the Implementation HUB at Thrive to coordinate and oversee Washington's quality implementation of EBHV programs in local communities. See Attachment 2: Project Timeline.

The Implementation HUB will manage all aspects of implementation, including: grant-making and direct service; technical assistance, coaching, and training; working in close collaboration with Washington State University (WSU) to assure data, benchmarking and reporting are utilized at the program level for CQI and program development (Please see Section 7: Plan for CQI for full details of Implementation HUB). Four communities were selected for FY10 funding and will continue in FY11. Two additional counties will join the group in FY11 to implement EBHV. Additionally, community development work will begin in one rural county with no existing services (Grays Harbor County) and with a statewide tribal entity, the American Indian Health Commission, to explore options for addressing high needs of tribal populations through EBHV. Rural services and services to meet needs of tribal families have been identified as gaps in our system.

Community Planning and Engagement

The Washington team continues to involve a diverse cross-section of stakeholders in the development of the State Home Visiting Plan. (See FY State Plan for additional details -- p. 44).

State-Level Planning and Engagement

The groundwork for engaging communities, organizations, state agencies and key stakeholders began in June 2010. (See FY State Plan, p. 44 for full details).

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

For FY11 the additional community/model selection was determined by building off the FY10 process. The following communities are implementing two EBHV models and are selected for funding in the second year of the MIECHV Program. Clallam and Oreille County are the two communities added in FY11.

Region/County	Lead Agency	EBHV Model	Projected Number
Yakima County (NFP)	Yakima Valley Memorial Hospital	NFP	10-12 families
Yakima County (PAT)	Parent Trust for WA Children	PAT	25 families

REGION/COUNTY	LEAD AGENCY	EBHV MODEL	PROJECTED NUMBER
Pierce County - CD 2, 4, 5 & 6	Tacoma-Pierce County HD	NFP	25 families
Snohomish County –N. Everett	Snohomish Health District	NFP	25 families
King County – South	Seattle King County DPH	NFP	50 families
Pend Oreille County	Selkirk School District	PAT	25 families
Clallam County	First Steps Family Support Ctr	PAT	75 families
		TOTAL:	**235 FAMILIES**

MONITORING, ASSESSING & SUPPORTING IMPLEMENTATION & MAINTAINING QUALITY ASSURANCE (A-H)

A. **Assess Community Capacity to Implement with Fidelity:** Washington engages in an intentional assessment process 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" ("CA" - see Attachment A, in FY10 Plan). For the two new communities with existing PAT programs, the Implementation HUB at Thrive and the PAT State Lead coordinated with the PAT programs to complete a CA for implementing the PAT program model. The CA provides an initial self-report of resources available to implement with fidelity.
B. **Develop Implementation Plans ("IP"):** Baseline Implementation Planning follows, building off the CA with the selected communities/models. (See Attachment D, FY10 Plan). For the FY10 Communities/Models selected, a baseline IP was provided in the FY10 State Plan (see page 45-76 for detailed IPs for Yakima NFP; Yakima PAT; Pierce NFP; Snohomish NFP; King NFP). The IP for those communities will not be repeated again in this application. Summaries of Clallam and Pend Oreille IPs are provided below.
C. **Develop Implementation Improvement Plans:** Once the grant begins, from the baseline Implementations Plans a written Implementation Continuous Quality Improvement (CQI) Plan will be developed for each community/program to identify variables to be addressed to move towards increased fidelity. The written Implementation CQI Plans, with the specific variables (implementation drivers) from the Implementation Plan will be sent to programs and a technical assistance call will be scheduled to review the plan, and allow for additional input and suggestions for what should be prioritized. The Implementation CQI Plans will be implemented according to a timeline and technical assistance site visits, calls and program reporting with feedback from the HUB will help with monitoring the progress and CQI process. Implementation CQI Plans will be developed each year following administering of the Capacity Assessment.
D. **Develop Program Logic Models:** The logic model tool is the first step to engage programs in the program evaluation process. The HUB staff will schedule a half-day site visit to each of

the NFP sites. The logic model captures "what is" by identifying core model components and unique community/program characteristics and/or enhancements; helps programs with implementation focus to decrease "model drift;" and is a tool to align reporting for programs implementing the same EBHV models.

E. **Engage in Program Evaluation for CQI:** Program evaluation and monitoring support quality implementation, and require technical assistance and support to develop these skills at the program level. Program-level reporting will be produced by Washington State University (WSU) using the state data system, and will be utilized to both track progress and engage with Implementation HUB Staff and national model representatives to reflect on data for CQI. There are also Quarterly and Year-End Reporting consisting of demographics, core model activities, outputs and fidelity indicators and benchmarks. Implementation HUB staff provides feedback on each report for CQI and schedules feedback call.

F. **Work with National Model Developers for Technical Assistance and Support**
NFP: The intent of National Service Office (NSO) is to provide support for program implementation and clinical support; reporting and quality improvement systems; federal policy and program financing; and marketing and community outreach resources. Washington's NFP programs access two regional representatives for technical assistance and support assigned by the NSO, an NFP Regional program developer and a NFP Regional Nurse Consultant. The activities of the Implementation HUB will enhance and complement this existing model process. We will increase capacity for NFP Model specific support, by contracting with a NFP State Nurse Consultant to support implementation with fidelity and CQI for all NFP MIECHV funded programs in Washington.
PAT: National PAT provides *Quality Assurance Guidelines* and *Essential Requirements* necessary for model fidelity to guide the development of a PAT affiliate and the completion of an *Affiliate Plan*. Affiliates annually report data on service delivery, program implementation, and compliance through the *Affiliate Performance Report*. Ongoing affiliation with PAT requires regular program self-assessment for PAT fidelity and quality. Every four years, Affiliates engage in an expanded program assessment, incorporating additional data, input and documentation review. Washington State has a PAT State Office to develop, support, and sustain high quality PAT Affiliates. Through the State Office, the .5 FTE *WA PAT State Leader* provides technical assistance via monthly training calls with all statewide PAT programs. Trainings include updates regarding curriculum, state home visiting news and advocacy, news from PAT national office, and any upcoming training opportunities. We will increase capacity for PAT Model specific support, by subcontracting to increase the *PAT State Lead* by .25 FTE to ensure implementation with fidelity and CQI for all PAT MIECHV funded programs in the state.

G. **Support Initial and Ongoing Training and Professional Development**
NFP:
- NFP National Required Trainings: All MIECHV NFP programs will meet all NFP national training requirements.
- Technical assistance consultation and coaching from the HUB and NFP State Nurse Consultant.

PAT:

- Required "Affiliate" Training: PAT programs participating in the MIECHV Program must reach "Affiliate" status by December 8, 2011. As a part of the grant all MIECHV funded PAT programs will be supported for three required trainings:
    - *PAT Foundational Training* and a *Model Implementation Re-training (Note: PAT Curriculum will be provided in the training).*
    - *Tool Trainings*: in Ages and Stages 3– both developmental and social emotional Questionnaires (ASQ-3); Edinburgh Post Natal Depression Screening; Family Assessment Screening tool - Life Skills Progression ("LSP") recommended by national.
- Parent Educators' complete required in-service professional development hours annually.
- Technical assistance consultation and coaching from the HUB and State PAT Lead.

<u>Implementation HUB – All PAT and NFP WA MIECHV programs</u>

- Implementation Science Training – the grant supports half-day trainings for program level staff with practice session focused on applications to their work.
- Program Specific Trainings – the grant will support one training per year to review logic models, quarterly and year-end reporting requirements, with practice sessions.
- Two scheduled technical assistance (TA) site visits – to focus on individualized logic model development, quarterly reporting and year-end reporting.
- Monthly coaching check-in calls.
- One additional training for all MIECHV grantees based on the capacity assessment themes.

H. Implementation HUB Staffing Plan

The State Implementation HUB will be staffed with:

- .5 FTE Home Visiting Director to direct and oversee home visiting program.
- .5 FTE Home Visiting Manager to guide implementation and monitor HV programs.
- Contracted NFP Nurse Consultant to oversee NFP Community of Practice and NFP Implementation.
- .25 Contracted PAT Washington State Lead.

PEND OREILLE AND CLALLAM BASELINE IMPLEMENTATION PLANS

Pend Oreille County PAT: Selkirk School District ("SSD PAT") Implementation Plan

1. STAFFING AND SUPERVISION PLAN FOR IMPLEMENTATION:
    - <u>Staffing</u>: .5 FTE PAT Supervisor & 1.5 FTE Parent Educator ("PE").
    - <u>Staff Recruitment</u>: SSD PAT was in the process of closing due to funding cuts, so former staff will certainly be strongly considered. The PE's meet all the PE staffing requirements of PAT National.
    - <u>Staff Retention</u>: Competitive wages, benefits, annual increases, and professional development.
    - <u>Supervision</u>: The Supervisor at SSD meets all PAT National the requirements.
2. FIDELITY MONITORING AND QUALITY ASSURANCE IMPLEMENTATION PLAN

- Provided by PAT National: Pend Oreille will utilize all fidelity monitoring and quality assurance provided through PAT National - See Section above "Work with Model Developers – TA and Support through the National Model."
- Washington State Specific: In FY10, our state convened a PAT CQ work group to identify strengths and challenges of implementing PAT. Results included: PAT accessibility, flexibility and curriculum are strengths but variation in program implementation and measurement tools used is a challenge. PAT programs reported lack of accessible trainings & technical assistance; limited staffing of PAT State Office (.5 FTE for 28 programs in Washington); concern about meeting requirements to achieve "Affiliate Status;" difficultly for programs to access training due to costs. In the FY11 Plan, we will increase capacity of PAT programs to meet the new requirements and increase overall fidelity implementation through increased TA through PAT State Lead and HUB.

3. TRAINING AND PROFESSIONAL DEVELOPMENT PLAN

- PAT National, Washington PAT State Office and Implementation HUB: See Section below "Support Initial and Ongoing Training and Professional Development for PAT and NFP Implementation."
- Selkirk School District: Ongoing professional development and training through the school district.

4. INITIAL AND ONGOING TECHNICAL ASSISTANCE AND SUPPORT
   to be utilized to support implementation and maintaining quality assurance.
5. PLAN FOR PARTICIPANT OUTREACH, ENGAGEMENT, ASSESSMENT & TIMELINE
   - Recruitment and engagement plan**:** Families are recruited through the Selkirk School District, Selkirk Community Health Center, NE Tri-County Health District.
   - Plan for individualized assessments: PE must complete a family-centered assessment and family-centered goals with each family. This is requirement of a PAT Affiliate.
   - Plan for referrals to services: Pend Oreille is 95 miles from Spokane and 45 miles from the nearest hospital or city with community services. Referrals are made to local health providers, but families need to travel 45 miles for major health, developmental or social emotional issues.
   - Timeline to reach maximum caseload: Estimate full caseload of 25 in six months
   - Attrition rate and plan for minimizing: Average rate of attrition is 10% annually. 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.
6. PLAN FOR COORDINATION BETWEEN LOCAL HV PROGRAMS AND OTHER SOCIAL SERVICE AND HEALTH AGENCIES
   Selkirk PAT will coordinate with the local free medical and dental clinic, Community Health Clinic, and the resources available through the Selkirk School District. All other resources are located 45-60 miles away. There are no other HV Programs.

Clallam County (CC) PAT: First Steps Family Support Center ("FSFSC") is Fiscal Agent, Forks Hospital/West End Outreach and Quileute Tribal Schools Implementation Plan

1. STAFFING AND SUPERVISION PLAN FOR IMPLEMENTATION
   - Staffing:3 FTE PAT Supervisor&5.5 FTE Parent Educator ("PE").
   - Staff Recruitment: The Parent Educators and Supervisors meet staffing requirements of PAT National.
   - Staff Retention: Competitive wages, benefits, annual increases, and professional development.
   - Supervision: CC Supervisors meet all PAT National requirements.
2. FIDELITY MONITORING AND QUALITY ASSURANCE IMPLEMENTATION PLAN
   - Provided by PAT National: CC will utilize all fidelity monitoring and quality assurance provided through PAT National (see Section 4: "Work with Model Developers – TA and Support through the National Model".
   - Washington State Specific: CC will utilize all fidelity monitoring and quality assurance provided through Implementation HUB (see Section "Support Initial and Ongoing Training and professional development for PAT and for NFP Implementation."
3. TRAINING AND PROFESSIONAL DEVELOPMENT PLAN
   - PAT National, Washington PAT State Office and Implementation HUB (see Section above "Support Initial and Ongoing Training and Professional Development for PAT and NFP Implementation").
   - Clallam County: Parent Educators receive ongoing professional development and training through the District implementing CC PAT agencies.
4. INITIAL AND ONGOING TECHNICAL ASSISTANCE AND SUPPORT
   To be utilized to support implementation and maintaining quality assurance
5. PLAN FOR PARTICIPANT OUTREACH, ENGAGEMENT, ASSESSMENT & TIMELINE
   - Recruitment and engagement plan**:** Three CC PAT programs work, recruit and refer families to the appropriate PAT program. Quileute PAT requirements: Native Americans living in Quileute Village; Tribal PAT staff refer Native Americans outside of the Village, and non-Native Americans living in the Village to two other PAT programs. FSFSC provides Maternity Support Services ("MSS") to Forks-area Hispanic women and will refer families to the Forks PAT program. FSFSC also provides MSS and Infant Case Management services to the Lower Elwha-KlallamTribe, Jamestown and S'Klallum Tribes and will recruit these families for PAT enrollment.
   - Plan for Individualized assessments: Parent Educator must complete a family-centered assessment and goals, a requirement of a PAT Affiliate.
   - Plan for Referrals to Services: CC to refer enrolled families to: CC Health Department, Jamestown and S'Klallum Tribal SAC, Jamestown Tribal Dental clinic, Healthy Families of Clallam County and Peninsula Mental Health.
   - Timeline to reach maximum caseload: Estimated caseload of 75 in six months.
   - Attrition Rate and Plan for Minimizing: Average rate of attrition is 12-15% annually, includes families who move out of the area, and those not located. As families are exited from the program, new families are enrolled.

6. PLAN FOR COORDINATION BETWEEN LOCAL HV PROGRAMS AND OTHER SOCIAL SERVICE AND HEALTH AGENCIES
   PAT programs work with the existing Early HeadStart program and local social and health agencies. The PAT State Leader will work with the PAT programs to increase collaboration and schedule ongoing meetings and/or informational updates to the local community to increase quality services to families.

Section 5: Meeting Legislatively-Mandated Benchmarks

There have been no changes to the MIECHV FY10 submitted plan. Because the proposed plan is under review at the time of this submission, any recommended modifications based on the federal review will be integrated into FY11 program activities. We will collect information on all required federal benchmarks and associated program characteristics and participant demographics.

For simplicity of presentation, we refer to activities in FY11 in this section. In the event that the Washington state home visiting plan is approved prior to October 1, 2011, we will begin to implement the benchmark and related assessment plans immediately.

Summary of the MIECHV Washington State Benchmark Data Plan

Consistent with the general home visiting literature,[6] several findings from the evaluation of home visiting in Washington state inform the present work. We propose that carefully addressing these issues is critical to the long term quality and sustainability of the MIECHV benchmark data plan. These findings include:

- Implementation agencies vary significantly in capacity. Key variables include:
  - 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.

[6] Daro, D., (2006). *Home Visitation: Assessing Progress, Managing Expectations.* Chicago: Chapin Hall at the University of Chicago; Daro, D. (2009). *Embedding Home Visitation Programs within a System of Early Childhood Services.* Chicago: Chapin Hall at the University of Chicago.; Gomby, D. (2005). Home *visitation in 2005: Outcomes for children and parents (Working Paper No. 7)*. Washington, DC: Invest in Kids Working Group.

- 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.

The Washington state data plan requires data collection on all individual participants in MIECHV-funded program services provided under the NFP and PAT models. To the extent consistent with model developer's support and fidelity of program delivery, we will adopt common assessment tools, adopt common risk and demographic variable definitions, and use standardized data collection periods across the two models.

Data collection will be integrated into standard program activities as part of a strategy to support sustainability of these data practices over time. As a result, the collection of uniform benchmark information by individual home visitors and programs involves a substantial change in the home visiting models' current practices. 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.

Managing these changes will require a development period to assure capacity for data collection, assure training to protect data quality, align model practices with federal benchmark requirements, and implement data collection in a manner that does not compromise model implementation fidelity. Because we adopt participatory research methods, inclusion of local program leadership and national model developers is an essential element in fully refining the benchmark data plan.

In the first six months of the FY11, we will (1) develop measures aligned with NFP and PAT practices and (2) provide training and develop infrastructure focused on implementing agencies' capacity to collect required information. Assessment tool development is required because neither NFP nor PAT have data collection protocols aligned with federal benchmark requirements and model recommendations on measures are still not released as we submit this FY11 proposal. Both of these development tasks are to be completed in first half of FY11 with

full implementation of benchmarks data collection underway no later than the mid-point of FY11. In addition to required benchmark data collection, we will collect participant demographic, service dose, staff and organizational characteristics (e.g., supervision frequency and staff ratios), and model fidelity indicators as required by MIECHV guidance. Benchmark collection will begin immediately with the first enrolled families using available common tools. Because data on all constructs are not currently collected, complete implementation of benchmark collection will require several months. This ramp-up in data collection will enable stronger program development. Examples of immediately available information include participant demographics, risk screenings, Ages and Stages baseline data, and possible rapid adoption of common tools such as Edinburgh Postnatal Depression Scale and risk screening questions in use in NFP and recommended for adoption by the national PAT office.

The Washington state plan operates under the assumption that benchmark assessment and continuous quality improvement are integrated functions. Day-to-day evaluation and CQI activities will be undertaken by Implementation staff at Thrive and WSU analytic staff that have advanced training in research and evaluation methods and design, social work, psychology, and epidemiology. Specific 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, and providing data to programs.
- Coaching program staff to use their own data for CQI and program development.

In summary, after a concentrated period of program and model consultation as well as data systems development, the federal benchmarks' collection effort and associated program evaluation activities will be fully implemented in FY11. This strategy supports building the capacity for high-quality data collection, aligning the benchmarks with model guidelines, and building the data management structures to support benchmark assessment and continuous quality improvement as a sustainable systems assuring high quality home visiting service delivery to Washington state families.

Benchmark Data Collection Plan

As noted above, the development of data collection practices for both NFP and PAT to meet benchmark data requirements is significant. Finalization of plans will require coordination with both local programs and national model offices. As a result, we present current plans within each model. Our goal is to settle on common assessment methods across the models wherever possible but existing practices particularly for NFP are integrated with fidelity measures and model-specific data collection may be required. In the finalization of benchmark measures, we will balance current practices with steps to maximize the use of valid and reliable assessments.

Construct Measurement: Reliability, Validity, and Definition of Improvement

Attachment 9 provides a summary by Benchmark Area and Construct of the candidate measures to be used in finalizing data collection. Consistent with the guidance in the FOA for FY11, we have examined reliability and validity of the instruments proposed for PAT and NFP. Selecting tools with the best quality of reliability and validity will be a principal standard for final adoption of tools to measure benchmarks. We conducted a review of the available psychometric data for each proposed NFP/PAT tool.[7]

Administrative data held by the State of Washington will be collected through memoranda of understanding to be established in Fall 2011. In participant-informed consent documents, explicit permission for sharing this information will be requested of all enrolled adults.

Data Collection and Analysis Plan -- Questions to be Addressed

The principal state performance questions to be analyzed under the MIECHV funding are:

- 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 Funding Opportunity Announcement? 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?

Secondary questions to be assessed in guiding continuous quality improvement 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?
- 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?

[7] http://extension.wsu.edu/ahec/homevisiting/Pages/default.aspx

- Are the models across communities sustainable both organizationally and financially? What local enhancements are needed to improve sustainability?

Data Collection and Reporting

Washington State University, acting as the benchmarks and data management lead, will be responsible for support of local staff training, data collection system development, and training on how to interpret and use benchmark data in services. All information collected through the benchmark assessment process will be integrated into continuous quality improvement planning directed through Thrive.

Data collection will be conducted by home visitors as part of their routine delivery of services. The limited exception will be for child abuse and neglect data. We will collect all data elements for all enrolled families in services supported by MIECHV funds. We will not use a sampling plan. We will support the right for individual voluntary participation in data sharing among enrolled families. Home visitors will be trained to conduct informed consent interviews to support data collection. All staff associated with data collection and data management will complete the Human Subjects Research training offered by the Washington state IRB.

Data will be shared at the individual child and family levels with identifying client information excluded from records shared for benchmark assessments. In addition to the benchmark assessment information, data shared will include participant demographics, risk and need assessments, model performance measures (e.g., screening completed), and service dose and compliance with program performance expectations. While the specific selection of instruments will be completed in the first quarter of FY11, below is a summary of the various tools under review:

- ASQ and ASQ-SE assess the child's development based on parent report.
- Life Skills Progression assesses both the family and the parents' adjustment.
- The Edinburgh Postnatal Depression Scale assesses maternal adjustment.
- Keys to Interactive Parenting Scales assesses parenting behavior and knowledge.
- Protective Factors Survey assesses parental and family adjustment.
- DOVE assesses parental risk of domestic violence.

Other construct measures involve reports of service need, access, and utilization addressing both child and parental need and progress.

Data will be collected at the local level and entered into a secure database at the program site. The database will be capable of extracting identified individual participant data to be entered into a WSU-managed data warehouse. We anticipate in later years that we will transition to a secure web-based system but believe program need and data quality control will be best handled in a set of easily adapted database solutions at the local and model level while we learn how best to collect, manage, and use the clients' and programs' information.

Data security will be maintained by strict use of staff training in data security strategies supported by use of double password protected files and encryption of data before sending it

via secure file transfer or CD to WSU, as well as other electronic data security protocol. Identified information will be held separately from other benchmark and program data but linked by a unique project ID. The ability to link the identifier to a specific family and child will be held by WSU and the local program, and only shared to the degree necessary to link administrative data resources with program level and benchmark information for children and families. Human subject review will be provided by the Washington state and WSU IRBs. As part of this review process, all specific data collection will be required to meet HIPPA and FERPA program requirements. Data will be maintained on password-protected computers in secure local program offices.

Several reasons guided this decision to emphasize program data collection. First, expanding current data collection practices is feasible and results in minimal new systems development. Integrating data collection into routine practice is likely to increase sustainability of the evaluation efforts. Second, integrating benchmark assessment into service delivery permits more detailed description of participant needs and change over time. Use of assessment tools in routine services may increase sensitivity of measurements when compared to administrative data. Third, balancing the burden of data collection with collection of data that can improve service delivery is likely to increase local program capacity for supervision and continuous quality improvement.

Choice of Assessment Tools and Diverse Populations

The specific assessment tools are intentionally drawn from the current proposals by NFP and PAT national offices to meet MIECHV benchmark requirements. As a first principal, we believe that making reasonable efforts to align with model developers is likely to increase sustainability of efforts and help avoid disputes about burden and the perception of threats to dissemination with fidelity because of expanded data collection requirements. Tools such as the ASQ, ASQ-SE, Protective Factors Survey, Life Skills Progression, DOVE, KIPS, and Edinburgh Postnatal Depression Scale are established to at least minimal degrees of psychometric acceptability. As a result, beginning with alignment to model developers' recommendations also results in selection of tools that are well-recognized in the early childhood assessment field.

Second, working across NFP and PAT recommendations may result in overall improvement in home visiting assessment. However, several of the model developers' proposals for benchmark construct assessment do not presently have reliability or validity information. When this is the case, while the models' proposed assessments may be the best available tools but unknown reliability and validity may be the reason we require a negotiated change in model practices to support stronger assessment methods. We note that the PAT national model proposed several new practices that if adopted could also address potential assessment gaps in NFP practices.

Third, we believe that best data quality will be supported by including local program leadership in the final selection of construct assessment tools. Local programs look to their national offices for guidance on practice. To the degree we can align with national model recommendations or offer clear rationales for why we cannot, we will build stronger local alliances, which will directly result in gains in data quality and information use in continuous quality improvement.

Assessments for young children and their parents are relatively limited particularly when addressing children with disabilities and families from diverse cultural groups. Spanish language versions of the ASQ, ASQ-SE, Edinburgh Scale, Keys to Interactive Parenting Scales and Protective Factors Survey are available. For other languages, it will be necessary to train to and support home visitor-provided translations of the tools. However, even acceptable language versions do not address interpretation of questions from a culturally meaningful framework. Several of the instruments have been used in other countries and culture but we conclude none of the instruments have been assessed as effective across a broad range of cultural settings. To address these limitations, we will assure that staff administering and interpreting assessment results are trained in cultural differences and appropriate caution in interpreting results. We also will routinely assess cultural subgroup variations to identify potential systematic differences suggesting cultural differences resulting from the tools rather than actual family need. As part of recurring process interviews, we will interview staff and community partners on any concerns in diverse populations. Implications for cross-cultural assessment will be routinely addressed in practice oversight meetings, policy governance meetings, and formally addressed in all evaluation reports. Cultural and linguistic characteristics of families and children will be included as predictors in all assessments of program outcomes.

In addition to the benchmark data collection, we will conduct repeated process evaluation interviews to capture lessons learned and provide context for the benchmark findings. Every six months, qualitative interviews will be held with all programs using the FRIENDS Discussion Tool with supplemental questions to identify and address acceptability of services, accessibility of services, cultural competency in deliver of care, challenges and barriers, community ability to meet service need, and community changes that enhance or impede delivery of the home visiting services.

Analysis and Reporting

Data interpretation and change over time on the benchmark measures will rely on standard scale and cut score interpretations when available for a given tool, statistically significant change in scale scores, and percent change on categorical risk data.

At the state level, data analysis will involve repeated measures change from baseline utilizing linear and logistic regression. Program model, program characteristics, service utilization (dose and duration of care), and key family demographic characteristics will be used as predictors of benchmark change. Because of comparatively small total participant counts and the large number of possible predictors, we will conduct progressive analyses to identify the mix of predictors with the best capacity to demonstrate change over time in the MIECHV benchmarks. At the program and model levels, we will provide quarterly reports of participant characteristics and service participation. We will provide descriptive reports of trends over time on the benchmarks and program performance (e.g., mean number of visits completed each month, participant dropout rates) based on cohorts of clients enrolled in either one or two calendar quarters within each program.

Benchmark data collection and program performance data will be organized in quarterly reports to guide continuous quality improvement efforts. Benchmark and program evaluative staff at WSU will have standing meetings with Implementation Hub staff at least every two weeks. In a coordinated planning process, benchmark and CQI staff will review program performance and emerging results to identify issues and formulate plans to support high quality data management and service delivery. This information will also be used as an informational resource in model, community, and state planning discussions within the governing process of the Washington state home visiting plan.

Section 6: Administrative Structure to Support the MIECHV Program

Lead Agency

The Washington State Department of Early Learning (DEL) is 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. See Attachment 3: Project Organizational Chart.

Management and 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 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 is the designated partner to raise the private dollars needed for matching the public dollars in the HVSA. For the MIECHV Program Thrive role and function includes:

- Home Visiting Grant making to selected models/communities.
- Provision of technical assistance, coaching and training.
- Lead Continuous Quality Improvement Efforts.

Thrive will ensure successful implementation of the State Home Visiting Program by monitoring key quality elements at the local level: staffing, supervision, organizational capacity development, resources and referral processes, and overall fidelity of implementation. They will also be working with the model developers to support strong services at the local program level, and comply with model-specific requirements.

The only difference in roles for FY11 is that DEL will contract directly with Washington State University for the Data/Benchmark work. FY 10 and 11 funds will support this work. The Washington Department of Health will provide analytic staff expertise to build a strong data/benchmark approach, and this work will be linked to Thrive for ongoing CQI efforts. The Washington Department of Social and Health Services will provide staffing to focus on administrative data development. The long-term plan is for the data to be housed in a state agency.

Collaborative Partners

Washington presented a Home Visiting Planning Structure in the Updated State Plan. Each of the three planning groups will support this work as we move into implementation. The Cross Agency Governance Structure (departments of Early Learning, Health, Social and Health Services and the Council for Children and Families) will continue to make decisions about implementation. The Partnership Group, a strategic group representing the four key agencies and Thrive will continue to make recommendations about the home visiting system development in Washington, and identify challenges and opportunities to build the federal and state work. The cross sector Home Visiting Advisory Committee will provide input on program development, community needs and core components of the Washington State Plan.

Members of the Advisory Committee represent the following organizations/affiliation:

Children's Home Society	Open Arms Perinatal Services
Council for Children and Families	Parent Child Home Program, State Lead
Department of Early Learning	Parents as Teachers, State Lead
Department of Health	Ready by Five Yakima
Department of Social and Health Services	Seattle King County Public Health
Fight Crime: Invest in Kid	St. James Family Center
Jamestown S'Kallam Tribe	Thrive
King County Children & Family Commission	Tulalip Tribal Council
Neighborhood House	United Ways of Washington
Nurse Family Partnership, Region Manager	Washington Dental Foundation
	Yakima Valley Memorial Hospital

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 identified in the Early Learning Plan includes: *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 ("CQI")

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

THE IMPORTANCE OF CQI

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 in a thoughtful and planned way 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.[8]

We know from the implementation science as well as our experiences in Washington that what a model's research says will be effective and what actually happens in the field can be quite different. Implementation science research findings 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; and implementation of evidence-based programs often do not adhere to fidelity and/or monitor for effect.

The goal of implementation is to have practitioners base their interactions with clients and stakeholders on research findings. The research suggests that there are several core implementation interactive components or "drivers" that can positively impact high fidelity program implementation.[9] These various interactive drivers are integrated to maximize their influence on staff behavior and organizational culture and are not an event but a series of processes.

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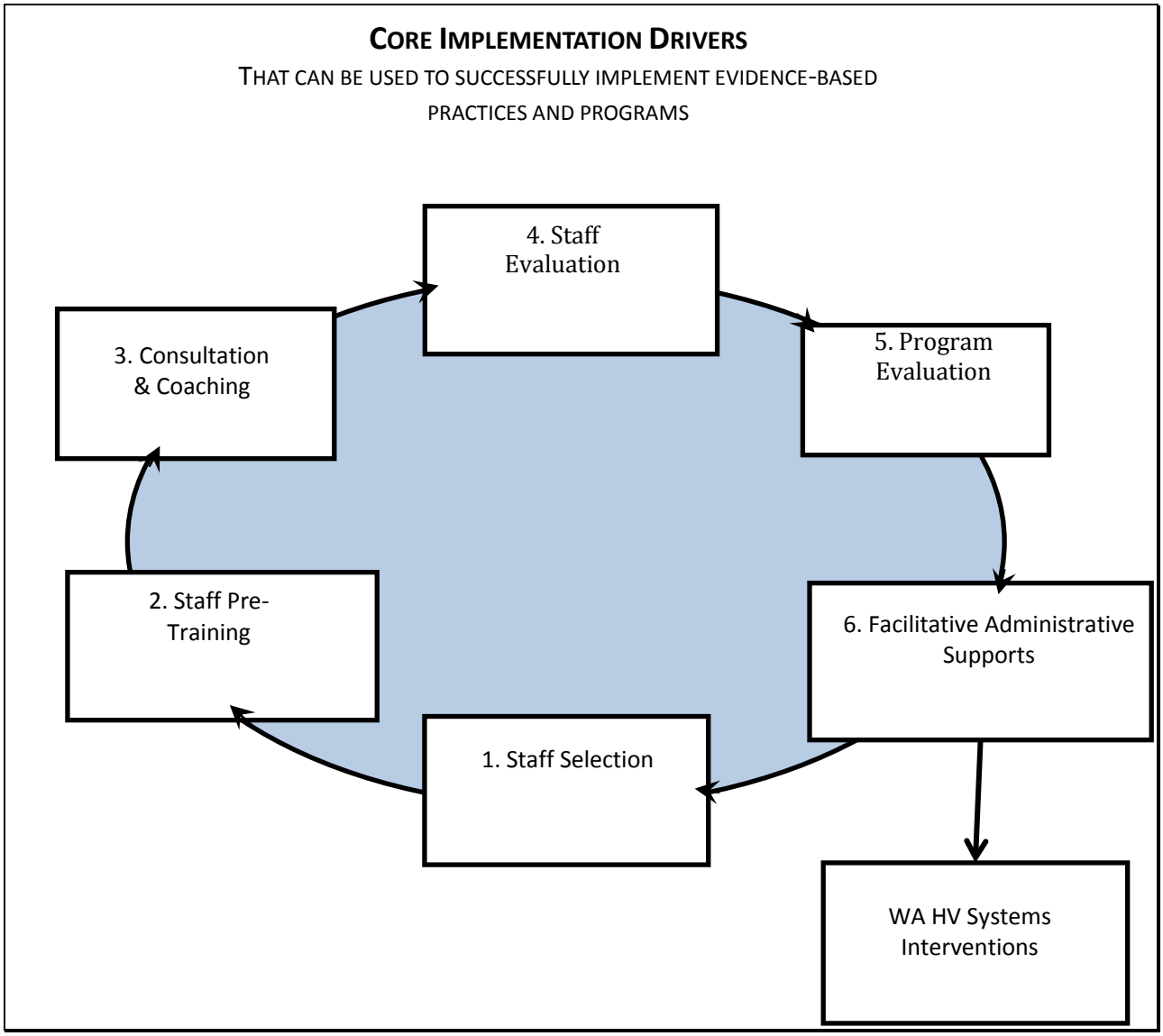
[8] DOHVE – Design Options for Home Visiting Evaluation, "Building a Culture of Quality in Home Visiting" Webinar 1/13/2011.

[9] 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.



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

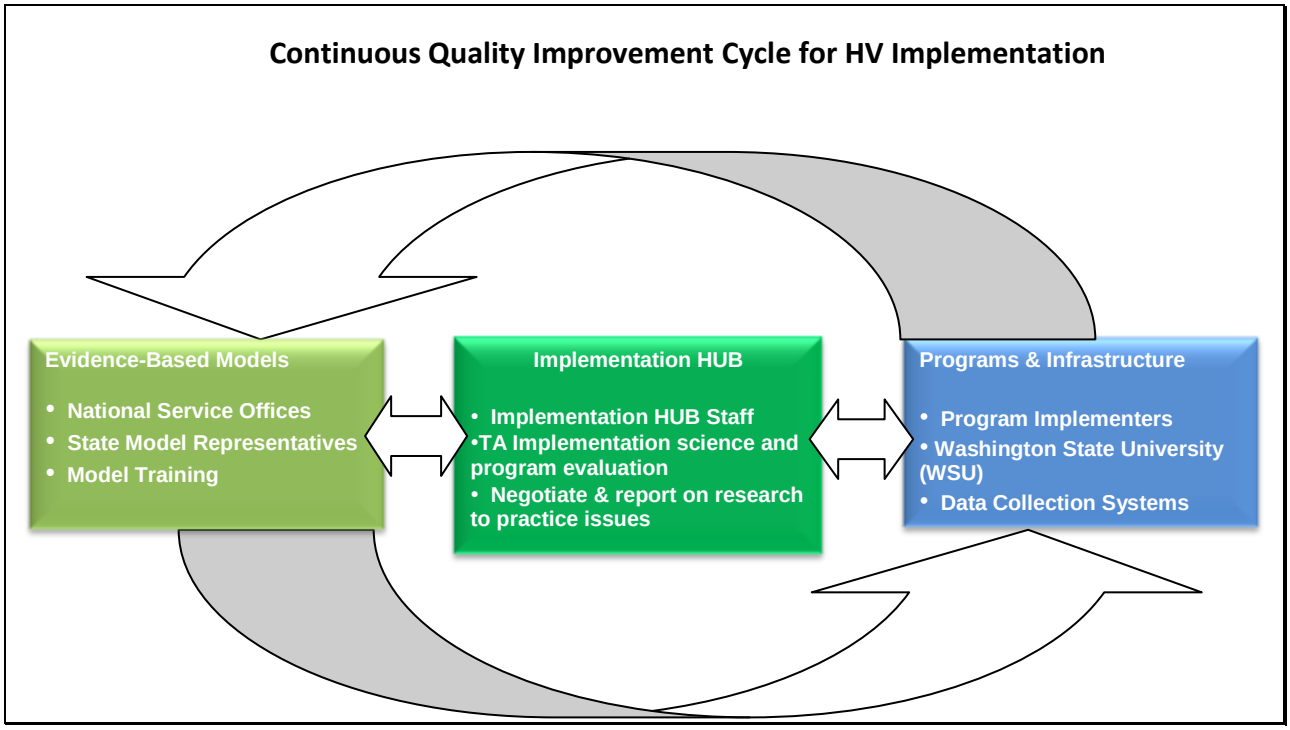
Using implementation science principles, our CQI approach focuses on development supports in the following areas to address the identified gap between research and practice:

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

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

A. Program and Model Level Development

To incorporate strong implementation in Washington, a centralized Implementation HUB s being developed. This HUB is designed to ensure high-quality evidence-based home visiting services by focusing on program and model level supports necessary to achieve positive outcomes for children and families. Implementation HUB will formalize and operationalize a "center" with a particular focus on professional development, staff-related implementation drivers and using data for CQI and program development. Thrive will serve as the HUB, the purveyor for quality program implementation to local communities and will accumulate data and experiential knowledge to negotiate and report on research to practice. Overseen by the Thrive HV Director (.5 FTE), this work will be supported on the ground with the Thrive HV Manager (.5 FTE), a Contracted NFP State Nurse Consultant and a .25 FTE Contracted PAT State Lead to provide training, consultation and coaching key program drivers for program quality and sustainability.



Building off our FY10 plan, we have refined and articulated our approach to supporting CQI at the program level. The HUB will focus on the following objectives proposed to develop and support CQI at the program level:

- Build professional development opportunities, training and technical assistance for specific models/programs to support quality implementation of home visiting services.
- Support communities in using their data for continuous quality improvement and ongoing learning in their organization.

1) *CQI SUPPORT*

NFP:

- NFP National Required Trainings: All MIECHV NFP programs and State Nurse Consultant will meet all NFP required national training.
- TA consultation and coaching from National and HUB NFP Nurse Consultant.

PAT:

- Required "Affiliate" Training: PAT programs participating in the MIECHV Program must reach "Affiliate" status by December 8, 2011. As a part of the grant all MIECHV funded PAT programs will be supported for three required trainings:
  - *PAT Foundational Training and a Model Implementation Re-training (PAT Curriculum will be provided in the training)*.
  - *Tool Trainings*: in Ages and Stages 3– both developmental and social emotional Questionnaires (ASQ-3); Edinburgh Post Natal Depression Screening; Family Assessment Screening tool (LSP recommended by national).
- TA consultation and coaching from the HUB staff and State PAT Lead.

Implementation HUB Staff:

- Two implementation training modules Technical Assistance monthly individual program-level consultation and reflective coaching from HUB Staff, with supervision from HUB Director.

All WA MIECHV programs

- Implementation Science Training – one training for program-level staff with practice session focused on applications to their work.
- Program Specific CQI Trainings – The grant will support two trainings to include orientation to MIECHV, logic models, quarterly and year-end reporting requirements, with practice sessions.
- Two scheduled technical assistance (TA) site visits – to focus on individualized logic model development, quarterly reporting and year-end reporting.
- Monthly coaching check-in calls and additional as requested.
- One additional training based on the capacity assessment themes (see below).

2) *TECHNICAL ASSISTANCE FOR PAT AND FOR NFP IMPLEMENTATION*

Through training, site visits, consultation and coaching programs, HUB Staff, State Model Leads (in collaboration with WSU) will engage development and implementation of the following. See Section 4: Implementation for a fuller description.

- **Capacity Assessment (CA) for CQI: A**ssessment of program capacity to implement the EBHV model with fidelity. "Community Program(s) Capacity Assessment to Implement the EBHV Model" (CA) will be used. Every six months.
- **Implementation Plans (IP) for CQI:** Implementation Planning building off the CA. Every six months.
- **Implementation Improvement Plans (IIP) for CQI:** Once the grant begins, from the baseline Implementations Plans a written Implementation CQI Plan will be

developed for each community/program to identify variables to be addressed in order to move towards increased fidelity. Every six months.

- **Logic Models:** The logic model tool engages programs in the evaluation process.
- **Program Evaluation for CQI:** Engage in technical assistance for program evaluation and monitoring through the following activities: Program Level Reporting will be produced by WSU using the state data system. In consultation with WSU and program leadership these reports will be utilized to both track progress, work with Implementation HUB Staff and State National Model representatives to reflect on data for CQI. Quarterly and year-end reporting consist of demographics, core model activities, outputs and fidelity indicators and benchmarks. Implementation HUB staff provides feedback on each report for CQI and schedules feedback call.
- **National Model Developers for TA and Support Provided**

B. Systems Level Development

At the state level, a key goal is to address performance by developing and supporting state-level infrastructure and maintenance of technical assistance to assure CQI is embedded at the program, model and systems level.

As the MIECHV Program rolls out in Washington in FY11, we will begin to explore the effectiveness of the newly developed state structures that support programs in implementation.

- Does a centralized hub for TA and CQI increase the capacity of programs to offer high quality services to families or assist communities in developing the capacity for start-up and sustainability?
- How can an integrated approach to model-specific technical assistance be developed across various funding streams?
- How does an emerging system to support rigorous data requirements best work to support CQI in local programs?
- How can we best gather feedback from the local communities to inform state level infrastructure CQI?

The existing planning structures (Home Visiting Executive Team, Partnership Group and Advisory Committee) will also be used to gather feedback to improve state-level infrastructure development.

Section 8: State Technical Assistance Needs

In the Updated State Plan, Washington identified four technical assistance areas that will enhance the work in our program. These are relevant to the Implementation work we will begin in FY11.

Project Narrative

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

The proposal for Washington state's system of home visiting involves building an Implementation Hub, to provide technical assistance and support CQI in local programs and with various models. Our request for technical assistance is related to supporting this structural element of our system. We would like to engage experts from the implementation science field to help us figure out how to best work with multiple home visiting models in diverse communities utilizing multiple funding streams.

2. Developing Sustainable Services in Rural, Isolated and Tribal Communities

We request assistance in planning for home visiting services in rural, isolated and tribal communities. Through our community selection/model matching process used in the development of the Updated State Plan, we identified high need geographic communities with no existing EBHV services. In FY11, we plan to work with one high risk rural county with no home visiting services. Since there are significant barriers to establishing sustainable services in some of these isolated areas such as this, we request technical assistance to support our efforts.

Through the Home Visiting Needs Assessment, we have also have identified high risk among American Indian/Native Alaskan populations. The American Indian Health Commission (AIHC) released a Maternal Infant Health Strategic Plan which identified specific needs and opportunities for collaborative work in supporting AI/AN pregnant women and infants. Preliminary conversations have begun, and in FY11 we propose work with AIHC to better understand needs, program challenges and models that match needs. 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.

3. 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 with home visiting models, try out processes on the ground level, and identify ways to enhance our ability to improve program performance and report on successes.

4. 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, and built local and state linkages to help build stronger screening and referrals using both systems.

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 and provide assurances on MOE requirement.