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INTRODUCTION

Project Purpose

The proposed project aims to expand two existing, evidence-based home visiting programs, Healthy Families and Nurse-Family Partnership (NFP). The expansion will allow an additional 1,730 women to enter into a home visiting program in the high-risk areas of Indiana. These areas include Grant, LaPorte, Elkhart, St. Joseph, Lake and Marion Counties. Additionally, Healthy Families Indiana (HFI) will expand the service array by offering a clinical mental health enhancement.

Both Healthy Families and NFP pair families—particularly low-income, single-parent ones—with trained professionals who provide parenting information, resources and support during a woman’s pregnancy and throughout a child’s first few years. These models have been shown to make a real difference in a child’s health, development, and ability to learn - such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. There is strong research evidence that these models can also yield Medicaid savings by reducing preterm births and the need for emergency room visits.

Expansion Grant Request

Description of State’s History of Significant Progress toward Implementing HV Programs

Indiana is experienced and well-positioned to expand its home visiting programs. The Updated State Home Visiting Plan identified the highest at-risk communities in Indiana. This proposal builds on that Plan by adding capacity to serve more families in need. Additionally HFI will expand the service array by offering a clinical mental health enhancement.

Indiana has an outstanding comprehensive, high-quality early childhood system characterized by multiple Collaboratives and leaders committed to the health and well being of mothers and children. This is evidenced by the fact that Indiana is the only state to have the Governor designate co-lead agencies for the Maternal Infant Early Childhood Home Visiting (MIECHV) Program. Both co-lead agencies, the Indiana State Department of Health (ISDH) and the Indiana Department of Child Services (DCS), have long standing histories of addressing needs of women and children through home visiting, as well as other programs and initiatives that contribute to a comprehensive, high-quality early childhood system throughout the state.

The collaborative relationship between ISDH and DCS mirrors the relationship between Maternal and Child Health Bureau (MCHB) Resources Services Administration (HRSA) and Administration for Children and Families (ACF) who are the national co-lead administrators of the MIECHV funds. These relationships were developed with the knowledge that successful home visiting programs are multi-faceted, providing services in the health, child protection, early education, and social services arenas based on a holistic assessment of what families may or may not need. HRSA, a division of HHS is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. ACF, within HHS, is responsible for Federal programs that promote the economic and social wellbeing of families, children, individuals, and communities. The same holds true for Indiana, making Indiana one of the strongest home visiting programs in the country.

State’s History Implementing HFI

HFI has a history of establishing statewide efforts to gain local support and collaboration. In 1992, state legislation was passed, which required comprehensive county assessment of needs for family and children

to be conducted by local advisory councils in all 92 counties. The purpose was to identify community gaps in services and assess the need to develop comprehensive, high quality early childhood systems to promote quality child care settings and also services targeting maternal and child health and safety.

This was a first directive to begin an intensive evaluation of assessments by local councils and state administrators who identified at-risk communities, community strengths, and existing services. Statewide, the assessments identified areas with high rates of child abuse and neglect and a critical need for home visiting services for high-risk mothers prenatally and immediately after the birth of the infant.

Indiana has one of the largest Healthy Families America (HFA) programs in the nation and was the first multi-site program accredited by HFA. Indiana provides significant financial support to HFI and assures that the program is available in all 92 counties. The DCS Programs and Services Department has the ability to administer the program effectively, allocate funds based on local need, consistently assessing and evaluating program quality and utilization, and redistributing funds based on findings.

State's Capacity to Implement NFP-IN

Goodwill Industries of Central Indiana is implementing Nurse-Family Partnership through an innovative public / private partnership. Goodwill will wrap its innovative program, Goodwill Guides (Guides), around NFP. Guides is an early childhood initiative, that provides services to the entire family, including:

1. Education, financial literacy, workforce development, and mental health;
2. Early childhood development by assisting families in navigating quality early childhood education options; and
3. A relationship with the family that will continue after the NFP program ends at the child's second birthday.

As a support service to NFP, Guides will be supported by in-kind and private investments of Goodwill Industries.

Goodwill has numerous experiences working with populations that are low-income and high-risk, and recognized that NFP is based on developing supportive relationships with families, similar to their approach to helping high school students achieve academic success. When Goodwill operated Indianapolis' WorkOne centers and reached 50,000 people annually, over 50% of its participants lacked a high school diploma. The organization determined that by helping young people stay in school and at least obtain a high school diploma, families would be less likely to need services from Goodwill once they become adults.

Through a number of small-scale initiatives to support youth in education, Goodwill recognized that it could effectively offer prevention services to young people. When the opportunity arose to apply for a charter authorization to operate a high school, Goodwill determined that the prospect of developing a targeted and long-term approach with young people could create substantial and lasting impact. Therefore, Goodwill formed a separate 501(c)3, Goodwill Education Initiatives, Inc., to hold the school charter and operate the school. The Indianapolis Metropolitan High School (Indianapolis Met) opened during the fall of 2004. Goodwill provided capital expenses for the school campus and continues to provide support through an ongoing operational subsidy and support infrastructure.

Goodwill monitors the long-term student outcomes through two measures: (1) graduation rates and (2) postsecondary enrollment and retention. Intermediate data on student scores (through end-of-course assessments) and school attendance are also evaluated by the boards of the school and of Goodwill as a whole. Goodwill recognized the impact of continuity of relationships, creating an individualized approach with each student to ignite their learning capacity, and providing extensive academic and non-academic

support services for participants. The Indianapolis Met began its seventh year last fall. The school has been successful in creating positive student outcomes, and administration has made several changes (including going to a year-round calendar) to improve the school's performance. The success of the school has also opened up new opportunities for other adults in need of education services. Last September, Goodwill opened a new charter high school, the Excel Center, which built upon the academic philosophy of the Indianapolis Met to provide a diploma option for older adults who have dropped out of school.

Goodwill's history to date indicates that Goodwill is well-positioned in the Indianapolis community and has the capacity to implement NFP as a new and broad-reaching program. Goodwill has easily positioned itself in the high-risk areas identified in Marion County and is dedicated to assisting families move out of poverty, and readying children for successful school entry. Once families are through the NFP portion of the program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5.

Additional Commitments to Sustaining Support for Early Childhood HV Programs

Examples of the Collaboratives that are the hallmark of Indiana's comprehensive early childhood system include Early Childhood Comprehensive Systems (Sunny Start), Healthy Families' Think Tank, The Head Start Collaborative, the Community Integrated Service System (CISS), and the Indiana Home Visiting Collaborative. Brief descriptions of these Collaboratives follow.

Sunny Start: Healthy Bodies Healthy Minds: This initiative is a comprehensive, collaborative, statewide effort to implement a strategic plan to support a coordinated system of resources and supports for young children from birth through age five and their families in Indiana. With funding from the Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems (ECCS) grant, the goal of the project is to ensure that Indiana's children arrive at school healthy and ready to learn. Members include key stakeholders representing families, state agencies, professional trade associations, public and private early childhood providers, etc. The Sunny Start Core Partners meet quarterly and subcommittees meet regularly. Over the current three-year grant cycle the initiative is developing opportunities for family leadership, maintaining and expanding the Early Childhood Meeting Place website, developing a "State of the Young Hoosier Child" data report, implementing a medical home learning collaborative and integrate activities related to parent education and medical home into the Early Care and Education efforts. The Sunny Start Core Partners oversee the activities of the project. Current membership includes leaders from the Indiana Chapter of the American Academy of Pediatrics, ISDH Maternal and Child Health, Division of Mental Health and Addiction, Indiana Perinatal Network, FSSA Bureau of Child Development, Indiana Department of Education, Healthy Families Indiana, IN Institute for Disability and Community/Early Childhood Center, parent representatives, Riley Hospital for Children Developmental Pediatrics, Juvenile Justice Task Force, Indiana Minority Health Coalition, Office of Medicaid Policy and Planning, United Way- Success by Six, About Special Kids, Commission on Hispanic/Latino Affairs, Indiana Head Start Association, First Steps, Office of Faith-Based and Community Initiatives, Covering Kids and Families Indiana State Project, Dyson Community Pediatrics Initiative, IN Child Care Resource & Referral, Infant and Toddler Mental Health Association, Family Voices, the Indiana Head Start State Collaboration Office, IN Academy of Family Physicians, Indiana Association for the Education of Young Children, Anthem WellPoint Insurance, and the National Association of Pediatric Nurse Practitioners.

Healthy Families Think Tank: The Think Tank provides recommendations to DCS for the operation of the HFI home visiting program and to maintain and assure consistent, high quality services, for parents of the birthing population. The committee sustains and enhances public/private partnerships that support the HFI program. The Think Tank advisory committee reviews policy issues and makes recommendations to DCS.

Head Start: The Head Start State Collaboration Office partners with Early Childhood stakeholders to provide coordination across early childhood programs. ECCS is a member of the Multi-Agency Advisory Council. The mission of this council is to build early childhood systems to enhance access to comprehensive services and support for children throughout the state. This group meets semiannually and includes the Indiana Department of Education, Ball State University, Indiana Coalition on Housing and Homeless Issues, First Steps, Purdue University, Indiana Community Action Association, DCS, Division of Disabilities and Rehabilitative Services, Office of Medicaid Policy and Planning, Indiana Division of Mental Health and Addiction, Indiana University, The Villages, ProKids, Indiana Commission on Hispanic/Latino Affairs, Indiana Department of Environmental Management, Indiana Association for the Education of Young Children, the Indiana Commission on the Social Status of Black Males and the ISDH's Oral Health Program.

CISS: The mission of the Indiana Community Integrated Systems of Services (IN-CISS) Program within the division of Children's Special Health Care Services (CSHCS) of the Indiana State Department of Health (ISDH) is to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. The IN CISS Project's objective is to develop lasting and sustainable integrated community systems of care for CYSHCN that ensure all families are able to access health and related services along the continuum of care in a manner that is affordable and meets their needs; appropriate policies and programs are in place to guarantee that children have access to quality health care; providers are adequately trained; financing issues are equitably addressed; and families play a pivotal role in how services are provided to their children.

Community Advisory Board: The community advisory board meets quarterly with collaborative partners such as About Special Kids (parent-to-parent), Indianapolis Resource Center for Independent Living, Indiana Division of Disabilities and Rehabilitative Services, Indiana Institute for Disability and Community (IIDC), Indiana Department of Education, Riley Hospital Parents as Faculty Program (family centered care initiative), and the IUPUI Department of Social Work. New partners include Down Syndrome Indiana (DSI), the Riley Hospital Christian Sarkine Autism Treatment Center and the Indiana University School of Medicine's Department of Public Health. The state Medicaid Care Management Organizations, Advantage Care Select and MDwise Care Select work on collaborations with primary care providers to meet their needs in providing care for youth and adults with disabilities of childhood.

Indiana Home Visiting Collaborative: This collaborative is very active and has an excellent track record for involving statewide home visiting and early childhood leaders and soliciting input from high-risk communities around the state. Indiana is fortunate to have both public and private organizations dedicated to improving the health and well-being of Hoosier families, especially through home visiting programs. In the past year, IHVC has very diligently mapped a strategy for ensuring families in need have access to an evidence-based home visiting program that best suits the needs of each specific high-risk area. As part of this strategy, IHVC conducted a comprehensive, detailed Home Visiting Needs Assessment and updated Indiana's State Home Visiting Plan. As will be described later in this proposal, findings from these two documents indicate a significant need to expand evidence-based home visiting programs.

Indiana has a long standing commitment to home visiting programs. The Department of Child Services has contributed to this effort with the continued support of HFI, which has been utilized by Indiana since 1994. DCS will continue to fund HFI with the support of the Indiana State Budget Agency to hold the state funding level for HFI consistent with March 23, 2010 levels. This commitment and the established infrastructure for HFI in local Indiana communities will allow DCS to use the funds from this grant to serve additional high risk children and families. DCS recognizes the important role that prevention services, such as HFI, play in preventing child abuse and neglect. DCS continues to emphasize the

importance of placing children in-home and with relatives and the need for home visiting services will continue to grow. DCS has been successful in finding efficiencies in the utilization of program funds and that has permitted the shifting of resources to other priorities.

As DCS increases efforts to keep children at home or with relatives, it will continue shifting funds from high level care of children to lower level interventions such as home based services and prevention efforts. HFI will remain a priority for these funds. In addition, HFI agency leaders meet regularly to monitor funding opportunities and brainstorm ways to increase support for the program. The infrastructure is in place to support this expansion and identify opportunities to sustain it. See Attachment 9 for Letter of Commitment from DCS and State Budget Agency to adhere to the Maintenance of Effort for an amount of \$1,090,892.

Problem Statement

In June 2011, ISDH's Sunny Start Collaborative completed *The State of the Young Hoosier Child: Birth to Age Five Report*. This document involved collaboration with over 30 agencies as well as parents of young children and children with special healthcare needs. Through life course research, we now know that the health and wellbeing of a child determines health and wellbeing of that child as an adult which in turn affects his/her children and future generations to come. This generational effect on certain populations leads to a cyclical effect on health and wellbeing.

Clear Description of Problems

Child Health Domain:

- Overall, children 0 to 5 in Indiana fare worse than the nation in several areas: teen births, first trimester prenatal care, preterm births, breastfeeding rates, infant mortality. Within a majority of these indicators, racial disparities are clear – with Black women and children being at greater risk for these complications or outcomes. For instance, when looking at a three year average (2005 – 2007) for low birthweight (LBW) babies, 13.9% of black babies are born at LBW in Indiana, compared to their white counterparts at 7.7%--almost double the rate. These racial and ethnic contrasts are apparent across many of the health indicators presented in this report – putting these groups of children at greater risk for later adverse outcomes.
- First trimester prenatal care continues to decline in Indiana, with the lowest rates among younger mothers and Hispanic and black mothers.
- Nearly one in five Hoosier mothers report smoking during pregnancy, with White mothers having the highest rate.
- Black women are more likely to give birth to a preterm, LBW and very LBW baby compared other racial and ethnic groups in Indiana.
- Indiana mothers are less likely than their national counterparts to breastfeed
- Infant mortality rates continue to be higher in Indiana compared to the nation, with Black babies dying at the highest rate.
- Children under age four account for over a third of neglect cases in Indiana, and infants under age one account for over a third of abuse/neglect deaths in the state.

School Readiness / Development:

- The most common service received by Hoosier children in First Steps is developmental therapy showing the high needs population.
- Male preschoolers and preschoolers who are black have higher rates of expulsion compared to other groups nationally.

Family Self Sufficiency:

- More than half of children ages zero to five in Indiana are on public insurance.
- One in four children zero to five live in poverty in Indiana, and one in ten lives in extreme poverty.
- Approximately, two out of five reported homeless children are under age six in Indiana.
- One in five Hoosier children lives in a single parent home.
- Over one-third of Indiana's children ages zero to five do not have all available parents in the labor force.

Proposed Interventions

To address these problems, Indiana will expand two existing home visiting models.

HFI (an accredited HFA multi-site) is present in all 92 counties in Indiana, and plans to expand HFI services in six counties with families that were identified as highest risk. This will help close the gap between the number of families who need services and the number that are provided services. The MIECHV expansion grant would also allow HFI the opportunity to serve the highest risk families by implementing the clinical Mental Health enhancement. Nurse-Family Partnership-Indiana (NFP-IN) will expand services into all of Marion County, rather than solely high-risk zip-codes as indicated in the Updated State Plan.

Anticipated Benefits

The U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) review lists outcomes of effectiveness on several home visiting programs throughout the nation. This thorough, transparent review of home visiting research literature used a seven-step process, which can be found at the HomVEE website (<http://homvee.acf.hhs.gov/Default.aspx>). The favorable primary and secondary outcomes found by HomVEE demonstrate a model's ability to positively affect a specific outcome. A favorable impact is defined as "a statistically significant impact on an outcome measure in a direction that is beneficial for children and parents. This impact could be statistically positive or negative and is determined "favorable" based on the end result." Primary outcome measures are defined as an outcome measured through direct assessment, direct observation, or administrative data; or self-reported data collected through a standardized instrument, while a secondary measure includes most self-reported data, excluding self-reports based on standardized instruments. Expanding HFI and NFP-IN will broaden the favorable effects found in the HomVEE study to a larger portion of Indiana's maternal and child population.

More specifically, the proposed project will produce the anticipated benefits to the targeted population in the domains of child health, child development/school readiness, and family self sufficiency.

Child Health Domain: HFA has shown significant impacts in the area of low-birth weight, as well as child health insurance / coverage, increase in number of well-child visits, and access to a primary care physician who knows family's concerns about the child. Similarly, NFP has shown favorable outcomes in areas of breastfeeding attempts, subsequent low birth weights, reported positive mood of mother, and number of child behavioral/ parental coping problems. These favorable outcomes specific to each program are anticipated within the targeted populations in Indiana. One of ISDH's 10 state priorities is to reduce the rate of low birth weight—these programs will further enable ISDH to achieve this priority.

Child Development/ School Readiness: Both programs demonstrate positive significant impacts in the areas of mental, language and cognitive development. Specifically, NFP has shown positive outcomes in

children attending Head Start, preschool, day care or early intervention. Implementing HFA and NFP will increase the school readiness and development of children in Indiana.

Family Self-Sufficiency: HFA and NFP both address areas of the outcome domain of family economic self-sufficiency. In particular, HFA has shown significant impact in mothers attending school and increasing caregiver's education by a year or more since baseline. Likewise, NFP shows positive outcomes in utilization of food stamps and supplemental nutrition vouchers, and months caregiver and care-givers' partner is employed. Economic self-sufficiency is a priority in Indiana as 51% of mothers are on Medicaid. Home visiting by HFI and NFP-IN will produce similar outcomes in Indiana to improve family's economic self sufficiency.

Maternal Health: NFP studies demonstrate positive impacts on maternal health measures such as subsequent births, short-interval between pregnancies, pregnancy-induced hypertension, and change in average adequacy of diet. While HFA did not demonstrate favorable outcomes in for maternal health in the HomeVEE study, HFI enrolls women prenatally whenever possible. Indiana's percent of short interpregnancy intervals in 2006 was 15.6%. Similarly, in 2008, women in Indiana had a higher prevalence of diabetes compared to men. These key issues, weight and obesity, and short interpregnancy intervals will be addressed and improved by Indiana's home visiting programs.

Reduction in Child Maltreatment: Each home visiting program the proposed project plans to expand demonstrate favorable outcomes in reduction of child maltreatment. Specifically, HFA has proven significant outcomes in psychological aggression frequency, mild/ minor and serious physical abuse frequency, and use of corporal or verbal punishment. NFP shows reductions in emergency department visits, number of injuries/ ingestions on physician records, outpatient visits, and days hospitalized for injury/ingestion. Both programs improve the number of substantiated reports of child neglect with home visiting families. This outcome domain is crucial for Indiana as children under four account for over a third of neglect cases in Indiana, and infants under one account for over a third of abuse/ neglect deaths in the state. HFI and NFP-IN will address child maltreatment in curriculum elements of the respective program.

Priority Elements to be Addressed

Priority Elements

Priority Element 1: To support improvements in maternal, child, and family health—As confirmed by Life Course Health Systems theory, a family's health is heavily based on socio-economic, cultural, and environmental factors. For example, people in poverty and Blacks in Indiana have much poorer birth outcomes. Likewise, pregnant women who are under stress have poorer birth outcomes and a stressed pregnant woman is much more likely to have a child who will be more stressed even in adulthood. Evidence-based home visiting programs are effective in addressing a number of factors that can improve maternal, child, and family health.

Priority Element 2: Supporting effective implementation and expansion of evidence-based home visiting programs with fidelity to the evidence-based model—The proposed expansion will allow an additional 1,730 families to be served by HFI and NFP. It will also allow HFI the opportunity to serve high risk families through a more clinical approach by implementing the clinical mental health enhancement and firmly establish NFP-IN in Indiana.

Priority Element 3: To support the development of statewide or multi-state home visiting programs—The proposed expansion will support the continued development of Indiana's statewide home visiting

program. The Indiana Home Visiting Collaborative continues to strengthen and the IHVC is interested in continued community input and learning from program evaluations.

Priority Element 4: To support the development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum—A comprehensive early childhood system prepares children from birth to age five for success in school and life by providing access to high quality programs and supporting a professional workforce. Home visiting supports this system by providing evidence-based programs to pregnant women and families with infants and children. ISDH and DCS support NFP and HFI as evidence-based programs in Indiana. Clients served by HFI and NFP-IN receive materials developed and approved by Indiana’s ECCS initiative. ISDH funds Indiana’s ECCS program, as well as its coordinator (Ms. Andrea Wilkes). As quarterly meetings occur with the Home Visiting Leadership Collaborative, the ECCS coordinator will be involved in decision-making for progress toward state goals and further development of a statewide comprehensive system.

Priority Element 5: To reach high-risk and hard-to-engage populations—The eligibility criteria of both home visiting models inherently recruit high-risk and hard-to-engage populations. Such eligibility criteria for NFP include:

- Clients must meet low-income criteria at intake
- Clients are first-time mothers

The NFP model’s research evidence shows its effects are actually strongest among eligible first-time mothers with multiple risk factors (e.g., low-income, teenaged, and unmarried). Nursing has been identified as one of the most trusted professions and for women who are pregnant for the first time, regardless of their risk level, the invitation to receive support and guidance from a nurse is generally well-received.

Eligibility criteria for HFI includes:

- Family must screen positive on 8 Item Screen that measures risks based on the following: single marital status, inadequate income/no information/income from disability, unstable housing, education under 12years, history of/ current substance abuse, history of/current psychiatric care, marital or family problems, history of/current depression.
- Income eligible at 250% of poverty or less
- Score 40 and above on Kempe Assessment that measures risk based on the following: parent beaten or deprived as child, parent with criminal/mental illness/substance abuse, parent suspected of abuse in the past, low self-esteem/social isolation/depression/no lifelines, multiple crises/stresses, violent temper outburst, rigid and unrealistic expectations of child, harsh punishment of child, child difficult and/or provocative as perceived by parents, child unwanted or at risk for poor bonding.
- Priority will be given to families that score at least 25 on the Kempe but that also have any of the following: safety concerns expressed by hospital staff, mother of father low functioning, teen parent with no support system, active untreated mental illness, active alcohol/drug abuse, active interpersonal violence reported, scores of 10 or above or 3 on question#10 on the Early Postpartum Depression Scale, target child born at 36 weeks of gestation or less, target child diagnosed with significant developmental delays at birth, family assessment worker witnesses physical punishment of child(ren) at visit.
- Family member must have social security number.

Priority Element 6: To support a family-centered approach to home visiting— Family-centeredness is one of the fundamental principles of Nurse-Family Partnership. Every nurse home visitor receives education to 1) use strategies to enlist each family in decisions about the program’s specific contents; 2) identify and build on specific individual and family strengths; and 3) respect and build on culture as an asset. All

members of the group of people a pregnant woman identifies as her ‘family’ are recognized and included in home visits, and strengthening a system of social support, including family members, is a core focus of the program. The Healthy Families America model is also nationally recognized as a family-centered home visiting model.

*Priority Element 7: To reach families in rural or frontier areas—*HFI is proposing to expand services in rural Indiana communities in Grant, Elkhart, and LaPorte Counties. While each of these counties have an urban center, much of the population lives outside of that center, and must travel to find services. Both HFI and NFP-IN have proven effectiveness in serving rural communities.

*Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability—*DCS/ISDH currently partner with many private/nonprofit organizations for the provision of home-visiting services. There is access to a variety of potential funding streams that can be leveraged to enhance program sustainability. One excellent example is Goodwill Industries. Goodwill has many businesses, private foundations and its own significant resources that sustain its operations. Goodwill is leveraging home visiting dollars by offering its Guides program as a companion piece to NFP, and has established a local community advisory board, which must support the local NFP program in identifying and securing diverse and sustainable funding.

Identification of Priority Elements

The core priority element, supporting effective implementation and expansion of evidence-based home visiting programs with fidelity to the evidence-based model, was identified through meetings of the ISDH/DCS Leadership Collaborative. Both agencies decided it imperative to expand existing services in order to serve more families through the two evidence-based home visiting programs identified in the Updated State Plan. After discussing all the priority elements, the Leadership Collaborative realized all priority elements can be addressed by expanding current home visiting programs.

How Project Will Enhance Updated State Plan

The project described in this proposal is a direct extension of the existing MIECHV program. The current MIECHV program extends home visiting services to women, children, and families in specific, high-risk zip-codes of Lake and St. Joseph County through Healthy Families Indiana and four high-risk zip-codes of Marion County through NFP-IN. This proposed expansion project provides funds to further expand Healthy Families Indiana into an additional 2 high-risk zip codes in Lake County, 3 additional high-risk zip codes in St. Joseph County, and increase the capacity of existing (non- MIECHV funded) HFI sites in the rural counties of LaPorte, Grant, and Elkhart. The expansion also includes the clinical mental health enhancement for HFI. The expansion funds will also allow NFP-IN to expand their services from four high-risk zip-codes in Marion County, to the entirety of Marion County. This will allow NFP to become close to complete saturation of eligible clients for Marion County.

Logic Model

The following logic model builds on the logic model for the existing state MIECHV program. However, a distinction is made between the existing program and services / programs to be provided by this grant. More specifically the proposed project will serve an additional 1730 families throughout the state. HFI will serve more families in Grant, LaPorte, Elkhart, St. Joseph, Marion and Lake Counties. NFP-IN will serve more families in Marion County. In the Updated State Plan, only a little over \$1.8 million was available for expanded home visiting programming. To serve a greater number of families who are at-risk in the state, the proposed project will expand to additional counties, which include more rural and hard-to-reach areas with highest needs. In the logic model below, please note the first objective’s changes in red, bold, underline.

Program Goal: The overall goal of the proposed project improve health and development outcomes for Hoosier children and families who are at risk by expanding the scale of two evidence-based home visiting programs (NFP-IN and HFI) to address: maternal and infant health, child development and school readiness, family economic self-sufficiency, improvements in coordination and referrals for other community resources, reduction in ED visits, and child abuse, neglect, and maltreatment

Objectives	Inputs	Outputs	Outcomes		
			Short	Intermediate	Long
<p>1). <u>Expand HFI programming to serve a greater number of families in Grant, LaPorte, Elkhart, St. Joseph, Marion and Lake counties and NFP-IN to serve more families in Marion County; totaling an additional 1,730 families who are low-income and high-risk.</u></p>	<p>ISDH Personnel DCS Personnel MIECHV Funds Indiana State General Funds Healthy Families Indiana / HFA Goodwill Industries of Central Indiana NFP-IN Datatude, Inc. Social Solutions</p>	<p>Provision of home visiting services to women who are high-risk and low-income reside in high-risk areas of Lake, St. Joseph. And Marion County through Healthy Families Indiana, and the entirety of Grant, Elkhart, and LaPorte County through expanding existing HFI services.</p> <p>Provision of home visiting services to women who are high-risk and low-income and reside in all areas of Marion County through Goodwill Industries of Central Indiana’s plan to implement NFP-IN</p>	<p>Indiana communicates expansion of existing HFI and NFP-IN services to partnering agencies</p> <p>Indiana identifies home visiting programs that meet the needs of high risk communities</p>	<p>Pregnant women, children and families will receive high quality home visits from appropriate services</p> <p>Home visiting programs in Indiana reach all women and families who are high risk and are willing to accept services</p>	<p>Home visiting clients demonstrate improved health and development outcomes for both children and their families</p>

<p>2). Inform all organizations in Indiana [that currently serve as a referral source for home visiting programs] regarding mechanisms and processes to coordinator referrals to provide appropriate, targeted, and unduplicated services to all children, mothers, and families who are high-risk throughout Indiana.</p>	<p>ISDH DCS Social service agencies Private organizations Non-profit organizations</p>	<p>Facilitate meetings of Indiana Home Visiting Advisory Board with social service organizations around the state</p> <p>Create a process through which to determine the appropriate home visiting service based on the needs/eligibility of each client</p>	<p>MIECHV program leads (Leadership Collaborative) meet quarterly to discuss home visiting and comprehensive, high-quality early childhood efforts throughout the State</p> <p>MIECHV program leads identify organizations and agencies that may have interest in collaborating to create state-wide home visiting networks</p>	<p>Leadership Collaborative develops a system to coordinate referrals in Marion County, which is expanding to fund both MIECHV-funded programs</p> <p>IHVAB meetings convene with a variety of identified stakeholders, existing and new HV programs, agencies that can provide referrals and services to home visiting clients</p>	<p>IHVAB creates policies and action plans to offer appropriate home visiting services to high-risk women, children, and families</p>
<p>3). Increase number of referrals [from agencies that provide wraparound to HV programs] to ensure coordination of services outside HV programs that address needs of participants; services may include mental health, primary care, dental health, children with special needs, substance use, child injury prevention, child abuse/neglect/ maltreatment, school readiness, employment training and adult education programs.</p>	<p>ISDH DCS Social service agencies Private organizations Non-profit organizations</p>	<p>Develop partnerships and linkages with a variety of wrap-around services for home visiting clients in expanded areas</p> <p>Identify new and non-traditional organizations that may assist in providing wrap-around services for home visiting clients</p>	<p>Identify organizations and agencies that will assist with other services home visiting clients may need</p> <p>Reach out to identified agencies to describe how their services can be used as wrap-around services for home visiting clients</p>	<p>Create formal agreements, such as Memorandum of Understanding with agencies that show interest in assisting home visiting clients with wrap-around services</p>	<p>Home visiting clients will receive all types of services that may arise as a need while client is enrolled in the program</p>

NEEDS ASSESSMENT

Current Home Visiting Program: HFI

Indiana has one of the largest Healthy Families programs in the nation and is one of only seven multi-site programs accredited by HFA. Indiana provides significant financial support to HFI and assures that the program is available in all 92 counties. HFI served 22,474 families throughout the state from July 1, 2009 to June 30, 2010. The proposed project will increase the number of families to be served through HFI, as written into the Updated State Plan, from 215 to 1,445.

Current Home Visiting Program: NFP

Goodwill Industries of Central Indiana will expand NFP-IN through an innovative public / private partnership. Goodwill's history to date indicates that Goodwill is well-positioned in the Indianapolis community and has the capacity to implement such a broad-reaching program. Goodwill has positioned itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP-IN portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5. The proposed project will increase the number of families to be served through NFP-IN, as written into the Updated State Plan, from 100 to 600.

Identification of Selected Communities to be Served

In addition to the statewide infrastructure enhancement activities to be funded in part by the proposed project funds, the following communities will be served through the requested grant funds:

- Grant County (HFI)
- LaPorte County (HFI)
- Elkhart County (HFI)
- St. Joseph County (HFI)
- Lake County (HFI)
- Marion County (NFP-IN & HFI)

Rationale for Community Selection

As the first step in identifying the highest risk communities, ISDH and its collaborating agencies identified 65 indicators that were linked to the established home visiting outcomes. As data were gathered and analyzed, the list of indicators was narrowed to 40 communities, which were then utilized to determine the high-risk status of counties in Indiana.

In determining which of Indiana's 92 counties were at highest risk, the 40 indicators with established rates and percentages were used to rank the 92 counties. ISDH ranked all 92 counties in the 40 different measures, individually. For example, for the infant mortality rate, all the counties were ranked from 1 through 92, with 92 representing the county with the worst rate. The same process was repeated for each of the indicators. A ranking was identified for each county regarding each indicator. All the measures were given equal weight. Once all measures were completed, the overall scores for each county were combined, then divided by the overall measures to give a score ranking the counties overall for all the measures, with the possibility of being 1 through 92. Through this ranking process, the county with the highest risk score across all indicators is Marion County with the score of 70.35.

ISDH then divided overall ranking results into quartiles. Eleven counties were identified within the highest quartile—all with a score above 60. These 11 counties are considered most “at risk” as identified in ISDH’s original needs assessment. To see the map of Indiana divided into quartiles, please refer to Figure 1-1 to 1-6. To further analyze each county (as requested by the Supplemental Information Request), Indiana developed a five-step process to determine specific areas within the at-risk counties that have especially high needs. For more information on the rationale of community selection, please see Indiana’s HV needs assessment and Updated State Plan.

Detailed Community-level Information

LaPorte County Profile: This is a northern Indiana county with several mid-size towns. Due to its population size, DCS was unable to analyze zip-code level data for the county. The HFI provider is located in Michigan City and will serve the entire county. LaPorte County has a poverty level of 19% and a high unemployment rate of 22.6%. A high 32.9% of pregnant women receive late or no prenatal care, 13.4% of births are premature and the low birth weight is 11.1%. Based on need and positive screens for HFI services received in LaPorte County, 166 additional families will potentially assess positive for home visiting services.

Elkhart County Profile: This is a rural northern Indiana county. Due to its population size, DCS was unable to analyze zip-code data for the county. The HFI provider is located in the town of Elkhart and will serve the entire county. Elkhart County has a poverty level of 18% and a high unemployment rate of 16.1%. Almost half of the pregnant women in the county, 48.2% receive late or no prenatal care. Based on need and positive screens received for HFI services in Elkhart County, 63 additional families will potentially assess positive for home visiting services.

Grant County Profile: This is a rural county in east central Indiana with few resources. Due to its population size, DCS was unable to analyze zip-code level data for the county. The HFI provider is located in Marion, the single mid-size town in the county. This provider will serve the entire county. Grant County has a poverty level of 26.5% and an extremely high 23% unemployment rate. Over a third of pregnant women in the county, 34%, receive late or no prenatal care. Based on need and positive screens received for HFI services in Grant County, 227 additional families will potentially assess positive for home visiting services. Grant will serve an additional 166 families.

Lake County Profile: Lake County is located in northwestern Indiana and is home to large urban cities like Gary, East Chicago, and Crown Pointe. Twenty percent of Lake County’s population lives in Gary, the biggest city in Lake County by population. HFI home visiting services will be further expanded in the highest-risk zip-codes. These highest-risk zip-codes are located in the inner-most cities of East Chicago and Gary and are currently served by two HFI providers. The first HFI provider will serve zip-codes 46320, 46312, and (new) 46327 in East Chicago. The second HFI provider will serve zip-codes 46406, 46402, 46408, and (new) 46407 in Gary. These zip-codes include the top six highest ranked zip-codes in Lake County in addition to the zip-code in East Chicago that also demonstrates high need. Based on need and positive screens received in Lake County, 1,072 additional families will potentially assess positive for HFI services. Lake County had seven of the 38 confirmed child abuse and neglect fatalities in 2009. The MIECHV services proposed are needed to help prevent future child deaths in this county. 332 additional families will receive HFI services through this grant.

St. Joseph County Profile: St. Joseph County is located in northwestern Indiana. The need for home visiting services was evident in five high-risk zip-codes located in inner-city South Bend within St. Joseph County. Forty percent of the county’s population lives in South Bend—the largest city within St. Joseph County—with another 20% living in Mishawaka. A pocket of five contiguous inner-city Zip-codes in South Bend have child abuse rates ranging from 1.10% to 4%. Of the 27 child deaths that

occurred in St. Joseph County in 2010, 21 of them occurred in these five Zip-codes. These five zip-codes are served by one large HFI provider in the zip-codes: 46601, 46619, 46628, 46613, and 46544. This grant application will add the extremely high risk zip-codes 46614, 46561, and 46617 for MIECHV services. Selection of these zip-codes allows HFI to target very high-risk areas while still addressing a large geographic area. For this application, a total of 1,230 additional families will potentially assess positive for HFI services. 166 additional families will be served under this grant in St. Joseph County.

Marion County Profile: Marion County, located in the center of Indiana, is the home of the capital city of Indianapolis, and is Indiana's largest county by population. About 25% of Marion County's population is under the age of 18. The median household income of the county in 2009 was \$41,201 while the Indiana's median household income was \$45,427. While the MIECHV Updated State Plan gave preference to four specific zip-codes in Marion County in which to implement NFP, these funds will allow expansion in the remainder of Marion County, including areas of highest risk. These zip-codes were determined as high risk by the analysis performed in the Updated State Plan. About 9% of the births in Marion County were of low birth, while 11.3% of infants were born low birth in the four contiguous counties identified in the Updated State Plan. Zip-code 46214 has the highest percentage LBW children. On average, more substantiated reports of child abuse and neglect occurred in these four zip-codes than in the entire county (189 and 113 respectively). Marion County will be able to serve an additional 337 families.

Estimated Number of Families to be Served

With requested grant funding, at least 1,730 families will be served. Specifically, HFI will serve at least 1,230 additional families, while NFP-IN will serve up to 500 additional families.

How Priority Elements will reach Outcomes for Families

As stated above, Indiana's core priority element is to support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected. Since the goal of the proposed program is to expand home-visiting services in Indiana, the priority element will be accomplished through expansion of HFI and NFP-IN. Expanding existing home visiting programs will allow for enrollment of more clients. As more clients are enrolled in respective programs, the programs and their home visitors will affect the lives of clients. These effects will relate specifically to the outcomes found in trials by model developers, which are also explained in the HomVee study.

METHODOLOGY

Evidence-based Models

The following evidence-based models will be supported with competitive funding:

1. Nurse-Family Partnership
2. Healthy Families Indiana (accredited by HFA)

Each of these evidence-based models is grounded in relevant empirical work and has an articulated theory of change. The following is a mini-literature review of each evidence-based model.

Healthy Families

HFA (HFA) is an evidence-based, nationally recognized home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is the primary home visiting model designed to work with families who may have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services are

offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby). (http://www.healthyfamiliesamerica.org/about_us/index.shtml)

HFA is one of the seven models chosen by the Department of Health and Human Services' Home Visiting Evidence of Effectiveness. HFA has a strong research base which includes randomized control trials and well designed quasi-experimental research. In 2006, HFA was named a "proven program" by the RAND Corporation based on research conducted on the Healthy Families New York programs. Additionally, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has rated HFA as Effective. To date, research and evaluation indicates impressive outcomes.

Reviews of more than 15 evaluation studies of HFA programs in 12 states produced the following outcomes:

- Reduced child maltreatment;
- Increased utilization of prenatal care and decreased pre-term, low weight babies;
- Improved parent-child interaction and school readiness;
- Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services;
- Increased access to primary care medical services; and
- Increased immunization rates. (Retrieved from HFA website)

The HFI program follows the HFA model and has been accredited as a state for the last 12 years. State accreditation signifies that not only do the local service delivery sites meet standards for accreditation; the state system provides Quality Assurance and Technical assistance at a level those results in a high degree of fidelity. This fidelity allows HFI to assert its ability to achieve the same outcomes.

Nurse-Family Partnership

NFP is an evidence-based community health program that helps transform the lives of vulnerable, low-income mothers pregnant with their first children. Built upon the pioneering work of Professor David Olds, NFP's model is based on more than 30 years of evidence from randomized, controlled trials that prove it works.

Beginning in the early 1970s, Dr. Olds initiated the development of a nurse home visitation program that targeted first-time mothers and their children. Over the next three decades, he and his colleagues continued to test the program in three separate, randomized, controlled trials with three different populations in Elmira, N.Y., Memphis, Tenn., and Denver, Colo. (see below). The trials were designed to study the effects of the NFP-IN model on maternal and child health, and child development, by comparing the short- and long-term outcomes of mothers and children enrolled in the NFP program to those of a control group of mothers and children not participating in the program.

Today, Olds and his team at The Prevention Research Center for Family and Child Health at the University of Colorado continue to study the model's long-term effects and lead research to continuously improve the NFP program model. Since 1979, more than 14 follow-up studies have been completed across the three trials, tracking program participants' outcomes. The implementation of longitudinal studies enables NFP to measure the short- and long-term outcomes of the program. Although the NFP National Service Office maintains a close association with the Prevention Research Center, the two remain professionally independent.

Trials of the Program

YEAR	1977	1988	1994
LOCATION	Elmira, NY	Memphis, TN	Denver, CO
PARTICIPANT	400	1,139	735
POPULATION	Low-income	Low-income	Large proportion of
STUDIED	Semi-rural area	Urban area	Nurses and

Trial outcomes demonstrate that NFP-IN delivers against its three primary goals of better pregnancy outcomes, improved child health and development and increased economic self-sufficiency—making a measurable impact on the lives of children, families and the communities in which they live. The evidentiary foundations for the NFP-IN model are among the strongest available for preventive interventions offered for public investment. Given that the original trials were relatively large, resulted in outcomes of public health importance, and were conducted with nearly entire populations of at-risk families in local community health settings, these findings are relevant to communities throughout the United States. NFP’s emphasis on randomized, controlled trials is consistent with the approach promoted by a growing chorus of evidence-based policy groups including the Coalition for Evidence-Based Policy, Blueprints for Violence Prevention, The RAND Corporation, and the Brookings Institution, which seek to provide policymakers and practitioners with clear, actionable information on programs that work—and are demonstrated in scientifically-valid studies.

Project Goal / Objectives

The project goal is to improve health and development outcomes for Hoosier children and families who are at risk by expanding the scale of two evidence-based home visiting programs (NFP-IN and HFI) to address: maternal and infant health, child development and school readiness, family economic self-sufficiency, improvements in coordination and referrals for other community resources, reduction in ED visits, and child abuse, neglect, and maltreatment. To achieve this goal, the proposed project will achieve the following three specific, measurable, attainable, realistic, and timely objectives:

1. By FY 2014, expand HFI programming to serve a greater number of families in Grant, LaPorte, Elkhart, St. Joseph, Marion, and Lake counties and NFP-IN to serve more families in Marion County; totaling an additional 1,730 families who are low-income and high-risk.
2. By FY 2014, inform all organizations in Indiana [that currently serve as a referral source for home visiting programs] regarding referral coordination and expansion of services in order to provide appropriate, targeted, and unduplicated services to all children, mothers, and families who are high-risk throughout Indiana.
3. By FY 2014, increase number of referrals [from agencies that provide wraparound services to home visiting programs] by 50% to ensure coordination of services outside of home visiting programs that address needs of participants; services may include mental health, primary care, dental health, children with special needs, substance use, child injury prevention, child abuse/neglect/ maltreatment, school readiness, employment training and adult education programs.

WORK PLAN

The following main activities will be completed to achieve the proposed objectives during the entire project period.

Statewide Activities

- Start-up of Indiana Home Visiting Advisory Board (IHVAB) through convening of Leadership Team
- Comprehensively analyze communities to determine most high-risk from original counties identified as at-risk

- Survey at-risk communities to determine input on what the community feels it needs and its capacity to support the need
- Meet quarterly to exchange information regarding relevant ECCS, home visiting, efforts of other committees and organizations
- Facilitate communication among co-lead agencies and other agencies, collaborations, organizations, committees by attending meetings and discussing ideas
- Collect Quarterly Reports from MIECHV sites
- Map current spending of evidence-based and promising practice home visiting programs throughout the state (including geographic location, fiscal contributions, funding sources)

HFI Activities

- Communicate expansion project with selected counties/communities.
- Work with local agencies to contract for services, including setting a budget and hiring additional staff.
- Work with local agencies to train new staff on service delivery requirements and HFA standards for accreditation.
- Connect families systematically, prenatally or at birth, and provide appropriate linkages to home visiting services, along with other information and referrals; fostering nurturing, parent-child relationships
- Increase referrals to HFI providers in the targeted communities/counties.
- Assess new families for services to be provided, enhancing family functioning by reducing risk and building protection factors.
- Provide HFI services to additional high-risk families in selected counties/communities.
- Work with local HFI providers to train staff on data collection and input.
- Collect data from local agencies.
- Analyze and report on data collected.
- Enhance clinical mental health services to serve the six counties identified in the grant application.
 - According to Dr. Robert Shapiro, Cincinnati Children's Hospital, 60% of families in home visiting are dealing with mental health, addictions, and domestic violence issues. These issues interfere with parent's ability to attach with their child and can cause neglect due to danger to the children. The HFI model is based on interventions provided by a mix of degreed and non-degreed home visitors. As part of its accreditation process, HFA requires rigorous training and supervision; however, this training is not clinically focused on mental health service. Indiana has very limited access to mental health support particularly in our many rural counties.
 - The MIECH Expansion grant would allow HFI the opportunity to serve our very high risk families by adding the following enhancement to HFI services in the counties identified in the HFI expansion. Three Mental Health Clinicians will be hired and supervised under the HFI Quality Assurance and Training Director, Marty Temple. Two Clinicians will serve Lake, LaPorte, St. Joseph and Elkhart counties. One Clinician will serve Grant, and Marion counties. Mental Health Clinicians (LSW/LMFT/LMHC) will oversee high risk cases through case review and clinical supervisions with each staff. Clinicians will be available to do face to face assessments, recommend interventions, and accompany and role model for staff. They will be available by phone or in person for crises. Clinicians will support staff in dealing with suicide threats, post partum depression, depression, personality disorders, severe mental health issues, addictions, and domestic violence. They will also focus on the social/emotional development of the child and deal with infant mental health issues. They will also provide on-going clinical training for all MIECV sites.

- The HFI Clinical Enhancement complies with accreditation standards and has been approved by HFA.

NFP-IN Activities

- Extend availability and scale of NFP-IN to reach every first-time, low-income mother in Marion County who elects to receive the service.
- Develop a countywide referral system by which service providers, potential participants, and home visiting agencies are able to receive the most effective referral links to their targeted participants based upon geographic area, level of need, and eligibility of service.
- Hire 20 nurse home visiting staff and 2 additional supervisors to develop nurse home visiting infrastructure in Marion County.
- Receive referrals from 1200 eligible first-time, low-income mothers within Marion County.
- Enroll 500 new home visiting clients within Marion County.
- Connect all participants of home visiting services with holistic, whole-family services provided by Goodwill Industries through the Goodwill Guides model
- Complete quarterly reports to ISDH.
- Complete all evaluation requirements determined by the national organization and all outcome measures identified in Updated State Plan.
- Perform gap and segmentation analysis of participant utilization of services, demographics, referral sources and other needs.
- Participate in rigorous evaluation steps established via an outside evaluator

Timeline

Please see Attachment 7 for a timeline that includes a summary of each activity described above and lists responsible staff.

Collaborations

Meaningful support and collaboration is vital for the proposed project, especially during planning, designing, implementing, and evaluating all activities. The following partners and stakeholders will be involved in the above-listed activities, including during the development of the current request.

MIECHV Partners

The statewide MIECHV Program has numerous partners for program implementation. Most importantly is the collaboration with DCS and Goodwill. DCS will be the implementing agency of HFI and Goodwill will be the implementing agency of NFP. Next, several organizations will collaborate with MIECHV in the Indiana Home Visiting Advisory Board (IHVAB). These advisory board members will include consumers, other home visiting agencies throughout the state, youth- and women-serving organizations throughout the state, and businesses and non-traditional partners. It also collaborates with numerous social service agencies to provide the array of wrap-around services that may be identified as a home visiting client need.

State home visiting personnel and programmatic personnel sit on a variety of boards to provide insight into home visiting services in Indiana. The Home Visiting Program Coordinator sits on the Indiana Injury Prevention Task Force to discuss how home visiting can be incorporated into Indiana's Injury Prevention Strategic Plan. Phyllis Kikendall, the Manager of Prevention Services for DCS, as well as Mary Weber, Director of Maternal and Child Health are both members of Sunny Start: Healthy Bodies, Healthy Minds Core Partners, Indiana Early Childhood Comprehensive Systems initiative. Charrie Buskirk, the Public

Health Administrator of Women's Health serves on the Office of Minority Health's Planning Committee as well as the Office of Women's Health advisory board.

The variety of organizations that provide wrap-around services to home visiting clients is too vast to mention all. However, within each individual program site's community, collaborations exist to provide all the necessary services to home visiting clients. These services (and partnerships) include: health care service providers (OB/GYN, pediatrician), mental health providers, substance abuse services, transportation services, child care services, child welfare groups, housing services, job training, education (alternative education) providers, food assistance, and many more.

HFI Partners

HFI has established Memoranda of Agreements with family service agencies, hospitals, WIC, public schools, physicians and health clinics in local communities to establish referrals and link families to appropriate services. These referrals are critical to the expansion and success of the MIECHV component of HFI/HFA. In addition, HFI is represented in numerous councils and advisory boards throughout the state, such as First Steps Interagency Coordinating Council (comprised of parents of child with special needs, state agency groups, early intervention service providers, legislators, pre-service professionals, etc.) and Head Start Collaboration Interagency Commission (in which HFI helps to develop intermediate and advanced training seminars at the Institute of Strengthening Families). Within each of the three communities HFI will expand its services with MIECHV funds, Healthy Families has formalized relationships for referrals and other collaborative agencies.

Over six years ago an early childhood training institute was formed by DCS to accommodate the growing need for a centralized training base to accommodate programs serving children zero to eight, the program was called The Institute for Strengthening Families. The Institute for Strengthening Families was formed to invite multiple partners from both the private sector and the public sector who expressed on-going training needs and commitment to quality training for early childhood systems. The partners became a Team of Advisors that sought inter-mediate and advanced training for their staff and others in the field. Expert trainers were identified by the Team and were selected for priority topics at the Institute that took place for three days every April and September. Priority training topics included child abuse and neglect, infant mental health, child development, pre-natal and post-natal depression, drug abuse, domestic violence, client relationships, emotional literacy, parent child interaction and child safety. All the partners contribute resources to the Institute for the special training seminars and key speakers. The Institute averages between 400 and 500 professionals. Partners and collaborators include; The Indiana DCS, Healthy Families Indiana, State Department of Health, Maternal and Child Health, FSSA; Bureau of Child Care, Inc. Head Start Collaboration Association, First Steps, Pro-Kids, Purdue Cooperative Extension, In. Institute on Disability and Community Early Child hood Center, Prevent Child Abuse Indiana, The Villages of Indiana, Riley Hospital Child Development Center, SCAN, and Datatude, Inc.

NFP-IN Partners

NFP-IN created an advisory board as part of the program implementation plan and planning process. The board members have committed to assisting NFP-IN in its endeavor to implement in Marion County. The Community Advisory Board is representative of numerous public and private organizations throughout Marion County and the State of Indiana. Members include organizations such as: Goodwill Industries; ISDH; Central Indiana Alliance for Health; Health Excel; IU School of Nursing; Community Action of Greater Indianapolis; Indiana University School of Medicine; Indiana Minority Health Coalition, and Eli Lilly & Company. While these individuals provide the core for NFP-IN's implementation plan, they will also serve as an advocate for NFP-IN within and outside their organization. These individuals will assist

Goodwill and NFP-IN in collaborating with referral sources to bring clients into the program as well as refer clients to other needed services.

Implementation Plan

The following section discusses the state's overall implementation plan, which builds on the elements of the State Home Visiting Plan. The majority of this plan is consistent with the information listed in the Updated State Plan, with the exception of (1) an increase in counties / communities to be served—and therefore an increase of families to be served; (2) a formalized summative and formative evaluation of statewide programming; and (3) mental health clinician components as an enhancement to HFI's services in select and high-risk counties. In addition, the Home Visiting Advisory Board is changing, with the leadership team, which consisted of key leaders of the MIECHV Program and has been in existence since July 2010. As the program has developed, this leadership group has grown. Members include: Lisa Rich, Mary Weber, Phyllis Kikendall, Mary Ann Galloway, Matt Gooding, Charrie Buskirk, Andrea Preston, and Mallory Quigley. Lisa Rich and Mary Weber will co-chair the Leadership Team, while Andrea Preston and Mallory Quigley (Home Visiting Co-Program Coordinators) will provide day-to-day communications and activities. Each member of the Leadership Team brings specific skills to the Team (which can be seen through the Biosketch section of this application).

Plan to Engage the Community

The partnership between ISDH and DCS is crucial for the state's approach to implementing the two home visiting programs (NFP-IN and HFI). Both HFI and NFP-IN will work closely with referral agencies within each of the counties that MIECHV-funded home visiting services will be provided, including: WIC, Head Start, ISDH Prenatal Care Coordination, hospitals, clinics, physicians, and social services agencies.

For HFI, state-wide agreements exist with WIC and Head Start for reciprocal referrals. Also, HFI program planners and staff sit on advisory committees within respective communities. Within these advisory committees, community members are represented and provide input on the community's needs as well as create inter-organizational relationships.

For NFP, Goodwill has convened an advisory committee within Marion County—this group has met two times in 2011. Similarly, this advisory committee also has representation of at-risk community members. Within the implementation plan for NFP, Goodwill has listed that it will also engage businesses and other non-traditional partners such as churches and schools to identify appropriate at-risk individuals who may fit enrollment eligibility. Moreover, on NFP's advisory committee sits Indiana University Health's Director of Community Outreach and Engagement (Ms. Maureen Weber, JD), as well as the Indiana Minority Health Coalition, Inc.'s Vice President of Planning and Program Development (Mr. Calvin Roberson, MA) who will assist in ensuring that the most appropriate target population is engaged.

Finally, ISDH's MCH Division hosts the Free Pregnancy Test Program, which offers free pregnancy tests to clinics that apply to serve as a program site. In exchange for the free pregnancy tests—which can be used for any low-income patient that may suspect a pregnancy and is seeking a test at the participating clinic—the program sites must collect and report data to ISDH. Specifically, if a woman enters a clinic within the Zip-codes to be served by the MIECHV funds, receives a free pregnancy test, and the result is positive, the clinic will refer the client to the community home visiting program.

Plan for Monitoring, Program Assessment / Support, and Technical Assistance

Continuous Quality Improvement (CQI) will ensure HFI and NFP-IN are implemented with fidelity to the model, in addition to monitoring program utilization, and progress made towards outcome measures. A hybrid CQI system will be established to allow the state to complete federally-required reporting and CQI activities will be completed timely and in its respective deadlines. HFI and NFP-IN and their national model developers will provide this information to the Co-Program Coordinators and provide CQI expertise for its respective program. In addition, a third-party evaluator will be hired to provide oversight on a statewide level. Technical assistance is provided to all HFI and NFP-IN sites by numerous entities. Coordinators from DCS and ISDH will serve as resources for each program and site, to assist in any concerns that may arise from visiting clients. In addition, each program's local administration and the national model developer are also available for regular consultation. The third-party evaluator will also be available for any technical assistance needs as they arise.

Plan for Professional Development / Training

MIECHV Training: The MIECHV program will be administered with staff from ISDH and DCS—including the Program Coordinators, the Public Health Administrator of Women's Health, the Director of Lifecourse Health Systems, and Director of MCH, as well as the Manager of Prevention Services of DCS and the DCS Deputy Director of Programs and Services and Director of MCH. Each of these team members will be provided with opportunities for professional development, such as: (1) personal development opportunities such as program management and data collection training offered by local universities, and leadership courses offered annually by ISDH; (2) conferences concerning home visiting, life course education, and maternal and child health, including annual conferences hosted by MCHB for MIECHV grantees and national service conferences like CityMatch and other federal and national, and statewide conferences; and (3) education opportunities offered by listservs and access to national journals and peer-reviewed articles. Finally, the MIECHV staff will have access to HFI and NFP-IN model developer information and training opportunities as needed and will also have the opportunity for receiving updated information from DCS and Goodwill.

HFI Training: HFA (and HFI) requires and provides the following training for all staff:

- Orientation prior to working with families and entering homes
- CORE (model training), which occurs within the first 6 months of employment, offered by certified HFA trainers, HFI (through a contractor hired by DCS) provides all CORE training, developmental screening training and tools training, in which sites are mandated to participate. HFI provides online training for the mandatory 6 and 12 month trainings.
- Twice a year DCS, through contractors, provides "The Institute for Strengthening Families." This training has multiple sessions which help sites meet their ongoing training needs. The sessions are based on surveys from the programs, input from the evaluator and the QA team and the Training Committee.
- Ongoing training based on the needs of staff and families. Annually all sites are surveyed for their training needs. The Training Committee reviews the surveys and prioritizes what trainings will be provided. Trainings are offered at the Institute, at regional trainings – rotated at various locations, or at the individual sites. Trainings are provided in classrooms, on-line, or by phone. Sites are encouraged to access local trainings that are appropriate for their staff, while Datatude, Inc. provides training as needed when changes are made to the database.
- Tools training—instrument used by the program must have training including proficiency testing.
- Annual training for cultural competency, based on the families served by the program.

NFP-IN Training: NFP-IN relies on the competency of the nurse supervisors and nurse home visitors to impact the clients served through implementation of the program with adherence to model fidelity. Therefore, education provided by National Service Office (NSO) during education sessions in Denver

provide Bachelor-prepared nurses with the skills needed to address clients served. Core education for the nurse home visitors and supervisor consists of two distance education components and two face-to-face education units.

- **Unit 1:** Fundamentals of NFP-IN Nursing Practice is the first distance unit and consists of completing a workbook, reading articles, and completing a self-assessment. The work must be completed and the self assessment submitted to NFP-IN NSO prior to attendance at the first face to face session, Unit 2.
- **Unit 2:** The first face-to-face session in Denver, consists of two days for supervisors only, Monday and Tuesday, and two and one half days for nurse home visitors and supervisors, Wednesday, Thursday, and Friday morning. Upon completion of Unit 2, the nurse home visitor and supervisor register for Unit 3. They can register to attend as soon as two months after attending Unit 2 or up to five months after attending Unit 2.
- **Unit 3:** This is a face-to-face session in Denver with supervisors only on Monday and Tuesday, while nurse home visitors and supervisors attend Wednesday, Thursday, and Friday morning.

Required Follow-Up Consultative Coaching: Upon completion of Unit 3 the new nursing team is scheduled for 9 months of standardized distance education and regular consultation with the supervisor. Additional clinical consultation is offered during the NFP-IN education sessions, through web-based forums, telephone and email, particularly during the first three years of program operation while nurse home visitors and their supervisors are first learning to work with families. Our emphasis is on building the competencies of NFP-IN supervisors in their role as clinical coaches for their nurse home visitors and as the front-line managers of quality assurance in the program.

Plan for Staffing / Subcontracting

MIECHV Program Staff Recruitment: All MIECHV Program Administration staff is hired with the exception of the Assistant Program Coordinator and the State Nurse Consultant for NFP-IN. These positions are expected to be filled by August 2011. Recruitment is underway through various undergraduate and graduate listservs, local postings, and internally throughout ISDH. Recruiting, hiring and retaining program-specific staff is unique to each program, as indicated below.

HFI Staff Recruitment: Each HFI site, in which MIECHV programming will occur, will recruit, hire, and train staff. Once funds are designated, sites will be notified of the number of families they will be expected to serve. This will determine the number of staff to be hired. HFA has a mandatory caseload size not to exceed 25 families. Due to recent funding cuts, sites have existing staff that were reduced to part-time or laid off. These staff will either be moved to full-time or will be rehired. This will reduce training time and costs. If these individuals are not available, then the established recruitment and hiring process will be followed. Recruitment occurs through local and statewide recruitment listservs and venues. In addition, when the grant is approved the DCS contractor will begin the recruitment of three mental health clinicians added to the HFI QA team.

NFP-IN Staff Recruitment: As NFP-IN's implementing agency, Goodwill recognizes that NFP-IN provides a unique opportunity for public health nurses to work in a relationship-focused model that delivers proven results. It also recognizes that Indiana is in a state of shortage of nurses and public health providers. Goodwill's policy of providing competitive compensation to its staff will give the organization opportunity to recruit nurses. The Talent Acquisition Plan developed for NFP-IN builds upon the input of key consultants—including NFP-IN staff—to provide insight and guidance on Goodwill's recruiting efforts. Goodwill will also rely on the experience of community allies to assess availability of qualified nurses in Indiana, including supporters from IU School of Nursing and the State Department of Health. Announcing positions in NFP-IN through these partner organizations will gain access to highly qualified

candidates, and their endorsement of Goodwill's implementation will also lend credibility to the organization's recruiting efforts.

Goodwill's Talent Acquisition Team will be responsible for leading recruiting process for the NFP-IN supervisor and home visitors. The team recruits and recommends candidates to departments across Goodwill, and as a result, the team is able to select and recommend highly-qualified candidates within areas that often have very specific technical needs. The team has recruited individuals in fields varying from store management, industrial engineers, and high school teachers. Through a detailed interview process, the team relies upon observations and desires of managers in each division to ensure that each candidate is a good fit for the operating culture and technical demands of each position.

During the initial hiring of the NFP-IN team, Goodwill will rely on the networks of partners to locate qualified candidates. Position announcements will be made via relationships with individuals in the IU School of Nursing, ISDH, and local hospitals to locate individuals with experience in public health nursing and administration of public health programs.

Recognizing the importance of attracting and retaining talent, Goodwill pays competitively for the market for its positions. Goodwill provides a diverse mix of products and services to individuals and organizations in all sectors of the economy. To achieve its objectives and better serve its clients, Goodwill must recruit highly-experienced employees and expects exceptional performance. Compensation levels must allow the organization to recruit talent from not-for-profit and for-profit organizations.

The Talent Acquisition Team's recruiting process consists of the following steps:

- Contact candidates and present them information about the available position
- Review documents and ensure they meet the requirements for the position
- Interview candidates to assess their interest & their abilities on of nursing competencies; interviews with nursing consultants and representatives from the State Department of Health will also be scheduled
- Prepare documents and schedule meetings with additional staff and reviewers
- Conduct background checks and instruct on fingerprinting process
- Debrief candidates and decide which candidates to extend offers

HFI Subcontracting Method: ISDH and DCS are developing internal Memorandum of Understanding (MOU) for the DCS' provision of HFI services. Based on data analysis, community input, and regional capacity, DCS identified existing contractors as the most capable to provide expanded services within the high-risk service area within St. Joseph, Elkhart, LaPorte, Grant, Marion, and Lake Counties. DCS, which operates and administers HFI, will subcontract funds to the local agencies that implement HFI within the selected high-risk communities.

HFI programs and sites are approved through a competitive application process. Every two years all programs seeking affiliation with the HFI multi-site system complete the DCS/HFI application process. First, DCS/HFI releases a RFP and prospective applicants submit an application for funding to DCS. These applications are reviewed and evaluated by team of DCS and other state agency staff and funding recommendations are made based upon the following criteria:

1. Applicant's proposed target area (single community or county vs. multiple) has sufficient number of live births annually to provide a population base for the program.
2. Applicant complies with HFI service definition: a voluntary multi-faceted home visitation program designed locally to promote healthy families and healthy children through services that include child development, access to health care, parent education, staff training and community coordination and education. Applicant follows the HFA model and complies with HFA accreditation standards as assessed annually by the HFI Quality Assurance Team.

3. Applicant provides a comprehensive budget included in the RFP and demonstrates capacity to manage program financially.

DCS awards contracts based on available funding, proposal scores using criteria above, and on the number of live births per year and number of children in poverty in the proposed service area. DCS and its subcontracted sites will be responsible for recruiting, hiring, and training staff members and overseeing day to day operations. DCS will be expected to report on a quarterly and annual basis on behalf of its contracted sites. DCS will invoice ISDH on a monthly basis. Invoices will be paid within a timely and efficient manner and only after deliverables have been met.

NFP-IN Subcontracting Method: ISDH will develop a sole source contract with Goodwill for the provision of NFP-IN services. Within 90 to 120 days of funding notification from Department of Health and Human Services, this initial contract process will be complete. The contract will list a specific and detailed scope of work with expected deliverables. Such deliverables will include quarterly and annual reports and participation in continued planning and continuous quality improvement activities. Goodwill's administration will be responsible for invoicing ISDH through the contract management system, which will be confirmed and reimbursed through ISDH's Finance Department

Plan for Recruiting / Retaining Participants

HFI and NFP-IN have similar referral sources and methods for identifying participants through physicians, clinics, WIC, high schools, social service agencies, and self-referrals, as described above in greater detail. While the referrals sources may be the same, due to the target populations of the specific programs, referrals will based on client eligibility and status, as well as agency agreements in place with either HFI or NFP-IN. Since HFI currently exists in all counties in Indiana, a mechanism for screening, identifying and referring families is already in place for Lake, LaPorte, Elkhart, Marion, Grant and St. Joseph counties.

Existing HFI Methods for Screening / Identifying / Referring Families: HFI must initiate services either prenatally (no earlier than the 6th month of pregnancy) or at birth of the target child. When an HFI site receives a referral (from WIC, hospitals, prenatal clinics, high schools, self referrals), the site will prioritize by postnatal. Within two working days, HFI personnel will attempt to contact the client, either by phone or attempted home visit (letters will not suffice for this contact method). Once contacted, an assessment will be scheduled within one week. Then, an HFI supervisor has two working days to review the assessment and classify as high risk or not high risk. If the client is deemed high risk, HFI will assign the client to a home visitor within one week of assessment. The home visitor will attempt contact within two working days (via aggressive outreach mechanisms); and a home visitor will attempt a home visit within five working days of assessment. The home visitor will conduct eight attempts, three of which are aggressive means. While each site determines how long outreach will continue to assess a client, the client must have the first home visit by time target child is three months old.

In order for a client to be entered into HFI, a client must screen positive on an *Eight Item Screen* that measures risks based on the following:

- Single marital status
- Inadequate income/no information/income from disability
- Unstable housing
- Education under 12 years
- History of/ current substance abuse
- History of/current psychiatric care
- Marital or family problems

- History of/current depression

The client must also be within an income eligibility of 250% of federal poverty line or less and at least one family member must have a social security number. The client must also score 40 and above on *Kempe Assessment* that measures risk based on the following:

- Parent beaten or deprived as child
- Parent with criminal/mental illness/substance abuse
- Parent suspected of abuse in the past
- Low self-esteem/social isolation/depression/no lifelines
- Multiple crises/stresses
- Violent temper outburst
- Rigid and unrealistic expectations of child
- Harsh punishment of child
- Child difficult and/or provocative as perceived by parents
- Child unwanted
- Child at risk for poor bonding

Priority will be given to families that score at least 25 on the Kempe but that also have any of the following:

- Safety concerns expressed by hospital staff
- Mother or father low functioning
- Teen parent with no support system
- Active untreated mental illness
- Active alcohol/drug abuse
- Active interpersonal violence reported
- Scores of 10 or above or 3 on question#10 on the Early Postpartum Depression Scale
- Target child born at 36 weeks of gestation or less
- Target child diagnosed with significant developmental delays at birth
- Family assessment worker witnesses physical punishment of child(ren) at visit

If the client or family screens negatively, the client will not be enrolled in the home visiting program. However the family assessment worker will obtain consent and make referrals to community resources as necessary.

NFP-IN Methods for Screening / Identifying / Referring Families:

Since NFP-IN is expanding its scope to all areas of Marion County, it will utilize existing mechanisms that are in place for referrals to NFP, as well as coordinate referrals with other existing home visiting programs. NFP-IN has specific criteria for identifying and screening clients that involve only enrolling mothers who are first time, low-income, and are identified before their third trimester of pregnancy. A mother will not be identified as possible NFP-IN client if they do not meet those specific criteria. After being identified as eligible, numerous screening mechanisms take place in order to assess the client's needs.

While HFI and NFP-IN both hope to improve outcomes in pregnant women, children and families, each program has very specific client eligibility that will enable two programs to work in tandem with one another, instead of against one another. HFI outcomes are strongest when assessing and working with families who in the third trimester or immediately after birth and have been identified with multiple home environment risk factors. NFP-IN outcomes are strongest among first-time, low-income mothers who

enroll in the program before their third trimester. This ensures that NFP-IN is achieving its desired impact and is replicating the model faithfully. This population, however, is only a subset of the number of pregnant women in our community who could benefit from some kind of home visiting service. Thousands of women in the community can—and do—benefit from home visitation services in Marion County who are not eligible to receive services through NFP-IN. Models with different eligibility requirements are able to reach segments of the population that NFP-IN is not eligible to serve. Improved coordination between these providers, especially in cases where target populations do not overlap, can make home visiting environments more effective.

CQI Plan

ISDH and DCS as its co-lead agency, as well as its partners have developed a strong plan for continuous quality improvement strategies to be utilized at the local and state levels. Each of the two programs to be implemented with MIECHV funds (Healthy Families and NFP-IN) has received national and local levels of quality assurance protocol. These protocols have been adapted from each national developer; in addition, the following Continuous Quality Improvement (CQI) methods and its corresponding measures have been developed for purposes of grant funding requirements. Although three specific levels of CQI are stated below, operationally, these three levels will work collaboratively to ensure CQI. While the Home Visiting Program Coordinators will be responsible for ensuring that reporting and CQI activities will be completed timely and in its respective deadlines, HFI and NFP-IN and their national model developers will provide this information to the Program Coordinators and provide CQI expertise for its respective program.

State Level CQI: The Home Visiting Program Coordinators (Ms. Mallory Quigley, MPH and Ms. Andrea Preston) will be providing CQI on a state level to both MIECHV programs. Ms. Quigley received her Master of Public Health degree from Indiana University in 2011. She also holds a Bachelor of Arts in both Biology and Spanish from Indiana University from 2009. Ms. Quigley is qualified to oversee the CQI process for the state of Indiana as indicated by her experience in data quality management for an international pharmaceutical company. In addition, Ms. Quigley was responsible for developing and overseeing the evaluation plan for Montana's statewide home visiting program—which included chart audits, case sample reviews, data collection, analysis, and reporting, along with recommendations for data quality improvement. Ms. Preston handles special projects for the Programs and Services Division of DCS and the DCS Research and Evaluation will work closely with her. Ms. Preston has had extensive experience in the field working directly with families and children who have experienced child abuse and neglect. Ms. Preston has worked on many projects related to prevention and is part of the HFI planning committee.

The Home Visiting Program Coordinators will oversee continuous quality improvement via qualitative and quantitative analysis of data as well as interviews with program staff for each implementation site and coordination with model specific CQI. They will assist each model in ensuring that home visitors in both programs are adhering to its respective model's fidelity, which will include collecting and reporting required measures appropriately. This type of CQI also allows each individual site to discuss site-specific technical assistance needs, as well as successes within its program. Critical information from each site ensures the state is serving as an available resource to all sites. In addition to the Program Coordinators' responsibilities and involvement in CQI, an independent external evaluator will work with and be hired to conduct CQI on a quarterly basis. This independent evaluator will report to the Program Coordinators and assist in the development of additional CQI measures. The evaluator is anticipated to be on board no later than 3 months of award notification.

The Home Visiting Program Coordinators will complete program utilization, process outcome measure evaluations as part of the CQI plan. The first evaluation will occur when both programs have reached its

full caseload (approximately nine months into program operations). This monitoring will take place through data transfers and chart audits. A sampling method will be used to complete chart audits and data transfers in order to ensure that a representative sample of the population is being assessed. Once the program reaches full capacity of 314 clients—to generate a statistically significant sample with 95% confidence intervals with a margin of error of $\pm 5.0\%$ —the Program Coordinators must sample at minimum 175 clients.

The following will be collected on a quarterly basis:

- 1) Each MIECHV funded site will report the number of clients enrolled during the specified quarter.
- 2) The Home Visiting Program Coordinators will inform each site of the sample size necessary to obtain statistical significance of 95% confidence intervals with a margin of error of $\pm 5.0\%$ as well as a quarterly self-evaluation.
- 3) Each site will transfer de-identified data and charts to the Home Visiting Program Coordinators via secured electronic transfer and completed quarterly self-evaluation.
- 4) The Home Visiting Program Coordinators will complete chart audits based on process and outcome measures, as well as program utilization and program-fidelity monitoring using the following:
 - Number of client assessments completed.
 - Number of outreach activities completed to engage clients.
 - Number of referrals received and agency from which it was received.
 - Client eligibility and priority given to specific risk factors.
 - Number of visits completed (per client and overall program).
 - Duration of visit.
 - Location of visits (home, office).
 - Number of new clients (since last data transfer).
 - Number of cases per home visitor.
 - Client demographic information (date of birth of parent(s) involved).
- 5) The Home Visiting Program Coordinators will complete phone interview with each site supervisor to discuss results of audit and self-evaluation as well as a written Program Improvement Plan for each site.

The supervisors will also report qualitative data to the Home Visiting Program Coordinators regarding reflective supervision practices with the home visitors. The supervisors will report any concerns the home visitors may have with the data collected as well as any other issues that may arise such as outreach, building relationships with the clients, or completing recommended number of home visits related to MIECHV recommendations. This will be done through a site self-evaluation. During these evaluations, the Program Coordinators will look for completeness of data, as well as any human errors that may be entered in the data set. Process measures will be evaluated to ensure progress towards MIECHV proposed outcome measures are being made.

The Home Visiting Program Coordinators for DCS and ISDH will conduct site visits annually. The details and processes of each site visit will be determined after assessing the efficiency and effectiveness of quarterly reports. The supervisors will also report qualitative data to The Home Visiting Program Coordinators regarding reflective supervision practices with the home visitors. The supervisors will report any concerns the home visitors may have with the data collected as well as any other issues that may arise such as outreach, building relationships with the clients, or completing recommended number of home visits specifically regarding MIECHV requirements.

The Home Visiting Program Coordinators hope to serve as a resource (in addition to each program's local administration and national model developer as well as each contracted evaluator) for each program and site, to assist in any concerns that may arise from visiting clients.

One of the most important aspects of CQI is the feedback programs will receive from the Home Visiting Program Coordinators based on its quarterly assessment. The Quarterly Evaluation Report will be a key resource completed by the Home Visiting Program Coordinators and sent to each site regarding improvement methods and processes. This report will provide each site with an assessment of their progress towards outcome measures, as well as assessment of process measures and program utilizations. The Home Visiting Program Coordinators hopes to use these plans as one method of communication and documented feedback to each site.

In addition to the Program Coordinators' responsibilities and involvement in CQI, an external evaluator will be hired to conduct CQI on a quarterly basis. This external evaluator will report to the Program Coordinators and assist in the development of addition CQI measures. This data will be combined to reflect statewide impact and CQI and disseminated to all stakeholders and committee members as well as subcontractors and partnering agencies on a quarterly basis.

Healthy Families Program Level CQI: HFI's contracted data team, Datatude, Inc. will provide information from its data system, Home Visiting Tracking Information Systems (HVTIS). Established in 1995, Datatude, Inc. has focused its services on the development and implementation of information systems that manage data collection for program management, research, and evaluation. Its services range from consulting, development and data management to training of staff, technical support, and program evaluation. Its definition of a quality data management system is to allow the data collected to be utilized in several aspects from service delivery management and quality assurance to research and evaluation. Datatude systems are developed with all stakeholders in mind, utilizing client and user feedback to create the most effective system available.

HVTIS, developed and operated by Datatude, provides HFI with the most complete set of tools available to track clients receiving services and to monitor quality assurance and quantify outcomes. HVTIS allows HFI instant access to its data so that HFI staff is able to make informed decisions quickly. As an internet-based application that addresses specific needs, HVTIS provides for program administration, research, evaluation, and ad hoc reporting available in real time, allowing connection to financial centers, administrators, and evaluators.

HFA requires statewide Quality Assurance (QA) system. HFI QA/TA team is lead by Marty Temple. Ms. Temple provides oversight of quality service delivery for all sites, including site visits and record reviews to monitor adherence to HFA standards, HFI policies, and MIECHV reporting requirements, quarterly report monitoring, training, and any technical assistance needed to assist sites in being adherent. Ms. Temple's position is contracted, and responds to technical assistant questions from all HFI committees. The following site level CQI requirements are monitored by Ms. Temple and her staff:

- HFI sites are required to provide weekly face-to-face supervision to all frontline staff by a qualified supervisor, for a minimum of 2 hours. Supervision has specific components that encompass case review, skill development and staff support. HFA outlines the areas to be covered in accreditation standards.
- HFI sites are required to provide monthly face-to-face supervision of all supervisors which include all of the above categories as well as agency and management issues. Most sites choose to do this at least twice per month.
- All HFI supervisors receive CORE supervisors training as well as meeting all the same requirements as staff.

- Managers are trained by a certified HFA trainer. This training includes extensive mentoring in providing accountability, clinical supervision and emotional support to all levels of staff.
- Many HFI sites employ mental health clinicians who guide staff and supervisors in dealing with mental health, additions, and IPV cases.
- All HFI sites have access to extensive TA at all time which can include staffing cases and mentoring of supervisors and managers.

During annual site visits the QA team reviews supervision records for errors.

NFP-IN Program Level CQI: As cited by NFP-IN National Service Office, NSO provides resources to the implementing agency to assure model fidelity and quality that includes the routine and systematic use of data combined with an awareness of contextual factors to identify priorities and design-specific intervention strategies and methods to address areas of improvement. The NFP-NSO CQI approach also includes following up with re-measurement to assess the effectiveness of an intervention strategy. NFP-IN uses CQI approaches identified by the American Society of Quality, the Institute of Healthcare Improvement, and the quality aims listed by the Institute of Medicine and the U.S. Public Health Quality Forum. NSO uses specific tools and reports during the various stages of NFP-IN site development. Prior to implementation, NFP-NSO conducts an Implementation Plan Review. After the first year of implementation, NFP-NSO uses reports such as Annual Plan, Year One Implementation Plan Report, and Fidelity Report to the implementation site. After the second year of implementation and beyond, NFO uses the Annual Plan, Maternal Outcomes, Child Health and Development Outcomes, Fidelity Report, Client Survey, and NFP-IN Nursing Practice Assessment to provide CQI.

NFP-IN will have continuous access to all program level data through the web-based software, Efforts to Outcomes (ETO). ETO is a performance management software system that was designed by Social Solutions. Its software allows organizations to track participant and family case history, diagnosis, and treatment while measuring progression of participants and families over time, and the overall impact of each program. Goodwill's focus on measurable outcomes carries from executive-level management down to individual performance. As a result, staff is held accountable to achieving program goals. Performance feedback will be based upon the performance reports generated through NFP-IN's data tracking system. Goodwill managers and administrators will review reports with nurse home visitors to ensure that visitors understand not only the importance of collecting data but also the potential benefits of how ultimate success can be shaped by this data. Goodwill's director of strategic planning will review reports and work with home visitors to help understand the reports and will work with the supervisor to make recommendations to improve service delivery and fidelity to the NFP-IN model.

Each site will be required to submit a self-evaluation on a quarterly basis. The following questions will be included in the self-evaluation:

- 1) How many new clients were enrolled into your site this quarter (using MIECHV funds)?
- 2) Did you give priority to clients who:
 - Have low income?
 - Are pregnant under 21 years?
 - History of child abuse or neglect or interactions with child welfare services?
 - History of substance abuse or need substance treatment?
 - Use of tobacco products in home?
 - Have or have children with low student achievement?
 - Children with developmental delays?
 - Families that include individuals who are serving or have formerly served in the armed forces (including multiple deployments outside of US)?

- 3) What types of outreach activities did your site complete to reach new clients? How many of these outreach activities did your organization complete?
- 4) What new connections or linkages were made with other community social service agencies? Please list the organizations or agencies with which your site has initiated linkages and how many families were involved.
- 5) What do you see as your program's strengths? (i.e., client outreach, referral linkages, client/ home visitor relationships) If applicable, please use data to support this decision.
- 6) What do you see as your program's weaknesses? If applicable, please use data to support this decision.
- 7) Please describe a memorable/touching moment or a success story one of your staff encountered during a home visit.
- 8) Describe a difficult situation in which home visitors had to manage while on a home visit.
- 9) What can the Program Coordinators do to assist in any needs you may have?

Results of the self-evaluation will be reviewed by the Home Visiting Program Coordinators and incorporated into each site's Quarterly Evaluation Report. Motifs that may arise from the self-evaluations will be relayed to each specific site as well all sites throughout the state, without relaying client specific identifiers. In addition to the Program Coordinators' responsibilities and involvement in CQI, an external evaluator will be hired to conduct CQI on a quarterly basis. This external evaluator will report to the Program Coordinators and assist in the development of additional CQI measures.

Plan to Maintain Model Fidelity

The Program Coordinators for ISDH and DCS will oversee QA via qualitative and quantitative analysis of data as well as interviews with program staff for each implementation site. They will assist in ensuring that home visitors in both programs are adhering to the respective model's fidelity (along with each model's individual QA staff). The Program Coordinators will also monitor data collection and reporting required measures appropriately. Qualitative and quantitative monitoring will allow each individual site to report site-specific technical assistance needs and successes to the Program Coordinators on a quarterly basis. Providing this critical information, such as reports on model fidelity and progress towards outcomes from each site assists in assessing the state's role as a resource the state is serving as an available resource to all sites.

Quarterly, the Program Coordinators will monitor various aspects of the programs, including program utilization, process measures, and outcome measures. This monitoring will take place through de-identified data transfers and chart audits. A sampling method will be used to complete chart audits and data transfers. The Program Coordinators will look for completeness of data, as well as any human errors that may be entered in the data set.

In addition, each site will be responsible for reporting its own respective model fidelity information to the Program Coordinators. Because HFI is accredited by HFA, which allows HFI to implement the Healthy Families Program, HFI is subject to exceptionally strict guidelines for model fidelity. As an accredited multi-site system, HFI has an extensive state-wide Quality Assurance mechanism. The Quality Assurance team, lead by Ms. Marty Temple, will monitor each of the funded sites, as usual, which has been shown to be a highly effective process in attaining successful model fidelity and child abuse prevention.

Activities involved in HFI QA:

- Requires statewide QA system (described later)
- HFA visits every 4 years to monitor system wide adherence to HFA standards
- HFI central administration submits a self-study responding to all standards

- HFA visits Indiana, interviewing DCS staff, state partners, committee members, program managers, QA/TA staff, trainers and the evaluator
- All HFI sites submit a self study, responding to all HFA standards
- At least 50% of HFI sites have a visit by HFA trained peer reviewers. Site visits include review of: policies, cultural sensitivity reviews, personnel records, training records, supervision records, and Advisory minutes. The visit includes interviews with all levels of staff
- Site visit results are submitted to the HFA Accreditation panel who decided if the system and individual sites are accredited
- DCS, who funds HFI, require all funded sites be accredited by and affiliated with HFA

Upon notification of funding, these requirements will be detailed in a report form and must be reported quarterly to the Program Coordinators.

Similarly, the NFP-IN program is an evidence-based program and requires authorization from the National NFP-IN program, the model developer. To even begin services, one must be an approved site—and only then will receive the developed curricula, materials, and technical assistance from the national level. Each NFP-IN site is continually assessed by the National Service Office to determine adherence to NFP's 18 Critical Elements. Said guidelines for adherence to model fidelity will also be listed on a specific report form and must be reported quarterly to the Program Coordinators.

The supervisors of each program will also report qualitative data to the Program Coordinators regarding reflective supervision practices with the home visitors. The supervisors will report any concerns the home visitors may have with the data collected as well as any other issues that may arise such as outreach, building relationships with the clients and community organizations, or completing recommended number of home visits. Chart audits and data transfers will also provide input regarding process measures to ensure programs are collecting data correctly. Below are the steps that will occur monthly to ensure quality. The exact start date of these processes will be determined by release of restricted funds from HHS and the details for the federally dictated reporting requirements.

- 1) Each home visiting site will report number of clients enrolled in the program for the quarter.
- 2) Program Coordinators will inform each site of the sample size necessary to obtain statistical significance of 95% confidence intervals with a margin of error of $\pm 5.0\%$.
- 3) Each site will transfer data and charts to Program Coordinators via secured electronic transfer.
- 4) Program Coordinators will complete audit for program utilization, process outcomes completeness.

Program Coordinators will provide feedback (Quarterly Evaluation Report) to each site based on outcomes of audit and self-evaluation, including phone interviews with each site supervisor to discuss results of audit and self-evaluation as well as a written Quarterly Evaluation Report for each site.

Plan to Collect Data on Benchmarks

In Indiana's statewide approach to home visiting, each program will collect data on each construct within each benchmark. Each home visiting program will collect data for eligible families that have been enrolled in the program who receive services funded with MIECHV funds. Indiana will provide detailed information on each benchmark, including a breakdown of constructs, definition of improvement, statewide process measures, outcome measures, reliability / validity, source of information, and population assessed as requested. This will be a complete reproduction of the Updated State Plan tables.

Data will be collected through client interviews, assessment tools, and administrative data such as child welfare groups. Both programs will also collect demographic information of the client and the family,

including language, socio-economic status, age, and race/ ethnicity. In addition, each program implemented through MIECHV funds will collect information regarding program utilization, such as number of visits, duration of each visit, and attempted outreach for each family. Please note that based on data collected by each of the two HV programs to be implemented, Indiana will only collect information on domestic violence (but not crime) to satisfy data collection in the Crime / Domestic Violence Benchmark.

HFI and NFP, through DCS and Goodwill have collaborated to ensure collection of similar measures across constructs and benchmark areas. During development of the Updated State Plan, Indiana identified measures for each benchmark that are similar across both HV models. Such methods for collecting benchmarks for both program models include:

1. Utilization of the *Ages and Stages* questionnaire to measure child growth and development in all areas and to evaluate parents' understanding of child development.
2. Administration of the Edinburgh Postpartum Depression Screening to assess maternal depressive symptoms.
3. Administration of a three-item interpersonal violence screen at intake interviews to maximize the number of mothers screened.
4. Collection of client report and home visitor observation.

The majority of constructs within all benchmarks are collected through client report and home visitor observation. For any remaining constructs not collected via one of the four methods listed above, both NFP-IN and HFI will collect similar but different measures in accordance to each program model. These "similar but different" measures are expected to be comparable in its ability to indicate success of each measure. For example, HFI collects information via the HOME Scale, the Healthy Families Parenting Inventory (HFPI), and the North Carolina Family Assessment Scale (NCFAS) while NFP-IN uses the Ages and Stages Questionnaire (ASQ) to collect information for measure success. The Benchmark Chart below details each model's measure and its source of data and respective collection methods.

HFI Data Collection Overview: DCS contracts with external agencies to conduct quality assurance (QA) and program evaluation. These two efforts work closely, with the HFI committee structure, and with DCS. Program standards outcomes, goals, objectives, and benchmarks are monitored by QA and evaluation teams. Results of the QA and evaluation reports and observations are reported to committees. These results are incorporated into policies, training, technical assistance, and evaluation. Annual data reports and evaluation results are shared with the Operations Committee. The committee recommends changes to the program based on this data.

NFP-IN Data Collection Overview: Data are collected on each client and a variety of reports are available on demand at the agency level. Data and reports are analyzed by staff members at the National Service Office (NSO), including the Nurse Consultants and Regional Quality Coordinators. This information is collected quarterly and the results are used for quality. Data are collected by the NFP-IN Nurse Home Visitor and entered directly into the national NFP-IN web-based information system. Outcomes are reported directly to each implementing agency and on-demand reports can be pulled at each agency. Assessment data are collected primarily through interviews, self-reporting and self-administered scales.

Plan to coordinate with Appropriate Entities / Programs

Coordination with existing home visiting services and other social services is crucial to the success of a home visiting program. Therefore, the proposed statewide project goal and its associated three overall objectives will be achieved via two main activities (and associated sub-activities within each activity): (1)

Appropriate referral coordination; and (2) Implementation of two evidence-based home visiting programs within the most high-risk areas in Indiana that have capacity for program implementation.

The first activity is key for development of a comprehensive, statewide, high-quality early childhood system. The crux of this activity is development of a state-wide home visiting advisory board. ISDH's MCH Director, Ms. Mary Weber and Indiana State DCS' Deputy Director of Programs and Services, Ms. Lisa Rich will convene this collaborative network, to be entitled "Indiana Home Visiting Advisory Board" (IHVAB).

This IHVAB will consist of Healthy Families Indiana's existing Think Tank Advisory Committee as well as leaders from all current home visiting programs throughout the state to ensure the coordination of all home visiting efforts. Since HFI has abundant experience in a similar expansive network of individuals and plans, HFI leaders, including Ms. Rich will provide guidance within each task force as the IHVAB develops and expands. Such task forces to be developed include: (1) Community Engagement; (2) Policy; (3) Program Coordination; (4) Evaluation; (5) Data Systems; and (6) Program Development.

The first movement of this IHVAB, once developed, will be mapping of all existing home visiting services, the gaps that currently exist, funding sources, and monetary contributions to respective projects. It is crucial that all home visiting programs that exist in the state be included in this board. Then, the IHVAB will develop a statewide method of ensuring that all residents eligible for home visiting services are recruited and enrolled in the home visiting service most appropriate to that family's needs. The IHVAB will determine if it is necessary to develop a community-based and managed home visiting referral framework to ensure all participants of home visiting services receive comprehensive referrals and follow-up. This referral coordination may mimic a "decision-tree" (or flow chart).

The well-established partnership between ISDH and DCS is the foundation of the coordination of State home visiting program. HFI, the state's largest home-visiting network, and ISDH, one of the state's largest providers of services for pregnant women, infants, mothers, and families working together will allow for high-quality home visiting and wrap-around services. As DCS is the umbrella agency for child and family prevention services, there are multiple partnerships formed at both the state and local level that can be utilized: prevention services, child welfare groups, local health services, social services and early childhood development services. ISDH is able to utilize existing collaborations with prevention and health care services and programs.

Description of State Administrative Structure & Fit with Proposed Activities

As Indiana develops a statewide home visiting network, collaborating with other private and public entities will ensure success in home visiting and peripheral services to clients. The statewide home visiting framework will include individuals from all agencies who concurred or supported Indiana's home visiting plan. Individual expertise in respective areas will allow the home visiting framework to incorporate a variety of health care, preventive services, social services, mental health, substance use, education, and child welfare programs as a way to meet all the needs of home visiting clients. Stakeholders and partners that are collaborating include the co-lead agencies for the initiative, ISDH and DCS, and other key partners, such as the Department of Mental Health and Addiction, the Bureau of Child Development, the Department of Education, the Indiana Head Start Collaboration Office and the criminal justice system.

Managing the day to day communications between the co-lead agencies and the collaborative partners is the Program Coordinators, In addition, the Program Coordinators at ISDH and DCS will provide the following support:

- Coordinate development and implementation of the MIECHV Program in partnership with the Indiana DCS' Healthy Families Program and Goodwill Industries of Central Indiana's implementation of the NFP-IN program
- Serve as the primary contacts for the MIECHV Program, including shepherding all communication with the DHHS's MCHB.
- Establish high level collaborative relationships with multiple partners, including local health departments, minority health coalitions, and other public and non-profit agencies.
- Develop measureable benchmarks within required MCHB health indicators, and develop a plan for collecting, measuring, and reporting those indicators.
- Monitor progress toward goals, and provides frequent progress reports to the Public Health Administrator of Women's Health (14-44).
- Ensure ongoing program evaluation and that all required benchmark data elements are measured.
- Develop, disseminate, and collect survey tools regarding the effectiveness of Home Visiting programs. This includes working with subcontractors and in-house Epidemiological experts on best methods for data collection and reporting.
- Oversee the Assistant MIECV Program Coordinator, including daily supervision of work activities and ensuring the Assistant Coordinator's responsibilities are achieved on time.
- Remain abreast of current literature regarding Maternal and Child Health and evidence-based models / promising practices of home visiting programs throughout the country. Appropriately relay this information to partners, colleagues, and sub-grantees of funds.
- Assist in continued updates of the Home Visiting Needs Assessment report by examining statewide and community level data on a periodic basis.
- Prepare quarterly and annual reports as required by HRSA guidance for the ACA Maternal, Infant and Early Childhood Home Visiting Program. Must confer with partners, and disseminate these reports for continuous quality improvement of project activities.
- Assist in submitting grant proposals to enhance and expand existing services or develop new services for Home Visiting in the state of Indiana.

Plan to Incorporate Project Goal / Objectives / Activities into Ongoing Work

Federal legislation and appropriations support the benefits of home visiting for the maternal and child population. Proven outcomes of home visiting combined with recent attention to evidence-based practices will ensure home visiting becomes included in direct health services and infrastructure building for years to come. In alignment with federal interests in home visiting and its ability to impact populations most of in need of its services, ISDH has ensured that its strategic plan is aligned with home visiting expansion and enhancement. That is, ISDH's MCH Division is a recipient of Title V Federal Block Grant Funds, and with these funds, ISDH supports activities to serve low-income families. Such activities include support of local health departments, maternal and child health clinics, adolescent health and education, prenatal care coordination, and the free pregnancy test program (to name a few). ISDH is committed to integrating all Title V programs with Home Visiting services.

Continued federal funding for home visiting and other supplemental funds (grants, state appropriates, etc.), ISDH envisions that all women and families served through Title V, and who are eligible for home visiting services, receive home visits. In addition, DCS has incorporated the proposed expansion's project goal, objectives, and activities within its organizational structure. To achieve its mission of eliminating child abuse and neglect, DCS has institutionalized home visiting services as a main vehicle for reaching families, educating caregivers, and engaging community organizations. For over a decade, DCS has maintained a State Healthy Families Coordinator, which indicates its commitment to home visiting services and incorporation of HFI objectives and activities.

RESOLUTION OF CHALLENGES

Implementing evidence-based programs can prove challenging. Such challenges and respective approaches to such anticipated challenges are listed below. Anticipated challenges include: (1) attrition of enrolled participants; (2) recruitment of qualified staff for the compensatory levels; and (3) strict enrollment criteria.

In anticipation of these challenges, HFI is an established service provider in communities that have greater needs than are currently met through home visiting. Sites in the selected communities currently receive more referrals than can be served with present funding levels. Recent funding cuts required the laying off or down grading the full-time equivalent (FTE) of many home visitors. Therefore, HFI does not anticipate an issue in recruiting qualified staff. As a long term service provider of the HFA model, HFI has been required to locate, assess and enroll high risk families and then provide services such that families remain enrolled in this voluntary program. All of these activities present challenges. Fortunately, the HFA model asserts activities to address the challenge of serving high risk, needy families within communities with inadequate resource.

Similarly, NFP-IN has very strict criteria for both the clients enrolled in the program and the home visitors. While recruiting bachelor-prepared nurses who are willing to leave the clinical setting to enter a job that involves entering patients' homes and identifying and addressing a wide range of familial issues can be difficult, Goodwill has established strong relationship with local hospitals and Indiana University Purdue University-Indianapolis School of Nursing will allow for selection of appropriate home visitors. Another risk of implementing NFP-IN is the strict criteria required to enroll a client in the program. The nurse home visitors must identify first-time mothers before 28 weeks gestation. However, quality networks of referral systems formed by Goodwill Industries will allow clients to be referred as necessary.

EVALUATION & TECHNICAL SUPPORT CAPACITY

Experience, Skills, Knowledge of Current Staff

Each of the staff members dedicating time to the proposed project has appropriate experience, skills, and knowledge. The following lists each staff member, including his / her current roles / responsibilities, materials published, and previous work of similar nature.

- *Lisa Rich*: Lisa Rich is currently the Deputy Director of Programs and Services for Indiana Department of Child Services (DCS). In this role, Ms. Rich oversees all DCS programs and services statewide including Prevention, Preservation, Adoption, Older Youth Initiatives as well as Research and Evaluation efforts. Previously, Ms. Rich managed a local office of the DCS including supervision of field staff assessing for child abuse and neglect as well as provision of services to families. Ms. Rich also serves as Co-Chair for the Home Visiting Leadership Collaborative.
- *Mary Weber*: Ms. Weber is the Maternal and Child Health Director at Indiana State Department of Health (ISDH) and serves as co-chair of the Home Visiting Leadership Collaborative. As the MCH Director, Ms. Weber oversees all MCH programs including Life Course Health Systems, Children's Special Healthcare Needs, Newborn Screening/ Genomics, and Indiana Family Help Line. Ms. Weber was awarded the Maternal and Child Health Public Health Leadership Institute fellowship at University of North Carolina Chapel Hill, Gillings School of Public Health. Her personal project while a fellow is to create an overarching infrastructure for home visiting throughout the state.
- *Mary Ann Galloway*: Ms. Galloway is the Director of Life Course Health Systems at ISDH. In this role, Ms. Galloway oversees all aspects of the Life-Course, including perinatal health, child

health, adolescent health, and health of women of childbearing ages. As a consultant for many years with various organizations, her expertise includes systems implementation, strategic planning, project development, marketing, project management, proposal development, consult and client management in private and public sectors.

- *Phyllis Kikendall*: Ms. Kikendall is the Child Care Coordinator and Manager of Prevention Services at DCS. Ms. Kikendall coordinated the beginning and development of HFI systems and the statewide expansion to a \$40m HFA accredited Program, and continues to work with the program today.
- *Charrie Buskirk*: As the Public Health Administrator of Women's Health at ISDH, Ms. Buskirk oversees federally-funded programs for women's health, manage staff, direct the free pregnancy test program, and ensure attainment of state performance measures related to preconception / interconception health. Previously, Ms. Buskirk served as Grants Director of Wishard Hospital and directed operations for Grants Department, including grant writing, accounting, management, and coordination.
- *Andrea Preston*: Ms. Preston currently serves as the Human Service Consultant Special Projects at DCS. In this role, Ms. Preston works with the Deputy Director of Programs and Services and the Program Managers to complete assigned projects and initiate new programs. Ms. Preston also serves Co- Home Visiting Program Coordinator. Ms. Preston has had extensive experience in the field working directly with families and children who have experienced child abuse and neglect. Ms. Preston has worked on many projects related to prevention and is part of the HFI planning committee.
- *Mallory Quigley*: Ms. Quigley serves as the Co-Home Visiting Program Coordinator at ISDH. Ms. Quigley handles all day-to-day activities and communications of the MIECHV program and the Leadership Collaborative. Previously, Ms. Quigley worked as a Maternal and Child Health Bureau Graduate Student Intern in which she was responsible for developing and overseeing the evaluation plan for Montana's statewide home visiting program—which included chart audits, case sample reviews, data collection, analysis, and reporting, along with recommendations for data quality improvement.

Organizational Experience / Capability

The ISDH and the DCS is well-equipped and has an abundant level of organizational experience and capability to coordinate and support planning, implementation, and evaluation of the comprehensive statewide plan to meet the objectives of this initiative. More specifically, as the State's Title V administrator, ISDH has planned, implemented, and evaluated many programs on a local and state-wide level. ISDH coordinates Indiana's Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems (ECCS) grant, *Sunny Start: Healthy Bodies, Healthy Minds*. Sunny Start is overseen by Project Director, Dr. Judith Ganser, MD, MPH, and Program Manager, Ms. Andrea Wilkes. Dr. Ganser also serves as ISDH's MCH Medical Director, while Ms. Wilkes also serves as ISDH's MCH Public Health Administrator of Children's Health. Sunny Start ensures that young children arrive at school healthy and ready to learn. MCH also houses the Free Pregnancy Test Program, Prenatal/ Family Care Coordination, a prenatal substance use prevention program and several other competitive grants that take thoughtful planning, implementation, and evaluation. In addition, DCS Deputy Director of Programs and Services, Lisa Rich has a long history of conducting Evaluation Research. Having worked in the social science research field for 10 years, managing program development and monitoring outcome data, Ms. Rich brings professional research expertise to the team. In addition, DCS's Research and Evaluation Team will be available to assist in the evaluation activities.

Evaluation Plan

The proposed project's evaluation plan will (1) measure whether the intended outcomes of the project were attained; (2) monitor the efficiency of the proposed project activities; and (3) meet the definitions of rigor and other evaluation criteria stipulated in the federal grant opportunity. Most of the data used for this evaluation will be collected as part of the MIECHV project and required State reporting. The broad goal of the external evaluation will be organized and study the data to examine the extent to which the MIECHV achieves its objectives. Thus, the research questions and sub-questions for this evaluation are broad enough to examine not just MIECHV's three project objectives but to inform improvement at both the practice and system levels. The longitudinal evaluation will be overseen by an advisory board of MIECHV stakeholders who will ensure that the research best meets the needs of the project's constituency. Data will be analyzed using contemporary and powerful multilevel approaches.

Background. Although the design of this study is constrained by limited resources such that an experiment using random assignment will not be feasible, the comprehensive plan described in this document will utilize a combination of quantitative and qualitative techniques and data sources to identify both process and outcome variables that MIECHV stakeholders have deemed important. Furthermore, this mix method design will promote the development of rich conceptions and understandings of the overall initiative, allowing the evaluation team to tease out and describe the *counterfactual* to the MIECHV (i.e., what would have happened to participating families and communities had the project not been implemented). This will allow stakeholders to more easily understand the program's impact as well as develop future experiments and quasi-experiments for further study of the MIECHV.

Framework. To address some of the shortcomings of our design, we plan to use multigenerational, multilevel and longitudinal approaches in our study. For example, we plan to study the overtime experiences of families who participate in MIECHV services. Through the use of multigenerational (i.e., dyadic) analyses, we can study mothers/children as a single unit, thereby focusing on the relationships between the "unit" and participation in services. Multilevel modeling allows us to examine change over time as well as how families are performing within specific programs by simultaneously accounting for both school level and individual level effects. Though these approaches remain susceptible to threats to validity, such as maturation and history (Shadish, Cook, & Campbell, 2002), measurements taken at the beginning of program involvement provide a proxy for pretest performance (i.e., what might have happened had the families not received the intervention). In turn, these pretest scores can be compared to measurements taken at later time points during the program (posttests), thereby offering insight into program influences, longitudinally. Moreover, as the program matures and sample sizes increase, we will be able to better isolate specific types of service configurations and explore, longitudinally, their relationships with program outcomes.

The evaluation of the MIECHV also will incorporate a risk and resiliency framework to focus on how services can be used to increase protective factors and reduce risks. In this way, evaluation will be used to improve outcomes for families by informing program administrators and practitioners of the relationships among risk and protective factors. Risk and resiliency approaches are emerging as alternatives to the traditionally used deficit models that tend to focus solely on factors that put families at risk, often concentrating on the cumulative effect of risk factors. While the deficit model may be appropriate when studying factors inherent to an individual, the resilience model is more appropriate when examining family and community factors that foster resiliency. For example, while researchers have successfully identified certain groups (e.g., families living in poverty) as being at greater risk of poor health and developmental outcomes, many families living in these kinds of hazardous contexts do not succumb to such risks. Instead, these families demonstrate what behavioral scientists have defined as *resiliency*, and a number of studies have been conducted to attempt to identify and understand the "protective factors" that moderate or counteract risk factors such as low SES status (Werner, 1993; Garnezy, 1993; Masten & Coatsworth, 1998; Rutter, 1989).

Evaluation Questions. Consistent with the goals that stakeholders from Indiana have developed in creating the MIECHV, the evaluation will seek to develop to understand the degree to which the project leads to (a) Improved interagency collaboration both among systems and agencies (local, state, and federal) and through partnerships with families; (b) improved outcomes for children and youth, including clinical indicators; school readiness; stability of living arrangements for children and youth; healthy social networks; (c) increased use of evidenced-based practices and the impact that using evidence-based interventions has for participating families; and (d) increased satisfaction with services among participants, including the extent to which families perceive services to be family-driven, youth-focused, and culturally competent.

The plan for the evaluation was derived from the project's Logic Model (included in this proposal). This evaluation plan will focus on four questions:

1. What is the process of the MIECHV providing comprehensive home visiting services to eligible families in Indiana?
2. How is coordination developed and maintained among home visiting services, both locally and statewide?
3. How is coordination between home visiting services and related services (e.g., mental, dental, and primary health, substance use, school readiness, etc.) developed and maintained both locally and statewide?
4. Is the long-term success of the MIECHV greater than the sum of the success of its components?

Starting with *MIECHV's* logic model, an overarching **theory of change** will be developed. Predicated on a comprehensive approach to service provision and coordination among programs and with agencies, the theory of change will delineate how MIECHV will achieve its three primary goals. Stakeholders work collaboratively to integrate, streamline, and align. Simply stated, the array of formal services provided through the MIECHV leads to improved outcomes for participating families and their children.

1. ***What is the process of the MIECHV providing comprehensive home visiting services to eligible families in Indiana?*** The purpose of this research question is to thoroughly understand, through description and information synthesis, the *MIECHV* initiative and how it is expected to function when it is fully implemented. The examination of this question begins with a review of all of the work that has been done to date to create this project, including needs assessments, formative data collection and analyses, plans for summative performance reviews, grant writing and presorting, etc. To begin, inputs, activities/services, and processes including the extent to which they are occurring with fidelity, will be studied. Measurable outputs/outcomes that result from MIECHV inputs, services, and processes also will be added to the analyses. Second, evaluation efforts will describe the target population of the *MIECHV*, specify the model's intended outcomes/effects; provide clarity about the relevant counterfactual; and describe model "implementability" (i.e., the context in which *MIECHV* can be implemented with enough fidelity in practice to be expected to plausibly lead to its intended effects). This would also articulate a sustainable system of data sharing and use for program maintenance, continued improvement, and replication; including a cost-benefit analysis.
2. ***How is coordination developed and maintained among home visiting services, both locally and statewide?*** This research question examines the comprehensive referral and service provision system. This coordinated system is designed to develop protective factors for families by identifying eligibility criteria (i.e. risk factors). The criteria will then match the client to appropriate program services. Ensuring the most appropriate home visiting program for the client will support positive outcomes for both the program and the client.
3. ***How is coordination between home visiting services and related services (e.g., mental, dental, and primary health, substance use, school readiness, etc.) developed and maintained both locally and statewide?*** MIECHV effects on access to primary health and dental care, mental health services, as well as Medicaid eligibility and maintenance and social services. This question examines the extent to which connecting families to outside community resources to ensures that

their basic needs are being met and assisting in coordinating medical care. MIECHV will coordinate outside services to ensure enriching and meaningful experiences that promote parenting, education, social development and safety; as well as utilizing resources in the most cost efficient manner

- 4. *Is the long-term success of the MIECHV greater than the sum of the success of its components?*** This evaluation area will evolve out of the other areas of the evaluation, providing an exploration of the evidence of MIECHV's effectiveness in improving outcomes for families. The purpose of this research question is to understand the effectiveness and impact of the overall MIECHV project. First, using case study methods, the MIECHV will be examined as a single program to understand its development and implementation. Second, given all of the available data, three specific questions will be examined: (a) what practices produce persistent, positive impacts on families? (b) are there identifiable factors that lead to differing outcomes at different MIECHV sites? and (c) how can longer term impacts be used to inform replication of the MIECHV model both locally and national?

Five specific sub-studies that will be conducted include:

1. ***Longitudinal examination of the outcomes of services provided through the MIECHV.*** Because service provision is contextualized by numerous local factors, the impact they have on a family's functioning depends on a host of variables, many which cannot be easily measured or replicated. This adds to the complexity of understanding who improves, under what conditions improvement occurs, and the factors that are associated with improvement. Thus, the purpose of this study is to examine the patterns of clinical improvement over time for participating families and explore the degree to which child, family, community characteristics, and referral source impact clinical patterns over time. The longitudinal nature of this question also examines the durability of effect over time. By better understanding contextual factors that are associated with improvement, MIECHV staff will be able to understand risk and resiliency at both the services level and the systems level. As part of this study, we will also examine how the targeted population of families actually served compares with the actual population families who are intended to be served?
2. ***Study of the barriers and achievements that result from interagency collaboration.*** Initially, this study will examine the existing relationships, both formal and informal, that make up the MIECHV. Using network analysis techniques, the organizational structures of the existing services, therapeutic alliances, and provider networks will be described and analytically "mapped". Gaps in the existing service structure also will be described and mapped. Benchmarks will detail the present state of the MIECHV and provide a starting point for this study. Specifically, study findings will be generated for positive impact at the community level, as well as the challenges to implementing and sustaining cross-system collaboration. Implications from the study are expected to highlight the importance of developing and enhancing strengths and collaboration among systems, integrating and coordinating across systems and services, and authentically involve families at all levels. Additionally, as part of this work, we will examine the development of linkages among the child-serving systems. Data from this study will be used to inform the community about what is and what is not happening in terms of linkages, connections, etc. and all gaps will be addressed.
3. ***Cost effectiveness study of the MIECHV.*** This study will examine expenditures, services usage, and outcomes in the MIECHV, using both point-in-time and longitudinal analyses. Initially, basic descriptive statistics will be computed to determine the most commonly used service categories, as well as total expenditures for these service categories. Data will be examined using several different 'unit of analysis' points, including time, family, service category, and community. Following this, cluster analyses will be conducted on the service data to determine the most commonly used service patterns within the MIECHV. Third, OLS regression will be used to examine the impact of demographic characteristics, diagnosis, referral source, level of functioning at enrollment and services received on a young person's overall expenditures. OLS regression will next be used to examine the

impact of demographic characteristics, diagnosis, referral source, and level of functioning at enrollment on expenditures within each service category. Finally, logistic regression will be used to model the effect of individual-level, service, and expenditure factors on the likelihood of successfully completing the program. Additionally studies will examine these data longitudinally to better understand the impact that types of service configurations have on outcomes.

4. **Caregiver and youth perceptions of the MIECHV.** This study will examine the perceptions of the young people and their families who participate in the MIECHV project. The underlying theory is that more successful the MIECHV is at implementing its core constructs, the more improvement will be seen in both process and outcome variables. Families will be queried about (1) their level of involvement in the planning of services; (2) their perceptions of the helpfulness of providers; and (3) their satisfaction with services. These data will be analyzed together with clinical change data to better understand how consumer perceptions of MIECHV involvement are related to objective measures of change over time. Similar analyses will be conducted with the ratings of families about the cultural competence of the services system
5. **Care coordination and Individual Service Plans and Planning.** The purpose of this study is to understand how the MIECHV coordinates and plans care. The child and family team process will be studied to understand how individual service plans are developed and monitored over time. Questions of interest will examine how well plans are implemented, along with both barriers to and departures from implementation. The underlying theory is that to the plans are fully implemented, with fidelity, outcomes are expected to improve. To test this theory, the impact that fidelity to the plan will be examined together with clinical data longitudinally. Additionally, this study will detail how plans are implemented in terms of who provides what service and how/how much; the development, delivery of integration of clinical care with nontraditional services also will be examined.

Evaluation Advisory Board. A core feature of the comprehensive evaluation of Indiana's *Maternal, Infant, and Early Childhood Home Visiting Program* is the establishment and functioning of an Evaluation Advisory Board (EAB) that will assist the community and the evaluation team in conducting the evaluation. The primary goal of the EAB's efforts is to ensure that the analyses of systematically gathered data drive all aspects of the project. The EAB is a subcommittee of the Leadership Collaborative. This purposeful arrangement ensures that evaluation activities are both informed by and contribute to the day-to-day and long-term functioning of the MIECHV. Indeed, the mission of the EAB will focus on developing an organizational culture in which MIECHV operates within a continuous quality improvement framework driven by systematic evaluation.

EAB membership will include evaluation team members, representatives from MIECHV, its partner agencies, practitioners, youth and caregivers, representatives from family and youth advocacy organizations, and other interested parties as appropriate. Further, the EAB will ensure it has geographic representation as well as representation from the culturally and ethnically diverse groups that are served by MIECHV. Further, to be responsive to the evaluation needs and interests of the project community, the EAB will identify (1) additional sources of data that are currently available in the community but not being collected or studied, including determining the quality of these data and (2) other types of data that are not currently available but are nonetheless needed for the evaluation. Community agencies often have far more data at their fingertips than is realized, most of which is never analyzed or incorporated into an evaluation framework.

The goal is to build evaluation capacity and create broad interests in using data to examine questions of interest. Moreover, this project has data needs that extend across systems (e.g., health and mental health, child welfare, education). Therefore, the EAB will work with its various child-serving systems to find or create necessary sources of data. Thus, the EAB will be to creating a data infrastructure that will support interagency evaluation vis-à-vis an integrated data-sharing system that also meets the technical (e.g., user-friendly) and ethical (e.g., confidentiality) standards of quality evaluation research.

Analysis of Data. To understand the impact of program participation on the youth and caregivers, we will examine the data in several ways. First, we will examine simple within subject changes in the youth/caregivers' reports using simple descriptive statistics (t-tests, chi-squares) of key outcomes including, but not limited to types and amounts of serves, symptomatology, and satisfaction with the program. In addition, we will conduct a series of parallel, multivariate panel analyses where we compute, depending on the level of measurement in the dependent variable, time-lagged, ordinary least squares, and logistic regression models for various outcome measures. These analyses will permit a more detailed analysis of which groups of youth or family caregivers have experienced the most change since joining the program.

Second, a powerful, relatively new analytic strategy called hierarchical linear modeling (HLM) will be used to examine individuals' clinical and behavioral change trajectories over time. HLM is a flexible analytic approach in which the number and spacing of measurement observations can vary across persons. A major advantage of using the HLM model for longitudinal data is not only that averaged change parameters are modeled but so too are the unique effects of the individuals. Thus, with the HLM model one set of parameters relate to the population, whereas another set relate to each individual's uniqueness. In turn, individual uniqueness can then be modeled by time invariant (fixed) variables (e.g., sex, ethnicity, etc.).

Using this method, level 1 is the repeated observations model and represents the patterns of individual change observed over time. The basic level 1 model can be expressed as $Y_{it} = \pi_{0i} + \pi_{1i}a_{it} + e_{it}$ in which Y_{it} represents the score at time t for the individual i , π_{0i} is the intercept, and π_{1i} is the rate of linear change for person i . More specifically, π_{0i} is the score for the individual when all other variables in the equation are zero and π_{1i} is the rate of change in Y_{it} for a one unit change in a_{it} (time). The level 2 equations, expressed as $\pi_{0i} = \mathbf{Y}_{0j} + \mathbf{u}_{0j}$ and $\pi_{1i} = \mathbf{Y}_{1j} + \mathbf{u}_{1j}$, are used to model the variation in the subjects' unique change coefficient in the level 1 model (i.e., π_{0i} and π_{1i}). Thus, in the level 2 model, both the intercept (π_{0i} or initial status) and behavioral change rate (π_{1i} or slope) are modeled and allowed to vary as a function of characteristics of the individual.

The evaluator will link interview data with the corresponding service use data and conduct a parallel series of analyses to explore the impact of receiving specific services (or arrays of services) on the same series of outcomes. Likewise, hierarchical and K-Means cluster analyses will be used to determine common configurations among the data, including service usage configurations and child and family team configurations. Clusters can then be entered into regression and other equations to understand the relationship between a cluster (e.g., type of team) and a variable (e.g., clinical improvement) or set of variables (e.g. improvement in school functioning). These analyses will help to identify services, which are related to particular kinds of outcomes. Overall, our objective in these analyses is to develop a more nuanced understanding of what aspects of the program are most effective and for which youth and families and under what conditions.

Analyses and Dissemination. Data will be reported in a variety of ways including submission of articles to scholarly journals, presentations at regional and national conferences, regularly scheduled public briefings, presentations to stakeholders and other interested parties, and the creation of publicly-accessible evaluation-related website.

Evaluation Staff. The *Indiana's Maternal, Infant, and Early Childhood Home Visiting Program* will be evaluated by Dr. Jeffrey A. Anderson, Evaluation Director. Dr. Anderson is faculty member in the Special Education Area in the School of Education at Indiana University-Bloomington (IUB), a research faculty in the Center for Adolescent Family Studies at IUB, and has held an appointment as adjunct professor with the Indiana University School of Medicine's Department of Public Health. His research focuses on

interagency systems of care and integrated social service supports for children and their families. He is an experienced evaluator in both children's social services and P-12 education and currently is the principal investigator of the One Community One Family system of care evaluation study, a federally funded, 6-year longitudinal evaluation in Southeastern Indiana. Additionally, he is an expert in longitudinal data analysis and mix-methods evaluation research and has published and presented his research extensively in both peer reviewed and more practice-oriented venues.

Institutional Review Board (IRB). Approval will be sought from the IRB at Indiana University. Indiana University holds a Federalwide Assurance, FWA00003544, which is on file with the Department of Health and Human Services (see: <http://www.iupui.edu/%7Eeresgrad/spon/fwa.htm>).

ORGANIZATIONAL INFORMATION

Organizational mission / structure

Indiana Governor Mitch Daniels has designated ISDH (ISDH) and Indiana DCS (DCS) as co-lead agencies for the purposes of this grant and its funding requirements. ISDH is the state's Title V agency, while DCS is the state's lead Child Abuse Prevention and Treatment Act (CAPTA) agency. The collaborative relationship mirrors the relationship between Health Resources Services Administration (HRSA) and Administration for Children and Families (ACF) on a federal level as the administrators of these funds. This working relationship is crucial to the success of a statewide program in that it unites Indiana's most extensive home visiting network (HFI) and Indiana's agency that provides services numerous services to mothers and children through Title V funds (MCH). ISDH will serve as the primary contact and fiscal agent.

Indiana DCS: The Indiana DCS protects children from abuse and neglect by partnering with families and communities to provide safe, nurturing, and stable homes. DCS HFI State Coordinator will be the primary contact at DCS. This position is responsible for general administration and supervision; and coordination of available federal, state funding sources; implementation of procedures that ensure continuity of services; implementation of formal agreements and policies related to the payment of services. The HFI Program Coordinator is overseen by the Manager of Prevention Services (Ms. Phyllis Kikendall). This position is responsible for overseeing the HFI Program Coordinator's day-to-day activities, including contract development and management and engagement with the operations work group within the HFI Think Tank Group. The HFI Deputy Director of Programs and Services (Ms. Lisa Rich) oversees the Manager of Prevention Services. Ms. Rich is responsible for fiscal and programmatic problem solving and stakeholder engagement. In addition, Ms. Rich will co-lead the convening of the Indiana Home Visiting Advisory Board.

ISDH: The ISDH supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities. To achieve a healthier Indiana, ISDH will focus on data-driven policy to determine appropriate evidence-based activities and evaluate activities to ensure measurable results. ISDH also engages its partners and include appropriate intra-agency programs in policy-making and programming. Its essential partners to include local health departments, physicians, hospitals and other health care providers, other state agencies and officials as well as local and federal agencies and officials, community leaders, businesses, health insurance companies, Medicaid, health and economic interest groups, and other groups outside the traditional public health model. ISDH also actively facilitates integration of public health and health care activities to improve Hoosiers' health.

The Home Visiting Program Coordinator housed at ISDH will be supervised by the Public Health Administrator of Women's Health (Ms. Charrie Buskirk, MPH) as part of the Life Course Health Systems team within ISDH's MCH Division. The Public Health Administrator of Women's Health will dedicate

10% full time equivalency (FTE) in-kind to ensure that she is achieving her tasks within a timely and efficient manner. She will also provide technical assistance and problem solving as issues arise with project management, data collection, reporting, and other grant requirements. The Director of Life Course Development (Ms. Mary Ann Galloway, MPH) oversees the Women's Health team within the MCH Division and will provide guidance throughout the administration process at a level of 5% FTE in-kind. The Director of MCH (Ms. Mary Weber, MSN, RN) is serving as the Principal Investigator on the proposed project at 10% FTE in-kind. Ms. Weber will provide oversight and lead the process of convening and facilitating the Indiana Home Visiting Advisory Board (IHVAB).

Scope of Organizational Activities Related to Home Visiting

ISDH houses the Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems (ECCS) grant. Indiana's ECCS initiative, Sunny Start: Healthy Bodies, Healthy Minds, is overseen by Project Director, Dr. Judith Ganser, MD, MPH, and Program Manager, Ms. Andrea Wilkes. Dr. Ganser also serves as ISDH's MCH Medical Director, while Ms. Wilkes also serves as ISDH's MCH Public Health Administrator of Children's Health. As indicative of both Dr. Ganser and Ms. Wilkes' currently held positions within ISDH's MCH Division, the Home Visiting Program Coordinators, located within ISDH's MCH Division, will continue to work closely to strengthen the early childhood collaborative through Sunny Start. In addition, the Program Coordinators for HFI is seated within the Sunny Start Core Partners collaborative—further adding to the integration of Home Visiting to the Early Childhood Comprehensive Systems (ECCS) program in Indiana.

The Perinatal Health program directed by Ms. Beth Johnson, MSN, RN, Public Health Nurse for Perinatal Health, which is also component of ISDH's MCH Division, aims to prevent maternal and infant morbidity and mortality through improved access to and enhanced utilization of perinatal and related services. The program includes Infant Mortality Disparity Initiative, Family Care Coordination and Prenatal Care Coordination, prenatal smoking cessation counseling and referrals to cessation services, Premature Birth Initiative, infrastructure building through the Indiana Perinatal Network, and direct medical services via prenatal care to high-risk women with low income. To integrate into these existing services, IHVAB will refer women enrolled in home visiting programs to the programs such as medical prenatal care. Family Care Coordination is another service in which home visiting clients may enroll after time in the home visiting program is complete.

The management process of HFI (HFI) is designed to ensure quality program oversight and adherence to HFA Critical Elements. HFI allows individual sites the flexibility to tailor the management process to meet the specific needs of the community. However, HFI has established guidelines that all sites follow. The management of Healthy Families is based on a parallel process of instructive support at each level of program structure. Healthy Families program sites are located in and managed by a wide variety of individual agencies. DCS senior leadership is responsible for contract management—ensuring program managers are held accountable for the quality of their work and are provided with skill development and professional support.

Program Managers across the state are responsible for the overall function of the HF program at their site. These duties include site policy development and implementation, quality assurance analysis and reporting, site data collection and program planning, hiring and training of staff in coordination with supervisors, and meeting the program standards set forth by HFA. HF Program Managers work with colleagues throughout the state system to share information and work to implement state directives and initiatives at the local level. Program Managers also provide regular, on-going supervision to program supervisor which holds program supervisors accountable for the quality of their work and provides them with skill development and professional support. The Program Manager provides supervisory and instructional support to Supervisors through mentoring, review of program progress, and staff

development opportunities as well as conducting administrative duties including grants, program and personnel management.

Healthy Families program supervisors are responsible for ensuring that direct service staff receive on-going, effective supervision so they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations to avoid stress-related burn-out. This is accomplished through a variety of tools which include weekly, face-to-face supervision, appropriate supervisor to staff ratios, and supervisory mechanisms to provide feedback, guidance, training, reflection, while holding staff accountable for the quality of their work. The face-to-face sessions help to form the core of the supervisory relationship. Conducted weekly, each session includes review of family progress, skill development, information, and opportunities for growth. This in turn provides the model for the supportive services which the direct service provider (Family Assessment and Family Support Workers) offer to families.

Please see Attachment 5 for an organizational chart. Also, please see Attachment 6 (Summary Progress Report) for information about the organization's record of accomplishments.

Provision of Culturally & Linguistically Competent & Health Literature Services

The MIECHV program will receive resources developed by ISDH's Early Childhood Comprehensive Systems program, Sunny Start, including materials to offer parents of young children. Many of these materials are offered in both English and Spanish are noted below. The materials are also offered through different mediums, such as websites, paper materials, brief fact sheets. This allows individual clients to choose the most appealing manner in which to receive information. Such materials include:

- The Early Childhood Meeting Place website to provide families and early childhood providers with resource and support information.
- A Developmental Calendar has been developed for families and providers, which highlights important health and safety information such as infant and toddler's nutritional needs, oral health issues, communication, and gross motor development. The calendar is available in English and Spanish.
- A Wellness Passport for Indiana's Kids, a personal healthcare record-keeping tool that allows parents to collect, track, store, and access important information about their children's growth and development—all in one easy-to-access location. An online tutorial about the passport is available.
- A Special Health Care Needs Addendum to the Wellness Passport, providing additional sections for families raising children with disabilities and special healthcare needs.
- Family Resource Fact Sheets, a series of 25 fact sheets that highlight the basics of key resources available for Hoosier families. They are also available in Spanish.

Currently, HFI provides these materials to home visiting clients through Sunny Start's Core Partners. As NFP-IN develops, nurse home visitors will also provide mothers Sunny Start materials to help navigate through their child's development. HFI developed eleven modules that would include the content required by HFA training requirements for HFA Accreditation: Child Abuse and Neglect, Family Violence, Substance Abuse, Staff Related issues, Family Issues and Mental Health. Under these categories are 31 required topic areas. This training is required for all direct service staff and supervisors within 12 months of hire. Due to the increased services to the Spanish speaking population in Indiana and other states, the training modules were translated and shared with HFA to allow other programs across the nation access to web-site training and HFA certification. This partnership has been acknowledged as a major cost savings for HFA programs particularly in rural and sparsely populated states. HFA has developed the web-site

for easy access to complete the training and receive their certificates of completion in real time. NFP-IN also recruits bi-lingual home visitors. Healthy Families has also developed brochures for distribution in Spanish speaking communities. HFI and NFP-IN programs will hire Spanish speaking staff as needed to conduct: points of screening, assessments and home visiting services.

How Unique Needs of Populations are Routinely Assessed / Improved

Routinely assessing the needs of communities that receive home visiting services, as well as other areas of the state will be tasked by the Leadership Collaborative. These key leaders in Indiana's home visiting programs will review the Home Visiting Needs Assessment to determine if areas identified as high-risk continue need additional support. This will be accomplished through communications with program sites and review of CQI and outcome measure data.

ISDH and DCS assess the needs of the state continually through numerous other mechanisms. ISDH Maternal and Child Health complete the Title V Needs Assessment on a five-year basis, with yearly updates. The Title V application utilizes public comments from various sources including a request for public comments on the MCH website and surveying providers, partners, and collaborators to identify priorities. MCH also utilizes quantitative data from a variety of sources including natality and mortality data, Office of Medicaid Policy and Planning, Children's Special Healthcare Services, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, Pregnancy Nutrition Surveillance System. Data from these sources, as well as others, allow MCH to identify the state of Hoosier women, children, and families. Based on the data compiled, MCH prioritizes, based on capacity and need, which measures will be addressed for the following five years. These measures guide activities that MCH will complete during the five-year period.

Biennial Regional Services Strategic Plan

The Regional Services Council is the structure responsible for the Biennial plan. Local services providers were represented in the evaluation of local child welfare service needs. A survey was sent to local providers as well as interested community partners. In addition, the regional services council conducted a meeting to take public testimony regarding local service needs and system changes. The timeline includes beginning work in February of uneven year and complete plan in February of even year. Each regional Services Council shall, according to guidelines and policies established by the department, include in its plan an evaluation of local child welfare service needs and a determination of appropriate delivery mechanisms. The policies shall provide an opportunity for local services providers to be represented in the evaluation of local child welfare service needs. In addition, the regional services council shall take public testimony regarding local service needs and system changes. The council shall also recommend in the plan, the allocation and distribution among service providers of funds that the department allocates to the service region and are used to pay for the expenses of child welfare programs and child services administered by the department within the region. Report contents include an evaluation of local child welfare service needs and a determination of appropriate delivery mechanisms. The plan is tailored to provide services targeted to the individual needs of children who have been: adjudicated as children in need of services or identified by the department based on information received from child's parent/guardian/custodian, schools, social service agency, court, probation department or an interested person in the community.

Organizational Capacity of Partnering Agencies

DCS Partnering Agencies

The following counties will be served with allowing more families in their programs: Marion, Lake, St. Joseph, Elkhart, LaPorte, and Grant. These sites currently receive referrals for HFI screening through partnerships with WIC, community hospitals, area schools, health clinics, and self referrals through agencies that have a memorandum of understanding. Healthy Families Indiana during 2010 served over 22,000 families statewide and with this expansion grant the above counties will be allowed to serve 1230 additional families.

ISDH Partner Agencies

Goodwill has numerous experiences working with populations that are low-income and high-risk. When Goodwill operated Indianapolis' WorkOne centers and reached 50,000 people annually, over 50% of its participants lacked a high school diploma. The organization determined that by helping young people stay in school and at least obtain a high school diploma, families would be less likely to need services from Goodwill once they become adults. With very low graduation rates in Indianapolis, helping young people complete high school would increase Goodwill's long term impact. Through a number of small-scale initiatives to support youth in its education, Goodwill recognized that it could effectively offer prevention services to young people. When the opportunity arose to apply for a charter authorization to operate a high school, Goodwill recognized that the opportunity to create a targeted and long-term approach with young people could create substantial and lasting impact. Therefore, Goodwill created a separate 501(c)3, Goodwill Education Initiatives, Inc., to hold the school charter and to operate the school. The Indianapolis Metropolitan High School (Indianapolis Met) opened during the fall of 2004. Goodwill provided capital expenses for the school campus and continues to provide support through an ongoing operational subsidy and through support infrastructure provided by Goodwill Industries.

Goodwill monitors the long-term student outcomes through two measures: (1) graduation rates and (2) postsecondary enrollment and retention. Intermediate data on student scores (through end-of-course assessments) and school attendance are also evaluated by the boards of the school and of Goodwill as a whole. Goodwill recognized the importance of continuity of relationships, creating an individualized approach with each student to ignite their learning capacity, and providing extensive academic and non-academic support services for participants. The success of the school has also opened up new opportunities among other adults in need of education services. Last September, Goodwill opened a new charter high school, the Excel Center, which built upon the academic philosophy of the Indianapolis Met to provide a diploma option for older adults who have dropped out of school. History to date indicates that Goodwill is well-positioned in the Indianapolis community and has the capacity to implement such broad-reaching program such as NFP. Goodwill has positioned itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP-IN portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5.

Adequacy of Resources to Sustain Project after Grant Period

The collaboration of DCS/ISDH allows multiple State agencies to work together to ensure adequate resources after the grant period ends. ISDH's MCH Division is a recipient of Title V Federal Block Grant Funds, and with these funds, ISDH supports activities to serve low-income families. Such activities include support of local health departments, maternal and child health clinics, adolescent health and education, prenatal care coordination, and the free pregnancy test program (to name a few). ISDH is committed to integrating all Title V programs with Home Visiting services. ISDH is also dedicated to seek additional support funds to expand its home visiting programming, implementation, evaluation, and statewide coordination efforts. Indiana has a long standing commitment to home visiting programs.

The Department of Child Services has contributed to this effort with the continued support of HFI, which has been utilized by Indiana since 1994. DCS will continue to fund HFI with the support of the Indiana State Budget Agency to hold the state funding level for HFI consistent with March 23, 2010 levels. This commitment and the established infrastructure for HFI in local Indiana communities will allow DCS to use the funds from this grant to serve additional high risk children and families. DCS recognizes the important role that prevention services, such as HFI, play in preventing child abuse and neglect. DCS continues to emphasize the importance of placing children in-home and with relatives the need for home visiting services will continue to grow. DCS has been successful in finding efficiencies and that has permitting the shifting of resources to other priorities. As DCS increases efforts to keep children at home or with relatives, it will continue shifting funds from high level care of children to lower level interventions such as home based services and prevention efforts. Healthy Families Indiana will remain a priority for these funds. In addition, HFI agency leaders meet regularly to monitor funding opportunities and brainstorm ways to increase support for the program. The infrastructure is in place to support this expansion and identify opportunities to sustain it.

Assurances of State Funding

Indiana State Budget Agency agrees to continue funding for home visiting programs at the same level as was appropriated on March 26, 2010. See Attachment 9 for Letter of Commitment from DCS and State Budget Agency to adhere to the Maintenance of Effort for an amount of \$1,090,892