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## Section 1: Identification of the State's Targeted At-Risk Community (ies)

**Identification of High-Risk Communities** 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 the data were gathered and analyzed, the list of indicators was narrowed to forty 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 forty 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. The following counties are rural, but have very high-risk scores:

1. Owen County
2. Fayette County
3. Jennings County
4. Scott County

Not surprisingly, the following highly-populated areas also revealed high-risk scores:

1. Marion County
2. Lake County
3. La Porte County
4. St. Joseph County
5. Elkhart County

These high-risk, high-populated counties (other than Marion County) are all located in the northern part of Indiana and have large, diverse populations. The final two counties at the highest risk are Starke County (which is also in northern Indiana) and Grant County (which is home to the city of Marion, Indiana).

### ***In-Depth Analysis of High-Risk Communities***

The final supplemental information request (SIR) requires states to analyze further the counties identified as high risk in the Statewide Home Visiting Needs Assessment. To do this, Indiana developed a five-step process to determine specific areas within the at-risk counties that have especially high needs.

#### Step 1: Elimination of least high-risk counties

To further analyze specific communities within these high-risk counties, Indiana immediately eliminated three counties based on their overall rank and geographic relevancy to begin the process. These three counties (Grant, Owen, and Fayette Counties) do not border any other county Indiana identified in the Statewide Home Visiting Needs Assessment. Based on the geographic isolation of these counties, its small populations, and its low rankings within the top 11 counties, these three counties were eliminated from the further review. Conversely, Marion and Lake Counties remained in the analysis due to its high rankings as compared to other high-risk counties, its large population, and urban nature. Four of the northern-located high-risk counties (Starke, La Porte, St. Joseph, and Elkhart Counties) are geographically clustered and, while different in urban and rural, have the possibility to affect a large number of people in a small geographical area. Finally, Scott and Jennings County are the most rural of the counties on Indiana's high-risk list. These two counties are adjacent, which can aid in implementing a program in a remote area to reach more individuals.

### Step 2: Collection of Zip-code Data

The next step in the analysis process was to collect Zip-code level data and survey the community organizations within the 8 final counties. Specifically, Indiana aimed to collect data related to the six benchmark areas within each county. The following table lists each of the indicators collected within each benchmark.

<b>Maternal and Newborn Health</b>
Breastfeeding
Gestation
Deliveries on Medicaid
Birthweight
1 <sup>st</sup> time mother
Infant Mortality
<b>Child Injuries, Child Abuse, Neglect and Maltreatment, and Reduction in ED Visits</b>
Outpatient/ED visits from all causes, children <1; 1-5
Substantiated Child Abuse <18
<b>Crime/ Domestic Violence</b>
Domestic Violence
<b>School Readiness/ Achievement</b>
% of 3 <sup>rd</sup> grade children who passed both Math and English on ISTEP+
<b>Family Economic Self-sufficiency</b>
Deliveries on Medicaid
% of children on reduced price lunch
% of children on free lunch
<b>Coordination of Referrals</b>
Unmet referrals of current HV programs

Several factors must be considered when collecting and interpreting data within each of the highest-risk counties. First, in many Zip-codes, a low population size may render data analysis and comparisons unreliable. Second, many indicators are either under- or over-reported. For example, *outpatient and emergency department visits for all injuries for children under the age of one and between one and five* are under-reported due to the limitation that not all children who seek services via outpatient visits or emergency departments are sought specifically for injuries. That is, some children who have a primary care physician may seek physician care within a community health center or private practice setting to receive treatment for an injury—thus, limiting the reliability of this indicator. Moreover, measurements for indicators of domestic violence were unavailable at the specific Zip-code, nor any other small community level.

### Step 3: Survey of Service Providers

Completed simultaneously with *Step 2*, this step involved distribution of an electronic survey to a wide variety of service providers within each of the eight identified highest-risk counties. This survey was developed to help ISDH and its partners to fully understand perceptions of community stakeholders of (1) needs for home visiting services; and (2) capacity to develop and implement a new, or enhance an existing, home visiting service in its specific community. For reference, a blank copy of this survey can be found in Appendix A.

### Step 4: Analysis of Zip-code and Survey Data

During this step, Indiana analyzed raw figures, rates, and community input to identify areas of higher risk, community's wants and needs, and the community's capacity to implement any specific home visiting program. For quantitative data, Indiana compared individual zip code indicators from all benchmark areas as stated above. After collecting the raw numbers, rates were calculated of each indicator using appropriate denominators, then standardized the rate to a score of 100, in which the highest (or lowest) rate received 100. The sum of the indicators within each benchmark standardized to 100 revealed the benchmark score for each individual zip code. Final scores and ranks were assigned as appropriate based on benchmark scores. A higher final score (closer to 100), and a lower rank (closer to 1) signify higher risk. Please note, no one indicator or benchmark was weighted in this process. Please see zip code level maps of the selected counties in

Attachment 7. The maps show where in the state the county is located, as well as color-codes each individual zip code based on its final ranking. The areas of darker red illustrate higher risk. The community assessment survey that was sent to the eight high-risk counties was also used data analysis to determine highest risk communities throughout the state. A detailed analysis of this survey is described in Section 3 of this proposal.

#### Step 5: Final Community Selections with Programs to Meet Needs

Final decisions were made based on county and grouped Zip-code analyses. This grouping is based on geography and community readiness or capacity to implement a program (either new or enhance an existing home visiting service). The Indiana Department of Child Health Services (DCS) will expand its HFI program in four of the most high-risk counties that offer Healthy Families America program service—Marion, Scott, Lake, and St. Joseph counties. Goodwill Industries of Central Indiana (Goodwill) will expand Nurse-Family Partnership (NFP) in Marion County with priority given to Zip-codes 46205, 46226, 46218. The following lists basic information regarding each county for which requested funds will be used for home visiting services within Indiana.

*Community 1: Scott County:* Scott County is a rural southern Indiana county with very few resources. Zip-codes in Scott County cross county lines; however, main Zip-codes in Scott County are 47102, 47170, 47138, and 47177. Due to the rural nature of Scott County as well as lack of Zip-code level data, Indiana will implement on county level but through a service provider located in Scottsburg. However, Scott County ranked third most at-risk in the Home Visiting Needs Assessment among 92 counties. Of the 346 live births in 2007, 45% were Medicaid eligible and the child abuse rate was extremely high (4%). Over 25% of Scott County's population under 18 years of age live in poverty, while over half the elementary school students receive free or reduced school lunch. Scottsburg, the largest city in Scott County is located in Zip-code 47170, which is where most of the resources in the county are located. Scott County's second largest city, Austin is located in Zip-code 47102. Scott County has identified high-need as well as great willingness and capacity to expand Healthy Families. Increasing programmatic funding in Scott County will allow HFI to reach a great span of families for greater impact.

*Community 2: Lake County:* Lake County, also located in northwestern Indiana 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. A pocket of five contiguous inner-city Zip-codes in East Chicago and Gary have exceptionally poor outcomes and demonstrate a need for home visiting services. These Zip-codes are currently served by two Healthy Families Indiana (HFI) providers. The first HFI provider will serve Zip-codes 46320 and 46312 in East Chicago. The second HFI provider will serve Zip-codes 46406, 46402, and 46408 in Gary. These Zip-codes ranked three of the top six highest-risk Zip-codes in Lake County, while the Zip-codes of East Chicago also demonstrated high need. In 2009, these five Zip-codes totaled 1,527 live births, of which 13% to 22% are preterm. The average median income of these Zip-codes is \$27,000, providing rationale for the 59% to 86% of births that were Medicaid eligible. Child abuse rates in these Zip-codes range from 1.19% to 1.95%. Of the 68 child deaths in Lake County, 16 occurred in these five Zip-codes.

*Community 3: St. Joseph County:* St. Joseph County is located in northwestern Indiana. Due to its population size, ISDH was able to analyze Zip-code level data for most Zip-codes in 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 show an evident need for home visiting services. These five zip codes 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. As seen by the map in Appendix G, selection of these Zip-codes allows HFI to target very high-risk areas while still addressing a large geographic area.

*Community 4: Marion County:* 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, while nearly 20% of children under 18 live in poverty. The median household income of the county in 2009

was 41,201. Of the average 30,864 monthly families on TANF in Indiana, about 30% of them live in Marion County. About 9% of the births in Marion County were of low birth weight. Marion County as a whole ranked 1<sup>st</sup> during the state-wide needs assessments due to its poor birth outcomes. There were 4,706 substantiated reports of child abuse for children under the age of 18 in 2009. Zip-code 46218 ranked 6<sup>th</sup> of 72 Zip-codes in Marion County during the in-depth analysis. Zip-code 46226 ranked 12<sup>th</sup>, and 46205 ranked 15<sup>th</sup>. The percent of infants born of low-birth weight in 46218 and 46205 is 11.4% and 11.1%, respectively, which is higher than the county average.

### ***Existing Mechanism for Screening/Identifying/Referring Families to HV Programs***

Since Healthy Families Indiana (HFI) currently exists in all counties in Indiana, a mechanism for screening, identifying and referring families is already in place for Marion, Lake, Scott, and St. Joseph counties.

### ***Existing HFI Methods for Screening / Identifying / Referring Families***

HFI must initiate services either prenatally (no earlier than the 6<sup>th</sup> 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 is to 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 the *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
- Cumulative 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.

### ***Nurse-Family Partnership (NFP) 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 the two programs to work in tandem with 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 each program is achieving its desired impact and is replicating the model faithfully. Marion County is currently the only county with two MIECHV sponsored programs. 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 either HFI or NFP-IN. Models with different eligibility requirements are able to reach segments of the population that HFI or NFP-IN is not eligible to serve.

### ***Plan for Coordination with Existing Services***

Indiana is fortunate that several home visiting programs (that are considered to be either evidence-based or a promising practice) are currently being implemented in various locations throughout Indiana. Each of these programs target similar population groups (groups of individuals who are low-income, at-risk, or high-needs). However, each program addresses its own specific set of benchmarks. For example, Parents as Teachers focuses primarily on school readiness and achievement while First Steps focuses primarily on child developmental delays. While both programs focus on children who are at-risk throughout the state, each program has measureable outcomes that are specifically related to its program objectives. Therefore, the state HV approach will navigate clients to the home visiting program that is most appropriate to each client's (and his/her family's) specific needs.

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) A network of locally coordinated referrals to home visiting programs; 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 Department of Child Services' 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 and, as a whole, the gaps that exist currently. It is crucial that all home visiting programs that exist in the state be included in this board. Then, the IHVAB will develop a state-wide 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 offer assistance to ensure local referral coordination exists for home visiting programs to help ensure all participants of home visiting services receive comprehensive referrals and follow-up. This 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 able to share in its partnerships formed through Family and Social Services Administration and child welfare groups, ISDH is able to utilize existing collaborations with prevention and health care services and programs.

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. Within each of the four communities HFI will expand its services with MIECHV funds, Healthy Families has formalized relationships for referrals and other collaborative agencies.

NFP requires all referrals be for first-time, low-income mothers who can enroll in the program before the 28 weeks of pregnancy. This structure requires a capable support network that reaches pregnant mothers early in pregnancy in order to refer sufficient numbers of pregnant women to fill the program. Goodwill has enlisted the support of hospital systems in order to build a referral system for NFP: Wishard Hospital, St. Vincent Hospital, and Indiana University Health have agreed to refer eligible mothers to NFP. Combined, analysis of their participant data reveals that they can reveal several dozen eligible participants to NFP every month. Other sources include schools (including the Indianapolis Metropolitan High School and The Excel Center) to support the pregnancies of young mothers in high school.

### **Capacity to Integrate Program into Early Childhood System**

Indiana has determined it has the capacity to integrate the proposed statewide home visiting program into the early childhood system. As stated in *Section 2*, the *statewide approach to home visiting* will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as develop strong parent-child relationships. This contribution will occur through an established partnership with the Sunny Start Core Partners of Indiana (Sunny Start). This program is funded through the Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems (ECCS) grant. 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. As indicative of both Dr. Ganser and Ms. Wilkes' currently held positions within ISDH's MCH Division, the Home Visiting Program Coordinator, located within ISDH's MCH Division, will continue to work closely to strengthen the early childhood collaborative through Sunny Start. In addition, the Program Coordinator for Healthy Families Indiana 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.

ISDH's ECCS plan, *Sunny Start: Healthy Bodies, Healthy Minds*, ensures that young children arrive at school healthy and ready to learn. Indiana's statewide home visiting approach will collaborate with Sunny Start's Healthy Bodies, Healthy Minds initiative to make progress towards the six benchmarks. This mutual partnership will ensure that each program's respective goal of *improving health and development outcomes for children and families who are at risk* and *ensuring that Indiana's children arrive at school and ready to learn* is achieved.

Specifically, the MIECHV program, through implementation of both home visiting models, will ensure that infants receive the best start in life by providing mothers and/or pregnant women with visits during the prenatal period and during infancy and early childhood. During these visits, home visitors ensure that infants and children are meeting developmental milestones. If milestones are not achieved within an expected timeframe, home visitors refer participants and their children to programs and/or services to assist with identified needs. Therefore, children enrolled into the respective home visiting programs will have a higher level of school readiness and achievement.

Furthermore, the MIECHV program will receive resources developed by Sunny Start, including materials to offer parents of young children. 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. 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.

Please see Section 1, page 2 for list of communities that were identified as at-risk during the needs assessment but not selected for implementation.

## [Section 2: State Home Visiting Program Goals and Objectives](#)

### ***Program Goal / Objectives***

The overall goal of Indiana's MIECHV Program is to *improve health and development outcomes for children and families who are at risk*. This overall statewide goal will be accomplished through the following *objectives*:

- Provide appropriate home visiting services to women residing in Indiana (based on needs) who are low-income and high-risk, as well as their infants and families.
- Develop a system of coordinated services statewide of existing and newly developed home visiting programs in order to provide appropriate, targeted, and unduplicated services and locally coordinated referrals to all children, mothers, and families who are high-risk throughout Indiana.

- Coordinate necessary services outside of home visiting programs to address needs of participants, which may include: mental health, primary care, dental health, children with special needs, substance use, childhood injury prevention, child abuse / neglect / maltreatment, school readiness, employment training and adult education programs.

In addition to the above-listed statewide goal and objectives, each home visiting program to be implemented with requested funds (Nurse-Family Partnership (NFP) and Healthy Families Indiana (HFI)) has its own unique program goal and objectives that play specific roles in the state’s overall plan.

Healthy Families’ goal is to “prevent child abuse and neglect of our nation’s children through intensive home visiting.” This goal is achieved by the following *four main objectives*:

- (1) Connect families systematically, prenatally or at birth, and provide appropriate linkages to home visiting services, along with other information and referrals.
- (2) Foster nurturing, parent-child relationships.
- (3) Promote healthy childhood growth and development.
- (4) Enhance family functioning by reducing risk and building protective factors.

Nurse-Family Partnership’s goal is to “foster long-term success for first-time moms, their babies, and society.” This goal is achieved by the following *three main objectives*:

- (1) Improve pregnancy outcomes by helping women practice sound health-related behaviors, including obtaining good prenatal care from their physicians, improving diet, and reducing use of cigarettes, alcohol, and illegal drugs.
- (2) Improve child health and development by helping parents provide more responsible and competent care for their children.
- (3) Improve families’ economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education, find work, and when appropriate, strengthen partner relationships.

To achieve each of the aims listed above, several activities will occur and within each activity (or group of activities), expected outcomes (process, evaluation, and impact) will be measured.

For Healthy Families Indiana, outputs as a result of achieving its program objectives include:

- *Prevention of negative outcomes.*
- *Increase in parenting skills/ behavior.*
- *Increase in healthy pregnancy practices.*
- *Increase in ongoing healthcare practices.*
- *Increase in mental health indicators.*
- *Increase in social support system.*
- *Improvement of family environmental factors.*

For Nurse-Family Partnership, expected outputs as a result of achieving its program objectives include:

- *Improved health behaviors among women who are pregnant.*
- *Increased number of newborns with appropriate birth weight.*
- *Improved caregiving.*
- *Appropriate child development.*
- *Parental economic self sufficiency.*

Please see Attachment 1 for a Logic Model of the proposed program.

### Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of Targeted Community (ies)

#### ***Selected Evidence Based Programs***

The Indiana State Department of Health (ISDH) and the Indiana Department of Child Services (DCS) will implement two evidence-based home visiting programs with the proposed MIECHV funds: Healthy Families Indiana (HFI) and Nurse-Family Partnership-Indiana (NFP-IN). DCS will expand upon current HFI programs in four different areas throughout the state: Marion County, Scott County, South Bend (an inner-city area of St. Joseph County), and a high-risk area in Lake County. In addition, NFP-IN will expand programming in Marion County, from four high-risk zip codes, to all of Marion County with priority given to Zip-codes 46205, 46226, 46218 as well as those identified in the Updated State Plan.

#### ***How model meets needs of proposed communities***

The home visiting programs selected will meet the needs of 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. 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 in 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 decrease 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 programs.

### ***State Engagement of Community to Assess Fit of Models***

In order to understand efforts existing in high-risk communities as well as to establish community needs, an electronic survey was developed and distributed to over 80 organizations identified by ISDH contacts and DCS Community Partners. Seventy organizations completed the survey for a response rate of 82.4%. However, only about half (48%) resided in the high risk communities identified for further analysis.

Indiana surveyed a wide range of service providers to guarantee a variety of agency input. The main service provided by respondents ranged from medical care / prenatal care, to education and job training, psychosocial/ mental health assessments, and support services for children and youth with special health needs. While many respondents (47.1%) indicated they served clients in Marion County, all 92 counties were served by at least one of the respondents.

When asked about home visiting programs that exist in the respondent's service area, responses were varied. Many organizations stated that HFI exists in their community but cannot currently meet the need. Many organizations asserted that HFI could not meet the need due to recent funding cuts. The majority of organizations felt that if HFI was able to hire more home visitors and staff, the program could be effective, citing statements such as "Great program but limited by funding, program has been cut," and "I believe that Healthy Families in our area has the capacity to serve more families and to partner with others in our communities to insure children grow up in a safe and nurturing environment."

Other respondents agree that reduction of HFI services due to funding cuts have negatively affected service areas but believe there is space for other home visiting programs within the area to meet various needs. Some organizations noted that expansion of Parents as Teachers in northwest Indiana may be beneficial as well as the expansion of Early Head Start. When asked specifically what programs would meet an unmet need in the respective communities, only 3 organizations responded. One response noted Parents as Teachers would meet the need of teen pregnancies. The other respondents noted that NFP would meet an unmet need in its community. Specifically, one respondent mentioned NFP's ability to connect clients with housing agencies, which is one service 38.7% of respondents noted as a service need in the area.

### ***State's Current / Prior Experiences with Implementing Models***

#### **HFI Experience**

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 HFI programs in the nation and is one of only seven multi-sites programs accredited by HFA. Indiana provides significant financial support to HFI and assures that the program is available in all 92 counties. The central office housed in the Department of Child Services, has the ability to administer the program effectively allocating funds based on local need, consistently assessing and evaluating program quality and utilization, and redistributing funds based on findings.

#### **NFP-Experience**

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.

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 the Indianapolis Metropolitan High School (Indianapolis Met) through a separate 501(c)3. Since its opening in the fall of 2004, Goodwill has provided capital expenses for the school campus and continues to provide support through an ongoing operational subsidy and support infrastructure.

Goodwill monitors student outcomes such as graduation rates, postsecondary enrollment and retention, student scores (through end-of-course assessments) and school attendance. Throughout its seven years, 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. Recently, 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 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.

### ***Plan for Ensuring Model Fidelity & Quality Assurance***

#### **State's Overall Approach to Quality Assurance (QA)**

The Home Visiting Co-Coordinators (Ms. Mallory Quigley and Ms. Andrea Preston), with guidance from supervisory staff, will be responsible for quality assurance processes. 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 QA process for the state of Indiana as indicated by her experiences in 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 Unit 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 Program Coordinators from DCS and ISDH will collect information quarterly on each program model and its respective implementation sites. In addition, they will jointly conduct site visits annually. The details and processes of each site visit will be determined after assessing the efficiency and effectiveness of quarterly reports. While the specific timelines and dates are in place to ensure activities are completed in a timely manner, communications between the respective Program Coordinators and each program and site will occur regularly. The Program Coordinators from DCS and ISDH will serve as resources (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. Moreover, each program will be required to collect client satisfaction surveys to obtain feedback from a sample of recruited, screened, enrolled, and ultimately "graduated" participants to its respective programs. This state approach to quality assurance is in addition to all program specific QA methods. The state QA system exists to ensure MIECHV specific reporting requirements. Each model will perform QA as specified by its respective national model developer.

### **State's Approach to Program Assessment & 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 will 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. For program utilization and model-fidelity monitoring, the Program Coordinators will monitor the following to ensure each program is completing required activities:

- Number of client assessments completed.
- Number of outreach activities completed to engaged clients.
- Number of referrals received and the agency/ organization from which it was received.
- Client eligibility and priority given to specific risk factors as listed in Section 5.
- 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).

In addition to the information listed above, 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. 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 program is an evidence-based program and requires authorization from the National Nurse-Family Partnership 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 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 (Marion County, Lake County, St. Joseph County, and Scott County) 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 (as stated in Section 5), and 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 Program Improvement Plan for each site.

#### **Anticipated Challenges / Risks to Quality & Fidelity**

Implementing evidence-based programs can prove challenging. 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 resources.

Similarly, NFP 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 which will allow for selection of appropriate home visitors. Another risk of implementing NFP 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.

#### **Section 4: Implementation Plan for Proposed State Home Visiting Program**

##### ***Process for Engaging At-Risk Communities***

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. The IHVAB will also bring together other home visiting programs that exist in Indiana such as Parents as Teachers, Early Head Start, and Healthy Start to ensure all community programs are being engaged.

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.

### ***MIECHV Policies and Standards***

Policies and Standards for the MIECHV program will be developed and finalized by the Indiana Home Visiting Advisory Board (IHVAB). Such policies and standards to be considered will include:

- Board meeting schedule, agenda, purpose, objectives, and task forces.
- Local referral coordination process.
- Reporting requirements for all home visiting programs throughout the state specifically regarding MIECHV outcomes within its benchmark measures (including NFP, HFI, and the other home visiting programs throughout the state.)
- Quality Assurance and CQI activities and the timeline for reporting.
- Dissemination of results to local community stakeholders and partners, consumers, statewide partners such as ISDH, DCS, Goodwill, and legislators and other policy makers.

Policies for HFI are initiated by either DCS or HFA and approved by DCS, as HFI's fiscal and operations agency. These policies are generally prompted by HFA standards, funding requirements, or DCS system internal requirements. Policy recommendations from individual HFI sites are reviewed by a statewide committee, beginning with the committee that matches the request.

The committees will send all proposed policies to the HFI Operations Committee, which includes 10 managers from all regions of the state, DCS staff, the QA/TA team, Training Subcontractor, and the Evaluator (Database Manager). This committee develops policies that are sent to the Think Tank Advisory Committee (HFI's collaborative public/private partnership involved in program planning and implementation) for review. Once the policy is reviewed, it is sent to DCS for approval. Once the policy is approved, it is added to the policy manual, which is posted on-line. The policy is sent to every site manager, the QA/TA, Training subcontractor, the evaluator and DCS staff by e-mail. It is also posted in the next quarterly e-mail and is then discussed at the next mandatory manager's meeting.

For NFP, Goodwill will abide by all policies and procedures recommended provided by the national model developer for service provision, quality assurance, and management. In addition, Goodwill will develop its own policies and procedures manual, using the model developer's recommendations as well as recommendations from the MIECHV program and its advisory board. This policies and procedures manual will be shared with all program implementation staff and reviewed as necessary for any changes to be made. Policies will include: provision of all home visiting services, grievances, unexpected issues that may arise, staff management and staff conduct expectations, etc. This manual will be provided to the MIECHV board as NFP-IN launches and implementation begins.

### State-mandated Policies

Aligned with policies and standards of the MIECHV federal legislation, Indiana will work toward creating statewide home visiting policies to ensure every high-risk family has the option of enrolling in appropriate home visiting services that fits its needs. Indiana currently does not have state-developed policy to mandate home visiting programming statewide (as compared to other states that have mandated legislation requiring a minimum state fiscal allocation dedicated to home visiting services). However, Indiana is dedicated to home visiting and its goal, as indicative of current and past budgeted state allocation of funds for Healthy Families Indiana.

Progress made toward MIECHV outcomes will provide additional justification for creating policies supporting home visiting in Indiana. The external evaluator hired by MIECHV funds will provide additional support to creating policies as ISDH and DCS will be well equipped to discuss benefits of the home visiting programs. Additionally, NFP and HFA have been deemed evidence-based by the HomVee study conducted by ACF. These three elements will draw attention of legislators to consider state-wide home visiting policies.

### Plan for Working with National Model Developers

The approval letters from Healthy Families America (HFA) and Nurse-Family Partnership (NFP) National Service Office are attached in Attachment 8 . These letters indicate that the national model developer is committed to assisting Indiana in implementing high-quality home visiting programs and that each will support and assist Indiana in any needs that may arise.

HFI has a long-standing relationship with HFA. In fact, Indiana, through HFI, was one of the first two states to bring HFA stateside from the original Healthy Start program in Hawaii. HFI was the first multi-site system in the accreditation process and has demonstrated success. HFI donated its online training system to HFA, which is now used by most sites in the national network. In addition, HFI is in regular communication with the HFA regional coordinator and has always had a representative on the HFA national advisory committee with current representation on the accreditation panel and training committee. As a commitment to the national model, HFI will continue to maintain its HFA accreditation. HFA is available to HFI at any point during program implementation to assist with all areas of needs. These needs may include maintaining model fidelity, client outreach and attrition, and outcomes.

HFA is based upon a set of critical program elements, defined by more than 20 years of research. Over the past several years, Indiana has embraced the critical elements of HFA. The critical elements represent the field's most current knowledge about how to implement successful home visitation programs. As an affiliated and credentialed HFA program, HFI will adhere to these critical elements, which provide the framework for program development and implementation. HFI will ensure that all to-be-hired staff is trained on the critical elements. In addition to helping assure quality, HFA will guide HFI on an as needed basis so that critical elements allow for flexibility in service implementation to permit integration into a wide range of communities and provide opportunities for innovation.

Technical assistance from the NFP National Service Office (NSO) is core to implementation of an NFP site. NSO ensures all implementing agency staff members are prepared to manage the program and serve the families in the community. NSO provides all items necessary during development of a site, education of nurse home visitors, guidelines for the operations of home visits, and data collection and reporting system. NSO also provides planning assistance, opportunities to interact with and learn from other implementing agencies around the country and initial education for the home visitors. NSO will continue to provide any type of technical assistance to the implementing agency through on-going communication with NSO staff, including assisting with CQI, maintaining model fidelity, and improving processes and outcomes. Since NSO has access to all implementing site's data, this type of communication can occur at any time.

### Timeline for Obtaining Curriculum

Each program (NFP-IN and HFI) has specific curricula provided and/or recommended by its respective model developer. Prenatally, all HFI sites must use the HFA-PN curriculum. Since HFI will be expanding its services with MIECHV funds, the curriculum is already present and therefore no timeline is necessary. While HFI does not have a prescribed curriculum for postnatal services; it does, however, utilize multiple curricula to address the family's need.

Each site must use at least three curricula, which may include Parents as Teachers, Partners in Parenting Education (PIPE), and Nurturing. HFI already utilizes and has access to each of these curricula.

NFP uses its own, model-developed “curriculum,” which includes 18 home visiting model elements. In addition, NFP sites utilize the PIPE curriculum for home visiting services. The curriculum will be obtained once NFP-IN is approved by the NFP-NSO. The NFP-NSO has granted conditional approval to Goodwill to implement NFP-IN. Upon notification of funding, Goodwill will notify NFP-NSO and will then be provided PIPE as well as its model elements curriculum.

#### Plan for Professional Development / Training

**MIECHV Training:** The MIECHV program staff 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, 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 throughout the state, 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— any 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. This position is 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.

**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. Through a detailed interview process, the team relies upon observations and desires of managers to ensure that each candidate is a good fit for the operating culture and technical demands of each position. 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 Dept. 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

Recognizing the importance of attracting and retaining talent, Goodwill pays competitively for the market for its positions. Compensation levels must allow the organization to recruit talent from not-for-profit and for-profit organizations.

***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, Scott, Marion, and Lake Counties. DCS 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 the criteria listed above, 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. Invoices will be paid within a timely and efficient manner and only after deliverables have been met.

### ***Plan to Ensure High-Quality Clinical Supervision***

#### *HFI Clinical Supervision*

HFI sites are required to provide weekly face-to-face supervision to all frontline staff by a qualified supervisor, for a minimum of two 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 from HFA and must meet the same requirements their staff meet. 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. All HFI sites have access to extensive technical assistance at all times which can include staffing cases and mentoring of supervisors and managers. During annual site visits the quality assurance team reviews supervision records for frequency, duration, and content.

#### *NFP Clinical Supervision*

At the core of Nurse-Family Partnership are its clinically trained nurses who conduct home visits and the nurse supervisor who oversees all aspects of the implementation site. Assurance that clinical supervision is guaranteed with Nurse-Family Partnership as the nurse home visitors must have a minimum of a baccalaureate degree in nursing, while the nurse supervisor must hold a Master's of Nursing. Nursing supervisors provide nurse home visitors with clinical supervision with reflection, demonstrate integration of the theories and facilitate professional development essential to the nurse home visitor role through specific supervisory activities, including 1:1 clinical supervision, case conferences, team meetings, and field supervision. Nurse supervisors are trained during initial NFP training that all staff members must complete. Supervisors attend specific session during the training to learn aspects of reflective supervisor and other supervisory elements of NFP. After returning to the implementation site, supervisors refer to Nurse-Family Partnership- National Service Office (NFP- NSO) for continual guidance and technical assisting. In the instance of NFP-IN, nurses and nurse supervisors will be employed by Goodwill Industries of Central Indiana and therefore will follow NFP- NSO guidelines as well as Goodwill's procedures and policies.

### ***Plan for Identifying and Recruiting 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. While the referrals sources may be the same, due to the target populations of the specific programs, referrals will be 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, Marion, Scott, and St. Joseph Counties.

***Existing HFI Methods for Screening / Identifying / Referring Families:*** HFI must initiate services either prenatally (no earlier than the 6<sup>th</sup> 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
- Cumulative score 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 in Marion County, it will utilize existing mechanisms that are in place for referrals to NFP, such as schools, local hospitals, and other Goodwill services. NFP-IN will also 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, 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 each program is achieving its desired impact and is replicating the model faithfully. Marion County is currently the only county with two MIECHV sponsored programs. 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 either HFI or NFP-IN. Models with different eligibility requirements are able to reach segments of the population that HFI either 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.

***Plan for Minimizing Attrition Rates***

Attrition will be kept low by providing quality and consistent outreach to program participants. HFI has consistently low attrition rates. However, HFI will work to minimize these through outreach and building strong relationships with clients. NFP-IN will use a new technology of blending services into an entire family solution to engage all family members.

***Estimated Timelines to Meet Max Case Loads***

Due to start-up time, nurses in NFP-IN will take about 9 months after funding is awarded to reach a full caseload, while new HFI home visitors will take about 3 months, based on assessment rates and enrollment.

#### Estimated Number of Families to be Served

Between both NFP and HFI, 385 new families will be served with home visiting services. Specifically, HFI will serve an estimated 285 families with the new MIECHV funds, while NFP-IN will serve 100 new participants with FY11 MIECHV funds.

#### ***Operational Plan for Coordination between Home Visiting Programs***

As described in *Section 6*, the overall statewide home visiting program organizational chart is listed in Attachment 3. Managing the day to day communications between the co-lead agencies and the collaborative partners is the Home Visiting Program Coordinators, housed at ISDH will ensure that DCS and Goodwill have and continue to collaborate fully to implement HFI and NFP. In addition, ISDH will continue to integrate other existing home visiting programs throughout Indiana through representation on the Indiana Home Visiting Advisory Board. These programs range from qualified evidence-based program such as Early Head Start and Parents as Teachers, as well as Indiana's local home visiting programs like Healthy Start and Even Steps. ISDH and DCS will have a Memorandum of Understanding, in which specific deliverables are described for the transfer of funds from ISDH, the MIECHV Program fiscal agent, to DCS. Similarly, ISDH and Goodwill are in the process of developing a contract detailing specific deliverables and outcomes as well as financial allocations.

With oversight from the Maternal and Child Health Division Director (Mary Weber), the Director of Life Course Health Systems (Mary Ann Galloway), and the Public Health Administrator of Women of Childbearing Age (Charrie Buskirk), the Home Visiting Program Coordinator (Mallory Quigley) will organize all communications and activities with:

1. The Director of Preventive Services (Phyllis Kikendall) at DCS and the Healthy Families Indiana Program Coordinator
2. The Director of Community Initiatives (Mr. Keith Reissaus) and the Director of Strategic Planning and Development (Mr. Eric Lange) at Goodwill Industries of Central Indiana

This core group of individuals will maintain an open line of communication and have shared goals of improving outcomes for mothers, infants, and families and pioneering Indiana's collaborative state-wide approach to home visiting. During Updated State Plan preparation, ISDH and DCS held weekly meetings to ensure all planning activities were within both agencies' strategic plans. After funding is awarded, meetings will be reduced to monthly and later, quarterly, for time management purposes. Both agencies have connections with existing home visiting and wrap-around services through-out the state. The knowledge of those wrap around services and their agencies provided by the core individuals involved in this program will assist in the development, implementation, and evaluation of the home visiting programs. Each MIECHV funded home visiting program will develop relationships throughout the respective communities regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services. Both programs will report back to the Program Coordinators for ISDH and DCS on MOU's created and referrals made to outside organizations.

#### ***Plan for Data Systems***

The Home Visiting Program Coordinators for ISDH and DCS will not use a specific data system to aggregately collect data. Rather, the Program Coordinators will collect data from individual programs through quarterly report that mimic templates provided by HRSA and ACF for Federal Reporting Requirements

#### **HFI Data Systems**

Healthy Families Indiana currently has a data system, Home Visiting Tracking Information System (HVTIS), developed and operated by Datatude, Inc. that can be used to create immediate reports. This data system will not require modification as it can produce reports with service utilization information as well as process and outcome

measures that the Home Visiting Program Coordinators will request quarterly to evaluate the program and assist in creating plans for improvements.

### **NFP Data Systems**

As Goodwill Industries receives funding for the NFP-IN program, NFP will provide its reporting data system, Efforts to Outcomes to NFP-IN. This data system will not require modification as it can produce reports with service utilization information as well as process and outcome measures that the Home Visiting Program Coordinators will request quarterly to evaluate the program and create plans for improvements. A more-detailed continuous quality improvement plan is provided in *Section 7*.

### ***State's Approach to Implementation with Fidelity and Quality Assurance***

ISDH and 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 (HFI 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, including progress towards MIECHV reporting requirements. Three specific levels of CQI will occur: (1) MIECHV state level; (2) HFI level CQI; and (3) NFP-IN level CQI. Operationally, these three levels will work collaboratively through open communication and quarterly reporting to ensure CQI. While the Home Visiting Program Coordinators will be responsible for ensuring MIECHV reporting and CQI activities will be completed timely and within its respective deadlines, HFI and NFP-IN and its respective national model developers will provide this information to the Program Coordinators and provide CQI expertise for its respective program. Please see *Section 7* for more detailed information on the state's approach of monitoring, assessing, and supporting implementation with fidelity to the chosen models and for quality assurance. Possible challenges may include implementing specific models in unique populations. However, national model developers are present to help respective models outreach to clients and provide adequate home visiting and wrap-around services to the clients.

### ***List of Collaborative Partners***

#### **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. Program Director of Healthy Families Indiana, 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.

Many agencies have also offered support for Indiana's approach to home visiting through letters of concurrence or support. These agencies are as follows: (Letters of Concurrence can be found in Attachment 5.)

- Title V Agency/ Public Health Agency: Indiana State Department of Health: Dr. Gregory Larkin
- Agency for Title II of CAPTA/ Child Welfare Agency: Department of Child Services: Judge James Payne
- Agency of Substance Abuse Services/ Mental Health Agency: Department of Mental Health and Addictions: Gina Eckart

- Child Care and Development Fund Administrator: Family and Social Services Agency: Melanie Brizzi
- Head Start Collaboration Office: Susan Lightle
- Advisory Council on Early Childhood Education and Care: Indiana Department of Education/ Early Childhood Specialist: Dana Jones

### **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. 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).

Healthy Families has formed partnership at the state and local level to integrate the program into referral systems and services for families with children zero to three years of age and in special areas of need up to five years; i.e. early Head Start, Head Start, Child Care, First Steps Early Intervention; Parents as Teachers and other support programs for families in their local environments.

Leadership to support this integration is the Indiana Head Start Collaboration Multi- Agency Council who has recently formed a sub-committee asking partners to come together to look at the results of the Head Start yearly needs assessment. The focus will be on how to work together to meet the needs of not only Head Start families and children but all children at risk in Indiana. The partners will review this from a point of view of all the early childhood stakeholders: First Steps, Department of Education, Bureau of Child Development Department of Child Services, State Head Start Association, ICCR&R and IAEYC .

### **NFP 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. 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.

### ***State's Integration Into the Broader Early Childhood System***

The MIECHV program will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as develop strong parent-child relationships. This contribution will occur through an established partnership with the Sunny Start Core Partners of Indiana (Sunny Start). This program is funded through the Maternal and Child Health Bureau's (MCHB) Early Childhood Comprehensive Systems (ECCS) grant.

Specifically, the MIECHV program, through implementation of both home visiting models, will ensure that infants receive the best start in life by providing mothers and/or pregnant women with visits during the prenatal period and during infancy and early childhood. During these visits, home visitors ensure that infants and children are meeting developmental milestones. If milestones are not achieved within an expected timeframe, home visitors refer participants and their children to programs and/or services to assist with identified needs. Therefore, children enrolled

into the respective home visiting programs will have a higher level of school readiness and achievement. Both home visiting programs also distribute materials developed by Sunny Start during home visits. A list of these materials can be found on page 8.

### ***Assurances that MIECHV is Designed to Result in Participant Outcomes***

As stated in the MIECHV legislation, state's must implement evidence-based home visiting programs to address six different benchmarks areas of improved maternal and newborn health, reduction in child injuries, abuse, neglect, and maltreatment, reduction in children's emergency department visits, improvements in school readiness and achievement, improvements in family's economic self-sufficiency, and coordination of referrals. Both models also meet the definition of evidence-based as defined by the legislation and through designation as "evidence-based" through the U.S. Department of Health and Human Services' Home Visiting Evaluation of Effectiveness (HomVee). As demonstrated below, both HFI and NFP address all areas dictated by the legislation.

#### ***HFI Assurances***

Healthy Families America (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](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 Healthy Families Indiana 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.

#### ***NFP Assurances***

Nurse-Family Partnership 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, Nurse-Family Partnership'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,

TN., and Denver, CO. The trials were designed to study the effects of the Nurse-Family Partnership model on maternal and child health, and child development, by comparing the short- and long-term outcomes of mothers and children enrolled in the Nurse-Family Partnership 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 Nurse-Family Partnership 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 Nurse-Family Partnership to measure the short- and long-term outcomes of the program. Although the Nurse-Family Partnership National Service Office maintains a close association with the Prevention Research Center, the two remain professionally independent.

Trial outcomes demonstrate that Nurse-Family Partnership 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. For example, the following outcomes have been observed among participants in at least one of the trials of the program:

- Improved pregnancy outcomes through reductions in preterm delivery for women who smoke and greater intervals between first and subsequent births
- Reductions in child injuries, abuse, neglect and emergency department visits due to accidents and poisonings
- Increased child's school readiness by reduction of language delays and behavioral/intellectual problems
- Increased work force participation by mother and reduced use of welfare
- Fewer unintended subsequent pregnancies

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

#### ***Assurances of Participant Provision in Accordance with Assessments***

Providing individualized home visiting services while maintaining adherence to the strict core elements of an evidence-based model can prove challenging. Both HFI and NFP begin client services by assessing each client using a standard assessment tool. These tools allow for home visitors to understand a client's needs, even if the client does not yet have a clear understanding of the needs. After the administering the assessment tool and talking with the client about their goals of the program, a home visitor can create an individualized plan to assist the client. These individual assessments will be recorded within each program's database and reviewed by the Program Coordinators to ensure each client received an individual assessment.

Specifically, all HFI participants receive the Kempe Assessment (Family Stress Checklist) to determine eligibility for the program. These assessments are conducted in a conversational manner, are documented in HVTIS, are both scores and narratives, and are reviewed by supervisors who establish inter-rater reliability.

The Kempe Assessment is reviewed prior to development of the Individual Family Support Plan. Issues in the assessment may be addressed in the plan for services. If families choose not to address the issues identified in the assessment then the home visitor and supervisor brainstorm ways to incorporate interventions into home visiting which will reduce risks identified in the assessment. Other tools may be used with families (EPDS, NCFAS, HFPI, CLS, DLC, Home). The same practice is used as above, for each instrument.

The voluntary nature of both HFI and NFP allows client's to be accepting of the assistance they are receiving. If client's feel services are being forced upon them, they will be less likely to be successful in the program. Via open communication between the home visitor and the client, the home visitor will assess if the client continues to accept

the services on a voluntary basis. This will be noted on the intake assessment and through-out ongoing home visits. Also, as part of assuring model fidelity, HFI and NFP require clients to accept services on a voluntary basis.

### ***Assurances of Participant Priority***

Both programs to be implemented by MIECHV funds will 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 U.S)

As clients enter the home visiting network, clients will be screened or assessed to identify risk factors that may contribute to poor outcomes. HFI's and NFP's intake assessment will be reviewed and, if necessary, modified to ensure clients with above risk factors are given priority.

### **Research and Evaluation**

#### ***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; Garmezzy, 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 local coordination developed and maintained among home visiting services?
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 local coordination developed and maintained among home visiting services?*** 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 ensure 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 of 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  $i$ ,  $\pi_{0i}$  is the intercept, and  $\pi_{1i}$  is the rate of linear change for person  $i$ . More specifically,  $\pi_{0i}$  is the score for the individual when all other variables in the equation are zero and  $\pi_{1i}$  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.,  $\pi_{0i}$  and  $\pi_{1i}$ ). Thus, in the level 2 model, both the intercept ( $\pi_{0i}$  or initial status) and behavioral change rate ( $\pi_{1i}$  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>).

### ***Section 5: Plan for Meeting Legislatively-Mandated Benchmarks***

#### ***Data Collection for 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. 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.

#### ***Anticipated Improvements in Benchmarks***

As required by the legislation, Indiana's statewide home visiting plan will show improvements in at least four benchmarks by the end of three years by showing improvements in at least half of the constructs under each benchmark area. These benchmark areas that demonstrate improvement will be reported at a later date.

#### ***Plan for Collecting Standard Measures for Constructs***

As seen by the Benchmark Chart below, 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 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 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 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 Nurse Home Visitor and entered directly into the national NFP 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.

Please see *Section 7* for more detailed information regarding statewide MIECHV methods for CQI to enhance program operation and decision making. The following information is a summation of such activities within each HV model and how such activities will enhance operations.

### ***State Level CQI***

Each of the two programs to be implemented with MIECHV funds (Healthy Families and Nurse-Family Partnership) 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.

The Program Coordinators from ISDH and DCS will *collect* information quarterly on each program model and its respective implementation sites. In addition, they will jointly *conduct site visits* annually. The details and processes of each site visit will be determined after assessing the efficiency and effectiveness of quarterly reports. While the specific timelines and dates are in place to ensure activities are completed in a timely manner, communications between the Program Coordinators and each program and site will occur regularly.

The Program Coordinators from DCS and ISDH will serve as resources (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. Moreover, each program will be required to collect client satisfaction surveys to obtain feedback from a sample of recruited, screened, enrolled, and ultimately "graduated" participants to its respective programs.

The final aspect of CQI plan is the feedback programs will receive from the Program Coordinators based on its quarterly assessment. The Quarterly Evaluation Report will be a key resource completed by the 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 specifically regarding MIECHV reporting requirements. These plans will be one method of communication and documented feedback to each site. The Program Coordinators will work in conjunction with the specific model CQI, to ensure there is no duplication of efforts.

As aforementioned, each program model has its own set of CQI methods, measures, and feedback processes—of which are outlined in *Section 7*.

### ***Plan for Collection of Benchmark Data***

The Benchmark Charts below identify Indiana's plan for collection of benchmark data. The charts identify each benchmark, and within each benchmark, the associated constructs. The Benchmark Chart also lists each construct's definition of improvement, a process measure and outcome measure, the reliability / validity of each measure, source

of the measure, and the population to be assessed. Both process and outcome measures are listed for each construct. However, only one measure will be used to show improvements within the benchmark.

Since Indiana's approach is supporting both an existing program and implementing a new program, it is difficult to identify baselines for many measures. For that reason, all of the outcome measures are based on the number of individuals screened and will be used to measure improvement within each construct. That is, only the outcomes of individuals who are enrolled and screened in the MIECHV programs will be used to show progress and success in outcome measures. Process measures (where applicable) will be used for continuous quality improvement plan to determine if programs are working towards an effective outcome. Any significant deviations in improvement or decline will be discussed quarterly and used for guidance in developing a Performance Improvement Plan for each HV model.

During quarterly reports, Program Coordinators will collect individual level demographic and service utilization data on participants in respective programs in addition to progress toward outcome measures.

Program Utilization:

- 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 as listed in Section 5.
- 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 of pregnant woman, expectant father, parent(s) or primary caregiver including:

- Gender
- Race/ ethnicity
- Age (including month of child)
- Family income
- Employment status
- Exposure/ use of languages

Healthy Families Indiana is already collecting the client demographic information listed above as well as: employer, Employment Position, Educational Level, Enrollment In School, and Current Marital Status. The de-identified demographic and service utilization data will be available for Program Coordinator to collect during quarterly report

These data elements are integrated into NFP's data system and collected at in-take and multiple points while the client is enrolled. Therefore individual-level demographic and service utilization data are available for Program Coordinators to collect during quarterly reports.

<b>Benchmark: Improved Maternal and Newborn Health</b>						
<b>Constructs</b>	<b>Definition of Improvement</b>	<b>State wide Process Measures</b>	<b>State-wide Outcome Measure</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>
<b>Prenatal care</b>	Changes over time for mothers	95% of women who enter HV program prenatally are screened for prenatal care	Of women screened, 80% receive prenatal care by the third trimester	Parents are valid and reliable sources of info re: construct.	Parent report/ interview	Mother at intake and ongoing
<b>Parental use of alcohol, tobacco, or illicit drugs</b>	Decrease over time	95% of all women enrolled in HV programs are screened for tobacco use	Of those women screened, 75% of demonstrated decrease in tobacco use from intake to client graduation	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother at intake and ongoing
<b>Preconception care</b>	Mother's care received after birth of child (mother receives 6 week postnatal visit)	95% of women enrolled in program are screened for preconception care (receiving care after birth of first child in program)	Of those women screened, 70% of women receive follow-up care after birth	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother at birth of child
<b>Inter-birth intervals</b>	Subsequent pregnancies while in the program	95% of women enrolled in program develop a plan for subsequent pregnancy	Of the women who have developed a plan, 90% achieve the objectives within plan	Parents are valid and reliable sources of information.	Parent report/ interview	Mother
<b>Screening for maternal depressive symptoms</b>	Changes in number of screens over time	95% of mothers enrolled in program are screened from depressive symptoms	Of the women screened for depressive symptoms and showed elevated depression scores, 70% of mothers demonstrate a decrease in depressive symptoms as indicated by the EPDS	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother
<b>Breastfeeding</b>	Increase in number of mothers who chose to breastfeed their infant	95% of women enrolled in the program receive information regarding benefits of breastfeeding	Of the women who received info re: breastfeeding, 50% of mothers who are physically able (i.e., not unable or on medication that prohibits breastfeeding) exclusively breastfeed for the first three months of baby's life	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother
<b>Well-child visits</b>	Increase in compliance with schedule of well-child visits	95% of families enrolled in the program receive information regarding well-child visit schedules	Of families who receive info re: well-child visits, 60% of children, ages 0-2, receive recommended schedule of well-child visits	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother
<b>Maternal and child health insurance status</b>	Change over time	95% of families enrolled in the program are assessed for health insurance status	Of families screened negative for health insurance status, 80% referred to agencies to assist with gaining health insurance	Parents are valid and reliable sources of information about the construct.	Parent report/ interview	Mother

<b>Benchmark: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits</b>						
<b>Constructs:</b>	<b>Definition of Improvement</b>	<b>State-wide Process Measure</b>	<b>State-wide Outcome Measure:</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>

<b>Visits for children to the emergency department (ED) from all causes</b>	Decrease over time	95% of families enrolled in program are assessed for ED usage	Of families assessed for ED usage, 30% of families will visit the ED due to escalating illness which could have been prevented through primary care	Parents are valid and reliable sources of information about the construct. In addition, Home Visitor will record observations regarding incidents.	Parent Report / Home Visitor Observation	Child/ infants as incident occurs
<b>Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby safety (i.e. drowning) and playground safety</b>	Increase in distribution of topics to clients	95% of families enrolled in program receive information on intervention topics including care seat, fire, shaken baby syndrome, safe sleep, injury safety	Of clients who receive information regarding intervention topics, 60% report increased knowledge on these topics	Home Visitors will record intervention information as due course of program.	Home Visitors	Families at each home visit
<b>Incidence of child injuries requiring medical treatment</b>	Decrease over time	95% of families enrolled in program are assessed for report of injuries requiring medical treatment	Of those families assessed for injuries requiring medical treatment, 30% of children enrolled in HV program will seek medical treatment due to injury that may have been prevented	Parents are valid and reliable sources of information about the construct. In addition, Home Visitor will record observations regarding incidents.	Home visitor/ participant report	Parents/ children in program
<b>Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)</b>	Decrease over time	95% of families enrolled in program are screened child maltreatment	Of those who screened positive for child maltreatment 100% are reported to CPS	Home visitors are mandatory reporters of abuse.	Home visitor observation / participant report with comparison to CPS	Children/ infants in program
<b>Reported substantiated maltreatment (substantiated/indicated /alternative response victim) for children in the program</b>	Decrease over time	95% of families enrolled in program are screened child maltreatment	Of those who screened positive for child maltreatment 100% are reported to CPS, while the number of substantiated reports within home visiting clients decrease as per client match in CPS data base	Child Protective Services database.	Home visitor observation/p participant report with comparisons to local & child welfare data	Children/ infants in program

<b>First-time victims of maltreatment for children in the program*</b>	Decrease over time	95% of families enrolled in program are screened child maltreatment	Of those who screened positive for child maltreatment 100% are reported to CPS, while the number of substantiated reports within home visiting clients decrease as per client match in CPS data base	Home visitors are mandatory reporters of abuse.	Participant report with comparisons to local & child welfare data	Children/ infants in program
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<b>Benchmark: Improvements in School Readiness and Achievement</b>						
<b>Constructs</b>	<b>Definition of Improvement</b>	<b>State-wide Process Measure</b>	<b>State-wide Outcome Measure:</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>
<b>Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of parents enrolled in the program will be assessed for support of child's learning and development	Of the parents assessed, 75% will score in appropriate range of the subscale assessing parent support for child's learning and development within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home Visitor observation/ parent report	Parents of children enrolled in the program
<b>Parent knowledge of child development and of their child's developmental progress</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of parents enrolled in the program will be assessed for knowledge of child development and child's developmental progress	Of the parents assessed, 75% will score in appropriate range of the subscale assessing parent knowledge of child development and of their child's development progress within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Parents of children enrolled in the program
<b>Child's communication, language and emergent literacy</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of children enrolled in the program will be assessed for communication, language, and emergency literacy	Of the children assessment, 75% will score in appropriate range of the subscale assessing child's communication, language, and emergent literacy within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Children enrolled in program
<b>Child's general cognitive skills</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of children enrolled in the program will be assessed for general cognitive skills	Of the children assessment, 75% will score in appropriate range of the subscale assessing child's general cognitive skills within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Children enrolled in program

<b>Child's positive approaches to learning including attention</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of children enrolled in the program will be assessed for positive approaches to learning including attention	Of the children assessment, 75% will score in appropriate range of the subscale assessing child's positive approaches to learning including attention within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Children enrolled in program
<b>Child's social behavior, emotion regulation, and emotional well-being</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of children enrolled in the program will be assessed for social behavior, emotional regulation, and emotional well-being	Of the children assessed, 75% will score in appropriate range of the subscale assessing child's social behavior, emotional regulation, and emotional well-being within respective tool (ASQ, HOME, etc.)	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Children enrolled in program
<b>Child's physical health and development</b>	Increases over time in the developmental progress of children between entry to the program & one year after enrollment.	85% of children enrolled in the program will be assessed for physical health and development	Of the children assessed, 75% will score as not at risk for physical health and developmental delays	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Children enrolled in program
<b>Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)</b>	Increases over time in the parenting behaviors and parent-child relationship from entry to the program & one year after enrollment.	85% of parents enrolled in the program will be assessed for positive parenting behaviors and parent-child relationship	Of parents assessed, 75% will demonstrate positive parenting behaviors and parent-child relationship	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Parents enrolled in program
<b>Parent emotional well-being or parenting stress (Note: <u>some</u> of these data may also be captured for maternal health under that benchmark area)</b>	Increases in individual family assessment	95% of mothers enrolled in program are screened from depressive symptoms	Of the women screened for depressive symptoms and showed elevated symptoms, 70% of mothers demonstrate a decrease in depressive symptoms as indicated by the Edinburgh Postnatal Depression Scale	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Parents enrolled in program

<b>Benchmark: Crime or Domestic Violence*</b>						
<b>Constructs</b>	<b>Definition of improvement</b>	<b>State-wide Process Measures</b>	<b>State-wide Outcome Measures</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>
<b>Domestic Violence ( DV): Screening for DV</b>	Increases rate of screening compared to population served	95% of clients enrolled in home visiting program are screened for DV	95% of clients enrolled in home visiting program are screened for DV	IPV Assessment Tool is reliable and valid as seen in the Tool V/R Chart	Parent/ Home Visitor Report	Parents of children enrolled in program
<b>DV: Of families identified for the presence of DV, referrals for relevant services</b>	Increase in rate of referrals over time	95% of clients enrolled in home visiting program are screened for DV	Of the clients who screen positive for DV, 70% are referred to appropriate services	IPV Assessment Tool is reliable and valid as seen in the Tool V/R Chart	Parent/ Home Visitor Report	Parents of children enrolled in program

<b>DV: Of families identified for the presence of DV, families for which a safety plan was completed</b>	Increase in number of safety plans completed over time.	95% of clients enrolled in home visiting program are screened for DV	Of the clients who screen positive for DV, 90% create a safety plan	IPV Assessment Tool is reliable and valid as seen in the Tool V/R Chart	Parent/ Home Visitor Report	Parents of children enrolled in program
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<b>Benchmark: Family Economic Self-Sufficiency</b>						
<b>Constructs</b>	<b>Definition of improvement</b>	<b>State-wide Process Measures</b>	<b>State-wide Outcome Measures</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>
<b>Household* income and benefits+</b>	Increase in total household income and benefits	95% of families enrolled in HV program are questioned regarding their income and benefits	50% of families enrolled in the program report feeling more economically stable at the end of the program than at when enrolled	Client report is reliable and valid for the purposes of this measure	Interview/ Parent report	Each individual in the household
<b>Employment or Education of adult members of the household</b>	Employment: Increase in number of paid hrs worked plus unpaid hrs devoted to care of an infant by all adults in household	90% of families enrolled in program create a plan for employment and/or education	Of the families for which an employment and/or education plan was created, 50% of families follow through with at least one goal from the initial plan by program graduation	Client report is reliable and valid for the purposes of this measure	Parent report/ Interview	Each individual in the household
<b>Health insurance status</b>	Increase in the number of household members who have health insurance over time	95% of families enrolled in the program are screened regarding health insurance status	Of families screened negative for health insurance status, 80% of those are referred to agencies/services to assist with gaining health insurance	Client report is reliable and valid for the purposes of this measure	Parent report/ Interview	Each individual in the household

<b>Benchmark: Coordination and Referrals for Other Community Resources and Support*</b>						
<b>Constructs</b>	<b>Definition of Improvement</b>	<b>State-wide Process Measures</b>	<b>State-wide Outcome Measure</b>	<b>Reliability/ Validity</b>	<b>Source</b>	<b>Population Assessed</b>
<b>Number of families identified for necessary services</b>	Increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes	95% of clients enrolled in the program are screened for necessary services as indicated by assessment tools	Of those screened, 90% are identified for a specific service or need	Home visitors record in data system screens completed	Home visitor	Parents/children in home visiting program
<b>Number of families that required services and received a referral to available community resources</b>	Increase in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.	95% of clients enrolled in the program are screened for necessary services as indicated by assessment tools	Of the families identified for a necessary service, 80% of those families receive an appropriate referral to a community resource	Home visitors record in data system screens/ referrals as completed	Home visitor	Parents/children in home visiting program

<b>MOU's: Number of Memoranda of Understanding or other formal agreements with other social services agencies in the community</b>	Increase in the number of formal agreements with other social service agencies	Maintenance of existing agreements and/or newly developed agreements	Maintenance of existing agreements and/or newly developed agreements	MOU's are on record with each agency and with the state	Direct assessment and agency administrative data	Community agencies
<b>Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaboration community agency that includes regular sharing of information between agencies</b>	Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider	Of the agencies with which an MOU exists, 70% of those MOU's also include collaboration and regular data sharing between agencies	Of the agencies with which an MOU exists, 70% of those MOU's also include collaboration and regular data sharing between agencies	MOU's are on record with each agency and with the state	Direct assessment and agency administrative data	Community agencies
<b>Number of completed referrals (i.e., home visiting provider is able to track individual family referrals and assess their completing (e.g., by obtaining a report of the service provided)</b>	Number of completed referrals: Increase in the percentage of families with referrals for which receipt of services can be confirmed	Home Visitor follows up with client or agency to determine if client has sought referral services	Of the families enrolled in the program that receive an appropriate referral, 50% of those referrals were completed	Home Visitors are a reliable source of data for this information	Direct assessment and agency administrative data	Parent/child enrolled in home visiting agency and community agencies

**Reliability and Validity for Assessment Tools**

Ensuring reliability and validity of assessment tools used during home visits allows tool administrators to be confident that responses provided by clients are true and correct. Specific tests have been conducted on a variety of assessment tools that will be used in Indiana’s two home visiting programs, as seen below. The questions asked of clients to gather other data have been tested formatively to assure clarity of interpretation by the client and nurse home visitor, and connection to the constructs being assessed. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems. The following tools will be used for data collection:

Reliability and Validity for Assessment Tools		
Tool	Studies	Validity and Reliability
Ages and Stages Questionnaire	<p>“Revision of a Parent-Completed Developmental Screening Tool: Ages and Stages Questionnaires”, <u>Journal of Pediatric Psychology</u>, 1997;22:3:313-328 by Jane Squires, Diane Bricker, and LaWanda Potter.</p> <p>“Parent-Completed Developmental Questionnaires: Effectiveness with the Low and Middle Income Parents”, <u>Early Childhood Research Quarterly</u>, 1998;13:2:345-354 by Jane Squires, LaWanda Potter, Diane Bricker and Suzanne Lamorey.</p>	<ul style="list-style-type: none"> <li>• Interrater agreement and test-retest agreement generally in excess of 90%</li> <li>• Parent and trained tester agreement ranged from 76-92% depending on test interval even with parents from low income backgrounds</li> <li>• Primary measure of Reliability was internal consistency between domain and overall scores – all correlations were significant</li> <li>• Test – retest reliability was 94%</li> <li>• Interobserver reliability was 94%</li> <li>• Concurrent Validity when compared with Revised Gesell and Armtruda Developmental and Neurologic Examination and Bayley ranged from 76% to 91%</li> </ul>
North Carolina Family Assessment Scale (NCFAS)	<p>The Reliability and Validity of the North Carolina Family Assessment Scale”, <u>Research on Social Work Practice</u>, 2001;11:503-520, by Kellie Reed-Ashcraft, Raymond S. Kirk and Mark W. Frazier</p>	<ul style="list-style-type: none"> <li>• Internal consistency reliability was supported for 4 factors (Environment, Child-Well Being, Family Interactions, and Family Safety) with Cronbach’s alpha ranging from .71 to .94.</li> <li>• Construct and Concurrent Validity when compared with Child Well Being Scale, Index of Family Relations, and the Family Inventory of Resources for Management was generally supported</li> <li>• Concurrent validity correlations ranging from .26 to .71</li> </ul>
Home Observation for Measurement of the Environment (HOME)	<p>“The Home Observation for Measure of the Environment Revisited”, <u>Child and Adolescent Mental Health</u>, 2004;9:1:25-35 by Vasiliki Totsika and Kathy Sylva</p>	<ul style="list-style-type: none"> <li>• Internal consistency Reliability was 89% for the total and averaged 70% for the six subscales</li> <li>• HOME is a more valid measure of the child’s developmental environment than family socioeconomic status, father’s presents and home crowding.</li> <li>• Interrater agreement was 90% and internal consistency ranged from 44% to 89%</li> <li>• Test – retest reliability was moderate for 18 months</li> <li>• Concurrent validity – small to moderate with welfare status, maternal education, maternal occupation, presence of father in home, paternal occupation and crowding in the house.</li> </ul>
IPV Screen	<p>The Colorado Behavioral Risk Factor Surveillance System (BRFSS) – “Predictive Validity of a Screen for Partner Violence Against Women”, <u>American Journal of Preventive Medicine</u>, 2001;21:2:93-100</p>	<p>Questions used with the BRFSS, a standardized, population-based, national survey</p> <ol style="list-style-type: none"> <li>1. Thinking back over the past year, on any occasion were you hit, slapped, kicked, raped, or otherwise physically hurt by someone you know or knew intimately, such as a spouse, partner, ex-spouse or partner, boyfriend, girlfriend, or date?</li> <li>2. Considering your current partners or friends, or any past partners or friends, is there anyone who is making you feel unsafe now?</li> <li>3. In the past year, have the police ever been called to your home because of a fight or argument, no matter who was fighting or who was at fault?</li> </ol> <p>The outcome variable was the CTS measured 3 to 5 months after the initial</p>

		screen. A positive IPV- BRFSS violence screen was a strong predictor of partner abuse during the follow up period as measured by the CTS. Women who screened positive for violence were 8.6 times more likely to experience one or more physically violent assaults from a current or past intimate partner in the next 4 months. In this study, two thirds of separated women with positive violence screens were victims of violence in the follow-up period.
Client self-report	Initial NFP trials including: David L. Olds, JoAnn Robinson; Ruth O'Brien; Dennis W. Luckey; Lisa M. Pettitt; Charles R. Henderson Jr.; Rosanna K. Ng; Karen L. Sheff; John Korfmacher; Susan Hiatt; Ayelet Talmi. <i>Pediatrics</i> . 2002;110(3):486-496	Outcomes examined in the original trials were based upon maternal report, and when administrative or laboratory data were available to compare with self-reprot data, the nurse-visited women typically were at least as accurate as their control goup counterparts in reporting

***Plan for Sampling***

Within nine months of award notification, all applicable data for the each construct will be examined as both program models will have full case loads by that point in time. A set of analyses will be conducted every 6 months thereafter. Because families will enroll into the program on an ongoing basis, new “initial” data will be created and ongoing data will be examined in each analysis as it becomes available.

A sampling method will be used to collect de-identified data and charts. The Program Coordinators will determine the number of home visiting clients must be reviewed of the all MIECHHV funded clients. The number of clients to be reviewed will be determined quarterly prior to CQI activities. The Program Coordinators will be transferred data on clients a specific number of clients that allow the sample to be representative of the entire MIECHV funded client population with a Confidence Interval of 95% and a margin of error of 5.0%. Each quarterly report will have a different sampling number that is representative based on the number of MIECHV funded clients served during the specific time period.

***Data Collection Schedule***

Data collection on the site level will be ongoing (on a daily basis) as home visitors enroll and visit clients. This data will be reviewed by program personnel for each program model on an as needed basis to ensure no data elements are missing. If data elements are missing, the program personnel will follow-up with the home visitor to ensure data is complete. The program personnel will provide data to the state personnel on a quarterly basis. The Program Coordinators and Ms. Quigley’s Assistant Coordinator will review de-identified data from each HV program, and analyze for quality assurance on a quarterly basis including: completeness of data, program utilization, process outcomes, and benchmark outcomes.

***Plan for Ensuring Quality of Data and Analysis***

***Minimum Requirements & Qualifications for Administrators of Measures:*** At a state level, the Program Coordinators from ISDH and DCS will collect data on a quarterly basis and perform basic analysis on MIECHV-designated outcomes. Mallory Quigley and Andrea Preston, will manage the measures listed in the Benchmark Chart. Ms. Quigley received her MPH in Social, Community, and Behavioral Health from Indiana University and has experience specifically in the monitoring of home visiting data. While the Assistant Program Coordinator has yet to be hired, minimum qualifications include a Bachelor’s degree, with a Master’s degree preferred. Andrea Preston handles Programs and Services special projects and has the resources of the DCS Research and Evaluation Team to assist. For HFI, all assessment tools will be administered by trained Healthy Families Assessment Workers or Home Visitors. Each staff member is trained on the tools as required by the tool publisher, and each tool is reviewed by the administering staff member’s supervisor. All data management is conducted by Datatude, Inc. The data base was created in 1996 and became web-based in 2001. Datatude, Inc. has developed, and administered the system for 15 years. Specialized staff provides technical assistance and reviews data for completeness and quality.

For the Healthy Families program, Kristin Cotter Mena, Ph.D. will provide analyses and evaluation regarding process and outcomes. Dr. Mena has conducted program evaluation for 11 years in a variety of social service program types. Dr. Mena has served as the statewide program evaluator for HFI for 5 years. She has also served on Healthy Families America's Research Practice Council, Panel on Accreditation and National Advisory Council.

For NFP, data quality and data security is monitored by the NFP Program Quality and Information Technology staffs through a formal process. Training on the reporting database is provided to nurse home visitors, supervisors, data assistants and administrators through online modules, manuals, webinars and in-person nursing education. Technical assistance is continuously available through NFP Information Technology and Program Quality.

***Plan for Identification of Scale Scores, Ratios, and Metrics:*** Each HV model has established scales, scores, and ratios to measure success indicators for its respective program. Due to the nature of NFP's national office, it is difficult to obtain specific information about the program before approval is guaranteed. At this time, two specific scales are used in both programs. Ages and Stages Questionnaire is used by both NFP-IN and HFI to measure child development. In addition, both programs also use Edinburgh Postnatal Depression Scale to monitor maternal depressive symptoms.

Please see the Benchmark Chart for information regarding metrics for each of the constructs to be measured as well as rationale for each metric or tool. This chart also contains information regarding scores or ratios that will indicate improvement in each specific indicator (increase vs. decrease).

***Plan for Analyzing Data:*** HFI data will be analyzed using several techniques. Each data point is identified by family, county of residence, and program; therefore, data may be aggregated or disaggregated for any analysis. Many of the benchmarks will evaluate improvement as an increase (or decrease) in proportion of participants with services available or behavior demonstrated. For HFI, there will be three standardized measures for which change over time will be evaluated (HOME, NCFAS, and HFPI). In each case, the proportion of families scoring in the 'at risk' level will be examined. In addition, change over time will be analyzed at the family (or parent) level through appropriate statistical tests, such as related samples t-test. Appropriate tests will be specified based on the characteristics of the data. Specific data analysis details for NFP-IN will be relayed to Program Coordinators as program implementation and data analysis becomes available from both the national level by Regional Consultants and from the local program level by nurse supervisors.

***Plans for Gathering & Analyzing Demographic & Utilization Data:*** For each family, many demographic characteristics are recorded as part of the standard intake process in both HFI and NFP-IN. Both programs collect date of birth for participating parent(s) and child of focus, ethnicity, language, gender, initial employment, education, risk factors, etc. NFP also collects data on demographics of the client and family, use of the program (number of visits, duration of sessions, etc.), language and socioeconomic indicators. HFI also collects data on all other types of contact, activities and referrals made with and for a family. When examining each construct, the appropriate demographics will also be examined for the correlation to the construct.

***Plan for Benchmark Data for CQI at Local Program, Community, and State Level:*** ISDH and 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 (HFI 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, including progress towards MIECHV reporting requirements. Three specific levels of CQI will occur: (1) MIECHV state level; (2) HFI level CQI; and (3) NFP-IN level CQI. Operationally, these three levels will work collaboratively through open communication and quarterly reporting to ensure CQI. While the Program Coordinators will be responsible for ensuring MIECHV reporting and CQI activities will be completed timely and within its respective deadlines, HFI and NFP-IN and its respective national model developers will provide this information to the Program Coordinators and provide CQI expertise for its respective program.

The process measures and outcome within each benchmark construct will be used as CQI for each program, the community in which it is being implemented, and statewide. For HFI, all benchmark data will be collected by Datatude—the external contracted agency to serve as HFI’s program evaluator. This data will be shared with designated sites, the QA/TA contractor, Marty Temple, and DCS. Sites will share relevant data within its communities in order to impact communitywide changes that may be deemed necessary. The QA/TA team will use this data to provide training and support to individual programs as well as making recommendations for system wide changes. System-wide changes will be sent through the HFI committee process, with DCS ultimately implementing necessary changes. For NFP-IN, the flagship site, Goodwill located in Marion County will house the data to be collected for each participant and construct. Therefore, NFP-IN has immediate access to any kind of report that may be requested for CQI purposes. Details of this plan will be discussed in the CQI plan. Please see Section 7 for a detailed, multi-level CQI plan.

***Plan for Data Safety and Monitoring:*** The Indiana State Department of Health employs a Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer that will be readily available to address any concerns that may arise throughout the home visiting implementation and data collection process.

**HFI:** Datatude’s online data base is constructed with security levels created to mirror typical social service structure. There are four security levels, allowing for specific access to data as delineated by program’s executive director (or program manager). Users of the database cannot edit or view any data that is not appropriate for their level of usage. In order to provide the highest level of system reliability, the server hardware stack that supports HVTIS/OS is co-located at a Tier IV data center with features which include, but are not limited to, physical security, elevated floor, diesel generator electrical backup, and enhanced cooling. This facility is located directly on the internet backbone, which ensures the most reliable internet connection. Datatude utilizes a system which features the highest quality hardware and solid security procedures. The maintenance of such system are tested by monthly penetration tests, and specially commissioned security audits. Personnel working to support the on-line system each have over 10 years of experience working on such projects. The central database administrator has contracted confidentiality agreements in place. In addition, the HFI evaluator is also part of the database administration. The evaluator and her research assistant are registered investigators with Sterling Institutional Review Board (SIRB). The ongoing data analysis and program evaluation are part of a registered study with SIRB. The study is required to undergo review every year. All participants in the program undergo informed consent as part of the routine data collection for program management and program evaluation. All data is reporting in aggregate and no client will be identified to any outside entity. At the home visiting programs, no outside entity is contacted on behalf of or regarding the participating family without prior written and specific consent for the sharing of information. The exception is the reporting of child abuse to the Department of Child Services when required. This program does not interact directly with schools or educational institutions, and will therefore not violate FERPA regulations.

**NFP-IN:** NFP utilizes a software platform into which only designated, NFP-approved persons may enter data collected about clients and the Program and obtain reports for managing and evaluating Program implementation and results. The web-based information system is secured against unauthorized use by VeriSign® 128-bit Security Encryption, the industry standard in Internet site protection. Authorized access to the database and website can only be provided by NFP. Furthermore, NFP complies with the rules and regulations concerning the privacy and security of protected health information (PHI) under HIPAA and the HiTech Act as if it were a Covered Entity, as defined by those regulations. NFP enters into HIPAA Business Associate Agreements to ensure all its implementing agencies, vendors and agents agree to the same restrictions. NFP protects against non-permitted use or disclosure of PHI using no less than a reasonable amount of care and will promptly report any non-compliance.

### **Section 6: Plan for Administration of State Home Visiting Program**

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.

### ***Collaborative 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), which may include other home visiting programs in the state, as well as social and health service agencies.

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. Program Director of Healthy Families Indiana, 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.

Many agencies have also offered support for Indiana's approach to home visiting through letters of concurrence or support. These agencies are as follows: (Letters of Concurrence and Support can be found in Attachment 5)

- Title V Agency/ Public Health Agency: Indiana State Department of Health: Dr. Gregory Larkin
- Agency for Title II of CAPTA/ Child Welfare Agency: Department of Child Services: Judge James Payne
- Agency of Substance Abuse Services/ Mental Health Agency: Department of Mental Health and Addictions: Gina Eckart
- Child Care and Development Fund Administrator: Family and Social Services Agency: Melanie Brizzi
- Head Start Collaboration Office: Susan Lightle
- Advisory Council on Early Childhood Education and Care: Indiana Department of Education/ Early Childhood Specialist: Dana Jones

Please see Section 4, page 24 for a more detailed description of HFI and NFP partners.

### ***Overall Management Plan***

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.

The overall statewide HV program organizational chart is listed in Attachment 3. 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 to the numerous programs. Please see Attachment 4 for job description.

The 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).

### **HFI Management**

DCS Healthy Families Indiana State Coordinator will be the primary contact at DCS. The job description can be found in Attachment 4. 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 DCS 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. The management process of Healthy Families Indiana (HFI) is designed to ensure quality program oversight and adherence to Healthy Families America Critical Elements. HFI allows individual sites the flexibility to tailor the management process to meet the specific needs of the program. 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 and supervision of the Healthy Families Program Manager, 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. Healthy Families program supervisors (supervised by the Program Managers) 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. Specific job descriptions for these positions can be found in Attachment 4.

### **NFP Management**

Prior to hiring of Nurse Supervisor and home visiting nurses, the Director of Community Initiatives (Ms. Keith Reissaus) and the Director of Strategic Planning and Development (Mr. Eric Lange) of Goodwill Industries will be responsible for creating community linkages for referrals in Marion County as well as recruiting, hiring, and training staff. Both Mr. Reissaus and Mr. Lange are in-kind their services for the initial development phase of NFP-IN.

In addition, the nurse supervisor will continue at 1.0 FTE and will serve as the primary point of contact. This person, as dictated by NFP's model is required to hold a Master of Science in Nursing and will oversee day-to-day activities of no greater than eight home visiting nurses. The job description can be found in Attachment 4.

Primary responsibilities of the home visiting nurses include NFP outreach and enrollment activities as well actual home visiting activities and data collection. The job description can be found in Attachment 4. The model developer's curriculum dictates specific home visiting nurse activities—which will be overseen by the Nurse Supervisor.

### ***Plan for Coordination of Referrals, Assessment, and Intake Process***

Since Healthy Families Indiana currently exists in all counties in Indiana, a mechanism for screening, identifying and referring families is already in place for Lake, Scott, Marion and St. Joseph counties.

### **HFI Methods for Screening / Identifying / Referring Families**

HFI must initiate services either prenatally (no earlier than the 6<sup>th</sup> 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
- Cumulative score 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 Methods for Screening / Identifying / Referring Families**

As a new provider of health prevention services in Indianapolis, Goodwill has been diligent in maximizing referrals to NFP, especially in its first year of implementation. Goodwill—and specifically, the Director of Community Initiatives has established community partnerships and earn guaranteed referral sources from various partner organizations. Other sources may include Community Health Clinics, Indianapolis Metropolitan High School (a Goodwill Education Initiative), and other social services agencies around the specified region in Marion County. Furthermore, NFP will partner with the MCH Division’s Free Pregnancy Test Program. This program provides free pregnancy tests to clinics throughout the state that request to participate.. The clinics in Marion County that have participants who receive a positive pregnancy test result will refer patients to the NFP program. Specific information regarding NFP screening tools is limited at this time. Until notification of funding from MCHB regarding the proposed Updated State Plan, Goodwill only has *conditional* approval for implementation of NFP-IN. That is, Goodwill will receive full approval from the NFP model developer once funding notification is received and a contract is signed between ISDH and Goodwill. At that time, screening tools as well as other specific curricula materials will be shared with Goodwill by the model developer.

### **State-Collaboration of Screening/ Identifying / Referring Families**

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. 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 each program is achieving its desired impact and is replicating the model faithfully. Marion County is currently the only county with two MIECHV sponsored programs. 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 HFI or NFP-IN. Models with different eligibility requirements are able to reach segments of the population that either HFI or NFP is not eligible to serve. That is, coordination of screening and identifying women and families between home visiting models will ensure home visiting clients receive the service most appropriately meets their needs. It will also ensure these families aren’t receiving duplicative home visiting services. HFI will refer, assess and enroll families that meet these requirements and that score 40 and above on the Kempe scale. Families who do not meet these criteria will be referred as appropriate to NFP who will then determine if the client is eligible for NFP. NFP also has MOU’s with community organizations and hospitals that commit a specific number of clients each month. Therefore, the referral provider will many times be the entity who decides on the best-fitting home visiting program.

### ***Identification of Other Evaluation Efforts for Promising Practices***

While numerous other home visiting programs throughout Indiana exist, none are currently being evaluated.

### ***Job Descriptions***

Please see job descriptions of key staff on Attachment 4 of this Proposal.

### ***How Statewide HV Plan Will Meet Legislation Requirements***

## **HFI**

Indiana has one of the largest HFI programs in the nation and is one of only seven multi-sites programs accredited by HFA. Indiana provides significant financial support to HFI and assures that the program is available in all 92 counties. The central office is housed in the Department of Child Services, and has the ability to administer the program effectively allocating funds based on local need, consistently assessing and evaluating program quality and utilization, and redistributing funds based on findings. 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. Within each of the four communities HFI will expand its services with MIECHV funds, Healthy Families has formalized relationships for referrals

## **NFP**

The proposed statewide HV program will meet all legislative requirements as listed in the Affordable Care Act (ACA) legislation. Specifically, high quality staff will be hired and/maintained and quality supervision of staff will be ensured within the recruitment and hiring process. Goodwill will utilize nurse consultants, NFP staff, and a Talent Acquisition Team to hire staff. Initial and ongoing NFP training keeps staff up to date on emerging practices. Similarly, HFI will continue its impeccable track record of recruiting and hiring competent staff through established hiring procedures. HFI hopes to rehire home visitors who had been released due to budget cuts throughout the state to ensure to-be-hired home visitors have an established understanding of home visiting and its expectations.

ISDH and DCS 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 (HFI 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, including progress towards MIECHV reporting requirements. Three specific levels of CQI will occur: (1) MIECHV state level; (2) HFI level CQI; and (3) NFP-IN level CQI. Operationally, these three levels will work collaboratively through open communication and quarterly reporting to ensure CQI. While the Home Visiting Program Coordinators will be responsible for ensuring MIECHV reporting and CQI activities will be completed timely and within its respective deadlines, HFI and NFP-IN and its respective national model developers will provide this information to the Program Coordinators and provide CQI expertise for its respective program. Please see *Section 7* for more detailed information on the state's approach of monitoring, assessing, and supporting implementation with fidelity to the chosen models and for quality assurance.

### ***Coordination of Statewide HV Program with Early Childhood Plans***

Indiana's home visiting program is already linked with the state's early childhood plan. Maternal and Child Health Bureau's Early Childhood Comprehensive Systems Initiative is housed in ISDH's MCH Division, similar to that of one of the MIECHV Program Coordinators. ISDH and DCS also both sit on many committees and advisory boards that contribute to Indiana's comprehensive early childhood plans. Also, HFI and NFP both utilize materials developed by Indiana's ECCS Initiative during home visits. Please see page 8, for more information.

### ***State Compliance with Model-Specific Prerequisites for Implementation***

The statewide HV program will consist of two evidence-based models: NFP and HFI. Both programs must meet rigid pre-requisites for accreditation and implementation of its respective program, as per requirement of the national model developers. These model-specific prerequisites for implementation have been adhered to and accredited for HFI in the four proposed sites: Marion County, St. Joseph County, Lake County, and Scott County. In addition, Goodwill has received conditional approval from its model developer to implement a flagship site of NFP. This conditional approval was obtained by completing a conditional approval implementation plan. Upon notification of funding, Goodwill will receive training in all aspects of model implementation and best methods for ensuring model fidelity.

Neither HFI nor NFP's specific model implementation methods will be modified for this proposed request. However, both models will supplement currently collected information with additional indicator to comply with legislative

benchmark measures. Such indicators to be collected that are not originally required by the respective national model developers include:

- NFP & HFI modification: Interpersonal violence screen and domestic violence safety plan
- NFP & HFI modification: Incident report involving emergency room visits, abuse / neglect reports, fire / police response, automobile accidents, and/or death of child / client
- HFI modification: Six-week postnatal check up
- HFI modification: Household record definition
- HFI modification: Employment status, educational attainment / enrollment, insurance status

These modifications, as stated, will not affect the model fidelity; rather, additional data pieces will be collected for purposes of reporting MIECHV benchmark constructs.

### ***Strategies for Modifications to State Plan for Home Visiting Success***

Currently, no modifications to state administrative structure are being made. However, the IHVAB will review the Updated State Plan during quarterly meetings. The IHVAB may make recommendations to update the Updated State Plan during these meetings due to lessons learned during quarterly site evaluations, data collection, and/or changes in Federal reporting requirements. Those recommendations will be reviewed by DCS and ISDH.

### ***Section 7: Plan for Continuous Quality Improvement***

ISDH and DCS 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 Nurse-Family Partnership) 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 Unit 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, Dr. Jeff Anderson and his evaluation team will

assist in conducting quarterly CQI. basis. This external evaluator will report to the Program Coordinators and assist in the development of additional CQI measures.

### ***Quarterly Plan***

The Home Visiting Program Coordinators will complete program utilization, process and 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 385 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 190 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 specified in Section 5, 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 as listed in Section 5.
  - 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 Quarterly Evaluation Report 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 is being made. The process measures are noted in Section 5 Benchmark Chart.

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.

While this process seems rigid and strict, the Home Visiting Program Coordinators hope to have an open and transparent relationship with each home visiting program. While the specific timelines and dates are in place to ensure activities are completed in a timely manner, communications between the Home Visiting Program Coordinators and each program and site will occur regularly. 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 that 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.

### ***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 Healthy Families Indiana 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.

HFI is an accredited multi-site system of Healthy Families America (HFA). HFA requires statewide Quality Assurance (QA) system. HFA visits every four-five years to monitor system wide adherence to HFA standards as well as interview HFI staff, state partners, committee members, program managers, QA staff, trainers, and the evaluator. HFI central administration submits a self-study report responding to all standards of HFA. HFI requests all implementation sites to do the same. 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. The results of the site visit are then submitted to the HFA Accreditation panel, which decides if the system and individual sites are accredited. 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.

### ***Nurse-Family Partnership Program Level CQI***

As cited by Nurse-Family Partnership 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 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 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 Nursing Practice Assessment to provide CQI.

Nurse-Family Partnership-Indiana (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 Nurse-Family Partnership model.

#### ***Quarterly Site Self-Evaluation***

As previously stated, 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 addition CQI measures.

### **Section 8: Technical Assistance Needs**

As stated previously, implementing rigorously evaluated home visiting programs in specific, targeted populations and specifying detailed measurable outcomes that must be collected, all while implementing according to model fidelity proves a challenging task. The national model developers of the home visiting models Indiana plans to implement, Nurse-Family Partnership and Healthy Families America provide quality and prompt technical assistance as needed.

Technical assistance for many model fidelity and program utilization issues will be resolved by model specific technical assistance. As a state, Indiana may look to Health and Human Services (HHS) for technical assistance regarding the over-arching, state-wide Indiana Home Visiting Advisory Board (IHVAB). The State may question HHS for recommendations on engaging all home visiting programs in the state to be involved in this board. Other questions regarding CQI plans may arise and will require technical assistance. The State may also request assistance in reaching outcomes required quarterly reports to be submitted to HHS. Indiana feels all technical assistance needs will be met through joint efforts by national model developers and HHS.

### **Section 9: Reporting Requirements**

Indiana will submit annual reports to the Secretary of Health and Human Services regarding the program and activities carried out under the program. Since due dates and formatting information has yet to be released, Indiana will give assurance that they will comply with updated information as well. In order to comply with the required aspects of the program, Indiana will collect on the following information in order to report in annual progress reports.

#### ***State Home Visiting Program Goals and Objectives***

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;
- Any updates/revisions to goal(s) and objectives identified in the Updated State Plan; and
- To the extent not articulated above, a brief summary regarding the State's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided in the Updated State Plan. Identify updates or changes to logic model, if necessary.

#### ***State Home Visiting Promising Program Update***

- Updates on the grantee's evaluation of any implemented promising programs;
- If applicable, copies of reports developed in the course of the local evaluation of promising programs and any other evaluation of the overall home visiting program undertaken by the grantee.

#### ***Implementation of Home Visiting Program in Targeted At-risk Communities***

Updates regarding experience in planning and implementing the home visiting programs selected for each community of need, as identified in the Updated State Plan, addressing each of the items listed below. Where applicable, States may discuss any barriers/challenges encountered and steps taken to overcome the identified barriers / challenges.

- An update on the State’s progress for engaging the at-risk community(ies) around the proposed State Home Visiting Plan;
- Update on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on the timeline provided in Updated State Plan, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by the State or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including subcontracts;
- Update on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

***Progress Toward Meeting Legislatively Mandated Benchmarks***

Update on data collection efforts for each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

***Home Visiting Program’s CQI Efforts***

Update on State’s efforts regarding planning and implementing CQI for the home visiting program. If applicable, copies of CQI reports developed addressing opportunities, changes implemented, data collected, and results obtained.

***Administration of State Home Visiting Program***

- Updated organization chart, if applicable;
- Updates regarding changes to key personnel, if any (include resumes for new staff, if applicable);
- An update on State efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
  - 1) Training efforts to ensure well-trained, competent staff;
  - 2) Steps taken to ensure high quality supervision;
  - 3) Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities; and
- Updates on new policy(ies) created by the State to support home visiting programs.

***Technical Assistance Needs***

An update on technical assistance needs anticipated for implementing the home visiting program or for developing a statewide early childhood system.