

Indiana's Maternal, Infant, and Early Childhood Home Visiting Program Updated State Plan

Indiana State Department of Health
Indiana Department of Child Services

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Healthy Families Indiana
Nurse-Family Partnership Indiana

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ABSTRACT

The Indiana State Department of Health (ISDH) and its partnering agency, the Indiana Department of Child Services (DCS) respectfully requests \$1, 665, 8757. The overall goal of Indiana's Maternal Infant and Early Childhood Home Visiting (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*:

1. 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.
2. 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 referrals to all children, mothers, and families who are high-risk throughout Indiana.
3. 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.

While working towards these objectives, Indiana's home visiting plan will support Healthy Families Indiana (HFI) through Department of Child Services, and fund Goodwill Industries of Central Indiana to implement Nurse-Family Partnership (NFP). These programs will be target high risk areas of Indiana, including Zip-codes 46406, 46402, 46320, and 46312 (Gary and East Chicago) of Lake County, Zip-codes 46601, 46619, 46628, 46613, and 46544 (South Bend) of St. Joseph County, Zip-codes 46222, 26214, 46228, and 46224 of Marion County, and the entirety of Scott County. Zip-code level data collection and community organization surveys guided the process of deciding which programs Indiana will implement and the high-risk areas in which the programs will be implemented. The home visiting programs are and will continue to be implemented within an early childhood comprehensive system as seen by the existing collaborative relationships with Early Comprehensive Childhood Systems Initiative, as well as other partnerships.

To show success of Indiana's program, the state has chosen measures to show improvement of recommended constructs within specific benchmark areas. The federally-dictated benchmarks are: improved maternal and newborn health, family economic self-sufficiency, school readiness and achievement, decreases in child injury, abuse, neglect, and maltreatment, use of emergency department, and domestic violence, and coordination of referrals. Continuous Quality Improvement (CQI) will ensure HFI and NFP-IN are implemented with fidelity to the model, in addition to monitoring program utilization, and progress made towards outcome measures. A hybrid CQI system will be established to allow the state to complete federally-required reporting and CQI activities will be completed timely and in its respective deadlines. HFI and NFP-IN and their national model developers will provide this information to the Program Coordinator and provide CQI expertise for its respective program.

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Section 1: Identification of the Indiana's Targeted At-Risk Communities

Assessment of Needs & Existing Resources

Indiana Overview

Indiana has a population of 6,423,113 (2009 est.), which represents a 5.6% growth since the 2000 census. Its growing population is spread unevenly among its 92 counties. Indiana has a total of 35,867 square miles with a population density of 179.1 per square mile. Its population patterns reflect the distinct rural and urban communities within the state with 70% of the population living in metropolitan areas and 30% in rural areas. These population patterns require that communities of risk be identified using a variety of variables.

Assessment of Like Communities

For the purposes of this proposal request, the term *community* will refer to specific geographic area. In some areas of the state, an entire county is a community, while in other counties the community will be defined as a city—which is both a population hub and an area of need. And still in other counties, communities will be defined at the neighborhood level within a city.

Because a few counties within Indiana hold a larger portion of the population, crude numbers per county do not present an accurate account of factors to be considered in these counties. In order to consider all communities of Indiana for inclusion in the identification of need, the Indiana State Department of Health (ISDH) utilized data that reflects rates of need rather than incidence calculations.

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. The list of final indicators used for establishing risk can be found in Figure 1-1.

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. To see the overall scores, please refer to Figure 1-2.

ISDH then divided overall ranking results into quartiles. Eleven counties were identified within the highest quartile—all with a score above 60. These 11 counties are considered most “at risk” as identified in ISDH’s original needs assessment. To see the map of Indiana divided into quartiles, please refer to Figure 1-3.

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. This process is detailed in *Section 3*.



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.

Maternal and Newborn Health
Breastfeeding
Gestation
Deliveries on Medicaid
Birthweight
1 st time mother
Infant Mortality
Child Injuries, Child Abuse, Neglect and Maltreatment, and Reduction in ED Visits
Outpatient/ED visits from all causes, children <1; 1-5
Substantiated Child Abuse <18
Crime/ Domestic Violence
Domestic Violence
School Readiness/ Achievement
% of 3 rd grade children who passed both Math and English on ISTEP+
Family Economic Self-sufficiency
Deliveries on Medicaid
% of children on reduced price lunch
% of children on free lunch
Coordination of Referrals
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. During preliminary data analysis, weight was given to zip codes based on population density. However, while completing this analysis, it seemed on very urban and densely populated zip codes were given too much weight and therefore were emerging at the top of each county's list. Hence, this weighting system was resigned to allow for the process that is stated above. Please see zip code level maps of the selected counties in Appendix G. 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 zip codes 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 three of the most high-risk counties that offer Healthy Families America program service—Scott, Lake, and St. Joseph counties. Goodwill Industries of Central Indiana (Goodwill) will implement Nurse-Family Partnership (NFP) in Marion County. The following lists basic information regarding each county for which requested funds will be used for home visiting services within Indiana.

Scott County: 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. This high-need, as well as Scott County's willingness and capacity to expand the Healthy Families Indiana program allows it to be a great site for home visiting dollars.

Lake County: In Lake County located in northwest Indiana, home visiting services will be implemented in five of the highest-risk Zip-codes. These highest-risk Zip-codes are located in the inner-most cities of East Chicago and Gary, 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.

St. Joseph County: The need for home visiting services was evident in five high-risk Zip-codes located in inner-city South Bend within St. Joseph County. 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.

Marion County: Goodwill Industries of Central Indiana (Goodwill) will implement Nurse-Family Partnership in four specific Zip-codes of Marion County: 46222, 46224, 46214, and 46218. Zip-codes 46222 and 46224 are ranked within the top five highest-risk zip-codes in Marion County, while 46214 and 46228 are lower in risk. Goodwill Industries offices are located in zip-code 46222, where Nurse-Family Partnership will be housed. The remaining Zip-codes were chosen based on geographic proximity and Goodwill's capacity to reach clients in those Zip-codes.

County Profiles

Scott County profile

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. 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. In the last year, HFI screened 244 clients in Scott County, while 60 families received at least one home visit. Moreover, 146 clients stopped receiving HFI services in Scott County, which implements Parents as Teachers curriculum. The majority of terminations were due to clients refusing initiation of services or no information was available on the client. Only 3 clients met all program requirements and completed the program. Therefore, a *definite gap in home visiting services is present*. Increasing programmatic funding in Scott County will allow HFI to reach a great span of families for greater impact.

St. Joseph County Profile

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 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.

Lake County Profile

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. 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.

Marion County Profile

Marion County, located in the center of Indiana, is the home of the capital city of Indianapolis, and is Indiana's largest county by population. About 25% of Marion

County's population is under the age of 18. The median household income of the county in 2009 was 41,201. However, the median household income of 46222, 46224, 46214, and 46254 is \$38,731. About 9% of the births in Marion County were of low birth, while 11.3% of infants were born low birth in the four contiguous counties, with 46214 having the highest percent low birthweight. On average, more substantiated reports of child abuse of child under 18 occurred in these four Zip-codes than the entire county (189 and 113 respectively).

Existing home visiting services

A variety of home visiting programs have emerged in recent years to serve Indiana communities with the growing awareness of the value that home visiting interventions bring to addressing health, safety and literacy needs.

The Indiana Department of Child Services (DCS) has more than a decade-long commitment to home visiting in the form of Healthy Families Indiana (HFI). HFI serves families in all 92 Indiana counties. In addition to HFI, additional programs have emerged including Even Start, Early Head Start, and Parents as Teachers (PAT). Diverse funding streams and outcome objectives, expanding eligibility criteria and targeted population have driven the growth of programs. Existing Indiana home visiting programs offer ongoing services to individuals primarily in a home setting, although many offer group services as well. Services are delivered by trained home visiting professionals or paraprofessionals with the goal of addressing specific issues based upon the individual family's eligibility for the program.

For the purposes of this proposal, the following overview of Indiana's home visiting programs will include those programs meeting the aforementioned criteria. Programs not included are those delivering services as part of federal IDEA Part C requirements, programs providing one-time home visits and programs that do not provide routine and sustained home visits. The discussion below summarizes home visiting programs in Indiana and describes in detail each individual home visiting program in the state. To the extent possible, program descriptions include the program components, scope of service, number and type of individuals and families served, ability of the programs to meet the needs of eligible families, and the individual program gaps and concerns.

Early Head Start

Early Head Start (EHS) is a national evidence-based multi-service early childhood, community-based program for low-income families with infants and toddlers and pregnant women. Early Head Start strives to

- Promote healthy prenatal outcomes for pregnant women;
- Enhance the development of children ages birth to three; and
- Support healthy family functioning.

EHS is administered by the Office of Head Start (OHS), Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (DHHS).

EHS's home visiting component provides – through the use of home visitors – comprehensive services to promote school readiness and enhance children's physical, dental, nutritional, social/emotional, and cognitive development.

In FY09, Indiana had 15 Early Head Start program sites. ARRA funding provided a significant expansion to the capacity of Early Head Start in Indiana with the creation of 1,037 new slots. Eleven additional sites were funded with some existing sites expanding enrollment. Indiana currently has 2,636 EHS slots in 26 programs. Program design and service delivery models vary from home visitation, social groups and classroom services to a combination of these models. Many sites designate slots from various program models to best meet the needs of the families served. The estimated cost of the Early Head Start home visiting program differs significantly from site to site ranging from approximately \$7,000 to \$14,000 per child. While the current waitlist for the EHS home visiting component is unknown, the cumulative waitlist for both the EHS and HS programs in the spring of 2010 was an estimated 7,000 families statewide. Program administrators feel that demand exceeds enrollment capacity for EHS and similar programs, and that more resources need to be dedicated to programs serving at-risk populations.

Healthy Families Indiana

Healthy Families Indiana (HFI) is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education. HFI awards grants from the Indiana Department of Child Services (DCS) to single county and cluster site grantees that provide assessment and home visiting services in all 92 Indiana counties. HFI serves eligible families of children prenatally to age three. Currently to qualify for services, a family's income must be at or below 250% of the federal poverty line and the family must score 40 or higher on the Kempe Family Stress Checklist. At the onset of services, each enrolled family is visited a minimum of once a week for a minimum of six months. Thereafter, based on well-defined criteria regarding family need, progress, and engagement in the program the required number of visits per family per month may be increased or decreased. The maximum cost per family per year is \$4,500. The HFI program uses a variety of curricula based on the needs of the families and their personal learning styles. Curricula and educational materials used are Prevent Child Abuse Indiana (PCI) activity-based, sequential and include an instruction manual for home visitors.

Curricula currently approved for use in HFI programs include:

- Great Beginnings- Prenatal;
- Healthy Start;
- MELD New Middle of the Night;
- MELD - Nueva Familia;
- MELD - Young Families at Home;
- Mom Project Prenatal Curriculum;
- Nurturing Program for Prenatal Families;
- Nurturing Program for Families with Special Needs;
- Nurturing Program for Teen Parents;

- Nurturing Program - Birth to Five;
- Nurturing Program - 4 to 12;
- PAT, 0-3;
- PAT, 3-K;
- Partners for a Healthy Baby – Prenatal;
- PIPE;
- Resource Mother's Handbook;
- E-parenting; and
- Partners for a Healthy Baby-Birth to 3.

From July 1, 2009 to June 30, 2010, HFI served 22,739 families, providing home visiting to 14,475 families statewide with a total budget of \$34,436,323. HFI programs are not permitted to develop waitlists for services, yet there are capacity limitations which require that families who are eligible but not enrolled in HFI be referred to other services to meet their needs. Significant reductions of funding are now limiting enrollment to families with a score 40 or higher on the Kempe Family Stress Checklist rather than the previously required minimum score of 25.

Healthy Families E-Parenting Project (EPP)

The E-Parenting Project is an ongoing, multi-state research project funded by the Centers for Disease Control and Prevention involving 420 Indiana families. One third of the families are in a control group and are not receiving any services. The other two-thirds are enrolled in two Healthy Family Indiana programs: HFI Allen County (SCAN) and the MOM Project in Marion County. The EPP curriculum is eight 20-30 minute sessions provided on a laptop touch screen computer as part of a regularly scheduled HFI home visit. These evidence-based interventions are designed to reduce risk factors for child maltreatment. The components include:

- 1) Motivational interviewing related to:
 - a. Participation in home visiting
 - b. Domestic (interpersonal) violence
 - c. Substance Use (drugs and alcohol)
 - d. Mental Health – primarily depression
- 2) Cognitive retraining that focuses on changing inappropriate maternal attributions for infant behaviors to appropriate attributions
- 3) Project Safe Care (health & safety behaviors to prevent neglect)

Families in this study who are receiving services are provided either regular HFI home visiting (using curriculum selected by HFI) or regular HFI home visiting augmented with E-Parenting on eight of the home visits that occur between birth and six months. The intent of the study is to determine if a computer-based program that incorporates evidence-based interventions can improve outcomes of families who participate in Healthy Families America home visiting. If E-Parenting is more effective than traditional

home visiting there are several advantages to this technology including: 1) consistent implementation, 2) ease of dissemination, and 3) negligible additional cost. Moreover, E-Parenting can be continually monitored and evaluated in order to improve implementation, acceptance and effectiveness. For example, E-parenting can be enhanced by incorporating new evidence-based interventions as they become available. EPP study participants are limited to English-speaking mothers age 18 and older. Mothers in the study include Non-Hispanic White, Hispanic, Black, Asian and Mixed/Other populations.

Parents as Teachers (PAT)

PAT, a national evidence-based home visiting model, provides family-centered services that help to increase parent knowledge, promote optimal child development, and increase school readiness. Grounded in research, PAT developed the *Born to Learn* evidence-based curriculum that supports and encourages school readiness and the improvement of child health. The *Born to Learn* curriculum includes a health assessment, annual developmental screen, and referrals to support parents in their role as their child's first and best teachers. Supporting parents using the BTL curriculum can help to improve parenting practices, provide early detection of developmental delays and health issues including nutrition and wellness, prevent child abuse and neglect, and ensure children are ready to learn. PAT's funding sources vary significantly across Indiana. The most current published data for July 2008 through June 2009 reports on the outcomes and progress of the 44 Indiana Parents as Teachers programs. Several communities have stand-alone Parents as Teachers programs that are funded by a combination of foundation dollars, local public resources and donations. Other Indiana programs that use PAT as part of home visiting programs and that are funded with federal or state dollars include Healthy Families Indiana (26 of the programs), Early Head Start (3), and Even Start (1). In total, 5,688 Indiana families received at least one PAT home visit during the 2008-09 program year.

The Newborn Individualized Developmental Care and Assessment Program

The Newborn Individualized Developmental Care and Assessment Program (NIDCAP) offers an individualized and nurturing approach to the care of infants in neonatal intensive care units (NICU) and special care nurseries (SCN). NIDCAP is a relationship-based, family-centered approach that promotes the idea that infants and their families are collaborators in developing an individualized program of support to maximize physical, mental, and emotional growth and health and to improve long-term outcomes for pre-term and high medical risk newborns.

The NIDCAP approach uses methods of detailed documentation of an infant's ongoing communication to teach parents and caregivers skills in observing an individual infant's behavioral signals. These sometimes subtle signals provide the basis for interpreting what the infant is trying to communicate and can be used to guide parents and caregivers to adapt all interaction and care to be supportive of the infant's behavior. Suggestions for care are made in support of the infant's self-regulation, calmness, well-being and strengths, and the infant's sense of competence and effectiveness. Such suggestions begin

with support, nurturance and respect for the infant's parents and family, who are the primary co-regulators of the infant's development.

These suggestions should extend to the atmosphere and ambiance of nursery space, the organization and layout of the infant's care space, and the structuring and delivery of specific medical and nursing care procedures and specialty care. These practices ensure that a developmental perspective and the infant's environment are incorporated into the infant's care.

The St. Vincent NICU in Indianapolis previously utilized the NIDCAP program. The staffing and training requirements of the program lead the hospital to translate the key concepts of the approach to a more global staffing and environment effort, ensuring that all bedside caregivers are trained to support healthy, positive infant development.

Even Start

The purpose of the William F. Goodling Even Start Family Literacy Program (Even Start) is to provide intensive family literacy services to help break the cycle of poverty and illiteracy by improving the educational opportunities of low-income families. The Indiana Department of Education administers federal Even Start funding, making competitive grants available to local applicants. In program year 2009-10, \$1,048,648 in funding supported six program sites. Indiana Even Start programs provide a year-round unified family literacy program which integrates child and adult literacy or basic education, parenting, and parent/child literacy activities. While program formats vary by site, each program is required to include a home visitation component to ensure parenting and family literacy is extended beyond the classroom and into the natural home environment. In addition to monthly home visits conducted by program staff, it is expected that families will carry out literacy activities and parenting strategies discussed.

Curriculum is chosen by the local program but must be a scientifically based. The Creative Curriculum, those offered by Steck-Vaughn and the High Scope curriculum have all been used at sites in Indiana. Funded sites are required to ensure that the families selected for Even Start are those most in need of the full range of services offered. To be eligible for Even Start parents must be 16 years of age or older, not be enrolled or required to be enrolled in secondary school, and lack sufficient mastery of basic educational skills to function effectively in society. To participate in an Even Start program, a family must have at least one eligible parent and one eligible child participating together in the full scope of the project. Enrolled children range from birth to eight years of age. During the 2009/2010 reporting year 204 families were served at six sites in six Indiana Counties.

Indiana Even Start sites do not maintain a waiting list. When space is no longer available to serve all eligible applicants, programs refer families to other community resources that may address some of the family needs until space opens. The Indiana Department of Education (IDOE) identifies that there is considerable unmet need for Even Start as the state currently only operates six programs and many other communities likely have

literacy needs that could be met effectively by this program. The IDOE continues to receive requests for additional programs however no additional funds are currently available.

Healthy Start

Indiana hosts two of the 104 Health Resources and Services Administration (HRSA) funded Healthy Start projects. Healthy Start provides community-based, culturally competent, family-centered, and comprehensive perinatal health services to women, infants, and their families in communities with very high rates of infant mortality. The target population is pregnant or parenting women who reside in communities with infant mortality rates 1.5 - 2.5 times the national average. The majority of population served is Medicaid eligible. Services provided include outreach, health education, case management, depression screening and referral, and interconception care.

Health and Hospital Corporation of Marion County is the grantee for the Indianapolis Healthy Start Project grant, while Northwest Indiana Health Department Cooperative is the grantee for Northwest Indiana Healthy Start Project. Both Indiana Healthy Start projects provide case management (which includes risk assessment), coordination services, home visitation, health education, counseling, and guidance.

Healthy Start receives 100% of its funding from HRSA. In FY09, case-managed home visiting services were provided to 568 families in Marion County and 554 in Lake County. The projects provided outreach to 32,916 families in Marion County and 58,211 families in Lake County.

Community Education reached 19,883 families in Lake County and 21,664 families in Marion County. Families receiving case management are served at a cost of \$1,125 in Marion County and \$1,040 in Lake County per family annually. HRSA flat funding of Healthy Start for the past thirteen years has limited the opportunity to expand this program.

First Steps

First Steps, Indiana's program for infants and young children with disabilities or who are developmentally vulnerable (Part C of IDEA), is a comprehensive statewide program of early intervention services for infants and toddlers with disabilities and their families. Families who are eligible to participate in the Indiana First Steps system have children under the age of three who: are experiencing developmental delays of 25% or -2 standard deviations from the mean in one or more developmental domains; are experiencing developmental delays of 20% or -1.5 standard deviations from the mean in two or more developmental domains; or have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

First Steps services are provided at no cost to eligible families whose income is under 250% of the federal poverty line; families with income greater than 250% pay cost

participation fees on a sliding scale. Indiana's Family and Social Services Administration (FSSA) serves as the lead agency and administrator of the program, and is advised and assisted by an Interagency Coordinating Council (ICC). Ten regional contractors provide intake, eligibility determination and service coordination for families. Individual Family Services Plans (IFSPs) outline services which may include Assistive Technology, Occupational Therapy, Audiology, Developmental Therapy, Physical Therapy, Health Services, Psychology, Interpreter Services, Social Work, Medical, Speech Therapy, Nursing, Vision, Nutrition and other services and are provided to the extent possible in the children's natural environment, often their homes.

Between April 1, 2009, and March 31, 2010, 20,997 children were served by First Steps statewide at a total cost of \$51,231,738.

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 Lake, Scott, and St. Joseph counties.

Existing HFI Methods for Screening / Identifying / Referring Families

HFI must initiate services either prenatally (no earlier than the 6th month of pregnancy) or at birth of the target child. When an HFI site receives a referral (from WIC, hospitals, prenatal clinics, high schools, self referrals), the site will prioritize by postnatal. Within two working days, HFI personnel will attempt to contact the client, either by phone or attempted home visit (letters will not suffice for this contact method). Once contacted, an assessment 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 *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 of father low functioning
- Teen parent with no support system
- Active untreated mental illness
- Active alcohol/drug abuse
- Active interpersonal violence reported
- Scores of 10 or above or 3 on question#10 on the Early Postpartum Depression Scale
- Target child born at 36 weeks of gestation or less
- Target child diagnosed with significant developmental delays at birth
- Family assessment worker witnesses physical punishment of child(ren) at visit

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 will be a new program to Indiana, specifically Marion County, it will utilize existing mechanisms that are in place for home visiting referrals, such as those that exist for HFI. NFP has specific criteria for identifying and screening clients that involve

only enrolling mothers who are first time, low-income, and are identified before their third trimester of pregnancy. A mother will not be identified as possible NFP-IN client if they do not meet those specific criteria. After being identified as eligible, numerous screening mechanisms take place in order to assess the client's needs.

While HFI and NFP-IN both hope to improve outcomes in pregnant women, children and families, each program has very specific client eligibility that will enable two programs to work in tandem with one another, instead of against one another. Nurse-Family Partnership's outcomes are strongest among first-time, low-income mothers who enroll in the program before their third trimester. This ensures that NFP-IN is achieving its desired impact and is replicating the model faithfully. This population, however, is only a subset of the number of pregnant women in our community who could benefit from some kind of home visiting service. Thousands of women in the community can—and do—benefit from home visitation services in Marion County who are not eligible to receive services through NFP-IN. Models with different eligibility requirements are able to reach segments of the population that NFP-IN is not eligible to serve. Improved coordination between these providers, especially in cases where target populations do not overlap, can make home visiting environments more effective.

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 referrals with a centralized intake process; 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). Please see Appendix F for details on this advisory board.

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 statewide method of ensuring that all residents eligible for home visiting services are recruited and enrolled in the home visiting service most appropriate to that family’s needs. The IHVAB will determine if it is necessary to develop a home visiting referral framework to ensure all participants of home visiting services receive comprehensive referrals and follow-up. This referral coordination may mimic a “decision-tree” (or flow chart).

The well-established partnership between ISDH and DCS is the foundation of the coordination of State home visiting program. HFI, the state’s largest home-visiting network, and ISDH, one of the state’s largest providers of services for pregnant women, infants, mothers, and families working together will allow for high-quality home visiting and wrap-around services. As DCS is 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.

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 achieve one of the six benchmarks to be addressed—school readiness and achievement. This mutual partnership will ensure that each agency'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. Such materials include:

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

Currently, HFI provides these materials to home visiting clients through Sunny Start's Core Partners. As NFP-IN develops, nurse home visitors will also provide mothers Sunny Start materials to help navigate through their child's development.

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 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.

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.

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.

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

- *Improved health behaviors among women who are pregnant:* Women who are pregnant and participating in NFP will demonstrate reduced cigarette smoking, reduced pregnancy-induced hypertension, and increased use of community resources.
- *Increased number of newborns with appropriate birth weight:* Babies who are greater than or equal to 37 weeks gestation, born to women who are participating in NFP, weigh at least 2500 grams or more; pre-term delivery among smokers will decrease; birth weight among young teens will increase; and neurodevelopment impairment among babies born to mothers in program will decrease.
- *Improved caregiving:* Parents participating in program will demonstrate sensitive and competent care giving for infants and toddlers, resulting in: (1) decreased child maltreatment; (2) reduced number of verified cases of child abuse / neglect; and (3) increased number of stimulating home environments.
- *Appropriate child development:* Children participating in NFP display age- and gender-appropriate development, resulting in decreased language and cognitive / mental delays and more responsive interactions with mothers as well as less distress.
- *Parental economic self sufficiency:* Parents will develop plans for economic self sufficiency, resulting in: (1) reduced subsequent pregnancies; (2) increased intervals between first and second child; (3) increased number of months women unemployed during child's second year; (4) reduced months on welfare; and (5) increased father involvement in childcare and support.

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

- *Prevent of negative outcomes:* Families participating in HFI will demonstrate lower incidence of low birth weight babies and birth complications, less substance abuse, fewer inappropriate and unnecessary out-of-home placements of children, less

criminal activity I future generations, and lower incidence of child abuse and neglect than nonparticipating families.

- *Increase in parenting skills/behavior:* Participating families will demonstrate an increase in parenting knowledge and skills, positive parenting behaviors, high parenting self-esteem, and positive family interaction.
- *Increase in healthy pregnancy practices:* Participating families will practice healthy behaviors during pregnancy and will consciously consider healthy family planning practices.
- *Increase in ongoing healthcare practices:* Participating families will establish a medical home, will complete immunizations on a recommended schedule, and will participate in well-child visits at a higher rate than nonparticipating families.
- *Increase in mental health indicators:* Participating families will demonstrate increases in positive mental health indicators, self-esteem, and stress management skills.
- *Increase in social support system:* Participating families will use formal and informal support systems more effectively and appropriately and will provide more support to others, as appropriate, than nonparticipating families.
- *Improvement of family environmental factors:* Participating families will become more economically self-sufficient and will use more family resource management skill (including budgeting and financial decision-making) than nonparticipating families.

Development of an Early Childhood Comprehensive System

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.

The following individuals are seated within Sunny Start Core Partners, which meets quarterly:

Name	Division/Organization
Karen Amstutz, MD,	MPH Anthem
Daniel Clendenning	Center for Health Policy
Ryan Brown	Indiana Department of Education
Sarah Stelzner, M.D.	Dyson Community Pediatrics Initiative
Mary Weber	Maternal & Child Health, ISDH
Julie Brillhart	Anthem, Hoosier Healthwise
Melanie Brizzi	FSSA Bureau of Child Care
Michael Conn-Powers	IN Institute for Disability and Community
Janet Deahl	FSSA, Bureau of Child Care
Dawn Downer	FSSA Bureau of Child Development - First Steps
Anna Dusick, M.D.	INAAP and Riley Developmental Pediatrics
Carl Ellison	Indiana Minority Health Coalition
Audie Gilmer	Healthy Families
Melissa Hahn	Office of Medicaid Policy and Planning
Lisa Henley	Indiana Association for Child Care Resource and Referral
Gayla Hutsell	ISDH EHDI Program
Phyllis Kikendall	Dept. of Child Services
Rebecca Kirby	About Special Kids
Melissa Lewis	Indiana Academy of Family Physicians
Susan Lightle	Indiana Head Start Collaboration
Ted Maple	United Way - Success by Six
Allison Matters	Indiana Academy of Family Physicians
Paula McClain	FSSA, Bureau of Child Care
Cheryl Miller	Indiana Head Start Association
Lora Miller	FSSA Bureau of Child Development - First Steps
Kimberly Minniear	Community Integrated System of Services/CSHCS
Kevin Porter	The Indiana Division of Mental Health and Addiction
Mary Jo Paladino	Family Voices
Isaac E. Randolph Jr.	Office of Faith-Based & Community Initiatives
John Rau, M.D.	Riley Child Development Center
David Roos	Covering Kids & Families
Pat Sanchez	Commission on Hispanic/Latino Affairs
Karen Teliha	Indiana Dept. of Environmental Management
Marsha Thompson	IN Child Care Resource & Referral
Julia Tipton-Hogan	Indiana Perinatal Network
Angela Tomlin	IN Association for Infant and Toddler Mental Health
Dianna Wallace	IAEYC
Meredith Edwards	Indiana Academy of Family Physicians

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 achieve one of the six benchmarks to be addressed—school readiness and achievement. This mutual partnership will ensure that each agency’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. Such materials include:

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

Currently, HFI provides these materials to home visiting clients through Sunny Start's Core Partners. As NFP-IN develops, nurse home visitors will also provide mothers Sunny Start materials to help navigate through their child's development.

Integration of MCH, Early Childhood, and Development Programs

The statewide approach to home visiting will integrate existing home visiting services and programs that focus on maternal and child health throughout the state.

Integration of Home Visiting Programs

Indiana is fortunate that the following home visiting programs (that are considered to be either evidence-based or a promising practice) are currently being implemented in various locations throughout Indiana:

1. Parents as Teachers
2. Early Head Start
3. Healthy Families
4. Healthy Families E-Parenting Project
5. Even Start
6. Healthy Start
7. First Steps
8. The Newborn Individualized Care and Assessment Program

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.

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 referrals with a centralized intake process; 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 a collaborative network, to be entitled "*Indiana Home Visiting Advisory Board*" (IHVAB).

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

The first movement of this IHVAB, once developed, will be mapping of all existing home visiting services, the gaps that exist currently. Then, the IHVAB will develop a statewide method of ensuring that all residents eligible for home visiting services are recruited and enrolled in the home visiting service most appropriate to that family's needs. Then, the IHVAB will develop a strong, sustainable home visiting referral framework to ensure all participants of home visiting

services receive comprehensive referrals and follow-up. This referral coordination will mimic a “decision-tree” (or flow chart).

Specifically, any referral to a home visiting service from a health care provider, social service agency, etc. will be submitted directly to the Home Visiting Intake Center, prospectively to be housed at ISDH. Client information, including demographics and client eligibility will be assessed and the client will be referred to the home visiting program in his or her geographic location in which he or she is eligible and best fits the family’s needs. The client information will then be relayed to the respective home visiting program for client outreach and intake. More specific details and intricate planning will occur upon notification of funding through the SIR.

Integration of other MCH programs throughout the state

Since the MIECHV Program is housed within ISDH’s MCH Division, collaboration and integration into other MCH programs housed within ISDH is well-facilitated.

- The Perinatal Health program directed by Ms. Beth Johnson, MSN, RN, Public Health Nurse for Perinatal Health, aims to prevent maternal and infant morbidity and mortality through improved access to and enhanced utilization of perinatal and related services. The program includes Infant Mortality Disparity Initiative, Family Care Coordination and Prenatal Care Coordination, prenatal smoking cessation counseling and referrals to cessation services, Premature Birth Initiative, infrastructure building through the Indiana Perinatal Network, and direct medical services via prenatal care to high-risk women with low income. To integrate into these existing services, IHVAB will refer women enrolled in home visiting programs to the programs such as medical prenatal care. Family Care Coordination is another service in which home visiting clients may enroll after time in the home visiting program is complete.
- The Adolescent Health Services Program, directed by Stephanie Woodcox, MPH, CHES, Public Health Administrator of Adolescent Health, is comprised of programs and initiatives that serve the Hoosier adolescent population, ages 10-24. The school-based adolescent health clinics funded in part through Title V Block Grant funds provide medical care and preventative health services such as screening to approximately 2,400 students in Indiana annually. These school-based clinics can provide a source of referrals of young, pregnant women to home visiting services. Moreover, Indiana’s Family Planning Partnership agencies have agreed that the coordinated funding of family planning services in Indiana would increase access to services by patients, ensure quality of services, and minimize administrative overhead. All funds have been granted to the IFHC, Indiana’s Title X agency. IFHC contracts with local agencies in locations with the highest risk populations to provide comprehensive reproductive health and family planning services to the citizens of Indiana. The goal of the coordinated funding is to use the public family planning funds as efficiently and effectively as possible to target the women most in need and to provide complete services to all low income women. The local agencies contracted can provide referrals to home visiting services and family planning services to women in need who are enrolled in home visiting services.

- The Free Pregnancy Test Program, directed by Charrie Buskirk, MPH, Public Health Administrator of Women’s Health, strives to outreach to women of child-bearing age who are sexually active to improve access to primary, prenatal, and family planning care to impact the state’s high infant mortality rate. Once a woman is identified as pregnant from the free pregnancy test program, she can be immediately identified as high risk and enrolled in or referred to home visiting services.
- Marsha Glass, RN, directs the Prenatal Substance Use Prevention Program (PSUPP). The goals of the PSUPP program are to provide intervention to prevent poor birth outcomes by reducing prenatal substance use, through screening, counseling and referral to treatment of pregnant women who are using ATOD, community and healthcare provider education, and through collaboration with community and other groups with related goals, such as Coalition for a Drug-free (name of community/county). MCH also facilitates a Cross Agency Committee, lead by Ms. Glass, consisting of members from MCH, Department of Mental Health and Addiction, Department of Child Services, and the Office of Management and Budget. This committee was formed on the recommendation of the Prenatal Substance Abuse Commission, or PSAC (2007-2009) to carry forward the work of assessing and designing strategies to address the problem in Indiana. Both of these programs are crucial to home visiting services as they the construct of substance abuse

Logic Model of Updated State Plan

Please see the next page for a logic model of the updated state plan.

Logic Model

Program Goal: The overall goal of Indiana’s MIECHV Program is to <i>improve health and development outcomes for children and families who are at risk.</i>					
Objectives	Inputs	Outputs	Outcomes		
			Short	Intermediate	Long
1). 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.	<p>Indiana State Department of Health Personnel / Time</p> <p>Department of Child Services Staff / Time</p> <p>Affordable Care Act Maternal, Infant, and Early Childhood Program Funds</p> <p>Indiana State General Funds</p> <p>Healthy Families Indiana / Healthy Families America</p> <p>Goodwill Industries of Central Indiana Nurse Family Partnership</p> <p>Datatude, Inc.</p> <p>Social Solutions</p>	<p>Provision of home visiting services to women who are high-risk and low-income reside in high-risk areas of Lake County and St. Joseph County and the entirety of Scott County through Healthy Families Indiana</p> <p>Provision of home visiting services to women who are high-risk and low-income reside in high-risk areas of Marion County through Goodwill Industries of Central Indiana to implement Nurse-Family Partnership</p>	<p>Indiana identifies high-risk communities within at-risk counties</p> <p>Indiana identifies home visiting programs that meet the needs of high risk communities</p>	<p>Pregnant women, children and families will receive high quality home visits from appropriate services</p> <p>Home visiting programs in Indiana reach all women and families who are high risk and are willing to accept services</p>	<p>Home visiting clients demonstrate improved health and development outcomes for both children and their families</p>
2). Develop a system of coordinated services statewide of existing and newly developed home	<p>Indiana State Department of Health</p> <p>Department of Child Services</p>	<p>Facilitate meetings of Indiana Home Visiting Advisory Board with social service organizations around the state</p>	<p>MIECHV program leads identify organizations and agencies that may have</p>	<p>IHVAB meetings convene with a variety of identified stakeholders,</p>	<p>IHVAB creates policies and action plans to offer appropriate home visiting</p>

<p>visiting programs in order to provide appropriate, targeted, and unduplicated services and referrals to all children, mothers, and families who are high-risk throughout Indiana.</p>	<p>Social service agencies Private organizations Non-profit organizations</p>	<p>Create a process through which to determine the appropriate home visiting service based on the needs/eligibility of each client</p>	<p>interest in collaborating to create state-wide home visiting networks</p>	<p>including existing and new home visiting programs, as well as organizations and agencies that can provide referrals and services to home visiting clients</p>	<p>services to high-risk women, children, and families</p>
<p>3). Coordinate necessary services outside of home visiting programs to address the needs of participants, which may include: mental health, primary health care, dental health, children with special health needs, substance use, child injury prevention, child abuse/ neglect/ maltreatment, school readiness, and adult employment and education</p>	<p>Indiana State Department of Health Department of Child Services Social service agencies Private organizations Non-profit organizations</p>	<p>Develop partnerships and linkages with a variety of wrap-around services for home visiting clients Identify new and non-traditional organizations that may assist in providing wrap-around services for home visiting clients</p>	<p>Identify organizations and agencies that will assist with other services home visiting clients may need Reach out to identified agencies to describe how their services can be used as wrap-around services for home visiting clients</p>	<p>Create formal agreements, such as Memorandum of Understanding with agencies that show interest in assisting home visiting clients with wrap-around services</p>	<p>Home visiting clients will receive all types of services that may arise as a need while client is enrolled in the program</p>

Section 3: Selection of Proposed Home Visiting Models

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 three different areas throughout the state: 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 establish programming in high-risk areas of Marion County.

Healthy Families as an Evidence Based Program

Initially, the Healthy Families America (HFA) home visitation model was selected in 1992 by a Think Tank Advisory Committee comprised of public and private professionals with intent to seek funding and initiate the HFA home visitation model in Indiana. The state administration and the Think Tank Advisory Committee coordinated leadership from across the state to develop work groups and committees to address the HFA Model and build a statewide system that would assure quality services and meet HFA accreditation standards. Local needs assessments were completed and local communities chose to initiate Healthy Families in Indiana after the model was presented to local agencies interested in HFI funding.

While local agencies and Think Tank Advisory Committees continue to be included in site selection, HFI sites are now selected and funded through offerings by state administration of bi-annual Request for Funds. The requested support to expand existing HFI services with the three specific communities came after reviewing data and surveying the community.

Nurse-Family Partnership as an Evidence Based Program

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, Tenn., and Denver, Colo. (see below). 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.

Trials of the Program

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

TRIAL OUTCOMES

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.

The evidentiary foundations for the Nurse-Family Partnership model are among the strongest available for preventive interventions offered for public investment. Given that the original trials were relatively large, resulted in outcomes of public health importance, and were conducted with nearly entire populations of at-risk families in local community health settings, these findings are relevant to communities throughout the United States.

Nurse-Family Partnership's emphasis on randomized, controlled trials is consistent with the approach promoted by a growing chorus of evidence-based policy groups including the Coalition for Evidence-Based Policy, Blueprints for Violence Prevention, The RAND Corporation, and the Brookings Institution, which seek to provide policymakers and practitioners with clear, actionable information on programs that work—and are demonstrated in scientifically-valid studies.

Addressing Needs of Proposed Communities through HV Models

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 (blank survey is attached as Figure 3-1. in Appendix A) 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 Marion County, all 92 counties were served by at least one of the respondents. Please see Figure 3-2 in Appendix A for a table with responses to inquiry of whether service area has appropriate amounts of services.

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.

Currently, 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 will implement a pilot program of Nurse-Family Partnership through an innovative public / private partnership. This will be the state's first implementation of NFP. Goodwill will wrap its innovated program, Goodwill Guides (Guides), around NFP. Guides is Goodwill's early childhood initiative. Guides works with the entire family, which in this case would be the family members of the NFP participants to:

1. Provide holistic services such as education, financial literacy, workforce development, and health;
2. Early childhood development by navigating quality childcare options; and
3. Continue a relationship with the family and NFP clients after the NFP program ends after the child's second birthday.

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

NFP will be a new endeavor for Goodwill Industries. However, Goodwill has numerous experiences working with populations that are low-income and high-risk. When Goodwill operated Indianapolis' WorkOne centers and reached 50,000 people annually, over 50% of its participants lacked a high school diploma. The organization determined that by helping young people stay in school and at least obtain a high school diploma, families would be less likely to need services from Goodwill once they become adults. With very low graduation rates in Indianapolis, helping young people complete high school would increase Goodwill's long term impact.

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

Goodwill monitors the long-term student outcomes through two measures: (1) graduation rates and (2) postsecondary enrollment and retention. Intermediate data on student scores (through

end-of-course assessments) and school attendance are also evaluated by the boards of the school and of Goodwill as a whole.

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

While Goodwill's history to date does not account for experience implementing NFP, it does, however, indicate that Goodwill is well-positioned in the Indianapolis community and has the capacity to implement such a new and broad-reaching program. Goodwill can easily position itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5.

Process of Subcontracting

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, HFI was identified as the most capable organization to provide expanded services within the high-risk service area within St. Joseph, Scott, and Lake Counties. DCS, which operates and administers HFI, will subcontract funds to the local agencies that implement HFI within the selected high-risk communities.

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

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

model and complies with HFA accreditation standards as assessed annually by the HFI Quality Assurance Team.

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

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

NFP Subcontracting Method

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

Plan for Ensuring Model Fidelity & Quality Assurance

State's Overall Approach to Quality Assurance (QA)

The Home Visiting Coordinator (Ms. Mallory Quigley), with guidance from the ISDH Public Health Administrator of Women's Health, Director of Life Course Health Systems, and Director of MCH, 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.

The Program Coordinator will collect information quarterly on each program and its respective implementation sites. In addition, she 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. While the specific timelines and dates are in place to ensure activities are completed in a timely manner, communications between the Program Coordinator and each program and site will occur regularly. The Program Coordinator will 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 that apply to federal reporting requirements. 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 Coordinator will oversee QA via qualitative and quantitative analysis of data as well as interviews with program staff for each implementation site. She 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 Coordinator will aslo monitordata 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 Coordinator on a quarterly basis. Providing this critical information, such as reports on model fidelity and progress towards outcomesfrom 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 Home Visiting Program Coordinator will monitor various aspects of the program, 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 Coordinator 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 Coordinator 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 Coordinator. 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 Coordinator.

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 Coordinator.

The supervisors of each program will also report qualitative data to the Program Coordinator 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 Coordinator 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 Coordinator via secured electronic transfer.
- 4) Program Coordinator will complete audit for program utilization, process outcomes (as stated in Section 5), and completeness.
- 5) Program Coordinator will provide feedback (Program Improvement Plan) 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 (4) strict enrollment criteria.

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

Similarly, NFP has very strict criteria for both the clients enrolled in the program and the home visitors. While recruiting bachelor-prepared nurses who are willing to leave the clinical setting to enter a job that involves entering patients' homes and identifying and addressing a wide range of familial issues can be difficult, Goodwill has established strong relationship with local hospitals and Indiana University Purdue University-Indianapolis School of Nursing will allow for selection of appropriate home visitors. Another risk of implementing NFP 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.

Anticipated Technical Assistance Needs for QA & Fidelity

To date, ISDH and its partners do not anticipate any additional technical assistance needs. Fortunately, ISDH has several departments that are able to assist in many specific needs, including: Epidemiology, Data Analysis, Information Technology, and Maternal and Child Health. Similarly, DCS is able to rely on numerous in-house branches as well as its two main contractors (Datatude for evaluation services, data monitoring, data management and information technology and SCAN for HFA Quality Assurance and Technical Assistance) for assistance with anticipated needs

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 and HFI). Both HFI and NFP 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 and community health centers
- Physicians
- Social service agencies

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

For NFP, Goodwill has convened an advisory committee within Marion County—this group has met three times in 2011. Similarly, this advisory committee also has representation of at-risk community members. Within the implementation plan for NFP, Goodwill has listed that it will also engage businesses and other non-traditional partners such as churches and schools to identify appropriate at-risk individuals who may fit enrollment eligibility.

Moreover, on NFP’s advisory committee sits Indiana University Health’s Director of Community Outreach and Engagement (Ms. Maureen Weber, JD), as well as the Indiana Minority Health Coalition, Inc.’s Vice President of Planning and Program Development (Mr. Calvin Roberson, MA) who will assist in ensuring that the most appropriate target population is engaged.

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

Development of Policy / Standards for MIECHV Program

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
- Centralized Intake Process Standards
- 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 its 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 are:

- QA subgroup
- Training and Technical Assistance
- Evaluation workgroup
- Recommendations committee
- Communications committee

These committees 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. Any significant changes to the policies and procedures manual for HFI will be provided to the MIECHV advisory board (IHVAB) for review as changes are made.

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 to create 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.

Indiana's MIECHV programming aims to achieve the expected outcomes within the six benchmark areas. These improvements will provide additional justification for continued and additional support for home visiting programming in the state—specifically to provide this information to legislators who may consider authoring such bills to mandate HV services. Legislators are likely more interested in implementing programs with rigorous evaluation and evidence, which the proposed project will provide. Programs such as NFP and HFA have been deemed evidence-based by the HomVee study conducted by ACF. This rigorous study—combined with the outcomes of Indiana's approach—will draw attention of legislators for additional consideration.

Also, the external agencies with which Indiana's MIECHV program will partner will likely push for increased funding from the state. These external partnering agencies will be crucial to development of statewide policies as these agencies will be well-equipped to discuss the benefits of the program with legislators.

Plan for Working with National Model Developer

The approval letters from Healthy Families America (HFA) and Nurse-Family Partnership (NFP) National Service Office are attached in Appendix E. 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 systems in the accreditation process and having 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 Curricula

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, the only other curriculum not developed by NFP but is used by NFP sites is the PIPE curriculum for home visiting services. The curriculum will be obtained once NFP-IN is conditionally 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.

Training and Professional Development Activities

MIECHV Program Training / Development Activities

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

The Director of MCH is an RN and has an MSN and must receive Continuing Nurse Education credits. She is also currently working toward a fellowship from the MCH Public Health Leadership Institute at North Carolina University. The Public Health Leadership Institute convenes new leaders and new public health partners who together to confront new challenges in public health. The goal is to support public health leaders who will help lead change in the public health system for years to come.

HFI Program Training / Development Activities

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

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

NFP 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 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 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 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 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 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 Recruiting / Hiring / Training Staff

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 and 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.

Staff retention within HFI is high. Sites provide competitive wages and benefits. Staff is highly trained and is provided regular (weekly) intensive supervision and support. Site supervisors must monitor staff satisfaction annually, must address any identified issues, and must analyze staff retention annually. If a site falls below state averages for retention, that site must have a plan of correction.

NFP Staff Recruitment

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

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

Recognizing the importance of attracting and retaining talent, Goodwill pays competitively for the market for its positions. Goodwill provides a diverse mix of products and services to individuals and organizations in all sectors of the economy. To achieve its objectives and better serve its clients, Goodwill must recruit highly-experienced employees and expects exceptional

performance. Compensation levels must allow the organization to recruit talent from not-for-profit and for-profit organizations.

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

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

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. Many HFI sites employ mental health clinicians who guide staff and supervisors in dealing with mental health, addictions, and IPV cases. All HFI sites have access to extensive technical assistance at all time 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 lean 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.

Estimated Number of Families to be Served

Between both NFP and HFI, 314 new families will be served with home visiting services. Specifically, HFI will serve an estimated 214 families with the new MIECHV funds, while NFP-IN will serve 100 new participants with MIECHV funds.

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, as described above in greater detail. While the referrals sources may be the same, due to the target populations of the specific programs, referrals will be based on client eligibility and status, as well as agency agreements in place with either HFI or NFP-IN.

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.

Operational Plan for Coordination between Home Visiting Programs

As described in *Section 6*, the overall statewide home visiting program organizational chart is listed in Appendix D. Managing the day to day communications between the co-lead agencies and the collaborative partners is the Home Visiting Program Coordinator, 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.

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 (Audie Gilmer)
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 provide by the core individuals involved in this program will

Each MIECHV funded home visiting program will develop relationships with efforts 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. While many of these relationships exist for HFI, NFP-IN will work with collaborative partners to form these relationships. Both program will report back to the Home Visiting Program Coordinator on MOU's created and referrals made to outside organizations.

Plan for Data Systems

The Home Visiting Program Coordinator will not use a specific data system to aggregately collect data. Rather, the Program Coordinator will collect data from individual programs through quarterly reports. Child Protective Services (CPS) data base will be used with both programs to track child abuse, neglect, and maltreatment cases.

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 Coordinator 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 Coordinator 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 Coordinator 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 Coordinator 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. Audie Gilmer, the 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 other organizations also provide referrals to a home visiting program or allow the home visiting program to refer a client to services provided by an organization. Dr. Gregory Larkin, M.D., Indiana State Health Commissioner has provided his support through a letter of concurrence on behalf of the State's Title V administrator and the State's public health agency. Head Start Collaboration Office Director Susan Lightle, has also provided a letter of concurrence in support of Indiana's Home Visiting Plan and its place within the Head Start Collaboration Office.

The State's administrator of Title II of Child Abuse Prevention and Treatment Act and the State's child welfare agency, Department of Child Services has provided support through a letter of concurrence, as well as being the State's co-lead agency. The Early Childhood Support Specialist, Dana Jones, of Indiana Department of Education (IDOE), as well as the State's Comprehensive Child Development Fund (CCDF) contact Melanie Brizzi have proven to be collaborative partners by signing a letter of concurrence. Department of Mental Health and Addiction (DMHA) provide substance use and mental health wrap-around services for home visiting clients. Gina Eckart, Director of DMHA has provided her concurrence with the plan. Required letters of concurrence can be found in Appendix B.

The Family and Social Services Administration (FSSA) have also show support and commitment to assisting the State's home visiting efforts. FSSA's Division of Family Resources, TANF Program Manager has decided to collaborate to assist home visiting families in need. Dr. Joan Duwve, Indiana State Department of Health's Chief Medical Officer has provided support and collaboration for home visiting and injury prevention. IDOE's Title I administrator, Amy Bush, has also shown support of the Updated State Plan through the letter of support attached. These relationships ensure that the administration personnel maintain collaborations with statewide and local-level partners. Letters of support can be found in Appendix C.

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

groups, housing services, job training, education (alternative education) providers, food assistance, and many more.

HFI Partners

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

NFP Partners

Nurse-Family Partnership-Indiana 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 has convened two times to date and is representative of numerous public and private organizations throughout Marion County and the State of Indiana. Members include:

- Kent Kramer, VP-Retail Operations Goodwill Industries
- Mary Weber, MSN, RN, Director-Maternal and Child Health Division, Indiana State Department of Health
- Nancy Meadows, RN, BS, Project Director-Health Excel, Central Indiana Alliance for Health, A Robert Wood Johnson Foundation Aligning Forces for Quality Community
- Joanne Martin, Dr. PH, MPH, MS, RN, Nurse Consultant- IU School of Nursing (Retired)
- Maureen Weber, JD, Director- Community Outreach & Engagement, Indiana University Health
- Betsy Lee, BSN, MSPH, Director- Indiana Patient Safety Center, Indiana Hospital Association
- Ed Tipton, Executive Director- Community Action of Greater Indianapolis
- Lee Livin, CFO & EVP- Strategic Planning & Business Department, Wishard Health Services
- Jim Lemons, MD, Indiana University School of Medicine- Department of Neonatal/ Perinatal Medicine
- Calvin Roberson, MHA, MPH, VP-Planning & Program Development, Indiana Minority Health Coalition, Inc.
- Karen R. Kelly, MSN, RNC, FNP, Nursing Managing- Corporate Health Services, 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.

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)

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, Tenn., and Denver, Colo. (see below). 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.

Trials of the Program

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

Trial Outcomes

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:

- Improvement in women's prenatal health 79% reduction in preterm delivery for women who smoke, and reductions in high-risk pregnancies as a result of greater intervals between first and subsequent births

Improved Child Health and Development:

- Reduction in criminal activity 59% reduction in child arrests at age 15
- Reduction in injuries 39% fewer injuries among children
- 56% reduction in emergency room visits for accidents and poisonings
- 48% reduction in child abuse and neglect
- Increase in children's school readiness 50% reduction in language delays of child age 21 months; 67% reduction in behavioral/intellectual problems at age six

Increased Economic Self-Sufficiency:

- Fewer unintended subsequent pregnancies 32% fewer subsequent pregnancies
- Increase in labor force participation by the mother 83% increase by the child's fourth birthday
- Reduction in welfare use 20% reduction in months on welfare
- Increase in father involvement 46% increase in father's presence in household
- Reduction in criminal activity 60% fewer arrests of the mother; 72% fewer convictions of the mother

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. Each client's needs are unique, and can differ between visits, from signing up for a health insurance plan to care for mother and baby, to finding a way to pay this month's rent, to assisting a young mother realize her goals of graduating high school. Since home visiting provides such an intimate, relationship building service, success of the program depends on home visitors keen ability to assess the client's needs and provide appropriate services or referrals based on those needs. The home visitor must have a strong sense of the home visiting model being implemented to ensure maintenance of model fidelity while assessing individual client's daily and long term needs and goals.

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 Home Visiting Program Coordinator 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.

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.

Plan for CQI to Enhance Program Operation & Decision-making

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 Coordinator will *collect* information quarterly on each program model and its respective implementation sites. In addition, she 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. While the specific timelines and dates are in place to ensure activities are completed in a timely manner, communications between the Program Coordinator and each program and site will occur regularly.

The Program Coordinator will 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. 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 Home Visiting Program Coordinator based on its quarterly assessment. The Quarterly Evaluation Report will be a key resource completed by the Home Visiting Program Coordinator 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. The Home Visiting Program Coordinator will work to use these plans as one method of communication and documented feedback to each site.

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.

Benchmark: Improved Maternal and Newborn Health

<u>Constructs</u>	<u>Definition of Improvement</u>	<u>State wide Process Measures</u>	<u>State-wide Outcome Measure</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Prenatal care	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
Parental use of alcohol, tobacco, or illicit drugs	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
Preconception care	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
Inter-birth intervals	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
Screening for maternal depressive symptoms	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
Breastfeeding	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
Well-child visits	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
Maternal and child health insurance status	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

Benchmark: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

<u>Constructs:</u>	<u>Definition of Improvement</u>	<u>State-wide Process Measure</u>	<u>State-wide Outcome Measure:</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Visits for children to the emergency department (ED) from all causes	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
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	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
Incidence of child injuries requiring medical treatment	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
Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)	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 child protective services	Children/ infants in program
Reported substantiated maltreatment (substantiated/indicated/alternative	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	Child Protective Services database.	Home visitor observation/ participant report with	Children/ infants in program

response victim) for children in the program			decrease as per client match in CPS data base		comparisons to local & child welfare data	
First-time victims of maltreatment for children in the program*	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

Benchmark: Improvements in School Readiness and Achievement						
<u>Constructs</u>	<u>Definition of Improvement</u>	<u>State-wide Process Measure</u>	<u>State-wide Outcome Measure:</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)	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	1) 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.) OR	Scales chosen are reliable and valid as per DOHVE Compendium	Home Visitor observation/ parent report	Parents of children enrolled in the program
Parent knowledge of child development and of their child's developmental progress	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.) Or	Scales chosen are reliable and valid as per DOHVE Compendium	Home visitor observation/ parent report	Parents of children enrolled in the program
Child's communication, language and emergent literacy	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

Child's general cognitive skills	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
Child's positive approaches to learning including attention	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
Child's social behavior, emotion regulation, and emotional well-being	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
Child's physical health and development	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
Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	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
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)	Increases in individual family assessment	1) 95% of mothers enrolled in program are screened from depressive symptoms	1) 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

Benchmark: Crime or Domestic Violence*						
<u>Constructs</u>	<u>Definition of improvement</u>	<u>State-wide Process Measures</u>	<u>State-wide Outcome Measures</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Domestic Violence: Screening for domestic violence	Increase in rate of screening compared to population served	95% of clients enrolled in home visiting program are screened for domestic violence	95% of clients enrolled in home visiting program are screened for domestic violence	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
Domestic Violence: Of families identified for the presence of domestic violence, referrals for relevant services	Increase in rate of referrals over time	95% of clients enrolled in home visiting program are screened for domestic violence	Of the clients who screen positive for domestic violence, 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
Domestic Violence: Of families identified for the presence of domestic violence, families for which a safety plan was completed	Increase in number of safety plans completed over time.	95% of clients enrolled in home visiting program are screened for domestic violence	Of the clients who screen positive for domestic violence, 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

Benchmark: Family Economic Self-Sufficiency						
<u>Constructs</u>	<u>Definition of improvement</u>	<u>State-wide Process Measures</u>	<u>State-wide Outcome Measures</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Household* income and benefits[†]	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
Employment or Education of adult members of the household	Employment: Increase in number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in	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

	household					
Health insurance status	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

Benchmark: Coordination and Referrals for Other Community Resources and Support*						
<u>Constructs</u>	<u>Definition of Improvement</u>	<u>State-wide Process Measures</u>	<u>State-wide Outcome Measure</u>	<u>Reliability/ Validity</u>	<u>Source</u>	<u>Population Assessed</u>
Number of families identified for necessary services	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
Number of families that required services and received a referral to available community resources	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
MOU's: Number of Memoranda of Understanding or other formal agreements with other social services agencies in the community	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

<p>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</p>	<p>Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider</p>	<p>Of the agencies with which an MOU exists, 70% of those MOU's also include collaboration and regular data sharing between agencies</p>	<p>Of the agencies with which an MOU exists, 70% of those MOU's also include collaboration and regular data sharing between agencies</p>	<p>MOU's are on record with each agency and with the state</p>	<p>Direct assessment and agency administrative data</p>	<p>Community agencies</p>
<p>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)</p>	<p>Number of completed referrals: Increase in the percentage of families with referrals for which receipt of services can be confirmed</p>	<p>Home Visitor follows up with client or agency to determine if client has sought referral services</p>	<p>Of the families enrolled in the program that receive an appropriate referral, 50% of those referrals were completed</p>	<p>Home Visitors are a reliable source of data for this information</p>	<p>Direct assessment and agency administrative data</p>	<p>Parent/child enrolled in home visiting agency and community agencies</p>

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"> • Interrater agreement and test-retest agreement generally in excess of 90% • Parent and trained tester agreement ranged from 76-92% depending on test interval even with parents from low income backgrounds • Primary measure of Reliability was internal consistency between domain and overall scores – all correlations were significant • Test – retest reliability was 94% • Interobserver reliability was 94% • Concurrent Validity when compared with Revised Gesell and Armtruda Developmental and Neurologic Examination and Bayley ranged from 76% to 91%
North Carolina Family Assessment Scale (NCFAS)	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	<ul style="list-style-type: none"> • 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. • 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 • Concurrent validity correlations ranging from .26 to .71
Home Observation for Measurement of the Environment (HOME)	“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	<ul style="list-style-type: none"> • Internal consistency Reliability was 89% for the total and averaged 70% for the six subscales • HOME is a more valid measure of the child’s developmental environment than family socioeconomic status, father’s presents and home crowding. • Interrater agreement was 90% and internal consistency ranged from 44% to 89% • Test – retest reliability was moderate for 18 months • Concurrent validity – small to moderate with welfare status, maternal education, maternal occupation, presence of father in home, paternal occupation and crowding in the house.
IPV Screen	The Colorado Behavioral Risk Factor Surveillance System (BRFSS) – “Predictive Validity of a Screen for Partner Violence Against Women”, <u>American Journal of Preventive</u>	<p>Questions used with the BRFSS, a standardized, population-based, national survey</p> <ol style="list-style-type: none"> 1. Thinking back over the past year, on any occasion were you hit, slapped, kicked, raped, or otherwise physically hurt by

	<u>Medicine</u> , 2001;21:2:93-100	<p>someone you know or knew intimately, such as a spouse, partner, ex-spouse or partner, boyfriend, girlfriend, or date?</p> <ol style="list-style-type: none"> 2. Considering your current partners or friends, or any past partners or friends, is there anyone who is making you feel unsafe now? 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? <p>The outcome variable was the CTS measured 3 to 5 months after the initial 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.</p>
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 gourp 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 Home Visiting Program Coordinator 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 Home Visiting Program Coordinator 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 Coordinator and her 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, and 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 Home Visiting Program Coordinator and her Assistant Program Coordinator will collect data on a quarterly basis and perform basic analysis on MIECHV-designated outcomes. Mallory Quigley, the Home Visiting Program Coordinator, will serve as the manager of the measures listed in the Benchmark Chart has previous. 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.

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 Coordinator 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 Home Visiting Program Coordinator 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 Coordinator 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, mutli-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 avialble 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.

Anticipated Barriers / Challenges to Benchmark Reporting w/Solutions

Anticipated challenges in benchmark reporting may arise when each individual program supported by MIEC HV funds collect measures in various manners. For example, while each program may measure maternal depressive symptoms, they may use different tools for assessments. These different tools measure the respective construct in different manners. During the planning process, this became an issue in determining measures of each benchmark construct. However, Indiana overcame these issues by deciding on general outcomes for each construct that do not contain specific measures of scores from assessment tools. Instead, Indiana specified ranges of measures that a client must fall in to be considered improving or adequate.

Section 6: Plan for Administration of State Home Visiting Program

Indiana Governor Mitch Daniels has designated Indiana State Department of Health (ISDH) and Indiana Department of Child Services (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

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. Audie Gilmer, the 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 other organizations also provide referrals to a home visiting program or allow the home visiting program to refer a client to services provided by an organization. Dr. Gregory Larkin, M.D., Indiana State Health Commissioner has provided his support through a letter of concurrence on behalf of the State's Title V administrator and the State's public health agency. Head Start Collaboration Office Director Susan Lightle, has also provided a letter of concurrence in support of Indiana's Home Visiting Plan and its place within the Head Start Collaboration Office.

The State's administrator of Title II of Child Abuse Prevention and Treatment Act and the State's child welfare agency, Department of Child Services has provided support through a letter of concurrence, as well as being the State's co-lead agency. The Early Childhood Support Specialist, Dana Jones, of Indiana Department of Education (IDOE), as well as the State's Comprehensive Child Development Fund (CCDF) contact Melanie Brizzi have proven to be collaborative partners by signing a letter of concurrence. Department of Mental Health and Addiction (DMHA) provide substance use and mental health wrap-around services for home visiting clients. Gina Eckart, Director of DMHA has provided her concurrence with the plan. Required letters of concurrence can be found in Appendix B.

The Family and Social Services Administration (FSSA) have also show support and commitment to assisting the State's home visiting efforts. FSSA's Division of Family Resources, TANF Program Manager has decided to collaborate to assist home visiting families in need. Dr. Joan Duwve, Indiana State Department of Health's Chief Medical Officer has provided support and collaboration for home visiting and injury prevention. IDOE's Tile I administrator, Amy Bush, has also shown support of the Updated State Plan through the letter of support attached. These relationships ensure that the administration personnel maintain collaborations with statewide and local-level partners. Letters of support can be found in Appendix C.

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

HFI Partners

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

NFP Partners

Nurse-Family Partnership-Indiana 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 has

convened two times to date and is representative of numerous public and private organizations throughout Marion County and the State of Indiana. Members include:

- Kent Kramer, VP-Retail Operations Goodwill Industries
- Mary Weber, MSN, RN, Director-Maternal and Child Health Division, Indiana State Department of Health
- Nancy Meadows, RN, BS, Project Director-Health Excel, Central Indiana Alliance for Health, A Robert Wood Johnson Foundation Aligning Forces for Quality Community
- Joanne Martin, Dr. PH, MPH, MS, RN, Nurse Consultant- IU School of Nursing (Retired)
- Maureen Weber, JD, Director- Community Outreach & Engagement, Indiana University Health
- Betsy Lee, BSN, MSPH, Director- Indiana Patient Safety Center, Indiana Hospital Association
- Ed Tipton, Executive Director- Community Action of Greater Indianapolis
- Lee Livin, CFO & EVP- Strategic Planning & Business Department, Wishard Health Services
- Jim Lemons, MD, Indiana University School of Medicine- Department of Neonatal/ Perinatal Medicine
- Calvin Roberson, MHA, MPH, VP-Planning & Program Development, Indiana Minority Health Coalition, Inc.
- Karen R. Kelly, MSN, RNC, FNP, Nursing Managing- Corporate Health Services, 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.

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, seen in Appendix F, 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 Appendix D. Managing the day to day communications between the co-lead agencies and the collaborative partners is the

Home Visiting Program Coordinator, housed at ISDH. In addition, the Program Coordinator will provide the following support.

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

The Program Coordinator 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 the Program Coordinator 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 (Ms. Audie Gilmer) will be the primary contact at DCS. This position is also responsible for:

- The enhancement of the capacity of communities in Indiana to provide quality HFA/HFI early intervention services and to facilitate the expansion and improvement of existing service being provided to pregnant women, infants and children up to 3 years of age and their families. Outcomes in this area include efforts to expand provider recruitment and enrollment, and enhanced development of partnerships with local resources for each of the 92 counties, and enhanced opportunities for families to access services in their communities as required HFA/HFI state policy and procedures.
- The monitoring and evaluation of each county's comprehensive, coordinated, multidisciplinary, interagency system of HFA/HFI early intervention services for pregnant women, infants and children up to 3 years of age and their families to ensure compliance with national accreditation standards and state and federal requirements.
- Collaboration with community agencies, associations and organizations that are key stakeholders in the local HFA/HFI early intervention system.
- Development and coordination of a training and technical assistance contract to provide local and regional trainings and technical assistance opportunities to ensure quality services for eligible families and their children and meet the required training standards for HFA/HFI multi-site accreditation.
- Over-site of consultant and support staff to insure consistent, timely and accurate information to local communities as they implement the HFA, federal and state regulations for the HFA/HFI early intervention system.

- The Healthy Families Indiana Coordinator is responsible for general administration and supervision; and coordination of available federal, state funding sources; implementation of procedures that ensure continuity of services; implementation of formal agreements and policies related to the payment of services.
- The HFI Coordinator is responsible for ensuring that all 92 Indiana counties are in compliance with HFA standards federal and state regulations.
- This position works with the HFI Think Tank Advisory council as an advisor to DCS agency as well as five work groups coordinated with the HFI Think Tank that are organized to address the various components of the HFA/HFI early intervention system.

The HFI Program Coordinator is overseen by the Manager of Prevention Services (Ms. Phyllis Kikendall). This position will dedicate 5% FTE and is responsible for overseeing the Program Coordinator's day-to-day activities, including contract development and management and engagement with the operations work group within the HFI Think Tank Group.

The HFI Deputy Director of Programs and Services (Ms. Lisa Rich) oversees the Manager of Prevention Services. Ms. Rich is responsible for fiscal and programmatic problem solving and stakeholder engagement. In addition, Ms. Rich will co-lead the convening of the Indiana Home Visiting Advisory Board.

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

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

NFP Management

Prior to hiring of Nurse Supervisor and home visiting nurses, the Director of Community Initiatives (Ms. Keith Reisshaus) 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. Reisshaus and Mr. Lange are in-kind providing their services for the initial development phase of NFP-IN.

The nurse supervisor will be hired 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 an Master of Science in Nursing and will oversee day-to-day activities of no greater than eight home visiting nurses. Specific responsibilities include:

- Management of RNs
- Reflective supervision
- Engagement with referral organizations to increase partnerships
- Research on Organizational Policies in use by other organizations
- Consult with external contracted Nurse Consultant for Goodwill Industries (who assisted in planning of NFP-IN) to establish working policies for NFP
- Maintaining confidentiality of participants and their families
- Record-keeping
- Client consent
- Safety planning for home visits
- Mandatory reporting
- Assessment of pregnant women's health
- Assessment of infants and children
- Communication with primary caregivers
- Supervising field staff

Primary responsibilities of the home visiting nurses include NFP outreach and enrollment activities as well as actual home visiting activities and data collection. 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, Starke, and St. Joseph counties.

HFI Methods for Screening / Identifying / Referring Families

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

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

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

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

- Parent beaten or deprived as child
- Parent with criminal/mental illness/substance abuse
- Parent suspected of abuse in the past
- Low self-esteem/social isolation/depression/no lifelines
- Multiple crises/stresses
- Violent temper outburst

- Rigid and unrealistic expectations of child
- Harsh punishment of child
- Child difficult and/or provocative as perceived by parents
- Child unwanted
- Child at risk for poor bonding

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

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

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

NFP Methods for Screening / Identifying / Referring Families

As a new provider of health prevention services in Indianapolis, Goodwill will be diligent in maximizing referrals to NFP, especially in its first year of implementation. Goodwill—and specifically, the Director of Community Initiatives will establish community partnerships and earn guaranteed referral sources from various partner organizations. As the largest provider of referrals to home visiting, WIC referrals will be an important referral source for NFP. 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. In exchange for free pregnancy tests, each clinic site must report a specific data set regarding the women who receive such tests. Information includes results (positive vs. negative), referrals, demographics, and intendedness. 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 both hope to improve outcomes in pregnant women, children and families, each program has very specific client eligibility that will enable to programs to work in tandem with one another, instead of against one another.

Nurse-Family Partnership’s outcomes are strongest among first-time, low-income mothers who enroll in the program before their third trimester. This ensures that NFP is achieving its desired impact and is replicating the model faithfully. This population, however, is only a subset of the number of pregnant women in our community who could benefit from some kind of home visiting service. Thousands of women in the community can—and do—benefit from home visitation services in Marion County who are not eligible to receive services through Nurse-Family Partnership. Models with different eligibility requirements are able to reach segments of the population that NFP 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. 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 duplicated home visiting services.

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 pages 78 and 79 of this Updated State Plan.

Organizational Chart

Please see Appendix D for an Organizational Chart.

How Statewide HV Plan Will Meet Legislation Requirements

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.

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.

Currently, 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

ISDH will implement a pilot program of Nurse-Family Partnership with an innovative public / private partnership with Goodwill Industries of Central Indiana. This will be the state's first implementation of NFP. Goodwill provides an innovative partnership with Goodwill Guides (Guides), a service provided by Goodwill for Early Childhood Initiatives. Guides will work with the entire family, which in this case would be the family members of the NFP participants to:

1. Provide holistic services such as education, financial literacy, workforce development, and health;
2. Early childhood development by navigating quality childcare options; and
3. Continue a relationship with the family and NFP clients after the NFP program ends after the child's second birthday.

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

NFP will be a new endeavor for Goodwill Industries. However, Goodwill has numerous experiences working with populations that are low-income and high-risk. When Goodwill

operated Indianapolis' WorkOne centers and reached 50,000 people annually, over 50% of its participants lacked a high school diploma. The organization determined that by helping young people stay in school and at least obtain a high school diploma, families would be less likely to need services from Goodwill once they become adults. With very low graduation rates in Indianapolis, helping young people complete high school would increase Goodwill's long term impact.

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

Goodwill monitors the long-term student outcomes through two measures: (1) graduation rates and (2) postsecondary enrollment and retention. Intermediate data on student scores (through end-of-course assessments) and school attendance are also evaluated by the boards of the school and of Goodwill as a whole. The Indianapolis Met has been the greatest organizational learning experience in Goodwill's history. The Indianapolis Met has become an "ideal laboratory" to test and discover how holistic approaches built on long-term relationships between participants and providers can create long-term impact.

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

While Goodwill's history to date does not account for experience implementing NFP, it does, however, indicate that Goodwill is well-positioned in the community and has the capacity to implement such a new and broad-reaching program. Goodwill can easily position itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of services until the child reaches age five.

Coordination of Statewide HV Program with Early Childhood Plans

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 achieve one of the six benchmarks to be addressed—school readiness and achievement. This mutual partnership will ensure that each agency'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. Such materials include:

- The Early Childhood Meeting Place website to provide families and early childhood providers with resource and support information.
- A Developmental Calendar has been developed for families and providers, which highlights important health and safety information such as infant and toddler's nutritional needs, oral health issues, communication, and gross motor development. The calendar is available in English and Spanish.

- A Wellness Passport for Indiana’s Kids, a personal healthcare record-keeping tool that allows parents to collect, track, store, and access important information about their children’s growth and development—all in one easy-to-access location. An online tutorial about the passport is available.
- A Special Health Care Needs Addendum to the Wellness Passport, providing additional sections for families raising children with disabilities and special healthcare needs.
- Family Resource Fact Sheets, a series of 25 fact sheets that highlight the basics of key resources available for Hoosier families. They are also available in Spanish.

Currently, HFI provides these materials to home visiting clients through Sunny Start’s Core Partners. As NFP-IN develops, nurse home visitors will also provide mothers Sunny Start materials to help navigate through their child’s development.

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 three proposed sites: 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.

Strategies for Modifications to State Plan for Home Visiting Success

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.

Section 7: Plan for Continuous Quality Improvement

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 (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 Coordinator 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 Coordinator and provide CQI expertise for its respective program.

State Level CQI

The Home Visiting Program Coordinator (Ms. Mallory Quigley, MPH) will be providing CQI on a state level to both MIECHV programs. The Home Visiting Program Coordinator 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. The Home Visiting Program Coordinator 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, The Home Visiting Program Coordinator 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.

The Home Visiting Program Coordinator 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. She 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.

Quarterly Plan

The Home Visiting Program Coordinator will complete program utilization, process outcome measure evaluations as part of the CQI plan. The first evaluation will occur when both programs have reached its full caseload (approximately nine months into program operations). This monitoring will take place through data transfers and chart audits. A sampling method will be used to complete chart audits and data transfers in order to ensure that a representative sample of the population is being assessed. Once the program reaches full capacity of 314 clients—to

generate a statistically significant sample with 95% confidence intervals with a margin of error of $\pm 5.0\%$ —the Program Coordinator must sample at minimum 175 clients.

The following will be collected on a quarterly basis:

- 1) Each MIECHV funded site will report the number of clients enrolled during the specified quarter.
- 2) The Home Visiting Program Coordinator 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 Coordinator via secured electronic transfer and completed quarterly self-evaluation.
- 4) The Home Visiting Program Coordinator 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 Coordinator will complete phone interview with each site supervisor to discuss results of audit and self-evaluation as well as a written Program Improvement Plan for each site.

The supervisors will also report qualitative data to The Home Visiting Program Coordinator 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 Coordinator 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 Coordinator 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 Coordinator 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 Coordinator hopes 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 Coordinator and each program and site will occur regularly. The Home Visiting Program Coordinator hopes 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.

Finally, one of the most important aspects of CQI is the feedback programs will receive from the Home Visiting Program Coordinator based on its quarterly assessment. The Quarterly Evaluation Report will be a key resource completed by the Home Visiting Program Coordinator 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 Coordinator hopes to use these plans as one method of communication and documented feedback to each site.

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 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 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 Coordinator do to assist in any needs you may have?

Results of the self-evaluation will be reviewed by the Home Visiting Program Coordinator 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.

Section 8: Technical Assistance

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 IHVAB and coordination of referrals and 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.

APPENDIX A

FIGURES AND CHARTS

Figure 1-1: Needs Assessment Indicators

Indicators
% Low Birth weight
% Very Low Birth weight
% Preterm Birth
Rate of Infant Deaths
Rate of Neonatal Deaths
Rate of Post Neonatal Deaths
% of Women with Late or No Prenatal Care
% of Women Smoking during Pregnancy
% of Adult Smokers
% of Births to First Time Mothers
Birth Rates (15-19)
% of Pregnant Women on WIC
% of Women Breastfeeding at Discharge
% of Births to Unmarried Parents
% of Births to Mothers w/o High School Degree
% of substantiated child abuse
% of substantiated child neglect
% of Immunizations
% of Adult obesity
% of binge drinking
% of uninsured children
% of children with confirmed EBL>10
% of schools meeting Annual Yearly Progress (AYP)
Number of slots available in licensed child care per 100 Age 0-4
% of children in public schools with limited English proficiency
% of public school dropouts
% of 4 th graders passing their ISTEP tests
% of unemployment
% of unemployment annual average
% of children in poverty
% of children receiving free or reduced lunch
% of households on food stamps
% of households on TANF
% of high school graduates
% of adults with a college education
% single parent households
% of children birth to 6 receiving Medicaid
Helpline Calls

Figure 1-2: Overall Scores of Counties from Needs Assessment

High Risk Counties	Score	Rank	Average
Marion	2814	92	70.35
Lake	2626	91	65.65
Scott	2538	90	63.45
Elkhart	2533	89	63.325
St Joseph	2512	88	62.8
Fayette	2477	87	61.925
Jennings	2466	86	61.65
Starke	2444	85	61.1
LaPorte	2434	84	60.85
Grant	2422	83	60.55
Owen	2409	82	60.225
Madison	2365	81	59.125
Cass	2354	80	58.85
Switzerland	2333	79	58.325
Wayne	2225	78	55.625
Randolph	2220	77	55.5
Vanderburgh	2199	76	54.975
Clark	2183	75	54.575
Jefferson	2178	74	54.45
Vigo	2170	73	54.25
Wabash	2169	72	54.225
Noble	2161	71	54.025
Blackford	2158	70	53.95
Allen	2156	69	53.9
Washington	2132	68	53.3
Crawford	2116	67	52.9

High Risk Counties	Score	Rank	Average
Clinton	2112	66	52.8
White	2102	65	52.55
Orange	2074	64	51.85
Rush	2071	63	51.775
Vermillion	2061	62	51.525
Sullivan	2059	61	51.475
Fulton	2044	60	51.1
Miami	2037	59	50.925
Fountain	2036	58	50.9
Steuben	2026	57	50.65
Henry	2013	56	50.325
Montgomery	2012	55	50.3
Jackson	2006	54	50.15
Howard	1979	53	49.475
Jay	1969	52	49.225
Clay	1960	51	49
Delaware	1956	50	48.9
Newton	1942	49	48.55
Pulaski	1904	48	47.6
Lawrence	1903	47	47.575
Greene	1892	46	47.3
Shelby	1874	45	46.85
Marshall	1865	44	46.625
Decatur	1865	43	46.625
Kosciusko	1858	42	46.45
Daviess	1835	41	45.875
Morgan	1834	40	45.85
Union	1820	39	45.5

High Risk Counties	Score	Rank	Average
Parke	1819	38	45.475
Knox	1810	37	45.25
Perry	1809	36	45.225
Floyd	1802	35	45.05
Putnam	1798	34	44.95
Tippecanoe	1793	33	44.825
Adams	1788	32	44.7
Martin	1786	31	44.65
Harrison	1767	30	44.175
Bartholomew	1756	29	43.9
Huntington	1725	28	43.125
Ohio	1717	27	42.925
Jasper	1712	26	42.8
Ripley	1707	25	42.675
Pike	1683	24	42.075
Warren	1657	23	41.425
LaGrange	1642	22	41.05
Whitley	1614	21	40.35
DeKalb	1549	20	38.725
Wells	1528	19	38.2
Porter	1484	18	37.1
Monroe	1483	17	37.075
Franklin	1471	16	36.775
Benton	1460	15	36.5
Dearborn	1455	14	36.375
Tipton	1445	13	36.125
Brown	1441	12	36.025
Posey	1410	11	35.25

High Risk Counties	Score	Rank	Average
Spencer	1371	10	34.275
Johnson	1371	9	34.275
Carroll	1262	8	31.55
Warrick	1248	7	31.2
Gibson	1234	6	30.85
Dubois	1185	5	29.625
Hancock	1177	4	29.425
Hendricks	1113	3	27.825
Hamilton	948	2	23.7
Boone	940	1	23.5

Figure 3-1: Blank Survey

1. Welcome!

Thank you for your interest in completing the Maternal, Infant, and Early Childhood (MIEC) Home Visiting Program Community Assessment Survey. While you are not required to complete this survey, it will assist Indiana in accurately selecting the highest-risk, most in-need communities for the implementation of the MIEC Home Visiting Program. The results of the survey will be connected to your organization, however identified information will not be shared without your organization's consent. This survey will likely take 5-10 minutes to complete. Please complete by Thursday, May 5.

2. Organization Location

1. Is your organization located in or service clients in **AT LEAST** one of the following counties?

Elkhart

Jennings

La Porte

Lake

Marion

Scott

Starke

St. Joseph

Yes

No

3. Organization Information

*** 1. Please provide the following information about you and your organization.**

Contact Name:	<input type="text"/>
Organization Name:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City/Town:	<input type="text"/>
State:	<input type="text"/>
ZIP:	<input type="text"/>
Contact Email Address:	<input type="text"/>
Contact Phone Number:	<input type="text"/>

4. Primary Service

*** 1. What is the primary service your organization provides?**

*** 2. Do the services offered by your organization address any of the following categories? Check all that apply.**

- Improved Maternal and Newborn Health
- Child Injuries, Abuse, Neglect, Maltreatment/ Reduction in Emergency Department Visits
- Improvements in School Readiness and Achievement
- Reduction in Crime and/or Domestic Violence
- Family Economic Self-Sufficiency
- Coordination of Community Resources and Referrals

Other (please specify)

5. Service Area

* 1. In what counties do your clients/ patients reside?

- | | | |
|---------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Adams | <input type="checkbox"/> Hendricks | <input type="checkbox"/> Pike |
| <input type="checkbox"/> Allen | <input type="checkbox"/> Henry | <input type="checkbox"/> Porter |
| <input type="checkbox"/> Bartholomew | <input type="checkbox"/> Howard | <input type="checkbox"/> Posey |
| <input type="checkbox"/> Benton | <input type="checkbox"/> Huntington | <input type="checkbox"/> Pulaski |
| <input type="checkbox"/> Blackford | <input type="checkbox"/> Jackson | <input type="checkbox"/> Putnam |
| <input type="checkbox"/> Boone | <input type="checkbox"/> Jasper | <input type="checkbox"/> Randolph |
| <input type="checkbox"/> Brown | <input type="checkbox"/> Jay | <input type="checkbox"/> Ripley |
| <input type="checkbox"/> Carroll | <input type="checkbox"/> Jefferson | <input type="checkbox"/> Rush |
| <input type="checkbox"/> Cass | <input type="checkbox"/> Jennings | <input type="checkbox"/> Saint Joseph |
| <input type="checkbox"/> Clark | <input type="checkbox"/> Johnson | <input type="checkbox"/> Scott |
| <input type="checkbox"/> Clay | <input type="checkbox"/> Knox | <input type="checkbox"/> Shelby |
| <input type="checkbox"/> Clinton | <input type="checkbox"/> Kosciusko | <input type="checkbox"/> Spencer |
| <input type="checkbox"/> Crawford | <input type="checkbox"/> LaGrange | <input type="checkbox"/> Starke |
| <input type="checkbox"/> Daviess | <input type="checkbox"/> Lake | <input type="checkbox"/> Steuben |
| <input type="checkbox"/> Dearborn | <input type="checkbox"/> Laporte | <input type="checkbox"/> Sullivan |
| <input type="checkbox"/> Decatur | <input type="checkbox"/> Lawrence | <input type="checkbox"/> Switzerland |
| <input type="checkbox"/> DeKalb | <input type="checkbox"/> Madison | <input type="checkbox"/> Tippecanoe |
| <input type="checkbox"/> Delaware | <input type="checkbox"/> Marion | <input type="checkbox"/> Tipton |
| <input type="checkbox"/> Dubois | <input type="checkbox"/> Marshall | <input type="checkbox"/> Union |
| <input type="checkbox"/> Elkhart | <input type="checkbox"/> Martin | <input type="checkbox"/> Vanderburgh |
| <input type="checkbox"/> Ellettsville | <input type="checkbox"/> Miami | <input type="checkbox"/> Vermillion |
| <input type="checkbox"/> Floyd | <input type="checkbox"/> Monroe | <input type="checkbox"/> Vigo |
| <input type="checkbox"/> Fountain | <input type="checkbox"/> Montgomery | <input type="checkbox"/> Wabash |
| <input type="checkbox"/> Franklin | <input type="checkbox"/> Morgan | <input type="checkbox"/> Warren |
| <input type="checkbox"/> Fulton | <input type="checkbox"/> Newton | <input type="checkbox"/> Warrick |
| <input type="checkbox"/> Gibson | <input type="checkbox"/> Noble | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Grant | <input type="checkbox"/> Ohio | <input type="checkbox"/> Wayne |
| <input type="checkbox"/> Greene | <input type="checkbox"/> Orange | <input type="checkbox"/> Wells |
| <input type="checkbox"/> Hamilton | <input type="checkbox"/> Owen | <input type="checkbox"/> White |

<input type="checkbox"/> Hancock	<input type="checkbox"/> Parke	<input type="checkbox"/> Whitley
<input type="checkbox"/> Harrison	<input type="checkbox"/> Perry	
Other (please specify)		
<input type="text"/>		

6. Community's Services

*** 1. Please indicate your opinions as to if your service area has appropriate amounts of the following services: (Choose one for each category)**

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know
Affordable child/ day care	<input type="radio"/>				
Child advocacy center services	<input type="radio"/>				
Parenting education	<input type="radio"/>				
Homemaker/ Parent aid services	<input type="radio"/>				
Independent living skills development	<input type="radio"/>				
In-home family support services for families with children 0-5 years of age who are not involved with DCS or probation	<input type="radio"/>				
Outreach services to at-risk children and adults from culturally or ethnically diverse backgrounds	<input type="radio"/>				
Counseling/ Treatment services for victims of domestic violence	<input type="radio"/>				
Shelter care for battered women and their children	<input type="radio"/>				
Victims of sexual abuse counselling/ treatment services	<input type="radio"/>				
Early childhood education/ pre-school programs	<input type="radio"/>				
Early childhood interventions/ identification of developmental delays	<input type="radio"/>				
Support programs for teen parents/ pregnant teens to stay in school and complete their high school education	<input type="radio"/>				
Job retraining, employment preparation/ search/ placement service	<input type="radio"/>				
Low-income health services/ clinics- children/ youth	<input type="radio"/>				
Low-income health services/ clinics- adults	<input type="radio"/>				
Obstetrics/ Gynecology providers	<input type="radio"/>				
Dental care for low income adults/ children/ youth	<input type="radio"/>				
Family planning/ pregnancy counseling service	<input type="radio"/>				
Family shelters for the homeless	<input type="radio"/>				

Safe, affordable low-income housing	<input type="radio"/>				
Food and nutrition resources (e.g. food pantry)	<input type="radio"/>				
Assistance with clothing and household goods	<input type="radio"/>				
Emergency, financial assistance (e.g. utilities, rent)	<input type="radio"/>				
Transportation assistance (formal and informal) so people can access available services	<input type="radio"/>				

7. Home Visiting Programs

*** 1. Do maternal, infant, and/or early childhood home visiting program(s) exist in your community?**

- Yes
- No

8. Home Visiting Services-Yes

*** 1. If yes, please indicate which home visiting programs exist, and explain if you feel these programs meet the need in your community.**

Early Head Start-Home-Based Option	<input type="text"/>
Family Check-Up	<input type="text"/>
Healthy Families-Indiana	<input type="text"/>
Healthy Start	<input type="text"/>
Home Instruction Program for Preschool Youngsters	<input type="text"/>
Nurse-Family Partnership	<input type="text"/>
Parents as Teachers	<input type="text"/>

*** 2. Do you feel these programs have the capacity to serve more families and children?**

*** 3. Which home visiting programs would you like to see added to your community to continue addressing issues within your community? Explain.**

Early Head Start-Home-Based Option	<input type="text"/>
Family Check-Up	<input type="text"/>
Healthy Families-Indiana	<input type="text"/>
Healthy Start	<input type="text"/>
Home Instruction Program for Preschool Youngsters	<input type="text"/>
Nurse-Family Partnership	<input type="text"/>
Parents as Teachers	<input type="text"/>

*** 4. Answers Completed?**

- Yes
- No

9. Home Visiting Services- No

1. If no, do you feel adding home visiting services to your network of existing services will meet a community need? Explain.

*** 2. Which home visiting programs do you feel would meet a community need? Explain.**

Early Head Start- Home- Based Option

Family Checkup

Healthy Start

Healthy Families Indiana

Home Instruction Program for Preschool Youngsters (HIPPY)

Nurse-Family Partnership

Parents as Teachers

10. Thank you!

Thank you for completing the Home Visiting Community Assessment Survey. Please contact Mallory Quigley (mquigley@isdh.in.gov) with any questions.

Figure 3-2

Please indicate your opinions as to if your service area has appropriate amounts of the following services: (Choose one for each category)						
Answer Options	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know	Response Count
Affordable child/ day care	0	4	15 (48.4%)	10	2	31
Child advocacy center services	3	13 (41.9%)	12	1	2	31
Parenting education	1	13 (41.9%)	10	4	3	31
Homemaker/ Parent aid services	1	6	14 (45.2%)	4	6	31
Independent living skills development	0	8	15 (48.4%)	2	6	31
In-home family support services for families with children 0-5 years of age who are not involved with DCS or probation	3	6	12 (38.7%)	8	2	31
Outreach services to at-risk children and adults from culturally or ethnically diverse backgrounds	1	6	14 (45.2%)	6	4	31
Counseling/ Treatment services for victims of domestic violence	2	13 (41.9%)	8	3	5	31
Shelter care for battered women and their children	0	15 (48.4%)	8	5	3	31
Victims of sexual abuse counseling/ treatment services	1	11 (35.5%)	11 (35.5%)	3	5	31
Early childhood education/ pre-school programs	0	15 (48.4%)	11	4	1	31
Early childhood intervention/ identification of developmental delays	2	15 (48.4%)	9	4	1	31
Support programs for teen parents/ pregnant teens to stay in school and complete their high school education	0	5	10 (32.3%)	10 (32.3%)	6	31
Job retraining, employment preparation/ search/ placement service	2	8	9 (29.0%)	5	7	31
Low-income health services/ clinics- children/ youth	2	11	12 (38.7%)	4	2	31

Low-income health services/ clinics- adults	1	8	13 (41.9%)	6	3	31
Obstetrics/ Gynecology providers	0	16 (51.6%)	8	2	5	31
Dental care for low income adults/ children/ youth	0	6	12 (38.7%)	8	5	31
Family planning/ pregnancy counseling service	0	9	13 (41.9%)	5	4	31
Family shelters for the homeless	0	7	13 (41.9%)	8	3	31
Safe, affordable low-Income housing	0	3	11	12 (38.7%)	5	31
Food and nutrition resources (e.g. food pantry)	1	17 (54.8%)	10	1	2	31
Assistance with clothing and household goods	1	14 (45.2%)	9	4	3	31
Emergency, financial assistance (e.g. utilities, rent)	0	2	16 (51.6%)	8	5	31
Transportation assistance (formal and informal) so people can access available services	0	3	11	13 (41.9%)	4	31
					<i>answered question</i>	31
					<i>skipped question</i>	54

APPENDIX B

LETTERS OF CONCURRENCE



Audrey M Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

Please allow this letter to represent concurrence with Indiana's application for the Maternal, Infant, and Early Childhood Home Visiting Program. We support Indiana State Department of Health's (ISDH) and Indiana Department of Child Services' (DCS) plan to expend \$1.6 million to:

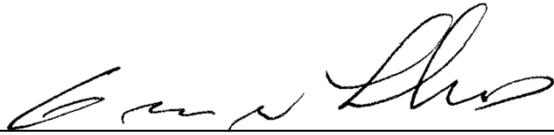
- 1) Develop a state-wide home visiting network
- 2) Expand Healthy Families Indiana in specific high-risk areas of Lake County and St. Joseph County and the entirety of Scott County
- 3) Implement Nurse-Family Partnership in a high-risk area of Marion County in collaboration with Goodwill Industries of Central Indiana

These funds will assist in improving maternal and newborn health; reducing child injuries, abuse, neglect, and maltreatment; reducing children's emergency department visits; improving children's school readiness and achievement; reducing crime and domestic violence; improving family economic self-sufficiency; and coordinating referrals between programs and services, as directed by federal legislation.

Concurrence with the plan is based on Indiana's collaborative and transparent process in developing the state-wide home visiting plan. ISDH and DCS used a variety of data and data sources as well as community input in the development of the plan. Our support indicates our willingness to assist in this endeavor by providing insight into programs and services offered by our respective agencies and by assisting in coordinating referrals to home visiting programs and to relevant programs within each agency. The lead agencies have made a clear assurance to share and disseminate any findings and data gained from this plan.

Again, we support Indiana's plan for the Maternal, Infant and Early Childhood Home Visiting Program and the unique partnership between ISDH and DCS within this plan. If we can provide any more comments or input, please do not hesitate to contact us.

Sincerely,



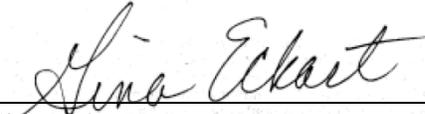
Dr. Gregory Larkin, M.D.
State Health Commissioner, Indiana State Department of Health
GLarkin1@isdh.IN.gov
317-233-7400

05/27/2011

Date

James W. Payne
Director, Department of Child Services
James.Payne@dcs.IN.gov
317-234-1391

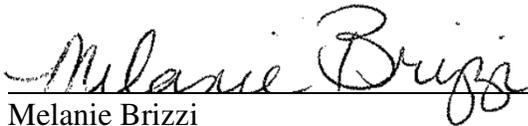
Date



Gina Eckart
Director, Department of Mental Health and Addiction
Gina.Eckart@fssa.IN.gov
317-232-7860

06/01/2011

Date



Melanie Brizzi
Director, Child Care and Development Fund
Melanie.Brizzi@fssa.IN.gov
317-234-3313

05/26/2011

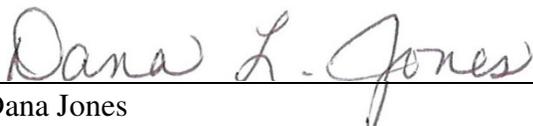
Date



Susan Lightle
Director, Head Start Collaboration Office
Susan.Lightle@fssa.IN.gov
317- 233-6837

06/02/2011

Date



Dana Jones
Early Childhood Specialist, Indiana Department of Education
DJones@doe.IN.gov
317-234-6523

06/01/2011

Date

APPENDIX C

LETTERS OF SUPPORT



"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Family Resources
402 W. WASHINGTON STREET
INDIANAPOLIS, IN 46204-2747

Audrey M Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Audrey Yowell

I'm writing this letter in support of Indiana State Department of Health and Department of Child Services in Indiana's application for the Maternal, Infant, and Early Childhood Home Visiting Program. This grant will assist providing health and social services and coordination of such services to pregnant women, infants, children and families throughout Indiana to improve maternal and newborn health outcomes, decrease child injury, abuse, neglect and maltreatment, reduce child emergency room visits, improve school readiness and achievement, decrease crime and domestic violence, improve family economic self sufficiency, and coordinate appropriate referrals.

Indiana's Family and Social Services Administration (FSSA) is a health care and social service funding agency in which 94% of funds are paid to thousands of service providers throughout Indiana. As one of five divisions within FSSA, the Division of Family Resources provides various tools to strengthen families through services that focus on prevention, early intervention, self-sufficiency, family support and preservation. DFR administers food stamps (Supplemental Nutrition Assistance Program) and Temporary Assistance for Needy Families (TANF), as well as employment and training services to low-income clients. The lead agencies have made a clear assurance to share and disseminate any findings and data gained from this program.

As a supporter of this program, FSSA's DFR will assist in program activities, such as agreements in coordinating referrals of appropriate programs and services, such as TANF, SNAP, and job training services, and the collaboration in data collection regarding maternal and newborn health, family economic self-sufficiency. I believe Maternal, Infant and Early Childhood Home Visiting Program will positively affect families and children throughout the state and therefore fully support the program. If I can provide any more comments or input, please do not hesitate to contact me.

Sincerely,

James Dunn, Program Manager
TANF/IMPACT
FSSA Division of Family Services

www.IN.gov/fssa
Equal Opportunity/Affirmative Action Employer



30% POST-CONSUMER FIBER





Mitchell E. Daniels, Jr.
Governor

Gregory N. Larkin, M.D., F.A.A.F.P.
State Health Commissioner

June 1, 2011

Audrey M. Yowell, PhD, MSSW
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

I am pleased to support Indiana State Department of Health and Department of Child Services in Indiana's application for the Maternal, Infant, and Early Childhood Home Visiting Program. This grant will assist providing health and social services and coordination of such services to pregnant women, infants, children and families throughout Indiana to improve maternal and newborn health outcomes, decrease child injury, abuse, neglect and maltreatment, reduce child emergency room visits, improve school readiness and achievement, decrease crime and domestic violence, improve family economic self-sufficiency, and coordinate appropriate referrals.

As a division of Public Health and Preparedness within Indiana State Department of Health, Injury Prevention Program's mission is to aid in the development of strategies for decreasing injury and death among Hoosiers, which will improve the quality of life for all persons in Indiana. Currently the Injury Prevention Program is working to collect and analyze injury data, design, implement and evaluate interventions at multiple levels, build solid infrastructure for injury prevention, provide technical support and training, and work with communities for policy change.

Indiana's Injury Prevention Program has assisted in the Indiana's home visiting proposal by contributing data of emergency department and outpatient injury data for children ages zero to 5 at a zip code level for the eight counties analyzed in the updated state plan. In the future, the Injury Prevention Program hopes to assist in other data sharing ventures, as well as collaborate address the benchmark area of child injuries and visits to the emergency department. The lead agencies have made a clear assurance to share and disseminate any findings and data gained from this program.

I am excited about supporting the MIECHV Home Visiting Program and believe it positively affect children and families throughout the state. If I can provide any more comments or input, please do not hesitate to contact me.

Sincerely,

JOAN M. DUWVE, M.D.
MEDICAL DIRECTOR
PUBLIC HEALTH AND PREPAREDNESS COMMISSION
317/233-7164
jduwve@isdh.in.gov

2 North Meridian Street • Indianapolis, IN 46204
317.233.1325 tdd 317.233.5577
www.statehealth.in.gov

The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.

Dear Ms. Audrey Yowell,

I'm writing this letter in support of Indiana State Department of Health and Department of Child Services in Indiana's application for the Maternal, Infant, and Early Childhood Home Visiting Program. This grant will assist providing health and social services and coordination of such services to pregnant women, infants, children and families throughout Indiana to improve maternal and newborn health outcomes, decrease child injury, abuse, neglect and maltreatment, reduce child emergency room visits, improve school readiness and achievement, decrease crime and domestic violence, improve family economic self-sufficiency, and coordinate appropriate referrals.

Indiana Department of Education's vision is the academic achievement and career preparation of all Indiana students will be best in the United States and on par with the most competitive counties in the world. The mission of Title I is to provide a continuum of services and resources to Title I districts and charter schools that enrich curriculum and instruction, promote interaction and coordination of supplementary services and resources, and result in excellence and high expectations for educators and students by assisting over 900 schools throughout Indiana.

As a supporter of this program, IDOE Office of Title I will assist in program activities, such as agreements in coordinating referrals of appropriate programs and services and the collaboration in data collection regarding school readiness and achievement. While MIEC HV services are focused on four high-risk areas of the state, the program will benefit communities and the state as a whole.

I believe Maternal, Infant and Early Childhood Home Visiting Program will positively affect families and children throughout the state and therefore fully support the program. If I can provide any more comments or input, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Amy Bush". The signature is written in a cursive, flowing style.

Amy Bush

Title I Director

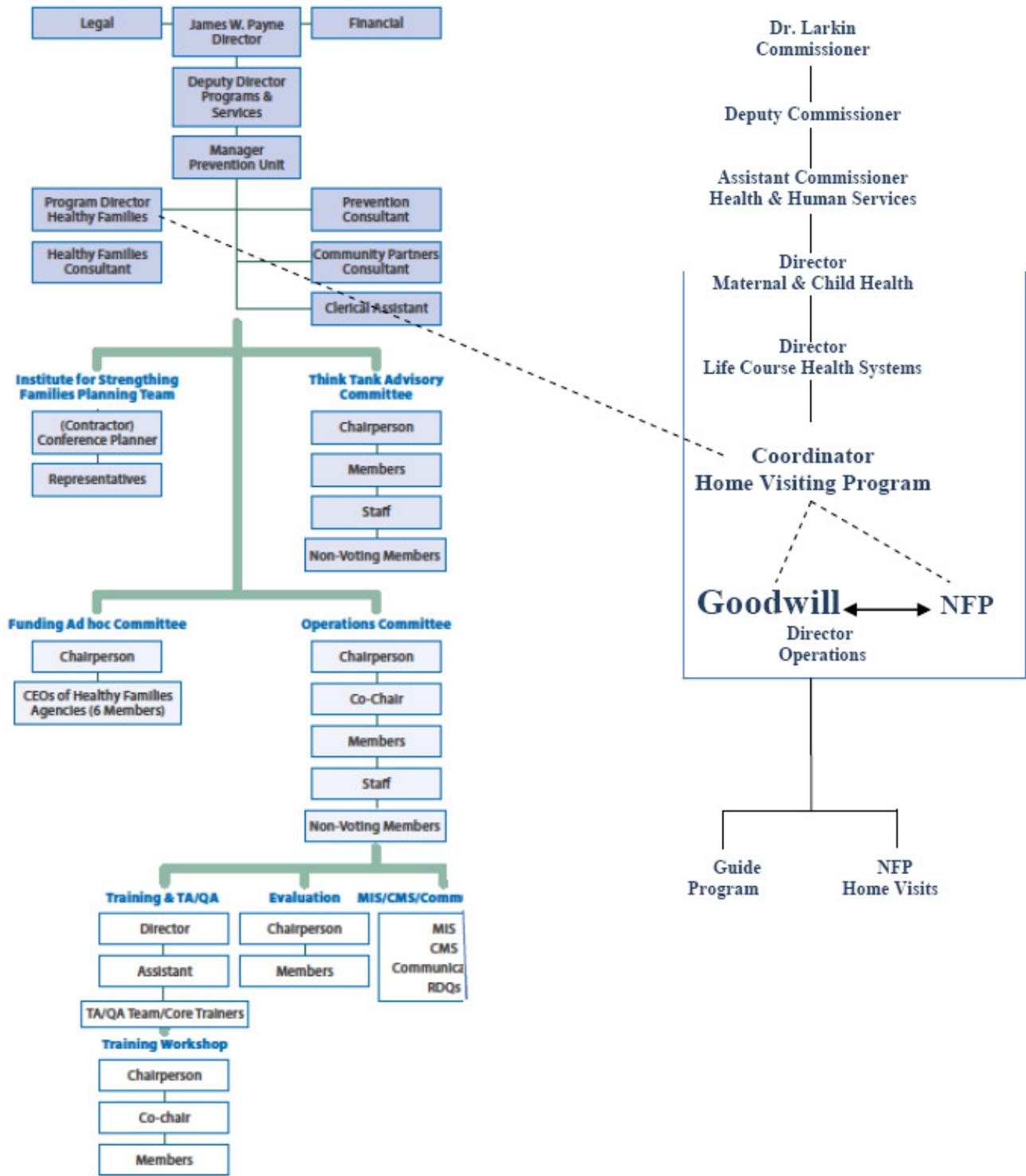
Indiana Department of Education

APPENDIX D

ORGANIZATIONAL CHART

Department of Child Services

Indiana State Department of Health



APPENDIX E

MODEL DEVELOPER APPROVAL



228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

March 25, 2011

Lisa Rich
Deputy Director
Department of Child Services.
302 West Washington St. Rm306
Indianapolis In 46240

Re: Documentation of Approval to Utilize the HFA Model

Dear Ms. Rich:

This letter is in response to the requirement of the Supplemental Information Request (SIR) from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding implementation of the Healthy Families America (HFA) model and any intentions to implement adaptations to the HFA model. **This letter outlines the approval from the HFA national office at Prevent Child Abuse America to use the HFA model in Indiana.** Approval to make adaptation to the model has not been granted as adaptations were not proposed.

Currently, HFA is present in 35 states and D.C. Healthy Families Indiana is one of largest and most experienced multi-site accredited systems in our network and currently operates 41 accredited HFA program sites through the oversight and support of an accredited Central Administration at the Department of Child Services. Of these 41 sites, 8 county sites have been targeted as at-risk in regard to the MIECHV program and will continue to implement the HFA model. These include: Elkhart, Jennings, LaPorte, Lake, Marion, Scott, St. Joseph and Starke.

When a state system of sites is accredited through HFA's multi-site process it means there is a Central Administration providing critical functions such as training, quality assurance, technical assistance and ongoing evaluation and quality improvement to ensure model fidelity and quality. The Central Administration in Indiana provides an infrastructure that allows the HFA National Office to grant certain privileges. These privileges include the following:

1. Any sites currently existing in this multi-site infrastructure are automatically approved from the HFA National Office to receive any funding that would be allocated from the MIEC Home Visiting Program. Included is a listing of sites accountable to the Healthy Families Indiana Central Office. Therefore, if any of the federal funds were to be allocated to these host agencies (attached) to increase their current capacity or to implement enhancements to the HFA model they are automatically approved by the HFA National Office.



2. Healthy Families Indiana Central Administration can affiliate and disaffiliate sites within its state network. Any new Healthy Families local site agencies interested in implementing the Healthy Families model would have to be approved by the Healthy Families Indiana Central Administration. These new host agencies would become a part of the current statewide system and be accountable to the Healthy Families Indiana Central Administration. The Central Administration will work with the HFA national office to get final approval of any proposed new host agencies that are not reflected on the attached listing of current sites.
3. Because Healthy Families Indiana is an accredited multi-site system, the annual fee for each site in 2011 is discounted to \$1150 versus the standard \$1350 annual fee. The Department of Child Services will be required to ensure that all annual fees are paid in a timely way and kept up-to-date consistent with national office policy.
4. Healthy Families Indiana Central Administration has its own certified trainers allowing for a cost effective process in training new hires as required by the HFA national standards. Should additional certified HFA trainers be required the state agrees to utilize HFA's train-the trainer process.

To maintain the fidelity of the model which is required by the federal legislation, it is critical that all current sites and any new sites in Indiana be a part of the Healthy Families Indiana multi-site system administered by the Department of Child Services, which is required to collaborate with the HFA national office in the planning, development, implementation and accreditation of any HFA program in the state. From our perspective the multi-site infrastructure creates the highest level of model fidelity and greater outcomes in the most cost effective manner.

We are pleased to grant approval to the State of Indiana's Department of Child Services to implement the HFA model as specified above. If you would like to discuss this further, I can be reached at kstrader@preventchildabuse.org or 248.988.8990. I appreciate your commitment to Indiana's children and families and look forward to our continued work together.

Sincerely,



Kathleen Strader, MSW
Director, HFA Central Region
Prevent Child Abuse America

Cc: Phyllis Kikendall and Audie Gilmer
Healthy Families Indiana

Cydney M. Wessel, MSW
Senior Director of HFA
Prevent Child Abuse America



Prevent Child Abuse America



3/18/11

Mary M. Weber, Director Maternal and Child Health Division
Indiana State Department of Health
2 N. Meridian St.
Section 7C
Indianapolis, IN 46204

Dear Ms. Weber:

Based on the information provided in your state plan, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your revised state plan submission to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed Indiana's plan as submitted and that it includes the specific elements required in the SIR; and
- NFP NSO is supportive of Indiana's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

Because the Updated State Plan, as required by the SIR, must include additional information on how you will implement the model(s) chosen, it will be important to provide a copy of this to the NFP NSO. We would like to review the following additional details in order to better support the implementation of NFP in your state:

- Identification of the evidence-based home visiting model(s) to be implemented in the State and describe how each model meets the needs of the community(ies) proposed;
- A description of the State's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- A plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Any anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs;

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the SIR, NFP NSO expects that Indiana will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline expectations for the State as well as what supports will be provided by the NFP NSO to include:

- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

- Understanding the 18 required model elements;
- Using NFP-specific implementation planning tools;
- Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
- Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.
- Ensure that every team of nurses employed to deliver NFP will:
 - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
 - Receive adequate support and reflective supervision within their agencies;
 - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;
 - Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
 - Utilize ongoing nurse consultation for ongoing implementation success.
- Participate in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Assure that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of [online resources](#) that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,



Kammie Monarch.
 Chief Operating Officer
 Nurse-Family Partnership National Service Office

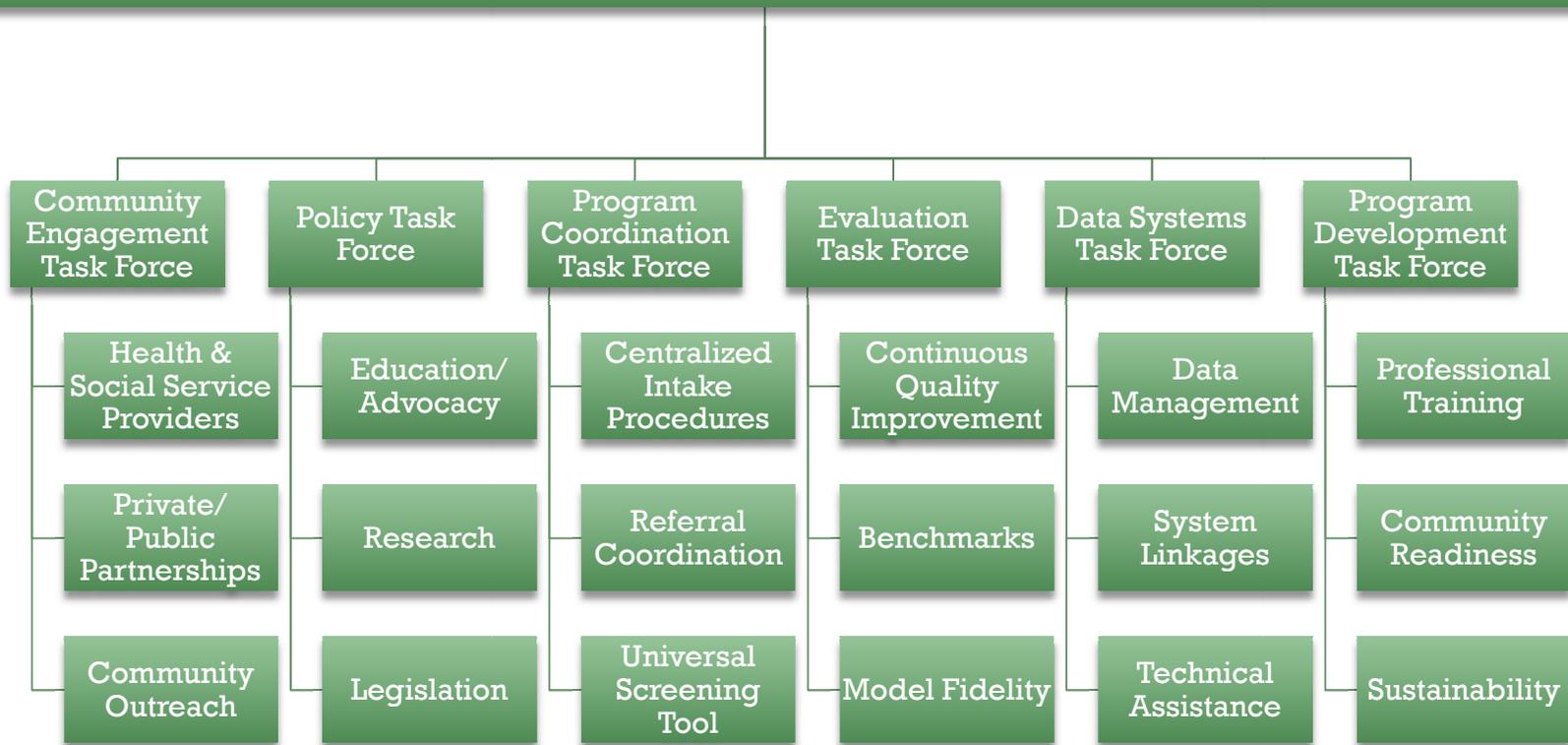
APPENDIX F

FRAMEWORK

Indiana Home Visiting Advisory Board

To improve the lives of mothers, children, and families through coordinated, non-duplicative, and evidence-based home visiting services.

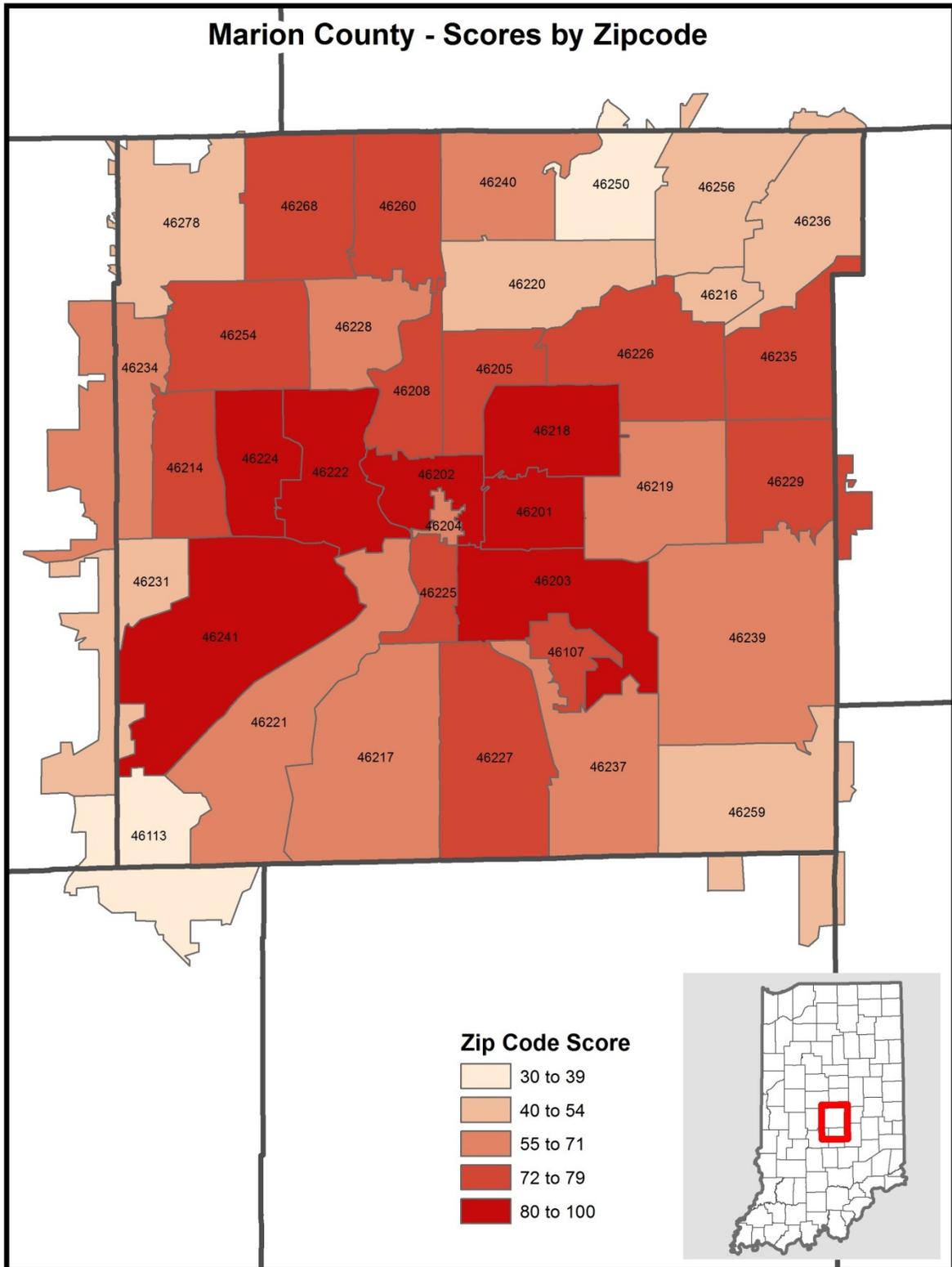
Executive Board: DCS, ISDH, FSSA, DOE, DMHA, Head Start Collaboration Office, American Association of Pediatrics, American College of Gynogolgist, Children's Bureau, March of Dimes, Indiana Perinatal Network



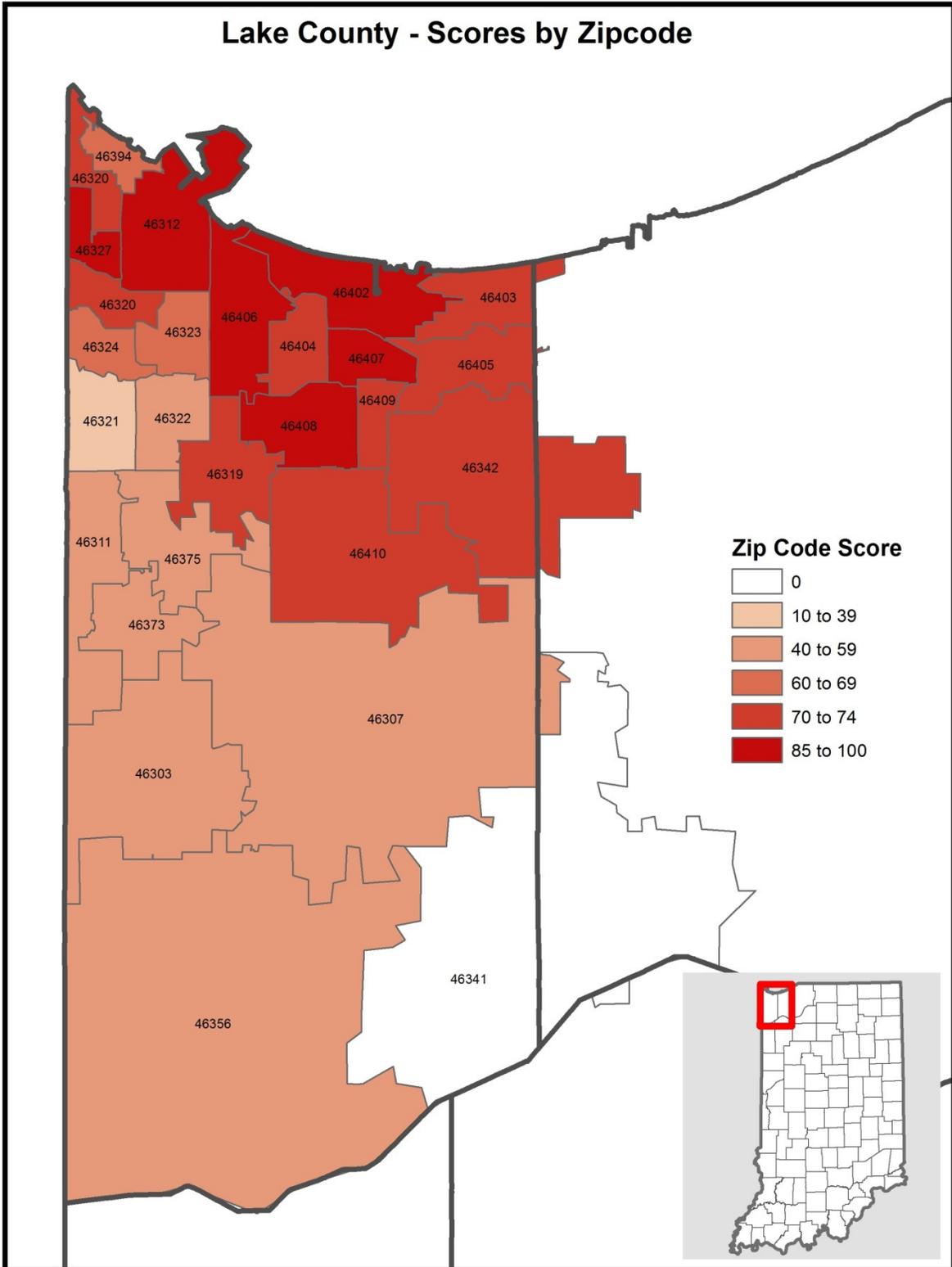
APPENDIX G

MAPS

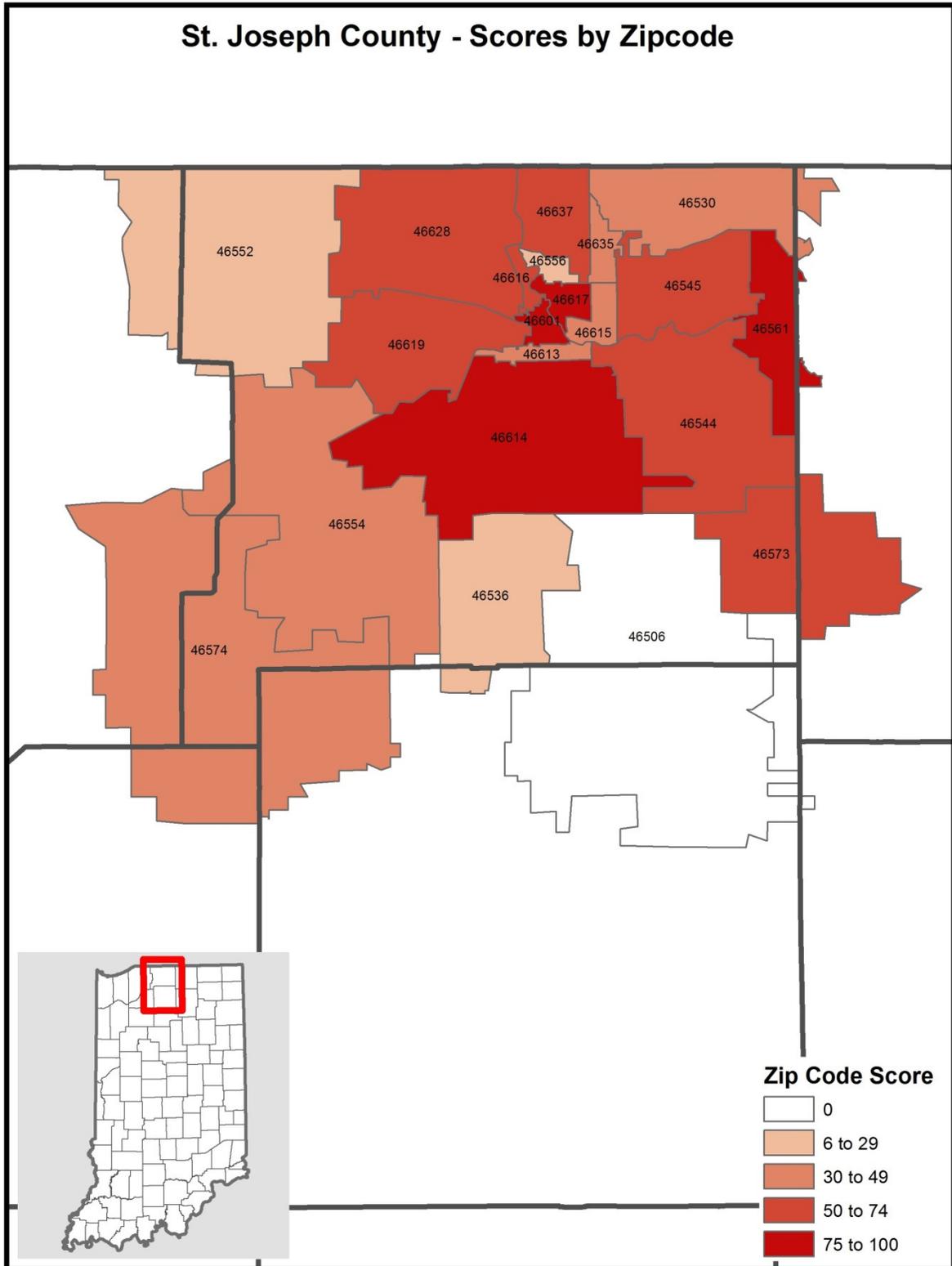
Marion County



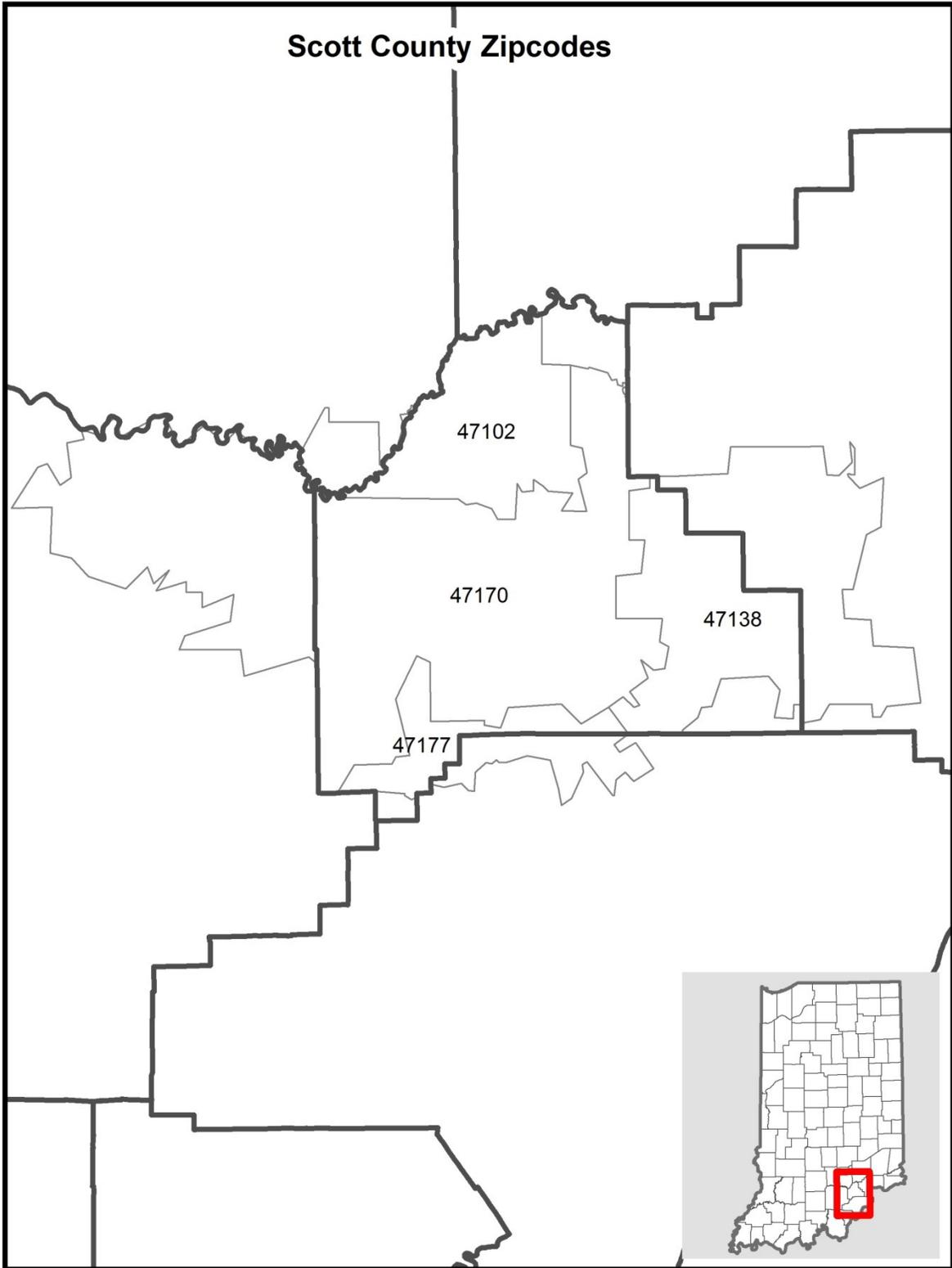
Lake County



St. Joseph County



Scott County



APPENDIX H

MAINTENANCE OF EFFORT

Maintenance of Effort Assurance



Mitchell E. Daniels, Jr., Governor
James W. Payne, Director

Indiana Department of Child Services
Room W392 – MS53
302 W. Washington Street
Indianapolis, Indiana 46204-2739

317-234-5437
FAX: 317-234-4497

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-6566

FROM: Lisa Rich, Deputy Director, DCS Program & Services

THROUGH: Doug Weinberg, CFO, DCS

THROUGH: Adam Horst, Director, Indiana State Budget Agency

TO: Michael Kistler, CFO, Indiana State Department of Health

DATE: April 25, 2011

RE: Title V Affordable Care Act (ACA) – Maintenance of Effort (MOE)

In order to meet a \$62.2 million dollar reversion requirement in State Fiscal Year 2010, DCS elected to reduce obligations and spending in particular programs. One of those programs was the Healthy Families Program which provides services that fall within the Title V list of eligible activities. Per the direction received in the April 4, 2011 conference call with the U.S. Department of Health and Human Services, the Department of Child Services (DCS) has determined the amount of State dollars under contract as of March 23, 2010 supporting Home Visitation services in the Healthy Families Indiana program.

We have identified personnel costs and contracts that were funded with State dollars as listed below. DCS is committed to holding this level of funding for these Contracts through State Fiscal Year 2013 as reflected in our Biennial Budget Proposal and will pursue retaining these levels into the future. We are committed to labeling these as MOE for the purposes of Title V ACA funding.

Staff and Support Costs	\$125,215
Contract: Datatude	\$406,849
Contract: Scan	\$540,043
Contract: Think Tank	\$18,785

TOTAL \$1,090,892

Please feel free to contact me if you have any questions or concerns.



Protecting our children, families and future