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IDAHO DEPARTMENT OF HEALTH & WELFARE  
DIVISION OF PUBLIC HEALTH

**Idaho MIECHV program**

Department of Health and Welfare  
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# [HOME VISITING SERVICE GUIDE]

The document outlines requirements and guidelines for service delivery contractors implementing Idaho's Maternal Infant and Early Childhood Home Visiting Program.

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## INTRODUCTION

### Purpose and Background

In March 2010, the Maternal, Infant and Early Childhood Home Visiting program, hereafter the MIECHV program, was established through the federally enacted Patient Protection and Affordable Care Act (PPACA) through an amendment to Title V of the Social Security Act of 1935. The legislation authorized 1.5 billion dollars for the Federal MIECHV program for five years to be carried out by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (US HHS). The MIECHV program's goal is to implement evidence-based home visiting programs in at-risk communities for voluntary participation by pregnant women, infants, children birth through age five or kindergarten entry, and their families in coordination with the early childhood and health systems.

Evidence-based home visiting is commonly viewed as one of many effective service delivery strategies that can help families promote positive parenting, learning and school readiness, overcome barriers to access preventive health care, and prevent child abuse and neglect. According to the PPACA, the MIECHV program is designed to: 1) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities, 2) improve coordination of services for at-risk communities, and 3) strengthen and improve the program's activities carried out under Title V of the Social Security Act.

The Idaho Department of Health and Welfare's MIECHV program will support implementation of three evidence-based home visiting models in the first two years of the program:

#### **Early Head Start Home-based**

Home visitors provide support, guidance, information, and child development services directly to families in their homes. The Head Start Home-based program is one of the options for delivering comprehensive Head Start services. Early Head Start home visitors use the home environment to help parents create learning opportunities that builds on everyday routines and support their child's development. They provide support to families who confront stressors like maternal depression or substance abuse which may prevent accessing services outside the home. Early Head Start Home-based serves low-income pregnant women, infants, and their families until the child turns three years old. Weekly home visits are provided for 90 minutes as well as group socialization activities. Socialization activities are a play group that is offered to families a minimum of 24 times per year.

**Nurse-Family Partnership**

Nurse-Family Partnership, a maternal and early childhood health program, introduces first-time parents to maternal and child health nurses during pregnancy until the child turns two years old. Nurses deliver support to low-income, first-time moms during pregnancy, enrolled prior to the 28<sup>th</sup> week of gestation. Nurse home visitors provide guidance for the emotional, social, and physical challenges first-time moms face as they prepare and become parents.

**Parents as Teachers**

Parents as Teachers is a home visiting model providing parenting education and family support, and building protective factors, especially for those families in vulnerable situations. Parents as Teachers is relationship-based and parenting-focused, with a curriculum focused on parent-child interaction, development-centred parenting, and family well-being; strengths, capabilities and skills. Parents as Teachers serves a range of families with varying needs with young children from prenatal to kindergarten entry.

These high-quality early childhood programs promote maternal, infant and early childhood health, safety and development, and strong parent-child relationships. Participation in home visiting services is offered on a voluntary basis to pregnant women or families with children prenatal to kindergarten in the targeted service areas of Kootenai and Shoshone, Nez Perce and Clearwater, Canyon, Ada, Twin Falls and Jerome, Power and Bannock, and Bonneville Counties. As outlined in the PPACA Federal Legislation MIECHV program, priority populations and outcomes are as follows:

***MIECHV program priority populations***

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<b>Priority Populations</b>
Pregnant women under 21 years old
Families with a previous encounter with Child Protective Services
Tobacco users
Families with history of substance abuse
Low income
Children with developmental delay
Families of the armed services
Families with low academic achievement

<b>Outcome Areas</b>
Maternal and Newborn Health
Child Injuries, Abuse, Neglect, Maltreatment and Visits to the Emergency Department
Improvements in School Readiness and Achievement
Domestic Violence
Family Economic Self-Sufficiency
Coordination and Referrals for Other Community Resources and Supports

## PROGRAM REQUIREMENTS

### Organizational Staffing

The home visiting workforce is comprised of professionals and paraprofessionals with knowledge and skills related to early childhood, health, and development. Relationships between home visitors and families, as well as relationships between home visitors and program supervisors, are critical in facilitating participant achievement of program defined outcomes. Staff may include social workers, nurses, early childhood educators, psychologists, developmental specialists or personnel from other related fields.

Evidence-based home visiting models vary in personnel standards and requirements. The following positions and position requirements are a minimum standard for organizations delivering home visiting services through the Idaho MIECHV program. There must be access to at least one Master's level clinically licensed mental health professional who is available for consultation when potential high risk situations, crises, or other "clinical" issues or concerns arise. When necessary, bilingual staff should provide culturally relevant services. All participants with limited English speaking language skills should have translation services available.

#### ***Personnel Categories and Qualifications: Required Positions***

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The Idaho MIECHV Program requires that contractors maintain staff in at least the following positions throughout the duration of the contract.

Home Visiting Supervisor: Home visiting supervisors should have an advanced degree in a health, education, or human services field; a bachelor's degree in health, education, or human services field and two years of experience working with children and families; or an associate's degree in health, education, or human services field, and four years of experience working with children and families.

Home Visitor: Home visitors must have at least a high school diploma or GED and a minimum of two years previous supervised work experience with young children and/or parents. However, it is recommended that Home visitors have at least an associate's degree, bachelor's degree or four year degree in early childhood or a related field. Home visitors should demonstrate effective communication and interpersonal skills, with a commitment to professional growth.

Organization Administrator: Organization administrators, may also be home visiting supervisor, should be trained on the management information system to conduct continuous quality improvement and outcome analysis for performance management. Administrators should

demonstrate capacity to manage a human service organization, build a staffing and recruitment plan, and be familiar with the requirements of the evidence-based home visiting program. Administrators should have ability to assess data quality and trends between home visitors and participants. Administrators should spend between ten to thirty hours per month on data collection or analysis, continuous quality improvement, and management activities related to the home visiting program.

Financial Manager: The financial manager will be responsible for the financial management of the MIECHV contract. The financial manager may also be the organizational administrator, this person is responsible for tracking and managing funds related to all the activities in the contract. The financial manager should have relevant experience in fiscal management for health and human services programs. Sufficient time should be dedicated to the program needs according to the size and existing capacity.

#### ***Personnel Categories and Qualifications: Optional Positions***

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The Idaho MIECHV Program recommends that contractors maintain staff in at least the following positions throughout the duration of the contract.

Administrative Staff: Administrative staff, may also be data entry staff, should coordinate communication between the Contractor and other community organizations. Administrative staff should be trained in basic client eligibility and the organization intake process for the Contractor. Administrative staff must have skills for electronic communication and should be trained in the data management system to run basic reports and enter intake information for program participants. Administrative staff may spend varying hours dedicated to the home visiting program, dependent on program size.

Data Entry: Data entry staff is responsible for data entry and generating reports to support home visitors and supervisors. The data entry staff should attend relevant training for screening and assessment tools, and have extensive training in management information systems. Data entry staff should spend between twenty to eighty hours per month entering data, proportional to program size.

Information Technology Manager: The Information Technology (IT) manager will be responsible for the information management for the activities related to the resulting contract. The IT manager should have relevant experience developing, implementing or managing information management systems for health or human services programs. Sufficient time should be dedicated to meet the program needs, according to size and existing infrastructure.

### ***Home Visiting Model Specific Personnel Standards***

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In order to maintain model fidelity, each program has identified a minimum standard for qualifications for home visitors. The following includes minimum standards for home visitors as outlined by the evidence-based models:

Early Head Start Home-Based: Head Start Program Performance Standards require Early Head Start Home-Based programs to hire home visitors with “knowledge and experience in child development and early childhood education; the principles of child health, safety, and nutrition; adult learning principles; and family dynamics. They must be skilled in communicating with and motivating people. In addition, they must have knowledge of community resources and the skills to link families with appropriate agencies and services. ([45 CFR 1301-1311](#))” Home visitors must have at least a high school diploma or GED and a minimum of two years previous supervised work experience with young children and/or parents.

Nurse-Family Partnership: Nurse-Family Partnership’s model elements require home visitors to have a bachelor’s degree in nursing and current licensure in state of practice. If qualified BSNs are unavailable, than programs must communicate with NFP National Service Office and have a professional development plan for nurses hired with other qualifications.

Parents as Teachers: Parents as Teachers indicates in the 2014 Quality Assurance Guidelines for Parents as Teachers Affiliates that parent educators must have at least a high school diploma or GED and a minimum of two years previous supervised work experience with young children and/or parents. However, it is recommended that parent educators have at least a bachelor’s or four year degree in early childhood or a related field.

### ***Required Staffing Ratios***

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The Idaho MIECHV Program requires that contractors maintain staffing ratios as follows. In some cases, home visiting models may require lower ratios than as follows. When the models indicate lower staffing ratios, contractors are responsible for maintaining model required staffing ratios to maintain model fidelity.

1. Home visitor staff to participant ratio should not exceed twenty-five participants per home visitor.
2. Home visitor to supervisor ratio should not exceed ten home visitors per supervisor.

### ***Personnel Files***

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The Idaho MIECHV Program requires that contractors maintain employee files for each employee from hire. Personnel files should be maintained for one year from the date of voluntary or involuntary termination. Employee files will include:

1. Application/resume documenting qualifications
2. Annual verification of professional credentials for all staff
3. Documentation of trainings (enrolled, completed, credits earned)
4. Copy of a valid driver's license
5. Criminal history background checks for all staff working with program participants
6. Reflective Supervision notes
7. Demonstrated competency to engage, establish trust, and develop relationships and work with families with diverse backgrounds. Examples of documentation may include: training, documentation of interview using situations, client feedback surveys, peer feedback, supervisor notes from one-on-one supervision.
8. Demonstrated ability to observe family functioning, strengths, needs, and to recognize issues related to substance abuse, domestic violence, child abuse and neglect. Examples of documentation may include: supervisor documentation on/during field supervision, client feedback surveys, and participant outcomes.

### ***Professional Development and Training***

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Training should assist new and existing staff to build on their education and experience to promote continued learning and professional development. It should build an understanding of:

- The importance and requirements of confidentiality, privacy, and ethics related to specific licensures,
- Model-specific pre-service and on-going training,
- Strengths-based approach to focus on individual family needs, strengths, and parent-child interaction,
- Development-centered parenting, family systems, and family well-being, and
- Awareness and knowledge of process to access government and community resources.

### **Clinical, Administrative, and Reflective Supervision**

Contractors must provide administrative, clinical, and reflective supervision for all home visitors providing services through the contract. The following provides guidance for distinguishing between each type of supervision.

**Administrative supervision** relates to the oversight of federal, state, and agency regulations, program policies, rules, and procedures. Reflective supervision/consultation often includes administrative elements and is always clinical, while administrative and clinical supervision are not always reflective. Supervision that is primarily administrative will be driven to achieve the following objectives:

- hire
- train/educate

- oversee paperwork
- write reports
- explain rules and policies
- coordinate
- monitor productivity
- evaluate

**Clinical supervision/consultation**, while case-focused, does not necessarily consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/toddler and family. Supervision or consultation that is primarily clinical will most likely include many or all of the administrative objectives that are listed above as well as the following objectives:

- Review casework
- Review and evaluate clinical progress
- Give guidance/advice
- Teach
- Discuss the diagnostic impressions and diagnosis
- Discuss intervention strategies related to the intervention
- Review the intervention or treatment plan

Reflective supervision/consultation is distinct due to the shared exploration of the parallel process. That is, attention to all of the relationships is important, including the ones between practitioner and supervisor, between practitioner and parent, and between parent and infant/toddler. It is critical to understand how each of these relationships affects the others. Of additional importance, reflective supervision/consultation relates to professional and personal development within one's discipline by attending to the emotional content of the work and how reactions to the content affect the work. Finally, there is often greater emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor/consultant. The primary objectives of reflective supervision/consultation include the following:

- Form a trusting relationship between supervisor and practitioner
- Establish consistent and predictable meetings and times
- Ask questions that encourage details about the infant, parent and emerging relationship
- Listen
- Remain emotionally present
- Teach/guide
- Nurture/support
- Apply the integration of emotion and reason
- Foster the reflective process to be internalized by the supervisee
- Explore the parallel process and to allow time for personal reflection
- Attend to how reactions to the content affect the process

Reflective supervision/consultation may be carried out individually or within a group. Reflective supervision/consultation refers specifically to work done in the infant/family field on behalf of the

infant/toddler's primary care-giving relationships. Reflective supervision/consultation may mean different things depending on the program in which it occurs in all instances, the reflective supervisor/consultant is expected to set limits that are clear, firm & fair, to work collaboratively and to interact and respond respectfully. It is important to remember that relationship is the foundation for reflective supervision and consultation. All growth and discovery about the work and oneself takes place within the context of this trusting relationship.

### ***Reflective Supervision Requirements***

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All Contractors must adhere to the following requirements for reflective supervision. Please note that when the evidence-based home visiting model requires more reflective supervision, Contractors must adhere to model requirements to maintain model fidelity.

1. Reflective supervision will at a minimum adhere to specific model requirements.
2. At least twice monthly individual reflective supervision will be conducted with Home Visitor staff for a minimum of thirty minutes each session.

### ***Description of Reflective Supervision and Reflective Practice***

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As abbreviated from AimEarlyIdaho: Idaho Association for Infant and Early Childhood Mental Health

Reflective supervision recognizes that work with, and within, relationships requires opportunities for stepping back and reflecting on what is happening within relationships (CSEFEL, 2011). Reflective supervision is a relationship for learning, a partnership that nurtures a process of remembering, reviewing, and thinking out loud about a specific infant, parent or family, or acquaintances who surround them and what happens (or does not) between them (Heller & Gilkerson, 2009).

Reflective supervision provides a systematic way for practitioners to explore feelings about working with families, to help decrease burnout, and to increase staff satisfaction and morale (Watson, 2006). A trained reflective supervisor provides support and knowledge to allow the practitioner to come to their own decision making, explore reactions to the work, and to manage the stress and intensity of working with families (Parlakian, 2002). Reflective supervision allows the practitioner to experience the same type of support they provide to families and children, all the while learning to problem-solve the challenges they encounter in their work with them. It is an opportunity for therapists and other professionals to deepen and broaden knowledge, discuss reactions to experiences, discuss individual goals and progress, and develop and refine their individual style through self-understanding (Shahmoon-Shanok, et. al.1995).

There are three core principles of reflective supervision: regularity, collaboration, and reflection (Heffron & Murch, 2010) Reflective practice, as used in the field of infant mental health, allows practitioners to go beyond observable behaviors and specific skills, and examine feelings and relationships associated with working with families and their children (Gatti, et. al, 2011).

“Reflective practice is never solitary; it is always shared” (Schafer, 2007). All learning and development take place within the context of relationships, including the learning of the infant, parent, and practitioner. Therefore, reflective practice happens within the relationship context of a trusted facilitator and colleagues (Schön, 1987).

More information can be found on the Idaho Association for Infant and Early Childhood Mental Health (AIM Early Idaho) web page: [www.aimearlyidaho.org](http://www.aimearlyidaho.org)

## Home Visitor Safety

Contractors are responsible for informing and preparing home visitors for safety issues they might encounter while visiting families in their homes. Families participating in home visiting services may be dealing with a multitude of complex personal and social issues. When visiting families the home visitor should be trained to be aware of his or her environment. If at any time they should feel uncomfortable, threatened, or in jeopardy, the visit should be postponed and they should leave. Additionally, each contractor should develop and maintain agency specific safety check-in policies for after hour visits, such as supervisor or buddy check-in calls when visits are complete. Idaho MIECHV program recommends the follow safety precautions, particularly during initial visits with new participants.

### Before the Visit

- Always let someone know where you are going.
- Mentally rehearse the visit and what you need to accomplish.
- Don't wear excessive jewelry and dress appropriately.
- Take your ID with you, but do not wear your ID cord around your neck.
- Wear comfortable shoes with low or no heels.
- Carry a cell phone with you, if possible.

### Approaching the House

- Be aware of your surroundings.
- Park your vehicle in a way that you can make a quick exit, if necessary.
- Do not block anyone's parking space.
- Lock valuables in the trunk of your vehicle.

### During the Visit

- Be aware of the exits from the home. Keep yourself between the client and the door.
- Sit near an exit or facing the hallway so you can view hall and bedrooms.
- Use non-threatening body language and remain calm and polite.
- Respect the client's home and their emotions.
- Listen to your instincts and feelings.
- Do not touch the family pet.
- Be cautious and use common sense.

- Leave if you feel threatened or if you notice unlawful or peculiar behavior. Report your concerns to your supervisor or police when necessary.

#### Just in Case

- Make sure your vehicle is in good running condition and has enough gas.
- When possible, back your vehicle into parking spaces.
- Keep a flashlight and a first aid kit in your vehicle.
- Take dog biscuits along to calm excited/aggressive dogs.
- Don't reveal too much personal information about yourself or your family. Use first name only except on business cards or signed papers that must be left with the family. Use only business or public phones to prevent identification of personal phones with caller I.D.

## Participant Recruitment

### *Participant Recruitment*

For the first two years of the Idaho MIECHV program, the target communities are considered either one-county service areas or contiguous two-county, service delivery areas:

- North Idaho: Kootenai and Shoshone Counties
- North Central Idaho: Nez Perce and Clearwater Counties
- Southwest Idaho: Canyon County
- West Central Idaho: Ada County
- South Central Idaho: Twin Falls and Jerome Counties
- South East Idaho: Power and Bannock Counties
- Eastern Idaho: Bonneville County

Contractors with a two-county contiguous service area will provide home visiting services in both counties of the service area with a minimum of fifteen percent of the services provided to families in the smaller population county. For example, a contractor based in Kootenai County must identify, at a minimum, fifteen percent of its client base for home visiting services in Shoshone County.

Contractors should plan to be at capacity within nine to twelve months of initiating home visiting service delivery. **Prior to service delivery, contractors must conduct the following activities:**

1. Assess target-community needs for the home visiting program using data and other qualitative evidence, such as data in the MIECHV program needs assessment. (See Appendix for Sample Community Needs Assessment).
2. Develop and implement a plan for participant identification, recruitment and retention. The plan should include:
  - a. Plan for family recruitment
  - b. Outline of screening and selection process
  - c. Detail of the enrollment process including identification and documentation of the federally designated priority populations (listed below)

- d. Include notes of evidence-based models specific requirements for eligibility

*Federally Designated Priority Populations:*

- Pregnant women under twenty-one (21) years old
  - Families with a previous encounter with Child Protective Services
  - Tobacco users
  - Families with history of substance abuse
  - Low income
  - Children with developmental delay
  - Families of the armed services
  - Families with low academic achievement
3. Outline outreach and enrollment plans and processes to enroll families including plans to partner with community-based organizations within the two county service area.

**Throughout service delivery**, contractors should adhere to the following requirements and recommendations regarding participant recruitment:

1. Recruit and enroll participants according to model requirements to maintain model fidelity. When a home visiting model does not specify a specific population eligible for services, the program must recruit and enroll participants from the federally designated priority populations. Contractors may identify priority populations within the federally designated priority populations according to specific community characteristics or needs. Contractors should document and track determination of federally designated priority populations.
2. Ensure that program participation is voluntary, including documentation of affirmation or process that indicates participation is elective.
3. Ensure that service delivery is available for families outside of regular business hours.
4. Ensure that each participant receives at a minimum number of model required home visits:
  - a. **Parents as Teachers:** twelve monthly visits over the course of a year or a minimum of twenty-four individual family visits (twice monthly) annually for families with greater needs.
  - b. **Early Head Start Home-based:** weekly, 90 minute home visits with a minimum of 44 visits per year.
  - c. **Nurse-Family Partnership:** weekly home visits throughout pregnancy and first several months and according to the model specifications thereafter.
5. Create and implement a plan for participant retention such as specific engagement activities like text messages, wraparound services, or age appropriate toys or books.

### ***Family Needs Assessment***

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Contractors should engage participants in a participatory needs assessment process to gain insight on the family strengths and needs at the beginning for enrollment to inform service delivery. Comprehensive family needs assessment is a process. Engagement of family members in a discussion that is individualized to their situation is vital. The comprehensive needs assessment provides a general understanding of who is in the family, their connections with each other and their community, and

where they reside. Exploring their broader connections to faith communities; tribal, cultural, or ethnic bonds; or neighbors helps focus families on the resources that not only define them, but could also help address their current needs.

In addition to meeting and speaking with the family and children, key parts of the assessment process involve reviewing existing information, meeting with the staff of other agencies or providers with whom the parents or children are currently or recently involved, obtaining specialized assessments as indicated, identifying the family needs and circumstances, making decisions about services, documenting information and decision-making with the family, doing ongoing assessments of progress and needs, and disseminating information to the family and other providers to initiate and update the service plan and goals established through the needs assessment process. The service plan and goals should be derived from the strengths and needs assessment process as well as goals determined by the family.

Although simply completing a form will not capture all that is needed for comprehensive assessment, it can guide and focus efforts to define a family's strengths, needs and goals. There are several publicly available family needs assessment tools, including the Protective Factors Survey and the Scaled Family Assessment Tool, embedded in the Appendix. When considering assessment tools, contractors should select assessment tools that have been tested for reliability and validity.

## Privacy and Protections

### *Client Rights*

The MIECHV program Contractors will comply with the rules, regulations and policies as defined by the Patient Protection and Affordable Care Act Section 2951—Maternal, Infant and Early Childhood Home Visiting Program. To protect the confidentiality of information about clients and to assume a protective role regarding the disclosure of confidential information, the Program will:

- Provide the client with a written copy of their rights and responsibilities including grievance procedures
- Protect the confidentiality of Protected Health Information (PHI) both active and data at rest, and adhere to 45 CFR subsections 160, 162, and 164.
- Ensure that procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01, Use and Disclosure of Department Records.
- Ensure that participants are informed of client rights to confidentiality, consent for information release and other informed consent privacy protection, including use of photographs in postings or publications, during or before the first home visit. (See Appendix for sample Client Rights and Informed Consent.)

## ***Information Sharing***

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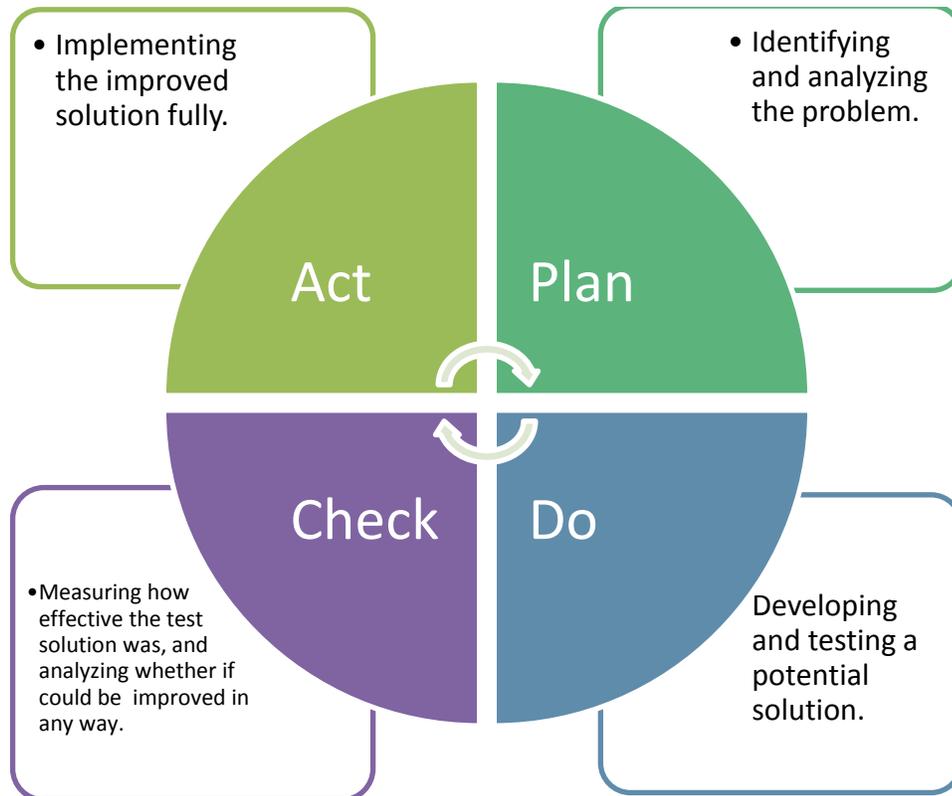
1. When the Program receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, the Program:
  - Determines if the request is valid;
  - Obtains the client’s informed, written authorization to release the information (see sample Information Release and Notice of Confidentiality in Appendix); and
  - Obtains informed, written authorization from a parent or legal guardian, if the person is a minor or an adult who is incapable of providing authorization to release the information.
2. Service recipients or designated legal representatives can access their case records, consistent with legal requirements. Access to confidential case records will be determined to meet legal requirements, and is limited to:
  - The service recipient (current or former) or, as appropriate, a parent or legal guardian;
  - Personnel authorized to access specific information on a “need-to-know” basis; and
  - Authorized Department employees, auditors, contractors, and licensing or accrediting personnel consistent with the organization’s confidentiality policy.
3. Contractors must maintain a formal mechanism through which applicants, clients, and other stakeholders can express and resolve grievances, including denial of service, which includes at a minimum:
  - Timely written notification of the resolution and an explanation of any further appeal, rights, or recourse;
  - At least one level of review that does not involve the person about whom the complaint has been made or the person who reached the decision under review; and
  - The right of the consumer or a family member to be heard by a panel or person delegated to review responsibility.
4. Contractors should notify the Department of upcoming news releases pertaining to any aspect of the services being provided under contract to the Department prior to releasing the information.

## **Continuous Quality Improvement**

Contractors are required to implement a Continuous Quality Improvement (CQI) plan which should outline activities to be performed throughout implementation of the contract in accordance with the Plan-Do-Check-Act Framework, or another nationally recognized continuous quality improvement framework. The Plan-Do-Check-Act is a four-step management method used in business, non-profit, and health settings for the continuous improvement of processes, services, and products. The

Continuous Quality Improvement plan must identify person(s) responsible for different aspects of the plan, including data collection, process analysis, data analysis, follow-up, and implementation. Contractors will be reporting on issues and progress every six months to the Idaho MIECHV program. Additionally, the Idaho MIECHV program will conduct monitoring on the CQI according to contract Performance Metrics.

### PDCA Cycle Framework



1. **Plan:** Identify the problem or issue that needs to be addressed. This may require process mapping or key informant interviews to get to the root of the problem.
2. **Do:** Generate solutions to the issues or problems and select the most likely solution(s). Implement a pilot project or policy to test the solution. The “Do” phase is the test phase.
3. **Check:** Measure the success of the pilot solutions before full implementation. Gather learnings and determine what may have made the pilot better. Incorporate improvements for additional pilots or full implementation.
4. **Act:** Implement the solution broadly and continue assessment of success of the solution. Then seek further areas in need of improvement.

## **Additional Resources**

1. Friends National Resource Center for Community-Based Child Abuse Prevention (FNRC – CBCAP): <http://friendsnrc.org/continuous-quality-improvement>.
2. Institute for Healthcare Improvement (IHI) Improvement Map and Gap Analysis: [www.ihl.org](http://www.ihl.org)

## **Model Fidelity**

### ***Maintaining Model Fidelity***

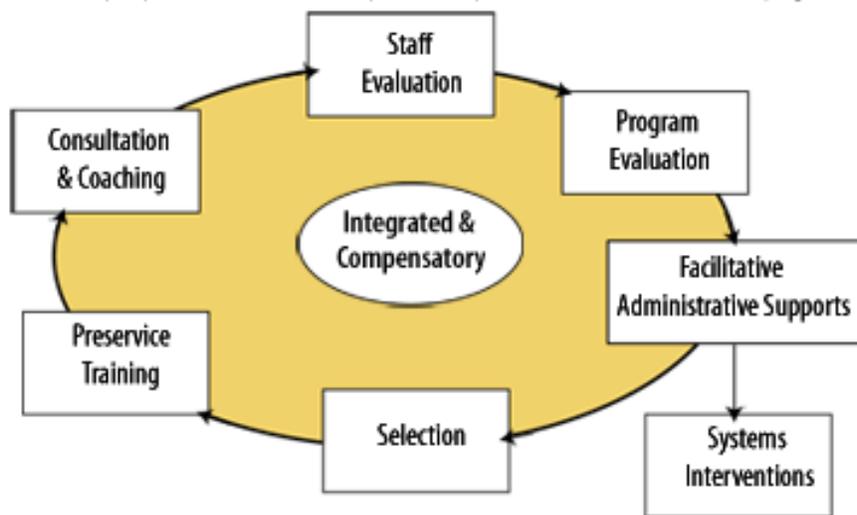
Contractors must implement the evidence-based home visiting model with model fidelity. Models, often used interchangeably with programs, include a set of activities and services that have been evaluated and studied with high quality research designs such as a randomized control trial or quasi-experimental study. These high quality research designs are considered the gold-standard, or best methodology available, because these studies can control for contextual factors that may have influenced program outcomes in the design and analysis phase of the research. The federal legislation governing the MIECHV program described the type of research that had to have been completed on the home visiting models (or programs) to be considered for implementation.

Model fidelity is considered the degree to which organizations implementing the evidence-based models (or programs) are able to implement the model (or program) as was designed and studied in the high quality research. There are a multitude of factors that influence how program implement evidence-based models. The MIECHV program contractors should pay particular attention to the implementation of the models or programs. Assessment of fidelity is necessary as there is often a practice gap between the research design and the implementation of the program. Identification and monitoring of several specific model fidelity indicators may be useful in assessing consistency in implementation of the home visiting model. Continuous quality improvement and process analysis are also acceptable methodologies for monitoring model fidelity.

The National Implementation Research Network (<http://nirn.fpg.unc.edu/>) has developed a number of tools and frameworks to assist organizations implementing evidence-based home visiting track and assess implementation according to research.

## Core Implementation Components

to successfully implement evidence-based practices or practices within evidence-based programs



### ***Model Fidelity Model Requirements***

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Each home visiting model defines fidelity to model (program) according to specific components that are critical to the implementation of the program to achieve the results as were shown in research. Additionally, each model utilizes various approaches to monitoring the implementation of the model (program).

- **Early Head Start Home-Based:** Maintaining compliance and adherence to *Head Start Program Performance Standards*
- **Nurse-Family Partnership:** Maintaining compliance and adherence to *Nurse-Family Partnership Model Elements*
- **Parents as Teachers:** Maintaining compliance and adherence to *Parents as Teachers Essential Requirements*

### ***National Model Developer Resources***

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- Early Head Start Webpage: <https://eclkc.ohs.acf.hhs.gov/hslc>
  - News and highlights
  - Resources
  - Listserv
  - Web events
  - Home-based Program Option
- Nurse-Family Partnership Webpage: [www.nursefamilypartnership.org](http://www.nursefamilypartnership.org)
  - Description
  - News
  - Policy
  - Model elements

- Parents as Teachers : [www.parentsasteachers.org](http://www.parentsasteachers.org)
  - Program description
  - Program research
  - Definitions
  - Resources
  - Planning documents

## **Program Advisory Committee**

### ***Program Advisory Committee***

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Contractors must convene a program advisory committee, which includes the persons listed below at least every six months. Contractors must document the program advisory committee meetings by maintaining at least sign-in sheets, agendas, minutes, and member contact information. Contractors should outline governance structure, function, and policies of the program advisory committee. Program advisory committee members should understand their role and responsibilities on the committee, purpose and decision making structures of the committee, and duration of expected participation on the program advisory committee.

Home visiting models have a various requirements for advisory committees, contractors must also adhere to the model specific requirements regarding program advisory committees. In some cases, there may be existing program advisory committees that may meet both the Idaho MIECHV program and model requirements that contractors may utilize existing program advisory committees to meet contract requirements. Please see appendix for sample sign-in sheets and agenda's for program advisory committee meetings.

- Home visitors
- Community service providers
- Community members or leaders
- Participants
- Other stakeholders

## **Coordination of Community Resources**

### ***Referrals and Referral Partnership***

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Contractors must document partnerships with entities in the community in which have resources or supports that participants may need. Documentation of the referrals may include formal referral agreements such as interagency agreements, letters of commitment or support, or organizational policies and procedures with clear direction and contact information services providers utilize when making a resource. Contractors will report on informal and formal referral partnerships to the MIECHV at program initiation and annually thereafter. Contractors should consider the following types of organizations when developing referral partnerships:

- Other home visiting programs
- Health care providers
- Social Services
- Mental Health
- Education
- Child Care and Child Development
- Child Welfare
- Domestic Violence
- Housing
- Community Action Agencies
- Employment organizations

The MIECHV Efforts to Outcomes data system has some capacity to maintain referral partnership information. Contractors complete referral partnership report forms. See appendix for informal and formal community partnership document forms.

### ***Coordination of Services***

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Contractors must explore, develop, and implement processes to collaborate with other home visiting program and other service delivery organizations, as appropriate, in the service area to enroll or refer participants into each home visiting program based on family needs and program strengths. Contractors may develop and define the processes in partnership with home visiting programs and other service delivery organizations for implementation referral and enrollment coordination. This process is often called broadly a centralized intake process. Centralized intake processes may occur through common forms, standard enrollment protocol, referral and enrollment meetings, automated referrals, or other methods.

Contractors should coordinate services with other home-based service providers, including Infant Toddler Program or Child Welfare Program staff providing services in the home. Coordination of visits with other service providers may facilitate joint service planning, as appropriate and when feasible. Contractors may partner with other organizations or agencies where families seek services, such as hospitals, health departments, or direct outreach programs.

Contractors are required to refer children with a suspected developmental delay to the Infant Toddler Program to be screened for program eligibility, if the child is less than three years old and not already receiving services. Home visitors must refer families with children scoring at below cut-off or referral needed on the Ages and Stages Questionnaire – 3<sup>rd</sup> edition within five days of business days.

### ***Community Engagement***

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Contractors are required to implement and document community engagement strategies, which may include a variety of activities. Contractors will report on successes, challenges, and activities related to community on engagement on quarterly performance reports. Examples of community engagement include:

- Collecting community feedback and input on needs of the community to inform service delivery
- Working community leaders to assure awareness of availability and benefit of home visiting
- Outreaching to schools, community-based organizations, medical practices, and businesses
- Inviting community member participant on the program advisory board

### ***Community Needs Assessment Resources***

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There are a multitude of resources available with information and statistics that help paint the picture of communities, counties, regions, and states. Below are a few credible resources available for community needs assessments.

#### **Idaho State, Regional, and County Data can be found at:**

1. Idaho Vital Statistics: [www.healthstatistics.dhw.idaho.gov](http://www.healthstatistics.dhw.idaho.gov)
2. Idaho Pregnancy Risk Assessment Tracking System: [www.healthstatistics.dhw.idaho.gov](http://www.healthstatistics.dhw.idaho.gov)
3. Idaho Behavioral Risk Factor Surveillance System: [www.healthstatistics.dhw.idaho.gov](http://www.healthstatistics.dhw.idaho.gov)
4. Idaho Kid's Count: [www.idahokidscount.org](http://www.idahokidscount.org)
5. US Census Bureau: [www.census.gov](http://www.census.gov)
6. County Health Rankings: [www.countyhealthrankings.org](http://www.countyhealthrankings.org)
7. Kaiser State Health Facts: [www.statehealthfacts.org](http://www.statehealthfacts.org)
8. Annie E. Casey Foundation Kids Count Data Center: [www.datacenter.kidscount.org](http://www.datacenter.kidscount.org)

#### **Web examples:**

- Utah State University Community Needs Assessment Survey Guide: [www.extension.usu.edu/files/uploads/surveyguide.pdf](http://www.extension.usu.edu/files/uploads/surveyguide.pdf)
- Community Assessment Tools: <https://www.rotary.org/myrotary/en/document/community-assessment-tools>

## CONTRACT INVOICING AND REPORTING

### Performance Metrics and Monitoring

#### *Ongoing Monitoring*

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Contractors will be expected to adhere to the requirements outlined in the contract. The Department will monitor Contractor compliance and performance of the requirements outlined in the contract according to a number of performance metrics. The Department utilizes a number of mechanisms to monitor contract compliance and performance on-site and ongoing report review including:

- Meeting Notes and Attendance
- Participant Files
- Staff Files
- Contractor Reports
- Data System Reports
- Planning Documents
- Contract Required Deliverables
- Check in calls

At a minimum, the Contractor will coordinate with the Department to plan and conduct one annual on-site monitoring visit of the Contractor by Department staff. The Department may determine that additional on-site monitoring visits are necessary in more frequent intervals. The annual on-site monitoring visit will assess program and contract requirements, in addition to an on-site fiscal review. The Idaho MIECHV program will notify the Contractors at least between three to four weeks prior to the monitoring visit. This notification will include further instruction of what to prepare and expect during the on-site visit.

During the monitoring and review process, if it is determined that the Contractor is not meeting the required level of expectation, the Department will document any findings and contact the Contractor to determine the reason(s) for non-compliance. The Contractor and the Department will work together to identify a resolution, for example the Contractor may agree to submit a written corrective action plan within ten business days explaining what corrective action they will take and the timelines for completion. If the issues are not corrected as agreed, the Department will consider further remedies as sited in the General Terms and Conditions XV Remedies including remedial action such as further attempts at corrective action, reduction in payment, or termination of contract.

#### **Performance Metric 1: Continuous Quality Improvement (CQI)**

The Contractor shall develop and implement a Continuous Quality Improvement Plan. The CQI Plan should outline the activities and persons responsible for implementing the plan. Teams of Contractor staff, participants, or community members may be assembled to assess and monitor program performance. The CQI Plan should detail the framework, timeline, persons responsible, and activities required to complete the CQI Plan.

*Required Level of Expectation: 90%*

*Method of Monitoring:* On site visits, review of CQI reports bi-annually, monthly reports, and written and verbal communication between the Contractor and the Department.

**Performance Metric 2: Reflective Supervision**

The Contractor shall conduct at least twice monthly individual reflective supervision with home visitor staff for a minimum of thirty minutes per home visitor or one individual reflection and two group reflections per month for all home visitors. In some cases as approved by the Department, group reflections may be substituted for individual reflections. The supervisor providing reflective supervision for the home visiting staff must have training in and at least fifty hours of reflective supervision or partner with a qualified subcontractor to provide reflective supervision.

*Required Level of Expectation:* 95%

*Method of Monitoring:* Review of MIECHV Quarterly Program Performance Report, data collected in the Idaho MIECHV database, employee files documentation of individual reflections, and written and verbal communication between Contractor and the Department.

**Performance Metric 3: Home Visiting Staffing Plan**

The Contractor shall develop or enhance an existing staffing plan which outlines the recruitment, retention, caseloads, and training of staff for the program. The Contractor shall adhere to the staffing plan including timeframes and activities related to training, hiring, and managing of caseload. The staffing plan will outline the Contractors plan for maintaining the evidence-based home visiting model personnel fidelity requirements.

*Required Level of Expectation:* 90%

*Method of Monitoring:* Review of reports, on-site visits, review of employee files for the required documentation, and written and verbal communication between the Contractor and the Department.

**Performance Metric 4: Data Collection and Use**

The Contractor shall ensure data entry occurs within five business days of collection, such that when information is gathered for any contract or model required activity including but not limited to: information collected during enrollment, home visits, case management, supervision, or discharge. This information is recorded within the Efforts to Outcomes Data Management System within five business days of collection.

*Required Level of Expectation:* 90%

*Method of Monitoring:* **Review of case files during on-site** visits and review of participant electronic files, and written and verbal communication between the Contractor and the Department.

**Performance Metric 5: Program Advisory Committee/Community Advisory Board**

The Contractor shall convene a program advisory committee (Community Advisory Board for Nurse-Family Partnership) that includes program personnel, community service providers, community leaders, participants, and other stakeholders. The Contractor shall ensure the program advisory committee convenes at least every six

months, seeking input from members to provide guidance to the program regarding at least the following: outreach and enrollment, coordination of services, and program quality.

*Required Level of Expectation: 90%*

*Method of Monitoring:* Review of program advisory committee meeting minutes and attendance, CQI reports, and written and verbal communication between the Contractor and the Department. (Sample forms found in Appendix)

#### **Performance Metric 6: Data Quality**

The Contractor shall ensure accurate data entry, such that the error rate for data entry is less than three percent. Quality data is critical for assessing participant progress and outcome and to facilitate CQI processes and activities. Data should be entered into the Efforts to Outcomes Data Management System to provide an accurate representation of the actual information observed or stated. Definition of error discrepancy will be developed by the Department and mutually agreed upon by the Contractor.

*Required Level of Expectation: 97%*

*Method of Monitoring:* Review of participant case files during on-site visits, and written and verbal communication between the Contractor and the Department.

#### **Performance Metric 7: Service Delivery**

The Contractor shall implement and maintain fidelity to the PAT model requirements. The Contractor shall ensure enrollment of participants in the Service Area, with no fewer than fifteen percent (15%) of participants enrolled residing in the smaller county if the Contractor serves a contiguous two-county area. The Contractor shall enroll twenty to twenty five (20-25) pregnant women or families of children between zero (0) and six (6) years of age, unless exempt, per full-time home visitor within six (6) months of completion of required PAT training and maintain that level of enrollment on an ongoing basis thereafter.

*Required Level of Expectation: 100%*

*Method of Monitoring:* On-site visits, review of written and verbal communication with local contractors, monthly reports, and forms through auditing the Department Data Management System.

#### **Performance Metric 8: Community Partnership**

The Contractor shall develop, maintain, and document a referral network of existing and proposed partnerships with relevant community agencies within the Service Area for recruitment, enrollment, and support resources. The Contractor shall develop and document formal and informal partnerships on an ongoing basis, which may include, but not be limited to, letters of commitment, interagency agreements, or organizational policies.

*Required Level of Expectation: 100%*

*Method of Monitoring:* Review of annual on-site visit, annual and monthly reports, and written and verbal communication between the Contractor and the Department.

**Performance Metric 9: Voluntary Participation**

The Contractor shall ensure participation in home visiting is voluntary for all participants during the first home visit. Home visitors shall document consent for services with participant rights and consents.

*Required Level of Expectation: 100%*

*Method of Monitoring: Review of on-site visits.*

**Performance Metric 10: Sustainability Plan**

The Contractor shall maintain a plan for the PAT program sustainability which will outline measures to pursue in order to encourage program sustainability beyond the duration of this contract.

*Required Level of Expectation: 100%*

*Method of Monitoring: Review of on-site visits, written and verbal communication with the Contractor and the Department, and the sustainability plan.*

**Invoicing**

**Cost and Billing**

Contractors will submit monthly invoices to the Idaho MIECHV program. Invoices can be submitted in electronic or paper to the following contact information. When submitting the monthly invoices, the monthly fiscal reports should accompany the monthly invoices detailing the actually billable costs for the prior month contract required activities. Invoices received without the required reports/documentation will be returned to the contractor for resubmission.

Electronic	Paper
Deborah Drain at <a href="mailto:DrainD@dhw.idaho.gov">DrainD@dhw.idaho.gov</a> CC: Carrie Weaver at <a href="mailto:WeaverC@dhw.idaho.gov">WeaverC@dhw.idaho.gov</a> Subject Line: Monthly Invoice and Fiscal Report	Deborah Drain Department of Health and Welfare Maternal and Child Health Program – 4 <sup>th</sup> Floor PO Box 83720 Boise, ID 83720-0036

## MIECHV Program Monthly Invoice Sample

**Organizational Letterhead:**

**Organizational Name:**

**Contract Name:**

Invoice Number	Date of Invoice	Vendor Identification Number	Contract #
<b>INVOICE FOR Dates of Service:</b>	From:		To:
Contractor Name			
Contractor Address			
Contractor Phone Number			
Contractor E-mail			
<b>Cost Categories</b>	<b>Total Cost</b>	<b>Description</b>	
Personnel Cost			
Operating Cost			
Pre-Implementation Cost			
Total Direct Cost			
Indirect Cost			
<b>TOTAL COST</b>			
Original Signature of Authorized Representative:			
Please make check payable to:			
Send to Address:			
For questions contact:			

## Cost Analysis

### *Cost Analysis Study*

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Contractors are required to participate in the Idaho MIECHV program cost analysis throughout at least the first two years of the contract. The cost analysis provide information related to both billable costs, actual costs, and time costs required to implement difference evidence-based home visiting models. There will be three primary information sources that will provide data for the cost analysis study. Information provided in the study will provide a baseline or foundation for understanding the costs to implement different evidence-based models in Idaho. Cost analysis will provide information to derive actual costs, cost centers, cost drivers related to implementing different evidence-based home visiting models. Based on the design of the costs analysis study, the MIECHV program will not have sufficient information to suggest costs impact with participant outcome. Boise State University Center for Health Policy will be conducting the surveys for the cost analysis.

1. Monthly Billing Cost Report – Monthly
2. Personnel Detail Report – Quarterly
3. Fiscal Detail Report – Quarterly
4. Annual Fiscal Report - Annually
5. Time Cost Survey – Every 3-4 months

## Fiscal Accountability

### *Fiscal Monitoring*

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The MIECHV program will conduct annual fiscal monitoring as a component of other program monitoring activities. During fiscal monitoring contractors should be prepared to provide documentation of any costs charged to the contract throughout the past contract year. The MIECHV program will determine the number or percentage of charges that it will review during the fiscal monitoring review process. Fiscal reviewers may or may not notify contractors of the time frames that will be monitored prior to the on-site fiscal monitoring review.

## Reporting

Contractors will be required to submit reports throughout the contract year. Reports and information required within the reports will largely be extracted from documentation maintained within the Efforts to Outcomes Data Management System. Reports are considered Contract required deliverables and are associated with some of the performance metrics. Reports shall be submitted to the Department in an electronic file transfer. Report forms for the Monthly, Performance, Continuous Quality Improvement, and Monthly Fiscal report are as follows. Contractors may submit forms through electronic file transfer either in a Microsoft Word or Excel format.

- **Report 1: Personnel Detail Report**
- **Report 2: Fiscal Operating Detail Report**

- **Report 3: Monthly Report**
- **Report 4: Quarterly Program Performance Report**
- **Report 5: Continuous Quality Improvement (CQI) Report**
- **Report 5: Fiscal Report**
- **Report 6: Informal and Formal Community Partnerships Report**
- **Report 7: Annual Report**

Reports Schedule

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly		X	X		X	X		X	X		X	X
CQI	X						X					
Performance	X			X			X			X		
Annual	X											
Billing Cost	X	X	X	X	X	X	X	X	X	X	X	X
Fiscal Detail	X			X			X			X		
Personnel Detail	X			X			X			X		
Community	X											

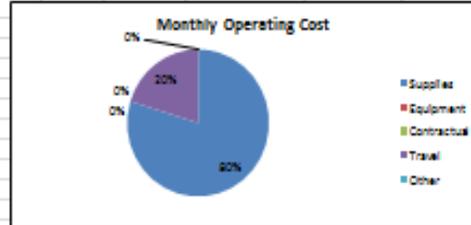
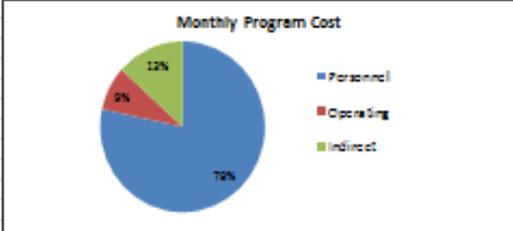
## MIECHV Program Monthly Fiscal Report Sample

**Instructions:** Contractors will complete the excel sheet of costs incurred throughout the month to submit with the invoice. The Monthly Fiscal Report is locked with exception of the yellow cells. Contractors fill in the yellow cells, which then populate the rest of the cells. The total amount per cost category must be equivalent to those on the monthly invoice. If the totals are not the same, the invoice and fiscal report will require resubmission.

Maternal, Infant, and Early Childhood Home Visiting Program									
Monthly Fiscal Report Year 1									
<i>Contractors will fill in the yellow cells. All other cells will be populated by the system and should not be edited.</i>									
<b>Contractor Name</b>		Speakeer Regional Health District							
<b>Contract Number</b>									
<b>Fiscal Report Period</b>									
	Hours	Hour Wage	Fringe	Total	XFTE	Health	Year Projected	Total	Notes
<b>Personnel Cost</b>									
Program Administrator (Home & Facility)			\$8.00	\$8	14X	0.00	0.00	\$8.00	
Supervisor	42.0	32.00	\$483.20	\$1,747	56X	302.76	11,733.00	\$302.76	
Data Entry			\$8.00	\$8	14X	0.00	0.00	\$8.00	
Administrative Personnel			\$8.00	\$8	24X	0.00	0.00	\$8.00	
Other			\$8.00	\$8	18X	0.00	0.00	\$8.00	
<b>Personnel Total</b>			<b>485.20</b>	<b>800000</b>	<b>1.45</b>	<b>302.76</b>	<b>11,733.00</b>	<b>\$302.76</b>	
<b>Operating Cost</b>									
<b>Supplies</b>									
Examples include:						0.00	0.00	0.00	
Cell Phones	42.00	2				04.00	1,000.00	04.00	
Office Supplies (paper, postage, etc.)						0.00	0.00	0.00	
						0.00	0.00	0.00	
						0.00	0.00	0.00	
<b>Equipment</b>									
Examples include:						0.00	0.00	0.00	
Computers						0.00	0.00	0.00	
Data Collection Equip't (Laptop, Tablets, etc.)						0.00	0.00	0.00	
Office Equipment (Desks/Chairs, etc.)						0.00	0.00	0.00	
						0.00	0.00	0.00	
<b>Contractual</b>									
Examples include:						0.00	0.00	0.00	
Training						0.00	0.00	0.00	
<b>Travel</b>									
Examples include:						0.00	0.00	0.00	
Travel to Contractor Meetings	24.34	1				24.34	256.00	24.34	
Mileage to Home Visits						0.00	0.00	0.00	
<b>Other</b>									
Examples include:						0.00	0.00	0.00	
Meeting Room						0.00	0.00	0.00	
						0.00	0.00	0.00	
<b>Operating Total</b>	<b>69.34</b>	<b>3</b>				<b>485.34</b>	<b>1,264.00</b>	<b>485.34</b>	
<b>Total Direct Cost</b>						<b>1,000.40</b>	<b>13,057.46</b>	<b>1,000.40</b>	
<b>Indirect Cost</b>									
Rate									
Cost to Maintain/Operate Facilities, see Def	47%		of total direct cost			167.86	2,084.73	4,167.86	
<b>Total Indirect Cost</b>								<b>4,167.86</b>	
<b>TOTAL MONTHLY COST</b>						<b>1,255.46</b>		<b>\$1,255.46</b>	
<b>Number of Families Enrolled</b>									
<b>Estimated Cost Per Family (DIVIDE)</b>									

**Fringe Benefits:** List the components that comprise the fringe benefit rate, for example health insurance, leave, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to the portion of personnel costs that are allocated for the project.

**Indirect Costs:** Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, etc.



<b>Other Costs</b>	
<b>Volunteer Time and Donations</b>	
<b>Estimated Volunteer Hours</b>	
<b>Estimated Value of Donations</b>	

## Data Collection Requirements

### *Participant Data*

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Contractors must maintain documentation of participants from enrollment to exit.

1. Data must be collected on all required MIECHV program data elements for all MIECHV program participants.
  - a. Demographic data includes: parent and child age, employment, race, ethnicity, income, education, and primary language spoken in the home will be required at intake for families enrolling in the program.
  - b. Program data includes: data collected throughout program participation.
2. Participant data collected from program enrollment to exit must be documented within the MIECHV program Efforts to Outcomes Data Management System.
  - a. Case files must be maintained electronically within the Efforts to Outcomes Data Management System.
  - b. Hard copy case files are optional, but when a Contractor elects to maintain hard copy case files, they must be available to the Department upon request.
3. All required data elements for all MIECHV program participants are supported by consent and carries protections from disclosure and other anonymous or aggregate disclosure. (See Appendix for sample forms)
4. Supervisors will regularly review all completed screening tools and measures with home visitors and assure that referrals to appropriate services are completed when indicated and service planning is responsive to results and observations made with screening and assessment tools.

### **Benchmarks plan**

The Idaho MIECHV Program was required to compile plan to collect all of the data as outlined in the Federal Legislation and Federal MIECHV Program Guidance. The benchmarks plan outlines Idaho's plan to collect and analyze the 35 indicators across the six benchmark areas. The six benchmark areas include:

1. Maternal and Newborn Health,
2. Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits,
3. Improvements in School Readiness and Achievement,
4. Domestic Violence,
5. Family Economic Self-Sufficiency, and
6. Coordination and Referrals for Other Community Resources and Supports.

To ensure all the data for the benchmarks plan is collected, home visitors must document screening, assessments, and track referrals made and completed in the MIECHV data system. The MIECHV program has established a data sharing agreement in the form of a Memorandum of Understanding

with the Idaho Child Welfare program to exchange administrative data with the child welfare program for linkage and analysis by the MIECHV program. The following are identified screening and assessment tools will be used to measure the constructs defined in Benchmarks Plan. Screening Tools Used: Edinburgh Postnatal Depression Scale, Home Observation for Measurement of the Environment (HOME) Inventory, Everyday Stressors Index, Ages and Stages Questionnaire -3, Ages and Stages Questionnaire – Social Emotional. Local service delivery agencies will also be required to implement the Protective Factors Survey, though not included in the benchmarks plan.

Within the benchmarks plan, the term case file and case file review denotes data which will be extracted from the data system from individual clients (case) electronic files into report forms. Case files are considered the electronic information maintained for individual clients within the NFP and Idaho MIECHV ETO systems, which includes NFP NHV data forms, demographic data, and other client information. For the benchmarks plan, case file review will be completed by the State MIECHV Program staff at the Idaho Department of Health and Welfare or State MIECHV Program contracted evaluation staff at Boise State University from aggregated data extracted from the NFP and Idaho MIECHV ETO systems. In the context of performance monitoring, case file review generally means review and analysis of the entire caseload or individual client files by supervisors and home visitors to assess client progress and program performance.

### ***Forms & Data Collection***

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#### **Nurse-Family Partnership Data Collection:**

- Demographics Update (Form 5.0) –Enrollment, then 6, 12, 18, 24 months of child’s age
- Edinburgh Postnatal Depression Scale (EPDS) (Form 7.0) intake, 36 weeks pregnant, 1-4 weeks postpartum, 4-6 months, 12 months and as needed
- Health Habits Form (Form 8.0) 3<sup>rd</sup> or 4<sup>th</sup> visit, 36 weeks pregnant, then 12 months of child’s age
- Infant Health Care Form (Form 11.0) 6, 12, 18, 24 months
- Maternal Health Assessment: Pregnancy – Intake (Form 12.0) – intake
- Patient Health Questionnaire – 9 (PHQ – 9) (Form 13.0) intake, 36 weeks pregnant, 1-4 weeks postpartum, 4-6 months, 12 months and as needed
- Relationship Assessment: Pregnancy – Intake (Form 14.0)
- Relationship Assessment: Pregnancy – 36 weeks (Form 15.0)
- Relationship Assessment: Infancy – 12 months (Form 16.0)
- Use of Government and Community Services (Form 17.0) intake, 1<sup>st</sup> postpartum visit, then 6, 12, 18, 24 months of child’s age
- Home Visit Encounter Form (Form 9.0) – Every visit

#### **Idaho MIECHV ETO Forms for EHS and PAT:**

- Demographic Intake and Update – Enrollment and every 12 months thereafter
- Maternal Health: Intake and every 6 months thereafter
- Adult Health: Intake and every 6 months thereafter
- Child Health Form: Intake (or birth) and every 6 months (of age) thereafter: 6, 12, 18, 24, 30, 36, 42, 48, 54 months

- Home Visit Encounter Form: Every Visit
- Future Without Violence: Relationship Assessment Tool – within 3 months of enrollment and every year thereafter OR new relationship
- Ages and Stages Questionnaire – 3<sup>rd</sup> Edition – at 6 months of age and every 6 month interval thereafter
- Ages and Stages Questionnaire – Social Emotional – at 6 months of age and every 6 month interval thereafter
- HOME Inventory – Early Childhood and Infant/Toddler
- Everyday Stressors Index– First month post-delivery and at 12 months post-delivery or enrollment, then annually thereafter
- Edinburgh Postnatal Depression Scale– 45 days post-delivery and at six months post delivery
- Protective Factors Survey– Intake, 12 months and annually thereafter

Idaho has defined the following reporting years and cohorts for reporting and analysis of benchmarks related data:

- CO1 Cohort 1 = June 1<sup>st</sup>, 2012 – May 31<sup>st</sup>, 2013
- CO2 Cohort 2 = June 1<sup>st</sup>, 2013 – May 31<sup>st</sup>, 2014
- CO3 Cohort 3 = June 1<sup>st</sup>, 2014 – May 31<sup>st</sup>, 2015
- CO4 Cohort 4 = June 1<sup>st</sup>, 2015 – May 31<sup>st</sup>, 2016
- CO5 Cohort 5 = June 1<sup>st</sup>, 2016 – May 31<sup>st</sup>, 2017

Idaho has defined the following cross-sections (SC) for reporting and analysis of benchmark related data:

- **Cross-sections – Type I (Constructs 1.4, 1.6, 1.7, 1.8, 2.5, 2.6, 2.7, and 6.2):**
  - **Baseline = June 1<sup>st</sup>, 2012 – August 31<sup>st</sup>, 2013**
  - **Comparison = September 1<sup>st</sup>, 2013 – September 30<sup>th</sup>, 2014**
- **Cross-sections – Type II (Constructs 2.1, 2.4, 3.2, 3.5, 3.6, 3.7, 3.8, 3.9, and 6.5)**
  - **Baseline = June 1<sup>st</sup>, 2012 – December 31<sup>st</sup>, 2013**
  - **Comparison = January 1<sup>st</sup>, 2013 – September 30<sup>th</sup>, 2014**
- **Cross-sections – Type III (Constructs 4.1, 4.2, 4.3, 6.3, and 6.4)**
  - **Baseline = June 1<sup>st</sup>, 2012 – May 31<sup>st</sup>, 2013**
  - **Comparison = June 1<sup>st</sup>, 2013 – September 30<sup>th</sup>, 2014**

### ***Assessment Tools***

Contractors as required to procure and implement the following assessment tools. Several of the tools are free and available in the public domain, while others must be procured through a vendor or publishing company. Contractors are also responsible for ensuring that staffs are trained to implement the tools. Please note: The Idaho MIECHV program has developed a training request form for Contractors to submit training requests (See Appendix for Training Request Form).

- Ages and Stages Questionnaire – 3<sup>rd</sup> Edition
- Ages and Stages Questionnaire – Social Emotional
- Edinburgh Postnatal Depression Scale

- Everyday Stressors Index
- Future Without Violence: Relationship Assessment Tool
- HOME Inventory – Early Childhood and Infant/Toddler

### ***Data Management System***

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The Idaho MIECHV program has contracted with Social Solutions, LLC to develop an “Efforts to Outcomes” (ETO) enterprise as the data and performance management system for all Contractors. The Idaho MIECHV program is in the midst of an update process to its blueprint and configuration, which includes updating forms and adding, adding sites for new local Contractors, and installing a notifications engine to remind local staff of completion timelines. The Idaho MIECHV also holds a contract with Nurse-Family Partnership (NFP) National Service Office for data sharing between the NFP ETO and Idaho MIECHV ETO sites. Idaho MIECHV will be reviewing this agreement

Required MIECHV program data elements will be entered, analyzed and reported in the Department’s Data Management System Efforts to Outcomes and in mutually agreed upon format, such as an internal database or Excel spreadsheets for data not collected in the Social Solutions – Efforts to Outcomes Data System. Designated staff will participate in the development and customization process of the Efforts to Outcomes Data Management System on an as-needed basis to ensure updates are during system updates.

The Contractor will be notified by the Department when the Efforts to Outcomes Data Management System is available for use. Upon its availability the Contractor will:

1. Submit requests to the Department for access to the Efforts to Outcomes Data Management System for new Contractor staff.
2. Notify the Department of termination of access to the Efforts to Outcomes Data Management System for a Contractor affiliated user within four business days of change, e.g. terminated Contractor staff member.
3. Submit to the Department changes to Contractor user within four business days of change, e.g. non-administrator to administrator.
4. Notify the Department of problems encountered by Contractor staff in utilizing the Efforts to Outcomes Data Management System categorizing issues according to the escalation procedures document (as defined by the Department).

Contractors must ensure internet access with Internet Explorer version 5 or newer to ensure efficient transfer of information into the Efforts to Outcomes Data Management System. SSL encryption will be used for transferring and communicating MIECHV data over the Internet to Department approved web sites.

## ***Data Entry***

---

Contractors must ensure that data entry occurs within five business days of data collection with an error rate less than three percent. Quality data is critical for assessing program and participant progress and outcomes. Data will also be used to conduct continuous quality improvement activities. The Department will monitor Contractors on an ongoing and interval basis to ensure accuracy and timeliness of data entry is occurring according to contractual requirements. Contractors may also employ internal or other external monitoring to ensure accuracy and timeliness of data entry. Monitoring schedules will follow this approximate timeline:

1. Monthly: Timeliness (1% record review)
2. Quarterly: Accuracy (2% record review)
3. Annually: Timeliness and Accuracy (5% record review)

## Appendix A – Client Protections Forms

### Sample

#### Informed Consent

**Why:** To inform the participant about the home visiting data collection and evaluation and to get their agreement to participate in the program with required data collection and evaluation.

**Information Collected:** Demographic, service utilization, assessments and outcomes will be collected for all participants who accept home visiting services

**When:** The Informed Consent is completed as soon as possible during or after the first home visit by the home visitor. The form is only completed once throughout the participation of the program:

**Who Completes Form:** Home Visitor and Primary Caregiver, which is maintained in the clients paper and electronic files.

**Essential Items:** Primary Caregiver’s Unique ID Number

**Other Important Information:** The informed consent should be completed when the case is opened. The form is completed on all participants who enroll in the program. Data forms are still filled out on participants who refuse consent to participate in evaluation activities by Boise State University. De-identified data will be used for contract monitoring and federal reporting. There must be a Spanish version of the form, if the population reads and speaks Spanish.

Sample Form Language:

As a part of the Maternal, Infant, and Early Childhood Home Visiting program, we are offering services to pregnant women and families of children birth to age five to provide support and information about raising young children. The purpose of the program is to build strong families, increase well-being of parents, and encourage optimal growth and development of young children. As a part of the program routine data will be collected to monitor program success, understand participant and home visitor experience, and measure participant outcomes. The information learned from this data collection will be used to help understand how to provide quality services to meet the needs of families like yours.

The data is being collected by the home visitors and an evaluation team on behalf of the Boise State University Center for Health Policy and the Idaho Maternal, Infant, and Early Childhood Home Visiting Program. Before collecting some of the information, we must let you know how the information will be collected and used. We will be gathering information about your background and needs, experiences, and progress in the home visiting program. Some of the information will be provided directly by you and some of

it will be provided by your home visitor. The questions sometimes include difficult or upsetting topics, but by talking about these difficult issues it may also be beneficial to you and your family.

All information obtained in this program will be kept confidential according to Idaho State Code and the Department of Health and Welfare. The guidelines authorize disclosure only for a purpose which is directly related to the administration of the home visiting program or upon order of the court. You will not be personally identified in any report or other document. Rather your information will be combined with information provided by other participants and reported in group form only. The home visiting program will not share the information you provide with anyone else, unless they discover that you could be a danger to yourself or others. In these exceptional cases, the research team will have to report this information.

The information will be maintained with the Idaho Maternal, Infant, and Early Childhood Home Visiting Program. If you would like to access your information should you want to check it, please contact: [BergesOK@dhw.idaho.gov](mailto:BergesOK@dhw.idaho.gov) with an e-mail subject line of "records request." The records will be kept private unless officials from the Federal or State government may inspect the records to ensure that information is being properly protected. If you have any questions concerning your rights as a program participant, please contact the home visiting program administrator or call the Idaho Maternal, Infant, and Early Childhood Home Visiting Program at 208-334-5962. We urge you to participate in the program to help improve program quality for families like yours around Idaho. Thank you.

**Consent to Use Information:**

I have been given an explanation of the program's data collection and my questions have been answered. I understand my participation in the program is voluntary and I can refuse to participate or withdraw from the program at any time for any reason and this will not make a difference in the assistance or services I received.

---

Signature

Date

---

For Office Use Only: Participant ID: \_\_\_\_\_ Participant Date of Birth \_\_\_\_\_

## Sample

### Client Rights and Grievance Procedures

Client Name: \_\_\_\_\_

#### I understand my basic rights as a client.

#### These rights include:

As a client of [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], you have the following rights regarding the confidentiality of your personal information and communications with [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], staff and volunteers:

1. The information that you provide to [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], will be kept confidential to the greatest extent allowed by law.
2. You may choose what information you want to provide to [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)]. You will not be denied access to services if you choose to not provide certain identifying information.
3. The information that you provide to [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], including your name, address, phone number, and other personal information will not be shared with other individuals or agencies without your permission.
4. [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], staff may be required by law to report certain situations even if you don't give them permission to share or report the situations, such as suspected child abuse or neglect. Staff will inform you of any reporting requirements prior to having conversations with you and will tell you when they must make a report and what information will be shared. Even when these reports are made, [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], should not share information beyond what is required by law.
5. Some general information about the types of services provided and overall demographics (e.g., age and income ranges, average number of children, ethnicities) of people that use [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], services must be shared with the agencies that fund [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)]. However, information that specifically could identify **you** as someone who used [[Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)],] services will never be shared unless specifically authorized in writing by you.
6. After your intake with [[Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)],], you may choose to be referred to other agencies for additional help and support. Agencies we partner with include: [mental health services](#), [educational opportunities](#), [housing](#), [transportation](#), [health care](#), [substance abuse services](#).
7. You can decide how much or how little of your personal information [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)], will or will not be shared with each partner agency. You will be told, in general, what each partner's obligations are to keep your information confidential. If you choose to have [Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)] share some of your personal information with an agency we partner with, you will be told exactly *how* and *what* information will be shared. If you later decide that you don't want the information you have provided to be shared with any of [[Maternal, Infant, and Early Childhood Home Visiting Program (adapt as appropriate)],] partners, let us know and we won't share any more information with those partners.

8. Grievance Procedure: If you have any questions or concerns about this notice or your rights, or if you have a concern that your confidential information was not treated appropriately, please contact (*Organization Administration name and number of confidentiality monitor*).

I understand I have a right to contact the agencies below at any time to discuss my complaint of grievance:

Idaho Maternal, Infant, and Early Childhood Home Visiting Program

Idaho Department of Health and Welfare

[www.homevisiting.dhw.idaho.gov](http://www.homevisiting.dhw.idaho.gov)

Attn: Home Visiting Program

450 W. State Street – 4<sup>th</sup> Floor

Boise, ID 83720

Phone: 208-334-5962

Fax: 208:334-4946

I certify that I have read and understand this Client Rights/Grievance Policy.

---

Participant Signature

Date

---

Home Visitor Signature

Date

Sample

Client Consent to Release Information

Release of Information

Client Name: \_\_\_\_\_

Home Visitor: \_\_\_\_\_

I, (client's first and last name), hereby authorize (program name) to release information contained in my participant records to the individuals or organizations and only under the conditions listed below:

1. Name of person or agency making disclosure and requesting information:

\_\_\_\_\_  
\_\_\_\_\_

2. Specific type of information to be disclosed:

\_\_\_\_\_  
\_\_\_\_\_

3. The purpose or need for such disclosure:

\_\_\_\_\_  
\_\_\_\_\_

4. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. IF not previously revoked, the consent will terminate:

a. Condition: (example: End of Program Participation)

b. Date: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Visitor Signature

\_\_\_\_\_  
Date

## Sample

### Client Notice of Confidentiality

**The confidentiality of home visiting program participant records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a participant is enrolled in the program, or disclose any information identifying a participant as a home visiting program participant, unless:**

- 
1. The participant consents in writing
  2. The Disclosure is allowed by court order;
  3. The disclosure is made to medical personnel in a medical emergency or to quality personnel for research, audit, or program evaluation
- 

Violation of the Federal Law by the program is considered a crime and suspected violations may be reporting to appropriate authorities in accordance with Federal Regulations and organizational grievance policies.

Federal Law and Regulations do not protect any information about a crime committed by a participant or against any person who works for the home visiting program or about any threat to commit such a crime. Federal Laws and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local authorities.

# Appendix B - Sample Community and Family Needs Assessments

## Sample

### Community Needs Assessment

#### Community Needs Assessment Can Increase Participation in Community-Based Organizations

University of Nebraska-Lincoln Extension

#### What is a Community Needs Assessment?

The goal of a needs assessment is to identify the assets of a community and determine potential concerns that it faces. A straightforward way to estimate the needs of a community or neighborhood is to simply ask residents their opinions about the issues and problems they are dealing with.

#### Why Should You Do a Needs Assessment?

- To learn more about what your group or community needs are. A food survey can supplement your own observations and experiences. It can give you detailed information from a larger and more representative group of people.
- To get an honest and objective description of needs that people might tell you publicly.
- To anticipate and remain responsive to changing demographics, attitudes and needs.
- To become aware of possible needs you never saw as particularly important or never knew existed
- To document your needs, as is required in many applications for funding.
- To get group and community support for the actions you undertake in the near future.
- To get people actually involved in the following action will attract new members.
- To make sure any actions you eventually get involved in are in line with needs expressed by the community.

#### Why Should You Not Do a Needs Assessment?

A needs assessment is not necessary before every action, and especially:

- When there is no doubt what the most important needs in the group or community are.
- When it is urgent to act right now, without delay.
- When a recent assessment has already been done, and it is clear the needs have not changed.
- When you feel the community would see an assessment as redundant or wasteful, and it will be harmful to your cause.

#### How to Carry Out a Needs Assessment:

**There are several ways techniques for completing or supplementing a needs assessment.**

**Existing Data Approach:** Already existing statistical data is used to obtain insights about the well-being of people. This approach uses descriptive statistics, such as census data, labor surveys, bank deposit data, sales tax reports, police reports, etc.

**Community Attitude Survey Approach:** Information is gathered from a representative sample of community residents about issues affecting their well-being. Data is collected by personal interviews, telephone surveys, door-to door surveys or mail surveys.

**Key Informant Approach:** The key informant approach identifies community/ neighborhood leaders and people who are knowledgeable about the community and can accurately identify priority needs and concerns. Key informants complete a questionnaire or are personally interviewed to obtain their thoughts of community needs. The information is then analyzed and reported to the community through publications or a community meeting.

**Community Forum:** A public meeting(s) is held during which time the participants discuss what some of the needs facing the community are, what some of the priority needs are and what can be done about these priority needs. All members of the community are encouraged to attend and express their concerns and perceived needs.

**Focus Group Interview:** A group of people selected for their particular skills, experiences, views or position are asked a series of questions about a topic or issue to collect their opinions. Group interaction is used to obtain detailed information about a particular issue.

To get more information about each one of these techniques, go to the Iowa State University Extension Web site: <http://www.extension.iastate.edu/communities/tools/assess/>

**Sources:**

A Community Needs Assessment Guide, Center for Urban Research and Learning and the Department of Psychology Loyola University Chicago, 2000; Iowa State University Extension Web site: <http://www.extension.iastate.edu/communities/tools/assess/>, Community Tool Box Web site: <http://ctb.ku.edu/tools/>

***If you need more information about this resource, contact:***

Yelena Mitrofanova, Extension Educator

e-mail: [ymitrofanova2@unl.edu](mailto:ymitrofanova2@unl.edu)

University of Nebraska-Lincoln Extension in Lancaster County  
444 Cherrycreek Road, Suite A, Lincoln, NE 68528.

Phone: 402-441-7180

# Appendix C – Sample Program Advisory Committee Forms and Community Coordination

## Sample

### Agenda for Program Advisory Committee

[Letterhead]

Program Advisory Committee Meeting

[Name of Program]

[Date]

#### **Agenda**

[Time] Meeting Called to Order

Introductions

Approve Minutes

Program Updates

Old/Unfinished Business:

New Business:

Items for Next Meeting:

Next Meeting Date:





## Sample

### Memorandum of Understanding Components

*The following is an example of a generic template for Memorandums of Understanding (MOU). Please note that other sections may need to be added depending on the nature of the agreement and the parties involved. Duties and responsibilities of each party should be clearly defined.*

*Please state what is to be done or what is expected in plain, simple language. Be specific about any financial or other resource obligations of each party and include dates of when the actions are to be taken or completed. A third party with no other knowledge of the project should be able to easily read and understand the MOU.*

#### **MEMORANDUM OF UNDERSTANDING (MOU) between**

\_\_\_\_\_ [insert name of Party A] and  
\_\_\_\_\_ [insert name of Party B]. This is an agreement  
between "Party A", hereinafter called \_\_\_\_\_ and "Party B", hereinafter called  
\_\_\_\_\_.

#### **I. PURPOSE & SCOPE**

The purpose of this MOU is to clearly identify the roles and responsibilities of each party as they relate to....

In particular, this MOU is intended to:

*Examples:*

- Enhance
- Increase
- Reduce costs
- Establish

#### **II. BACKGROUND**

*Brief description of agencies involved in the MOU.*

#### **III. [PARTY A] RESPONSIBILITIES UNDER THIS MOU**

[Party A] shall undertake the following activities:

*Examples:*

- Develop
- Deliver
- Share
- Support
- Provide
- Promote
- Refer
- Review
- Comply
- Train
- Maintain records
- Sponsor
- Evaluate

**IV. [PARTY B] RESPONSIBILITIES UNDER THIS MOU**

[Party B] shall undertake the following activities:

Examples:

- Develop
- Deliver
- Share
- Support
- Provide
- Promote
- Refer
- Review
- Comply
- Train
- Maintain records
- Sponsor
- Evaluate

**V. IT IS MUTUALLY UNDERSTOOD AND AGREED BY AND BETWEEN THE PARTIES THAT:**

1. Modification
2. Termination

**VI. FUNDING**

This MOU *does (does not)* include the reimbursement of funds between the two parties.

**VII. EFFECTIVE DATE AND SIGNATURE**

This MOU shall be effective upon the signature of Parties A and B authorized officials. It shall be in force from October 1, 2\_\_\_\_ to September 30, 2\_\_\_\_. Parties A and B indicate agreement with this MOU by their signatures.

Signatures and dates

[insert name of Party A] [insert name of Party B]

\_\_\_\_\_  
Date D

## Sample

### Interagency Agreement Format

#### INTERDEPARTMENTAL AGREEMENT AMONG THE

(Identify all the Agencies Involved)

**FOR**

(Identify the Program or Initiatives)

#### **1. Purpose**

Identify the purpose of this agreement, goals and a description of the program or initiative.

#### **2. Period of Agreement**

Identify when the terms of this agreement takes effect and when it ends, including caveats such as “provided funding continues” or “based on the availability of funding”.

#### **3. Program Budget and Agreement Amounts**

Clearly delineate the amount of funding each agency will contribute, sources of funding to be provided and the fiscal year.

*Example: The following funding agencies, sources of funds and amounts will be provided for fiscal year 2006:*

☐ *Department of Education (State School Aid Act) \$ 2,000,000*

☐ *Department of Social Services (Federal TANF) \$ 4,000,000*

☐ *Children’s Trust Fund \$ 1,000,000*

#### **4. Methodology and Program Content (Statement of Work)**

Clearly identify the work to be conducted, how it is to be conducted, the agency designated as the lead responsible for administering the funds, how funding decisions will be made, when this begins, if this is a multi-year agreement, or other key pieces of information.

#### **5. Method of Payments and Financial Reports**

Clearly delineate how the money will be disbursed, financial reports required, and any other requirements the various funding agencies need for accountability. If other non- funding, but tangible supports (e.g. staffing, space, etc.) are given these should also be listed in the agreement.

#### **6. Responsibilities**

Clearly identify the roles and responsibilities of each party to this agreement. These may range from providing a specified amount of funding to day to day operations or oversight and advisory roles. However, be very specific for each partner so there will not be misunderstandings later.

#### **7. Performance/Progress Reports**

Clearly state the type of reports required, frequency of such and any other reporting requirements (e.g. written quarterly report, annual presentation to Department heads, etc.).

**8. Modifications**

Clearly state the conditions for modifications of this agreement.

*Example: Any changes, amendments or revisions to this agreement shall only be effective with the written concurrence of all parties.*

**9. Termination**

Clearly state the conditions for termination of this agreement.

*Example: This agreement shall be in full force and effective for the period specified in this agreement. Any of the parties may terminate their involvement in this agreement by giving at least a 60-day written notice. Upon the failure of any party to carry out the terms of this agreement, termination of the party's involvement in this agreement may be requested by the remaining parties by giving 30-days written notice stating the cause and the effective date.*

**10. Special Condition**

Delineate any other conditions not covered or that you wish to emphasize.

*Example: This agreement is conditionally approved subject to and contingent upon the availability of funds.*

**11. Special Certification**

The individual or officer signing this agreement certifies by his or her signature that he or she is authorized to sign this agreement on behalf of the responsible governing board, official, or agency.

**12. Signature Section**

_____	_____
Date	Department Director's Signature
_____	_____
Date	Director's Signature
_____	_____
Date	Director's Signature

**13. Copies**

Copies of this agreement with original signatures will be provided to each party of the agreement.

**Sample**  
**Letter of Support**

*Agency Letterhead*

*Date:*

*Name*

*Agency*

*Address*

*City, State Zip code*

**Dear Mr./Ms. Name:**

As *(Agency name; representative)* I welcome the opportunity to provide this letter of support for *(program name)*'s implementation of the *(identify model: Parents as Teachers, Nurse-Family Partnership, Early Head Start)* through the Idaho Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. The goals of Idaho's MIEHCV programs are to ensure the health, safety and well-being of the state's mothers, children and families. Collaboration with programs such as the MIECHV and *(program name)* help support the state's work in fulfilling this goal in *(identify community served)*.

*(Agency)* is committed to partnering and promoting collaboration with the *(program name)* to support MIECHV activities and promote collaboration within the Division of Public Health. *(Include statement(s) how your agency may be able to support MIECHV activities in the community)*. This ongoing communication and collaboration will be critical for successful outcomes for children and families of Idaho.

Sincerely,

## Appendix D – Sample Participant Correspondence

### Sample

#### Family Correspondence – Contact Letter

##### ORGANIZATION LETTER HEAD

NAME  
ADDRESS

Date: \_\_\_\_\_

Client's Name \_\_\_\_\_  
Address \_\_\_\_\_

Dear

Our program has tried several times to reach you without success. Perhaps there was a misunderstanding about the dates and times we were to meet. We would love to hear from you and tell you more about what our home visiting program can offer you.

Many of the families in our program like to meet with their home visitor and discuss the many changes their children are experiencing. Home visitors help you enjoy your children by providing interesting activities to help them learn and grow in a healthy way. Babies do not come with directions. Sometimes being a parent is exhausting and frustrating. It helps to talk to someone and share concerns and ideas. Home visitors are special friends to families.

If you would still like to take advantage of our home visitation service we would like to meet with you. Please call me to make an appointment at your convenience.

Sincerely,

Home Visitor

Sample

Family Correspondence – Discharge Letter

ORGANIZATION LETTER HEAD

NAME  
ADDRESS

Date

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dear

I have been trying to contact you by phone and/or leaving messages at your home, but have not heard from you. Our policy is that after attempting to contact a family for \_\_\_\_\_ without response from a parent, we discharge them from our program. Unless I hear from you in \_\_\_\_\_, I will assume that you are not interested in participating in the program and close your record.

You may reopen your record and/or receive information you may need regarding your child or family's health care by calling us at \_\_\_\_\_.

Sincerely,

Home Visitor

**Sample**

**Family Correspondence – Closure Letter**

ORGANIZATION LETTER HEAD

NAME  
ADDRESS

Date:

Parent's Name \_\_\_\_\_  
Address \_\_\_\_\_

Dear

You have been part of our program from \_\_\_\_\_ to \_\_\_\_\_. You have now completed your home visiting plan/requested closure to the program. Enclosed is a Parent Satisfaction Survey and self-addressed envelope. Please take the time to fill it out and mail it back to our office. Your answers will help us to know how to best serve the families that we visit.

Thank you for letting us get to know your family.

Sincerely,

Home Visitor

**Sample**

## Parent Satisfaction Survey

Home visitor name \_\_\_\_\_

1. Please mark (x) the following styles of your home visitor.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Supportive    | <input type="checkbox"/> Calm           | <input type="checkbox"/> Too business like                     |
| <input type="checkbox"/> Critical      | <input type="checkbox"/> Unavailable    | <input type="checkbox"/> Encourages me to do things for myself |
| <input type="checkbox"/> Truthful      | <input type="checkbox"/> Helpful        | <input type="checkbox"/> Available                             |
| <input type="checkbox"/> Warm          | <input type="checkbox"/> Organized      | <input type="checkbox"/> Trustworthy                           |
| <input type="checkbox"/> Understanding | <input type="checkbox"/> Not organized  | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Phony         | <input type="checkbox"/> Not on time    | _____  |
| <input type="checkbox"/> Rude          | <input type="checkbox"/> On time        |  |
| <input type="checkbox"/> Informed      | <input type="checkbox"/> Smothering     |  |
| <input type="checkbox"/> Rigid         | <input type="checkbox"/> Doesn't listen |  |

	Outstanding	Good	Needs Improvement
<b>How would you rate:</b>			
Satisfaction with Home Visitor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of information presented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Usefulness of referrals made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Convenience of visits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respect and consideration shown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Please rate the following:</b>			
	Yes	No	Somewhat
Have the services you received helped you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was your home visitor easy to talk to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did your home visitor spend enough time with you? Each visit was how long? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Would you recommend this service to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Which areas of your life have improved since beginning the program? (Please check those areas that apply to you).

- \_\_\_ More support
- \_\_\_ My ability to solve problems
- \_\_\_ My ability to cope with problems and stress (worry less)
- \_\_\_ More friends
- \_\_\_ My relationship with my boyfriend/husband/girlfriends/family members
- \_\_\_ Taking care of my children
- \_\_\_ My living situation
- \_\_\_ My ability to control my temper
- \_\_\_ My knowledge about the warning signs of potential child abuse/neglect  
(i.e. anger, depression, low self-esteem)
- \_\_\_ My patience with my child's negative behavior
- \_\_\_ My understanding of child development and parenting
- \_\_\_ The health care of my child(ren)
- \_\_\_ Other improvements \_\_\_\_\_

3. Please add suggestions regarding the program or your home visitor

---

---

Date: \_\_\_\_\_

**PLEASE MAIL THIS SURVEY IN THE STAMPED ENVELOPE PROVIDED  
YOU DO NOT NEED TO SIGN YOUR NAME**

*SURVEY CAN ALSO BE COMPLETED VIA PHONE WITH A HOME VISITING SUPERVISOR OR  
PROGRAM DIRECTOR*

## APPENDIX E – Benchmarks Constructs Guide

### Benchmarks Constructs

Local Implementing agencies (Contractors) will be required to collect information for the 32 federally mandated constructs listed below. The data for the remaining three constructs (suspected, substantiated, and first time victims of maltreatment for children in participating in the program) will be made available by the Idaho Department of Health and Welfare Child Welfare Program as a part of a data sharing agreement between the Maternal, Infant, and Early Childhood Home Visiting Program and the Child Welfare Program. Implementing agencies (Contractors) will be responsible for maintaining electronic case files for each individual client within the NFP and Idaho MIECHV ETO systems.

The 35 benchmarks constructs are grouped into six general benchmark areas:

- i) Maternal and Newborn Health,
- ii) Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits,
- iii) Improvements in School Readiness and Achievement,
- iv) Domestic Violence,
- v) Family Economic Self-Sufficiency, and
- vi) Coordination and Referrals for Other Community Resources and Supports.

Each of the 35 constructs is labeled as either a *process/performance indicator* or an *outcome indicator* depending on whether it is intended to assess program participants' progress (outcome indicator) or program performance (process/performance indicator). A good example of a process/performance indicator would be "percentage of caregivers who received any education on optimal birth spacing within six months of program participation" (Construct 1.4: Inter-birth Intervals). A good example of an outcome indicator would be tracking the "dollar value of client's income and benefits from intake to 12 months of program participation" (Construct 5.1: Household Income and Benefits). **Process or Performance Indicators:** Process indicator measure ways in which program services are provide and the efficiency of the provision of these services. **Outcome Indicators:** Outcome indicators measure the broader results achieve through the provision of the services and can exist at the individual, program, or population level. Outcome indicators provide information about the results achieved by the intervention.

*Note:* Within the benchmarks plan, the term case file and case file review denotes data which will be extracted from the data system from individual clients (case) electronic files into report forms. Case files are considered the electronic information maintained for individual clients within the NFP and Idaho MIECHV ETO systems, which includes NFP NHV data forms, demographic data, and other client information. For the benchmarks plan, case file review will be completed by the State MIECHV Program staff at the Idaho Department of Health and Welfare or State MIECHV Program contracted evaluation staff at Boise State University from aggregated data extracted from the NFP and Idaho MIECHV ETO systems. In the context of performance monitoring, case file review generally means review and

analysis of the entire caseload or individual client files by supervisors and home visitors to assess client progress and program performance.

*Note:* In addition to collecting data to meet the MIECHV requirements, programs will be required to complete the *Protective Factors Survey (PFS)* with each program participant at intake and every year of program participation thereafter. Also, in addition to the information that programs will be required to collect to meet the requirements of the federal government and Idaho MIECHV program, individual programs may have other model- or organizationally-required assessment forms that they will continue to use.

A complete list of data collection forms and assessment instruments is available elsewhere in this document. Some of the assessment tools are proprietary and will be made available to the programs in the near future by IDHW. The following assessment tools, however, are available in the public domain at no cost and can be shared with the programs at this time:

- Edinburgh Postnatal Depression Scale (EPDS) – Construct 1.5: Post-partum Depression (PPD) Screening
- Everyday Stressors Index (ESI) – Construct 3.4: Parental Stress or Parental Emotional Well-being
- Relationship Assessment Tool (RAT) – Construct 4.1: Domestic Violence Screening
- Protective Factors Survey (PFS) – supplemental assessment instrument to be completed with program participants at intake and annually thereafter

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.1: Prenatal Care (Process/Performance Indicator)

<b>Background and Purpose:</b> Prenatal care is vital in keeping the expecting mother and baby healthy. Mothers who do not get prenatal care are three times more likely to have a low birth weight baby.	
<b>Process:</b> Home visitors will document whether or not they have discussed an optimal prenatal care visits schedule with pregnant women enrolled in the program <i>within the first four weeks of enrollment</i> .	
<b>Target Population:</b>	Women enrolled in the program prenatally
<b>What:</b>	Did the participant ( <i>pregnant woman</i> ) receive information on the recommended schedule of <i>prenatal care visits</i> *?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within four weeks of program enrollment</li> </ul>
<b>How:</b>	<p>The home visitor discusses with the participant during the home visit and documents this interchange on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Maternal Health Assessment: Pregnancy—Intake (Form 12.0)</li> <li>b. EHS: ETO Form: Maternal Health Form and Home Visiting Encounter</li> <li>c. PAT: ETO Form: Maternal Health Form and Home Visiting Encounter</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Notes:</b>	<p>* Recommended Schedule of Prenatal Care Visits:</p> <ul style="list-style-type: none"> <li>• Every 4 weeks for the first 28 weeks</li> <li>• Every 2-3 weeks between 28 and 36 weeks</li> <li>• Weekly until birth</li> </ul>

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.2: Preconception Care (Outcome Indicator)

<p><b>Background and Purpose:</b> Preconception care is care provided to a woman before pregnancy to provide health promotion, screening, and interventions to manage conditions and behaviors that could be a risk to a mother or baby during pregnancy. Every woman capable of becoming pregnant is a candidate for preconception care, regardless of whether she is planning to conceive.</p>	
<p><b>Process:</b> Home visitors will ask non-pregnant women of childbearing age enrolled in the program how often they are taking a multiple vitamin and document responses on the ETO Maternal Health Form.</p>	
<b>Target Population:</b>	Non-pregnant women of childbearing age (15-45 years)
<b>What:</b>	Is the participant ( <i>non-pregnant woman of childbearing age</i> ) currently taking a multiple vitamin?
<b>When:</b>	<p>For women who are <i>not</i> pregnant and their oldest child is <i>six or more months old</i> when they enroll in the program:</p> <ul style="list-style-type: none"> <li>• At intake</li> <li>• 6 months later</li> </ul> <p>For women who are <i>pregnant</i> when they enroll in the program or their oldest child is <i>less than six months</i> old at enrollment:</p> <ul style="list-style-type: none"> <li>• At 6 months post-delivery</li> <li>• At 12 months post-delivery</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Maternal Health Assessment (Form 12.0)</li> <li>b. EHS: ETO Form: Maternal Health Form</li> <li>c. PAT: ETO Form: Maternal Health Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Questions:</b>	<p>1. Are you currently taking a multiple vitamin? If no, Score=0*</p> <p>If yes, then ask:</p> <p>2. How many times a week are you taking a multiple vitamin (a pill that contains many different vitamins and minerals)?</p> <ol style="list-style-type: none"> <li>a) 1 to 3 times a week (Score = 1)</li> <li>b) 4 to 6 times a week (Score = 2)</li> <li>c) Every day of the week (Score = 3)</li> </ol> <p>* Responses will be auto-scored upon entry into the ETO Form</p>

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.3: Parental Use of Tobacco (Process/Performance Indicator)

<b>Background and Purpose:</b> Parents who smoke expose their children to numerous diseases and dangers. According to the CDC, negative health effects may include increased incidence of obesity, asthma, cancers, bronchitis, pneumonia, and ear infections. Mothers who smoke are more likely to deliver low birth weight babies. Children who grow up with smoking parents are also more likely to start smoking than other children.	
<b>Process:</b> Home visitors will document whether or not they have discussed the risks associated with smoking with women who screened positive for smoking and document responses on the ETO Maternal Health Form.	
<b>Target Population:</b>	Women enrolled in the program who screened positive for smoking at intake as documented on the Maternal Health Form
<b>What:</b>	Did the participant ( <i>any woman who screened positive for smoking at intake</i> ) receive education on risks associated with smoking within 6 months of program participation?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul>
<b>How:</b>	<p>The home visitor discusses with the participant during the home visit and documents their interchange on the following forms</p> <ol style="list-style-type: none"> <li>a. NFP: Home Visitor Encounter Form (Form 9.0)</li> <li>b. EHS: ETO Form: Home Visit Encounter Form</li> <li>c. PAT: ETO Form: Home Visit Encounter Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.4: Inter-Birth Intervals (Process/Performance Indicator)

<b>Background and Purpose:</b> According to the CDC, women with short inter-birth intervals are at nutritional risk and more likely to experience adverse birth outcomes, including babies born with low birth weights, increased risk of a pre-term delivery, and neonatal death.	
<b>Process:</b> Home visitors will document whether or not they have discussed optimal birth spacing with mothers and/or fathers of a child ages birth-2 years enrolled in the program.	
<b>Target Population:</b>	Non-pregnant mothers and/or fathers (caregivers) with a target child birth-2 years of age
<b>What:</b>	Did the participant ( <i>any parent with a child birth-2 years old</i> ) receive any education on optimal birth spacing* within 6 months of program enrollment (non-pregnant) or within 45 days of delivery (pregnant at enrollment)?
<b>When:</b>	For participants who are <i>not</i> pregnant at enrollment: <ul style="list-style-type: none"> <li>• Within 6 months</li> </ul> For participants who are pregnant at enrollment: <ul style="list-style-type: none"> <li>• Within 45 of delivery</li> </ul>
<b>How:</b>	The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms: <ol style="list-style-type: none"> <li>a. NFP: Home Visit Encounter (Form 9.0)</li> <li>b. EHS: ETO Form: Home Visit Encounter Form</li> <li>c. PAT: ETO Form: Home Visit Encounter Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Note:</b>	* Optimal birth spacing: <ul style="list-style-type: none"> <li>• Two or more years between births</li> </ul>

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.5: Post-Partum Depression (PPD) Screening (Process/Performance Indicator)

<b>Background and Purpose:</b> Postpartum depression is a form of clinical depression which can affect women after childbirth. Symptoms can occur anytime in the first year postpartum and may include social withdrawal, sadness, exhaustion, and feeling inadequate in taking care of the baby.	
<b>Process:</b> The home visitors will document whether or not they have completed a PPD screen with mothers enrolled in the program within 45 days of delivery and six months post-delivery.	
<b>Target Population:</b>	Mothers who enrolled in the program within 45 days of delivery
<b>What:</b>	Was the participant ( <i>mothers enrolled in the program within 45 days of delivery</i> ) screened for PPD*?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 45 days of delivery</li> <li>• 6 months post-delivery</li> </ul>
<b>How:</b>	<p>The participant completes the Edinburgh Postnatal Depression Scale (EPDS) screen during home visit and the home visitor documents that the screen has been completed on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Edinburgh Postnatal Depression Scale (EPDS) (Form 7.0)</li> <li>b. EHS: ETO Form EPDS</li> <li>c. PAT: ETO Form EPDS</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Screening Instrument:</b>	* Edinburgh Postnatal Depression Scale (EPDS)

**Benchmark Area 1: Maternal and Infant Health**

**Construct 1.6: Breastfeeding  
(Outcome Indicator)**

<b>Background and Purpose:</b> Breastfeeding offers many benefits to both mother and baby and is viewed as one of the most highly effective preventive measures a mother can take to protect the health of her infant. Breast milk is widely acknowledged as the most complete form of nutrition for infants, offering a range of benefits for infants' health, growth, immunity, and development.	
<b>Process:</b> The home visitors will ask all women who gave birth during program participation how long they breastfed or pumped milk to feed their new babies and document participants' responses.	
<b>Target Population:</b>	Mothers who gave birth during program participation
<b>What:</b>	How long did the participant ( <i>mother who gave birth during program participation</i> ) breastfeed or pump milk to feed her new baby?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At 6 months post-delivery</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Infant Birth (Form 10.0)</li> <li>b. EHS: ETO Form Child Health Form</li> <li>c. PAT: ETO Form Child Health Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Question:</b>	<p>How many weeks or months did you breastfeed or pump milk to feed your new baby?</p> <p>_____weeks OR _____months</p>

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.7: Well-Child Visits (Outcome Indicator)

<p><b>Background and Purpose:</b> Well-child visits are childhood exams with a health care provider who checks the infant or young child's growth and development to detect problems and assess development throughout childhood. These exams are key times for communication when parents receive information about normal development, nutrition, sleep, safety, and other important topics.</p>	
<p><b>Process:</b> Home visitors will ask all mothers/caregivers of target children between 6 and 12 months of age enrolled in the program how many recommended well-child visits the target child accessed at 6 months of age and document participants' responses.</p>	
<b>Target Population:</b>	Target children between 6 and 12 months of age (Parents/Caretakers reporting)
<b>What:</b>	How many recommended well-child visits did the participant ( <i>target child between 6 and 12 months of age</i> ) access at 6 months of age?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At 6-12 months of target child's age</li> </ul>
<b>How:</b>	<p>The home visitor asks question to the participant during the home visit and documents the answers on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Infant Health Care (Form 11.0)</li> <li>b. EHS: ETO Form Child Health Form</li> <li>c. PAT: ETO Form Child Health Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Question:</b>	<p>Did you take your child to his/her ___ well-child visit:</p> <ol style="list-style-type: none"> <li>a) 1<sup>st</sup> week</li> <li>b) 1 month</li> <li>c) 2 months</li> <li>d) 4 months</li> </ol>

## Benchmark Area 1: Maternal and Infant Health

### Construct 1.8: Child Insurance Status (Outcome Indicator)

<b>Background and Purpose:</b> The health of the mother – before, during, and after pregnancy – has a direct impact on the health of the child. Both maternal and child health is impacted by their access to health care and preventive services.	
<b>Process:</b> Home visitors will ask the caregivers of target children enrolled in the program what type of health insurance the target child has and document responses.	
<b>Target Population:</b>	All target children enrolled in the program, as reported by caregivers
<b>What:</b>	Does the target child enrolled in the program have credible health insurance*? If so, what type of health insurance does he or she have?
<b>When:</b>	If enrolled post-delivery: <ul style="list-style-type: none"> <li>• At 6 months of program participation</li> </ul> If enrolled prenatally: <ul style="list-style-type: none"> <li>• At 6 months of age</li> </ul>
<b>How:</b>	The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms: <ol style="list-style-type: none"> <li>a. NFP: Use of Government &amp; Community Services (Form 17.0)</li> <li>b. EHS: Child Insurance: ETO Child Health Form</li> <li>c. PAT: Child Insurance: ETO Child Health Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Questions:</b>	<ol style="list-style-type: none"> <li>1. Does your child have health insurance? Yes___ No___</li> </ol> <p>If the answer is yes, then ask:</p> <ol style="list-style-type: none"> <li>2. What type of health insurance does your child have? <ol style="list-style-type: none"> <li>a) Medicaid</li> <li>b) SCHIP or CHIP</li> <li>c) Private Insurance _____</li> </ol> </li> </ol> <p>If no, home visitor explores why and makes appropriate referrals.</p>
<b>Notes:</b>	* Idaho definition of credible health insurance: Coverage that provides benefits for inpatient and outpatient hospital services and physician’s medical and surgical services. Credible coverage excludes liability, limited scope dental, vision, specific disease or other supplemental-type benefits, IDAPA 16.03.01

**Benchmark Area 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department (ED) Visits**

**Construct 2.1: Child Visits to ED all Causes  
(Outcome Indicator)**

<b>Background and Purpose:</b> Frequent Emergency Department (ED) use is associated with poverty, poor mental health, and poor physical health. Studies indicate that low-income persons without a primary care physician are more likely to utilize the emergency department for non-emergent care. Female patients, those without a regular physician, without a regular source of care, and those not referred to the ED by a physician also showed more inappropriate ED use. Difficulties in accessing primary health care (difficulties in setting appointments, longer waiting periods, and short business hours at the primary health care service) were also associated with inappropriate ED use (National Institute of Health, 2009).	
<b>Process:</b> Home visitors will ask caregivers of target children at intake and every six months of age interval how many times their child visited the Emergency Department (ED) for any cause in the past 6 months and document responses.	
<b>Target Population:</b>	Target children enrolled in the program
<b>What:</b>	How many times did the participant ( <i>target child 12 months of age</i> ) visit the ED in the past 12 months?*
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• Every six months of program participation thereafter</li> </ul>
<b>How:</b>	The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms: <ul style="list-style-type: none"> <li>a. NFP: Infant Health Care (Form 11.0)</li> <li>b. EHS: ETO Child Health Form</li> <li>c. PAT: ETO Child Health Form</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Question:</b>	How many times did your child visit the ED in the past 6 months?
<b>Note:</b>	* The aggregate from the two forms collected at 6 and 12 months will be used for benchmark reporting.

**Benchmark Area 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department (ED) Visits**

**Construct 2.2: Maternal Visits to ED all Causes  
(Outcome Indicator)**

<b>Background and Purpose:</b> Frequent Emergency Department (ED) use is associated with poverty, poor mental health, and poor physical health. Studies indicate that low-income persons without a primary care physician are more likely to utilize the emergency department for non-emergent care. Female patients, those without a regular physician, without a regular source of care, and those not referred to the ED by a physician also showed more inappropriate ED use. Difficulties in accessing primary health care (difficulties in setting appointments, longer waiting periods, and short business hours at the primary health care service) were also associated with inappropriate ED use (National Institute of Health, 2009).	
<b>Process:</b> The home visitors will ask all expectant mothers and mothers enrolled in the program how many times they visited the Emergency Department (ED) for any cause in the past six months and document responses. This question will be asked at intake and every six months of program participation.	
<b>Target Population:</b>	All expectant mothers and mothers enrolled in the program
<b>What:</b>	How many times did the participant ( <i>expectant mother or mother</i> ) visit the ED in the past 6 months?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• Every six months of program participation thereafter</li> </ul>
<b>How:</b>	The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms: <ul style="list-style-type: none"> <li>a. NFP: Demographic Update (Form 5.0)</li> <li>b. EHS: ETO Maternal Health Form</li> <li>c. PAT: ETO Maternal Health Form</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Question:</b>	How many times did you visit the ED for your own care in the past 6 months?

**Benchmark Area 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department (ED) Visits**

**Construct 2.3: Injury Prevention Education  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> Education about injury prevention aims to improve children’s health by preventing <a href="#">injuries</a> and improving <a href="#">quality of life</a> .	
<b>Process:</b> The home visitors will document whether or not they have had any injury prevention- related discussions appropriate to the age of the target child with caregivers of children enrolled in the program within five months of program participation.	
<b>Target Population:</b>	All caregivers of target children enrolled in the program
<b>What:</b>	Did the participant ( <i>caregiver of a target child enrolled in the program</i> ) receive any education related to injury prevention appropriate to the age of the target child?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 5 months of program participation</li> </ul>
<b>How:</b>	The home visitor discusses with the participant during the home visit and documents their interchange on the following forms: <ul style="list-style-type: none"> <li>a. NFP: Home Visit Encounter (Form 9.0)</li> <li>b. EHS: ETO Home Visit Encounter Form</li> <li>c. PAT: ETO Home Visit Encounter Form</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Note:</b>	* Injury prevention is defined as education on any of the following topics during the appropriate timelines: <ul style="list-style-type: none"> <li>a. Safe Sleep (birth-1 yr)</li> <li>b. Injury Prevention (birth-5 yrs)</li> <li>c. Poison Prevention (birth-5 yrs)</li> <li>d. Fire Safety (birth-5 yrs)</li> <li>e. Car Seat Safety (birth-5 yrs)</li> <li>f. Home Safety (birth-5 yrs), OR</li> <li>g. Shaken Baby Syndrome (birth-1 yr)</li> </ul>

**Benchmark Area 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department (ED) Visits**

**Construct 2.4: Child Injuries Requiring Medical Treatment  
(Outcome Indicator)**

<b>Background and Purpose:</b> Preventable childhood injuries are a major cause of death and disability to young children. Increasing supervision and taking simple safety precautions can greatly decrease the likelihood of childhood injuries.	
<b>Process:</b> Home visitors will ask caregivers of target children at intake or at birth and every six months of age interval how many times their child required medical treatment (i.e., ambulatory care, ED, or hospitalization) due to injury in the past 6 months and document responses.	
<b>Target Population:</b>	All target children enrolled in the program
<b>What:</b>	How many times did the participant ( <i>any target child enrolled in the program</i> ) require medical treatment due to injury in the past 12 months*?
<b>When:</b>	<p>If target child enrolled prenatally:</p> <ul style="list-style-type: none"> <li>• At birth</li> <li>• Every six months of program participation thereafter</li> </ul> <p>If target child enrolled post-delivery:</p> <ul style="list-style-type: none"> <li>• At intake</li> <li>• Every six months of program participation thereafter</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms:</p> <ul style="list-style-type: none"> <li>a. NFP: Infant Health Care (Form 11.0)</li> <li>b. EHS: ETO Child Health Form</li> <li>c. PAT: ETO Child Health Form</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Question:</b>	How many times did your child require medical treatment due to injury in the past 6 months?
<b>Note:</b>	* Aggregate from the two forms collected at 6 and 12 months will be used for benchmark reporting.

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.1: Parent Support for Children’s Learning and Development (Outcome Indicator)

<p><b>Background and Purpose:</b> Parents play a significant role in their children’s development. Research has shown that children’s success later in life is linked with how parents interact with their children. Safe and nurturing relationships are critical for children’s secure attachment and development.</p>	
<p><b>Process:</b> Home visitors will observe interaction between parents/caregivers and target children enrolled in the program using the HOME* (“Learning Materials” and “Involvement” subscales).</p>	
<p><b>Target Population:</b></p>	<p>All parents/caregivers enrolled in the program who were observed using the HOME at 6 months and 18 months of target child’s age (or at intake and 12 months later if target child is older than 6 months at enrollment)</p>
<p><b>What:</b></p>	<p>How the participant (<i>parent/caregiver of a target child six months of age or older</i>) scores on the HOME (“Learning Materials” and “Involvement” subscales) at 6 months and 18 months of target child’s age (or at intake and 12 months later if target child is older than 6 months at enrollment).</p>
<p><b>When:</b></p>	<p>If the participant is enrolling prenatally or target child is six months old or younger at enrollment:</p> <ul style="list-style-type: none"> <li>• At 6 months of target child’s age</li> <li>• At 18 months of target child’s age</li> </ul> <p>If the target child is older than 6 months at enrollment:</p> <ul style="list-style-type: none"> <li>• At intake (using the appropriate screen for the target child’s age at enrollment)</li> <li>• At 12 months of program participation</li> </ul>
<p><b>How:</b></p>	<p>The home visitor observes interaction between parents/caregivers and target children during home visit and documents the scores on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: HOME Inventory Form</li> <li>b. EHS: HOME Inventory Form</li> <li>c. PAT: HOME Inventory Form</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Observational Tool:</b></p>	<p>* HOME – Home Observation Measurement of the Environment; Infant/Toddler (IT)(birth to three) or Early Childhood (EC)(three to six)</p>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.2: Parental Knowledge of Child Development (Process/Performance Indicator)

<b>Background and Purpose:</b> When parents understand their child’s development they can create reasonable expectations for behavior and begin to identify which behaviors are typical and where they need to provide guidance and access early intervention services.	
<b>Process:</b> Home visitors will document whether or not they have discussed or reviewed the results of a completed age-appropriate ASQ screen with the parents/caregivers of target children enrolled in the program within 12 months of program participation.	
<b>Target Population:</b>	Parents/Caregivers enrolled in the program
<b>What:</b>	Did the participant ( <i>parent/caregiver of a target child</i> ) receive information on the target child’s development*?
<b>When:</b>	Within 12 months of program enrollment
<b>How:</b>	The home visitor talks to the participant during the home visit and documents this interchange on the following forms:  a. NFP: Home Visit Encounter (Form 9.0) b. EHS: ETO Home Visit Encounter Form c. PAT: ETO Home Visit Encounter Form
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Notes:</b>	* The home visitor will review the results of a completed age-appropriate ASQ screen with the parent/caregiver within 12 months program participation.  <i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.3: Parental Behavior and Parent-Child Relationship (Outcome Indicator)

<b>Background and Purpose:</b> Parental behavior during a child’s early years impacts the child’s development of social and cognitive abilities. Positive parent-child relationships foster healthy child development.	
<b>Process:</b> Home visitors will observe interaction between parents/caregivers and target children enrolled in the program using the HOME* (“Responsivity” and “Acceptance” subscales).	
<b>Target Population:</b>	All parents/caregivers enrolled in the program who were observed using the HOME at 6 months and 18 months of target child’s age (or at intake and 12 months later if target child is older than 6 months at enrollment)
<b>What:</b>	How did the ( <i>parent/caregiver of a target child six months of age or older</i> ) score on the HOME (“Responsivity” and “Acceptance” subscales) at 6 months and 18 months of target child’s age (or at intake and 12 months later if target child is older than 6 months at enrollment)?
<b>When:</b>	<p>If the participant is enrolling prenatally or target child is six months old or younger at enrollment:</p> <ul style="list-style-type: none"> <li>• At 6 months of target child’s age</li> <li>• At 18 months of target child’s age</li> </ul> <p>If the target child is older than 6 months at enrollment:</p> <ul style="list-style-type: none"> <li>• At intake (using the appropriate screen for the target child’s age at enrollment)</li> <li>• At 12 months of program participation</li> </ul>
<b>How:</b>	<p>The home visitor observes interaction between parents/caregivers and target children during home visit and documents the scores on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Home Inventory Form</li> <li>b. EHS: Home Inventory Form</li> <li>c. PAT: Home Inventory Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.
<b>Observational Tool:</b>	* HOME – Home Observation Measurement of the Environment; Infant/Toddler (IT)(birth to three) or Early Childhood (EC)(three to six)

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.4: Parental Stress or Parental Emotional Well-Being (Outcome Indicator)

<b>Background and Purpose:</b> Parental stress has many implications for the physical and emotional growth trajectory for young children. Chronic stress can negatively affect how a parent responds to their child and their reciprocal interaction.	
<b>Process:</b> Home visitors will administer the Everyday Stressors Index (ESI)* to the participants (parents/caregivers) enrolled in the program.	
<b>Target Population:</b>	All parents/caregivers enrolled in the program
<b>What:</b>	How did the participant ( <i>parent/caregiver</i> ) score on the ESI?
<b>When:</b>	<p>If the participant is enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• At one month post-delivery</li> <li>• 12 months later</li> <li>• Every 12 months thereafter</li> </ul> <p>If enrollment is postpartum:</p> <ul style="list-style-type: none"> <li>• At intake</li> <li>• 12 months later</li> <li>• Every 12 months thereafter</li> </ul>
<b>How:</b>	<p>The home visitor administers the ESI during home visit and documents the scores on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Everyday Stressors Index</li> <li>b. EHS: Everyday Stressors Index</li> <li>c. PAT: Everyday Stressors Index</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.
<b>Note:</b>	* Everyday Stressors Index (ESI) is a home visitor-administered instrument. It is publically available and simple to administer and score. No special training is required to administer or score this tool.

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.5: Child Communication, Language, and Emergent Literacy (Process/Performance Indicator)

<p><b>Background and Purpose:</b> Communication is critical to a child's development. Communication begins at birth with sounds and facial expressions and develops into verbal communication as a toddler. Parents play an important role in helping children learn to communicate and eventually, to read and write.</p>	
<p><b>Process:</b> Home visitors will document whether or not they have completed at least one ASQ-3 screen* with the families of target children participating in the program using the target child's age-appropriate "Communication" subscale.</p>	
<p><b>Target Population:</b></p>	<p>Target children enrolled in the program</p>
<p><b>What:</b></p>	<p>Did the home visitor complete at least one ASQ-3 screen using the "Communication" subscale within 6 months of enrollment or 6 months after target child's birth?</p>
<p><b>When:</b></p>	<p>If enrolling postpartum:</p> <ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul> <p>If enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• Within 6 months of target child's birth</li> </ul> <p><i>As best practice, home visitors should begin completing the ASQ screens with the participant as early as 4 or 6 months age and every six months. When a child is scoring below cut-off, more frequent screens may be appropriate.</i></p>
<p><b>How:</b></p>	<p>The home visitor completes the ASQ-3 screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>b. EHS: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>c. PAT: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Screening Instrument:</b></p>	<p>* Ages and Stages Questionnaire—3<sup>rd</sup> Edition</p> <p><i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i></p>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.6: Child Cognitive Skills (Process/Performance Indicator)

<p><b>Background and Purpose:</b> Cognitive skills are the basic mental abilities used for thinking, problem-solving, studying, and learning. As children develop cognitively they build capacity for problem solving and retaining knowledge while learning about their environment.</p>	
<p><b>Process:</b> Home visitors will document whether or not they have completed at least one ASQ-3 screen* with the families of target children participating in the program using the target child’s age-appropriate “Problem Solving” subscale.</p>	
<p><b>Target Population:</b></p>	<p>Target children enrolled in the program</p>
<p><b>What:</b></p>	<p>Did the home visitor complete at least one ASQ-3 screen using the “Problem Solving” subscale within 6 months of enrollment or 6 months after target child’s birth?</p>
<p><b>When:</b></p>	<p>If enrolling postpartum:</p> <ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul> <p>If enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• Within 6 months of target child’s birth</li> </ul> <p><i>As best practice, home visitors should begin completing the ASQ screens with the participant as early as 4 or 6 months age and every six months. When a child is scoring below cut-off, more frequent screens may be appropriate.</i></p>
<p><b>How:</b></p>	<p>The home visitor completes the ASQ-3 screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>b. EHS: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>c. PAT: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Screening Instrument:</b></p>	<p>* Ages and Stages Questionnaire—3<sup>rd</sup> Edition</p> <p><i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i></p>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.7: Child's Positive Approach to Learning (Process/Performance Indicators)

<p><b>Background and Purpose:</b> Parents and home visitors work together to provide a positive learning environment for children in the home. Parents can encourage creativity, exploration, communication, and inquiry for children to support positive learning experiences for children.</p>	
<p><b>Process:</b> Home visitors will document completion of at least one ASQ-3 screen* with the families of target children participating in the program using the target child's age-appropriate "Personal-Social" subscale.</p>	
<p><b>Target Population:</b></p>	<p>Target children enrolled in the program</p>
<p><b>What:</b></p>	<p>Did the home visitor complete at least one ASQ-3 screen using the "Personal-Social" subscale within 6 months of enrollment or 6 months after target child's birth?</p>
<p><b>When:</b></p>	<p>If enrolling postpartum:</p> <ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul> <p>If enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• Within 6 months of target child's birth</li> </ul> <p><i>As best practice, home visitors should begin completing the ASQ screens with the participant as early as 4 or 6 months age and every six months. When a child is scoring below cut-off, more frequent screens may be appropriate.</i></p>
<p><b>How:</b></p>	<p>The home visitor completes the ASQ-3 screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>b. EHS: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>c. PAT: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Screening Instrument:</b></p>	<p>* Ages and Stages Questionnaire—3<sup>rd</sup> Edition</p> <p><i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i></p>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.8: Child Social Behavior, Emotional Regulation, and Emotional Well-Being (Process/Performance Indicator)

<p><b>Background and Purpose:</b> Social-emotional well-being is the capacity to experience, regulate, and express emotions, form close, secure relationships, explore the environment, and learn. Parents' emotional health impacts the emotional health of their children beginning at birth and throughout development.</p>	
<p><b>Process:</b> Home visitors will document completion of at least one ASQ-SE* with the families of target children participating in the program using the target child's age-appropriate screen.</p>	
<p><b>Target Population:</b></p>	<p>Target children enrolled in the program</p>
<p><b>What:</b></p>	<p>Did the home visitor complete at least one ASQ-SE screen within 6 months of enrollment or 6 months after target child's birth?</p>
<p><b>When:</b></p>	<p>If enrolling postpartum:</p> <ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul> <p>If enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• Within 6 months of target child's birth</li> </ul> <p><i>As best practice, home visitors should begin completing the ASQ screens with the participant as early as 4 or 6 months age and every six months. When a child is scoring below cut-off, more frequent screens may be appropriate.</i></p>
<p><b>How:</b></p>	<p>The home visitor completes the ASQ-3 screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Ages and Stages Questionnaire—Social Emotional (ASQ-SE)</li> <li>b. EHS: Ages and Stages Questionnaire— Social Emotional (ASQ-SE)</li> <li>c. PAT: Ages and Stages Questionnaire— Social Emotional (ASQ-SE)</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Screening Instrument:</b></p>	<p>*Ages and Stages Questionnaire—Social Emotional</p> <p><i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i></p>

### Benchmark Area 3: Improvement in School Readiness and Achievement

#### Construct 3.9: Child's Physical Health and Development (Process/Performance Indicator)

<p><b>Background and Purpose:</b> The foundation for children's well-being involves their physical health. Parental knowledge of the importance of nutrition, physical activity, and healthy eating are key tools to support healthy child development.</p>	
<p><b>Process:</b> Home visitors will document completion of at least one ASQ-3* with the families of target children participating in the program using the target child's age-appropriate "Gross Motor Skills" and/or "Fine Motor Skills" subscale.</p>	
<p><b>Target Population:</b></p>	<p>Target children enrolled in the program</p>
<p><b>What:</b></p>	<p>Did the home visitor complete at least one ASQ-3 screen within 6 months of enrollment or 6 months after target child's birth?</p>
<p><b>When:</b></p>	<p>If enrolling postpartum:</p> <ul style="list-style-type: none"> <li>• Within 6 months of program participation</li> </ul> <p>If enrolling prenatally:</p> <ul style="list-style-type: none"> <li>• Within 6 months of target child's birth</li> </ul> <p><i>As best practice, home visitors should begin completing the ASQ screens with the participant as early as 4 or 6 months age and every six months. When a child is scoring below cut-off, more frequent screens may be appropriate.</i></p>
<p><b>How:</b></p>	<p>The home visitor completes the ASQ-3 screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Ages and Stages Questionnaire—3<sup>rd</sup> Edition (ASQ-3)</li> <li>b. EHS: Ages and Stages Questionnaire— 3<sup>rd</sup> Edition (ASQ-3)</li> <li>c. PAT: Ages and Stages Questionnaire— 3<sup>rd</sup> Edition (ASQ-3)</li> </ol>
<p><b>Where:</b></p>	<p>Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.</p>
<p><b>Screening Instrument:</b></p>	<p>* Ages and Stages Questionnaire—3<sup>rd</sup> Edition</p> <p><i>Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people.</i></p>

## Benchmark Area 4: Domestic Violence

### Construct 4.1: Domestic Violence Screening (Process/Performance Indicator)

<p><b>Background and Purpose:</b> Domestic violence is a pattern of abusive and threatening behaviors used by one person in a relationship, typically to control the other. Violence takes many forms and can happen all the time or once in a while. Children in homes where there is domestic violence are more likely to be abused and/or neglected. Most children in these homes know about the violence. Even when the child is not abused, awareness or witnessing these traumas can result in emotional or behavioral issues.</p>	
<p><b>Process:</b> Home visitors will document whether or not they have completed a domestic violence screen* with the families participating in the program within three months of program participation.</p>	
<b>Target Population:</b>	Target children enrolled in the program
<b>What:</b>	Did the home visitor complete a domestic violence screen with the participant ( <i>enrolled women who are participating in the program at 3 months post enrollment</i> ) within 3 months of program participation?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 3 months of program participation</li> </ul>
<b>How:</b>	<p>The home visitor completes the RA or RAT screen in partnership with the participant, discusses the screens with the participant during the home visit and documents the screen on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Relationship Assessment (RA)</li> <li>b. EHS: Relationship Assessment Tool (RAT)**</li> <li>c. PAT: Relationship Assessment Tool (RAT)</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.
<b>Screening Instrument:</b>	<p>* Domestic Violence Assessment Tools:</p> <ul style="list-style-type: none"> <li>• EHS: Relationship Assessment Tool (RAT)</li> <li>• PAT: Relationship Assessment Tool (RAT)</li> <li>• NFP: Relationship Assessment (RA)</li> </ul> <p>** Relationship Assessment Tool (RAT) is free and publicly available through <i>Futures Without Violence</i>.</p>

**Benchmark Area 4: Domestic Violence**

**Construct 4.2: Referrals Made for Families Identified with Domestic Violence  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> Those who experience domestic violence, including children, need trusted adults to turn to for help and comfort, and services that will help them to cope with their experiences.	
<b>Process:</b> The home visitors will document whether or not they have referred enrolled families identified as at-risk for domestic violence to the appropriate services within two weeks of screening.	
<b>Target Population:</b>	All families enrolled in the program who were identified as at-risk for domestic violence
<b>What:</b>	Did the home visitor refer enrolled families identified as at-risk for domestic violence to domestic violence services within two weeks of screening?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 2 weeks of positive screen for risk or experience of domestic violence</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Home Visit Encounter (Form 9.0)</li> <li>b. EHS: ETO Referral Form</li> <li>c. PAT: ETO Referral Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter referrals into the ETO system on the forms under the Referrals tab.

**Benchmark Area 4: Domestic Violence**

**Construct 4.3: Completion of Safety Plan for Families Identified with Domestic Violence  
(Process/Performance)**

<b>Background and Purpose:</b> A safety plan for domestic violence victims is a list of strategies, resources, and tips which outline strategies and outlets to help keep family members safe in the instance of future violence. This strategy can prepare victims to avoid or address future violence.	
<b>Process:</b> Home visitors will document whether or not they have completed a safety plan* with enrolled families identified as at-risk for domestic violence during home visit within one month of screening.	
<b>Target Population:</b>	All families enrolled in the program who were identified as at-risk for domestic violence
<b>What:</b>	Did the home visitor complete a safety plan with families identified as at-risk for domestic violence within one month of screening?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within one month of positive screen for domestic violence</li> </ul>
<b>How:</b>	<p>The home visitor works with the participant during the home visit to develop the safety plan utilizing the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Home Visit Encounter (Form 9.0)</li> <li>b. EHS: Futures Without Violence Safety Plan &amp; ETO Home Visit Encounter Form</li> <li>c. PAT: Futures Without Violence Safety Plan &amp; ETO Home Visit Encounter Form</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Note:</b>	<p>* Safety Plan:</p> <ul style="list-style-type: none"> <li>• EHS: Futures Without Violence Safety Plan</li> <li>• PAT: Futures Without Violence Safety Plan</li> <li>• NFP: Nurse Home Visitor Safety Plan</li> </ul>

## Benchmark Area 5: Family Economic Self-Sufficiency

### Construct 5.1: Household Income and Benefits (Outcome Indicator)

<b>Background and Purpose:</b> Household income influences access to health care, food, quality services, and often indirectly impacts child development. Children growing up in poverty have lower academic achievement and experience more illness compared to children living in more affluent homes.	
<b>Process:</b> Home visitors or intake workers will ask all primary caregivers enrolled in the program about their income and benefits at intake and 12 months later. The home visitor or intake worker will document participants' responses.	
<b>Target Population:</b>	All primary caregivers enrolled in the program
<b>What:</b>	What are the participant's ( <i>primary caregiver enrolled in the program</i> ) sources of income? How much money does the participant receive from those sources?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• At 12 months of program participation</li> <li>• Every 12 months thereafter</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the enrollment process or initial home visit and documents the responses on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</li> <li>b. EHS: ETO Form Intake and Intake Demographic Update</li> <li>c. PAT: ETO Form Intake and Intake Demographic Update</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Questions:</b>	<ol style="list-style-type: none"> <li>1. What are your sources of income, including paid work, cash assistance from family and friends, and public benefits (unemployment insurance, SSI, TANF, child support payments, etc.)?</li> <li>2. How much money do you get from _____ (insert sources of income and benefits from Q1)? _____ ( Numeric) – EHS and PAT, NFP as follows:             <ol style="list-style-type: none"> <li>a) Less than or equal to \$6,000</li> <li>b) \$6,001 - \$9,000</li> <li>c) \$9,001 - \$12,000</li> <li>d) \$12,001 - \$16,000</li> <li>e) \$16,001 - \$20,000</li> <li>f) \$20,001 - \$30,000</li> <li>g) <b>Over \$30,000</b></li> </ol> </li> </ol>

## Benchmark Area 5: Family Economic Self-Sufficiency

### Construct 5.2.1: Employment of Adults in Household (Outcome Indicator)

<b>Background and Purpose:</b> Parents' employment can have long-term implications for their children's development. Employment can be the source of financial support to family. Employment may also be the source of stress and result in less time between children and parents.	
<b>Process:</b> Home visitors or intake workers will ask all primary caregivers enrolled in the program how many hours a week they work and how many hours a week they devote to providing unpaid childcare.	
<b>Target Population:</b>	All primary caregivers enrolled in the program
<b>What:</b>	How many hours per week does the participant ( <i>primary caregiver enrolled in the program</i> ) work? How many hours per week does the participant devote to providing unpaid childcare?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• At 12 months post-enrollment</li> <li>• Every 12 months thereafter</li> </ul>
<b>How:</b>	<p>The home visitor or intake worker asks the questions to the participant during the enrollment process or initial home visit and documents the responses on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</li> <li>b. EHS: ETO Form Intake and Intake Demographic Update</li> <li>c. PAT: ETO Form Intake and Intake Demographic Update</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the completed forms into the ETO system on the forms under the Assessments tab.
<b>Questions:</b>	<ol style="list-style-type: none"> <li>1. How many hours do you work per week?             <ol style="list-style-type: none"> <li>a) 37 or more hours</li> <li>b) 20 – 36 hours</li> <li>c) 10 – 19 hours</li> <li>d) Less than 10 hours</li> <li>e) Unemployed</li> </ol> </li> <li>2. How many hours do you devote to providing unpaid childcare each week?             <ol style="list-style-type: none"> <li>a) More than 40 hours</li> <li>b) 30 – 39 hours</li> <li>c) 20 – 29 hours</li> <li>d) 10 – 19 hours</li> <li>e) Less than 10 hours</li> </ol> </li> </ol>

## Benchmark Area 5: Family Economic Self-Sufficiency

### Construct 5.2.2: Education of Adults in Household (Outcome Indicators)

<b>Background and Purpose:</b> Parental education is often considered an important predictor of children's achievement. Parental education affects parents' employment opportunities and access to available services, thus indirectly impacting children's economic, educational, and socio-emotional attainment.	
<b>Process:</b> Home visitors will ask all primary caregivers enrolled in the program whether they are currently enrolled in any school, vocational, or educational program at intake and 12 months later.	
<b>Target Population:</b>	All primary caregivers enrolled in the program
<b>What:</b>	Is the participant's ( <i>primary caregiver enrolled in the program</i> ) currently enrolled in any educational program?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• At 12 months post-enrollment</li> <li>• Every 12 months thereafter</li> <li>•</li> </ul>
<b>How:</b>	<p>The home visitor asks the questions to the participant during the home visit and documents the answers on the following forms:</p> <ol style="list-style-type: none"> <li>a. NFP: Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</li> <li>b. EHS: ETO Form Intake and Intake Demographic Update</li> <li>c. PAT: ETO Form Intake and Intake Demographic Update</li> </ol>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Questions:</b>	<ol style="list-style-type: none"> <li>1. Are you currently enrolled in any school, vocational, or educational program?             <ol style="list-style-type: none"> <li>a) Yes – Full time</li> <li>b) Yes – Part time</li> <li>c) No</li> </ol> </li> <li>2. If yes, average hours per week _____</li> </ol>

## Benchmark Area 5: Family Economic Self-Sufficiency

### 5.3: Health Insurance Status (Outcome Indicator)

<b>Background and Purpose:</b> Both maternal and child health is impacted by their access to health care and preventive services.	
<b>Process:</b> Home visitors will ask all primary caregivers enrolled in the program what type of health insurance they and their target child have at intake and 12 months of program participation.	
<b>Target Population:</b>	All primary caregivers and target children enrolled in the program
<b>What:</b>	Do the primary caregiver and the target child have credible health insurance*? If so, what type of health insurance do the primary caregiver and the target child have?
<b>When:</b>	<ul style="list-style-type: none"> <li>• At intake</li> <li>• At 12 months of program participation</li> <li>• Every 12 months thereafter</li> </ul>
<b>How:</b>	The home visitor asks the questions to the participant during the home visit and documents the responses on the following forms: <ul style="list-style-type: none"> <li>a. NFP: Demographics: Pregnancy – Intake (Form 4.0) &amp; Demographics Update (Form 5.0)</li> <li>b. EHS: ETO Form intake and intake Demographic Update</li> <li>c. PAT: ETO Form intake and intake Demographic Update</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Assessments tab.
<b>Questions Asked:</b>	<ol style="list-style-type: none"> <li>1. Do you have health insurance?</li> <li>2. Yes___ No___ If the answer is yes, then ask:</li> <li>3. What type of health insurance do you have? <ol style="list-style-type: none"> <li>a) Public Benefits (Medicaid, Medicare, VA, Military, etc.) _____</li> <li>b) Private Insurance _____</li> </ol> </li> <li>4. Does your child have health insurance?</li> <li>5. Yes___ No___ If the answer is yes, then ask:</li> <li>6. What type of health insurance does your child have? <ol style="list-style-type: none"> <li>d) Medicaid</li> <li>e) SCHIP or CHIP</li> <li>f) Private Insurance _____</li> </ol> </li> </ol>
	* Idaho's definition of credible health insurance: Coverage that provides benefits for inpatient and outpatient hospital services and physician's medical and surgical services. Credible coverage excludes liability, limited scope dental, vision, specific disease or other supplemental-type benefits, IDAPA 16.03.01

**Benchmark Area 6: Coordination and Referrals for Other Community Resources and Support**

**6.1: Number of Families Identified for Necessary Services  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> Families with many needs may often benefit from services that specifically address those issues. Without a formal referral for services, families may not be aware of or have access to resources available in the community. Identifying a family’s needs allows them to be referred to the appropriate service.	
<b>Process:</b> Home visitors will document whether or not they have screened families enrolled in the program for need of additional services* within the first six months of program participation.	
<b>Target Population:</b>	All families enrolled in the program
<b>What:</b>	Were the enrolled families screened for need of additional services within the first 6 months of program participation?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 6 months of program enrollment</li> </ul>
<b>How:</b>	<p>Family members’ need for additional support or intervention services will be recorded throughout the service delivery process from intake, regular screening, or home visit encounters. Referrals for services will be documented and tracked within ETO.</p> <ul style="list-style-type: none"> <li>a. NFP: Home Visit Encounter (Form 9.0)</li> <li>b. EHS: ETO Referral Form</li> <li>c. PAT: ETO Referral Form</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the referrals into the ETO system on the forms under the Referrals tab.
<b>Notes:</b>	<p>* Necessary services defined as any of the following services:</p> <ul style="list-style-type: none"> <li>• Health care (participants, adults or children, without a regular source of care (cannot be the ED or urgent care)</li> <li>• Substance Abuse Recovery or Treatment or Counseling (Smoking or substance use during pregnancy or self-report of substance abuse)</li> <li>• Mental Health Services (positive Post-Partum Depression screen, EPDS or ASQ-SE)</li> <li>• SNAP, Heating or Housing Assistance (Have identified needing services through interview or low scores on Concrete Supports of PFS or Everyday Stressors Index)</li> <li>• Domestic Violence Services (positive screen)</li> <li>• Developmental Services (Children identified with potential developmental delay for the following developmental services on ASQ-3 or ASQ – SE Infant Toddler Program(Part C) or Developmental Preschool (Part B)</li> </ul>

**Benchmark Area 6: Coordination and Referrals for Other Community Resources and Support**

**6.2: Number of Families Receiving Referrals to Necessary Services  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> When families indicate need for additional support or intervention services, referrals can be a way to support self-sufficiency, empowerment, and achieving optimal health.	
<b>Process:</b> Home visitors will document referrals for enrolled families identified or self-reported as needing additional services* to appropriate resources when available in the communities and documenting when not available.	
<b>Target Population:</b>	Enrolled families identified as needing additional services
<b>What:</b>	Were the enrolled families identified as needing additional services referred to appropriate services when these services were available in the community?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 12 months of program participation</li> </ul>
<b>How:</b>	<p>Family members' need for additional support or intervention services will be recorded throughout the service delivery process from intake, regular screening, or home visit encounters. Referrals for services will be documented and tracked within ETO.</p> <ul style="list-style-type: none"> <li>a. NFP: Use of Government &amp; Community Services (Form 17.0)</li> <li>b. EHS: ETO Form &amp; Referral Forms</li> <li>c. PAT: ETO Form &amp; Referral Forms</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the referrals into the ETO system on the forms under the Referrals tab.
<b>Notes:</b>	<p>* Necessary services defined as any of the following services:</p> <ul style="list-style-type: none"> <li>• Health care (participants, adults or children, without a regular source of care (cannot be the ED or urgent care)</li> <li>• Substance Abuse Recovery or Treatment or Counseling (Smoking or substance use during pregnancy or self-report of substance abuse)</li> <li>• Mental Health Services (positive Post-Partum Depression screen, EPDS or ASQ-SE)</li> <li>• SNAP, Heating or Housing Assistance (Have identified needing services through interview or low scores on Concrete Supports of PFS or Everyday Stressors Index)</li> <li>• Domestic Violence Services (positive screen)</li> <li>• Developmental Services (Children identified with potential developmental delay for the following developmental services on ASQ-3 or ASQ – SE Infant Toddler Program(Part C) or Developmental Preschool (Part B)</li> </ul>

**Benchmark Area 6: Coordination and Referrals for Other Community Resources and Support**

**6.3: Number of Memoranda of Understanding (MOUs) with Community Service Agencies  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> A Memorandum of Understanding (MOU) establishes a clear understanding of an agreement between parties to outline specific roles and responsibilities in the exchange of resource or information. MOUs may be a helpful tool when fostering collaboration between agencies and defining shared expectations. Families benefit when community service agencies are working together to address the needs of the community.	
<b>Process:</b> The contractor will document all Memoranda of Understanding (MOUs) or other formal agreements established with social services, health, or community service organizations within the service delivery area.	
<b>Target Population:</b>	Contractor Administration
<b>What:</b>	How many MOUs or other formal agreements were established with social services, health, or community service organizations within the service delivery area?
<b>When:</b>	<ul style="list-style-type: none"> <li>Throughout service delivery/program operation</li> </ul>
<b>How:</b>	The contractor documents this information in the ETO system and reports it to the State annually.
<b>Where:</b>	The contractor maintains this information in the ETO system under the Entities tab.
<b>Notes:</b>	This information may also be maintained outside of ETO in a document or spreadsheet for ready access for contractor staff.

**Benchmark Area 6: Coordination and Referrals for Other Community Resources and Support**

**6.4: Points of Contact in Agency Responsible for Connecting with Other Community-Based Organizations**  
*(Process/Performance Indicator)*

<b>Background and Purpose:</b> Building relationships between organizations enhances a program’s ability to collaborate with other community-based groups.	
<b>Process:</b> The contractor will document all unduplicated community-based organizations with which the contractor has a clear point of contact*.	
<b>Target Population:</b>	Contractor
<b>What:</b>	With how many organizations within the target community does your organization have clear points of contact regarding programmatic issues?
<b>When:</b>	<ul style="list-style-type: none"> <li>Throughout service delivery/program operation</li> </ul>
<b>How:</b>	The contractor documents this information in the ETO system and reports it to the State annually.
<b>Where:</b>	The contractor maintains this information in the ETO system under the Entities tab.
<b>Notes:</b>	<p>* Information that needs to be documented for each community-based organization with which the contractor has a clear point of contact:</p> <ul style="list-style-type: none"> <li>Organization name</li> <li>Organization address</li> <li>Contact name (this could be clinic manager, case worker, intake worker, school counselor, etc.)</li> <li>Contact phone or e-mail</li> </ul> <p>This information may also be maintained external of ETO in a document or spreadsheet for ready access for contractor staff.</p>

**Benchmark Area 6: Coordination and Referrals for Other Community Resources and Support**

**6.5: Number of Completed Referrals  
(Process/Performance Indicator)**

<b>Background and Purpose:</b> When families indicate need for additional support or intervention services, referrals can be a way to support self-sufficiency, empowerment, and achieving optimal health.	
<b>Process:</b> Home visitors will document whether or not participants have completed referrals to additional services.	
<b>Target Population:</b>	Families referred to any additional services
<b>What:</b>	Were participants ( <i>any enrolled family member who received a referral for additional services</i> ) identified as needing additional services referred to appropriate services when these services were available in the community?
<b>When:</b>	<ul style="list-style-type: none"> <li>• Within 12 months of program participation</li> <li>• Every 12 month period thereafter</li> </ul>
<b>How:</b>	<p>Family members' need for additional support or intervention services will be recorded throughout the service delivery process from intake, regular screening, or home visit encounters. Referrals for services will be documented and tracked within ETO.</p> <ul style="list-style-type: none"> <li>a. NFP: Use of Government &amp; Community Services (Form 17.0)</li> <li>b. EHS: ETO Form &amp; Referral Forms</li> <li>c. PAT: ETO Form &amp; Referral Forms</li> </ul>
<b>Where:</b>	Home visitors or data entry staff enter the forms into the ETO system on the forms under the Referrals tab.
<b>Notes:</b>	<p>* Necessary services defined as any of the following services:</p> <ul style="list-style-type: none"> <li>• Health care (participants, adults or children, without a regular source of care (cannot be the ED or urgent care)</li> <li>• Substance Abuse Recovery or Treatment or Counseling (Smoking or substance use during pregnancy or self-report of substance abuse)</li> <li>• Mental Health Services (positive Post-Partum Depression screen, EPDS or ASQ-SE)</li> <li>• SNAP, Heating or Housing Assistance (Have identified needing services through interview or low scores on Concrete Supports of PFS or Everyday Stressors Index)</li> <li>• Domestic Violence Services (positive screen)</li> <li>• Developmental Services (Children identified with potential developmental delay for the following developmental services on ASQ-3 or ASQ – SE Infant Toddler Program(Part C) or Developmental Preschool (Part B)</li> </ul>

## APPENDIX F – Training Checklist

The following set of standards may be used as a checklist for Contractors to review and assess organizational policies for training. The checklist has been adapted from the Iowa Family Support Standards. If there are areas which the organization does not currently address, the Contractor may consider requesting technical assistance from the Idaho MIECHV program.

Personnel throughout the agency are trained to fulfill their job responsibilities. New personnel are oriented within the first three months of hire to:

Training Content	Yes	No	Not Sure
<b>New personnel are oriented within the first three months of hire to:</b>			
The organization's mission, philosophy, goals, and services;	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The cultural and socioeconomic characteristics of the service population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The organization's place within its community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The organization's personnel manual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lines of accountability and authority within the organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>All personnel who have regular contact with clients receive training on legal issues, including:</b>			
Mandatory reporting and the identification of clinical indicators of suspected abuse and neglect, as applicable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reportable criminal behavior including criminal, acquaintance, and statutory rape	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duty to warn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The organization's policies and procedures on confidentiality and disclosure of service recipient information, and penalties for violation of these policies and procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The legal rights of service recipients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All personnel receive training on proper documentation techniques and the maintenance and security of case records	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Direct service personnel demonstrate competence in, or receive</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Training Content	Yes	No	Not Sure
<b>training on, as applicable:</b>			
The establishment of rapport and responsive behaviors with service recipients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The needs of individuals and families in crisis including special service needs of victims of violence, abuse, or neglect and their family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basic health and medical needs of the service population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Procedures for working with foreign language speakers and persons with communication impairments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Public assistance and government subsidies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Training for direct service personnel addresses differences within the organization's service population, including:</b>			
Interventions that address cultural and socioeconomic factors in service delivery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The role cultural identity plays in motivating human behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understanding bias or discrimination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Personnel demonstrate competence in, or receive training on, the needs of special populations* within the defined service population, including the need for normalizing experiences and social inclusion.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Direct service personnel demonstrate competence in, or receive training on, advocacy, including how to:</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access financial and other community resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identify the impact of the socioeconomic environment on the service population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empower service recipients and their families to advocate on their own behalf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*"Special populations" include, but are not limited to, those who are abused and neglected, those with a developmental disability, and those with mental health and substance use disorders.

## **APPENDIX G – Reflective Supervision Resources**

### **Best Practice Guidelines for the Reflective Supervisor/Consultant**

- Agree on a regular time and place to meet
- Arrive on time and remain open, curious and emotionally available
- Protect against interruptions, e.g. turn off phone, close door
- Set the agenda together with the supervisee(s) before you begin
- Respect each supervisee's pace/readiness to learn
- Ally with supervisee's strengths, offering reassurance and praise, as appropriate
- Observe and listen carefully
- Strengthen supervisee's observation and listening skills
- Suspend harsh or critical judgment
- Invite the sharing of details about a particular situation, infant, toddler, parent, their competencies, behaviors, interactions, strengths, concerns
- Listen for the emotional experiences that the supervisee is describing when discussing the case or response to the work, e.g. anger, impatience, sorrow, confusion, etc.
- Respond with appropriate empathy
- Invite supervisee to have and talk about feelings awakened in the presence of an infant or very young child and parent(s)
- Wonder about, name and respond to those feelings with appropriate empathy
- Encourage exploration of thoughts and feelings that the supervisee has about the work with very young children and families as well as about one's response(s) to the work, as the supervisee appears ready or able
- Encourage exploration of thoughts and feelings that the supervisee has about the experience of supervision as well as how that experience might influence his/her work with infants/toddlers and their families or his/her choices in developing relationships.
- Maintain a shared balance of attention on infant/toddler, parent/caregiver and supervisee
- Reflect on supervision/consultation session in preparation for the next meeting
- Remain available throughout the week if there is a crisis or concern that needs immediate attention

### **Best Practice Guidelines for the Reflective Supervisee/Consultee**

- Agree with the supervisor or consultant on a regular time and place to meet
- Arrive on time and remain open and emotionally available
- Come prepared to share the details of a particular situation, home visit, assessment, experience or dilemma
- Ask questions that allow you to think more deeply about your work with very young children and families and also yourself
- Be aware of the feelings that you have in response to your work and in the presence of an infant or very young child and parent(s)
- When you are able, share those feelings with your supervisor/consultant
- Explore the relationship of your feelings to the work you are doing
- Allow your supervisor/consultant to support you
- Remain curious
- Suspend critical or harsh judgment of yourself and of others
- Reflect on supervision/consultation to enhance professional practice and personal growth

**Reflective Questions and Statements:  
Gaining Perspective and Reframing Statements**  
Developed by Ann Orcutt, KCKids, Reedley, CA

1. What made you decide to. . .?
2. How did you know that. . .?
3. What is working for the family?
4. Tell me what's happening. . .
5. What other things have you tried before. . .?
6. Tell me about what works. . .
7. What does it look like when it's working?
8. How does \_\_\_\_ respond when. . .?
9. What happens when. . .?
10. What would make you feel good. . .?
11. What are some small changes you've noticed. . .?
12. What are some small changes you can make. . .?
13. How can you keep the focus on the child?
14. How did you figure that out?
15. What did the parent and child do together. . .?
16. What did you enjoy most about the visit?
17. When do the parent and child connect best?
18. Tell me something positive that the child did. How did the parent react?
19. What are the family's needs that they have identified?
20. How are things going?
21. Tell me what you enjoy about your visits.
22. Tell me what's difficult about your visit.
23. What are you thinking of doing?

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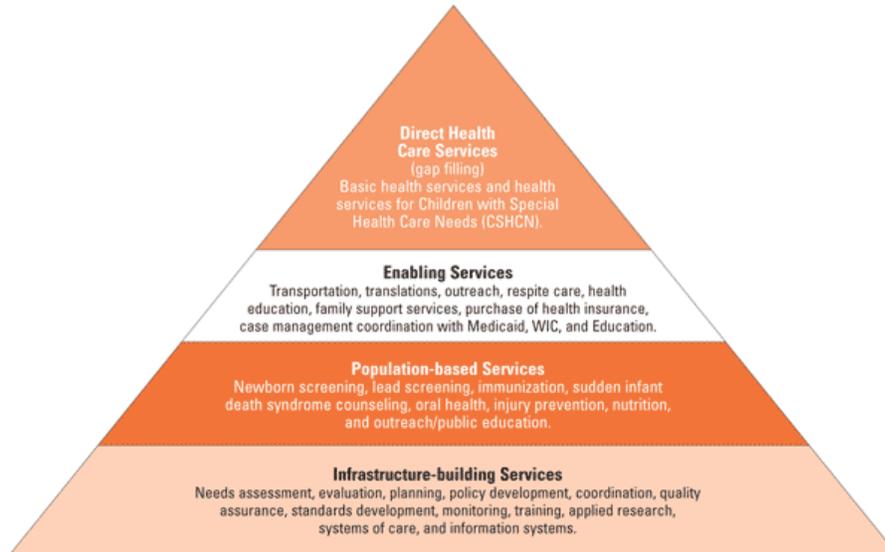
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## Appendix H – Maternal and Child Health Pyramid

The Idaho MIECHV Program will be required to report information about services provide across the Maternal and Child Health (MCH) Pyramid. Home visiting programs are largely considered enabling services, with direct service and population-based components included in a comprehensive program. Contractors should become familiar with the MCH pyramid as annual reporting will include categorization of services across the MCH pyramid by category. Contractors will estimate overall time spent providing services across each of the categories.



*JHU WCHPC February 2004*

### ***Frameworks for Describing MCH Functions***

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#### **10 Essential Public Health Services to Promote Maternal and Child Health in America**

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.
3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.
6. Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their wellbeing.
7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems.