



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

**Announcement Number: HRSA-13-215**  
**Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program**  
*Expansion Grants FY13*

**Submitted on July 1, 2013**  
**By the**  
**Idaho Department of Health and Welfare**  
**Division of Public Health**  
**Bureau of Clinical and Preventive Services**  
**Maternal and Child Health**  
**MIECHV Program**

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## Project Narrative

### *Introduction and Background*

The MIECHV program is situated within the Maternal and Child Health Program in the Bureau of Clinical and Preventive Services, Division of Public Health, Idaho Department of Health and Welfare. The Maternal and Child Health Program is one arm of the Title V Maternal and Child Health Block Grant. In addition to the MIECHV program, the Maternal and Child Health Program includes the Newborn Screening Program, and Children's Special Health Program (Children and Youth with Special Health Care Needs). The Department of Health and Welfare serves as the state agency charged with management of a multitude of public programs including: Medicaid, Early Intervention, Welfare, Behavioral Health, Child Welfare, Public Health, Temporary Assistance for Needy Families (TANF), Child Care, and the Idaho Food Stamp program. Idaho MIECHV has developed strong relationships with each of these entities.

Prior to the MIECHV program, there were 11 known programs providing home visiting services in a handful of Idaho communities. There were no state-funded or administered home visiting programs or state systems building efforts focused on high quality home visiting for young children and their families. Information gathered from national model developers indicated there were five Early Head Start Home-Based (EHS) programs and seven Parents as Teachers (PAT) programs providing services in Idaho in 2011. These home visiting programs were funded by the Office of Head Start and Parent Information Resource Center (PIRC) grants from the U.S. Department of Education, and other miscellaneous local and grant support. In 2011, PIRC grant funding was eliminated, eroding the stability of many PAT programs in Idaho. In 2012, with the addition of the MIECHV program, two existing and two new home visiting programs began delivering high quality home visiting services in Idaho communities, including the addition of a cross-state collaboration to implement Idaho first Nurse-Family Partnership (NFP) program. The MIECHV program is committed to supporting high quality home visiting in target communities and efforts to develop home visiting systems across the state.

### *Project Purpose*

The Expansion Grant will allow the MIECHV program to build onto the existing modest evidence-based home visiting (EBHV) infrastructure and capacity to serve pregnant women, infants, young children, and their families. The MIECHV program will continue to prioritize serving the legislatively designated priority populations. The MIECHV program will continue to strengthen partnerships with diverse stakeholders at the local and state level to improve understanding and visibility of high quality home visiting, consensus of the effectiveness and role of high quality visiting, and improve early childhood system's integration. Further, the MIECHV program will ensure the proposed work aligns with recommendations grounded in empirical literature and include a significant evaluation component to understand factors associated with developing the state's capacity to support and monitor the quality of home visiting programs and effective strategies for implementing and supporting home visiting programs. The MIECHV program has established six goals to achieve through the Expansion Grant. The goals, objectives, and work plan outlined in Attachment 6 for further details how the goals will be achieved within the project period.

- **Goal 1:** Conduct a two-phase workforce study to understand the home visiting workforce and develop recommendations for a coordinated training and professional development system.

- **Goal 2:** Increase implementation capacity for EBHV in target communities and integrate home visiting services into family-centered medical home and public health services.
- **Goal 3:** Include study of maternal stress and depression into existing evaluation of participant outcomes, effect modifiers, and implementation drivers.
- **Goal 4:** Partner with an organization to coordinate and provide training, technical assistance, and consultation for the local MIECHV programs.
- **Goal 5:** Continue to develop and build a cross-model data system.
- **Goal 6:** Partner with Early Childhood Comprehensive Systems work at state and local levels to integrate and advance home visiting into early childhood.

### *Landscape of Idaho*

Idaho is a large state with geographic characteristics unique to the western United States, comprised of mountain ranges, large expanses of desert, and valleys rich in agriculture. The bulk of Idaho land mass is uninhabited due to natural deterrents of desert, volcanic wastelands, and inaccessible mountainous terrain. The 2011 estimated population for Idaho was 1,584,985 and ranks 39th of the 50 United States. For population density, the state is ranked 44th with approximately 19 people per square mile. The national average population density is 87 people per square mile, a four-fold greater density than Idaho. Idaho has 44 counties and ranks 14<sup>th</sup> in the United States for total land area. More than half of Idaho's 44 counties are 'frontier' and have fewer than 15,000 residents [US Census Bureau, *State and National Quick Facts, June 2013*]. As a frontier state, Idaho is subject to challenges not found in highly populated, urban states. High mountain ranges and deserts separate the population into seven population centers. Radiating from these population centers are isolated rural and frontier communities, farms, and ranches. Much of Idaho is publicly owned which further constrains settlement and infrastructure connectivity. Access to health care and other needed services for this dispersed population is an issue of extreme importance for program implementation, evaluation, systems and infrastructure building. Serving special populations such as migrant and seasonal farm workers, children with special health care needs, pregnant women, and young children can be problematic.

Idaho's unique geography is matched by its unique demography, as the face of Idaho is rapidly changing. Between the 2000 and 2010 census, the population increased 21.1%, more than double the national average of 9.7%. Rapid demographic shifts are occurring in the ethnic and geographic composition of Idaho, both in rural and urban areas. Approximately 121,772 (7.8%) of Idaho residents are children under the age of 5. This percentage is greater than the US median of 6.5%. In 2011, an estimated 54% of young children lived in low income households (200% FPL or below). Of these, 23% were in poverty (100% FPL or below) [National Center for Children in Poverty, *Early Childhood Profiles, 2011*]. The recent economic recession significantly impacted small business in Idaho, in addition to some of the major industries including construction and logging.

Unemployment rose steadily and rapidly from 2.7% of the labor force being unemployed (seasonally adjusted) in 2007 to a high of 8.8% in 2010. In recent years, Idaho's economy has stabilized slightly and unemployed was at 6.1% in March 2013 [U.S. Bureau of Labor Statistics, *Local Area Unemployment Statistics for Idaho, June 2013*].

Local public health infrastructure is established around the population centers and arranged in seven autonomous public health districts (PHDs) across the state. Viable service provision in these disparate communities requires continuous dialogue, assessment, and outreach between local and

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 state partners. Idaho's citizenry and leadership tend to emphasize the importance of individual and local control over matters involving economy, health, education, and welfare. The conservative nature and philosophy of Idahoans manifests itself through development of local programs and services through grassroots efforts rather than a centralized approach. This philosophy is present within the political leadership, which influences allocations to programs within state government, including Idaho's health programs. The multiple and isolated population centers pose challenges for providing comprehensive, accessible home visiting services.

*History of High-Quality Home Visiting*

Idaho does not have an extensive history with high-quality home visiting programs. There are no state-funded or administered home visiting programs in Idaho and programs have historically received funding from federal, local, and private grants. In 2011, there were approximately 11 agencies implementing two home visiting models in twelve counties that served approximately 700 families.

**Table 1:** 2011 Idaho EHS Home-Based Grantees

2011 Idaho EHS Home-Based Grantees	Funded Enrollment	Service Area (County)
Western Idaho Community Action Partnership, Inc.	70	Valley, Canyon, Payette
Friends of Children and Families, Inc.	64	Ada
Lewis-Clark Early Childhood Program	30	Nez Perce
College of Southern Idaho	80	Twin Falls, Jerome
Mountain States Group	103	Kootenai, Bonner
<b>Total</b>	347	

**Table 2:** 2011 Idaho PAT Programs

2011 Idaho PAT Programs	Estimated Enrollment	Service Area (County)
Family Advocates Program	30	Ada
ICARE PAT	40	Kootenai
Project Love, Language, and Literacy	150	Madison
Help, Inc. PAT	40	Bonneville
Middleton School District	45	Canyon
Coeur d'Alene Tribal Baby Faces	50	Benewah
<b>Total</b>	355	

Since the inception of the MIECHV program in 2010, great strides have been made to build understanding of the purpose and benefit of high quality home visiting programs. MIECHV program staff have presented information about high quality home visiting to stakeholders from many disciplines at the state and local level at various meetings, trainings, and conferences. Additionally, the Early Childhood Coordinating Council (EC3), which develops and implements a statewide plan for early childhood in Idaho, has formed a "Home Visiting and Parent Education" committee to begin to shape the landscape of home visiting in Idaho.

In early 2012, the MIECHV program established contracts with five agencies to implement four EBHV programs in four counties, including a cross-state collaboration to implement NFP. The MIECHV program utilized a staged implementation and roll-out process, sensitive to organization and community readiness, to implement a high quality home visiting program with fidelity including:

1. Community Resource Survey (February 2011)

2. Community Meetings (June 2011)
3. Organizational Capacity Assessments (July 2011)
4. Request for Proposal to identify local MIECHV program sites (October 2011)
5. Contracts with Local MIECHV programs Established (February and April 2012)
6. Pre-Implementation Planning Phase for Local MIECHV programs (February - June 2012)
7. All Local MIECHV Program Contractor Orientation (April 2012)
8. Local MIECHV Program Readiness Assessments (June 2012)
9. Training, Monitoring, and Technical Assistance (March 2012 – ongoing)

As of June 2013, 103 families had received high quality home visiting services from local MIECHV implementing agencies. Each of the local MIECHV programs are contractually obligated to participate in local and state early childhood systems building efforts, including development of centralized intake where multiple home visiting programs operate in a single county. Although there are no other state administered home visiting programs or state funds allocated for EBHV, the MIECHV program is dedicated to developing high quality home visiting programs and systems to impact and improve service delivery and, in turn, improve lives of Idaho’s families with young children.

**Table 3:** 2013 Idaho’s Local MIECHV Program Enrollment (As of May 2013)

FY10 and FY11 MIECHV programs	Expected Enrollment	Actual Enrollment	Service Area (County)
ICARE PAT	40	38	Kootenai, Shoshone
Panhandle Health District NFP* (with Spokane Regional Health District)	50	36	Kootenai, Shoshone
Mountain States Group EHS	11	11	Kootenai, Shoshone
Community Council of Idaho EHS*	18	18	Twin Falls, Jerome
<b>Total</b>	119	103	

\* Indicates a program establishing a new home visiting program

In its short history, the MIECHV program has made great strides in advancing home visiting in target communities despite and unique situation as the only state administered home visiting program in Idaho. The MIECHV program has worked to increase awareness of high quality home visiting and systems building concepts. Accomplishments to date include, but are not limited to:

- Hosted community meetings to engage stakeholders and solicit feedback and input about the implementation of the MIECHV program in all four target communities.
- Conducted organizational capacity assessments with home visiting programs in target communities to assess organizational capacity to implement the MIECHV program prior to issuing a Request for Proposal to implement the MIECHV program.
- Implementation of a cross-state collaboration of NFP (NFP) in two target communities. This is the first NFP program in Idaho and the first cross-state collaboration in the nation. Spokane Regional Health District in Spokane, Washington provides supervision, mentoring, and training for a two-nurse team housed at Idaho’s Panhandle Health District.
- Established contracts with four community-based organizations to implement EHS Home-based, PAT, and NFP in target communities.
- Developed a contractor manual and hosted an orientation for all local MIECHV programs to learn about forms, reports, and expectations of the MIECHV program.

- Established a contract with the Boise State University Center for Health Policy to conduct an evaluation and cost study of the MIECHV program.
- Presented information to various audiences about high quality home visiting and published two newsletters for community partners and stakeholders to increase the awareness and understanding of the MIECHV program.
- Procured and customized a Social Solutions Efforts to Outcomes performance management data system for all local MIECHV programs to manage program data and performance.
- Initiated the creation of a Home Visiting and Parenting Education Committee through the Early Childhood Coordinating Council of Idaho (funded by the Early Childhood Comprehensive (ECCS) Systems Grant).
- Used facilitator for development of centralized intake process in two target communities.
- Built a customized report in the Efforts to Outcomes performance management data system to direct the centralized intake process in the north Idaho target community.

### *Problem, Intervention, and Benefit*

Factors including geographically-isolated communities, mindset of independence and self-determination, and lack of services have resulted in low immunization rates, lack of access to medical home, lack of regulation in child care, and no state-funded pre-kindergarten other than IDEA Part B. According to the US Department of Justice in 2008, 474 persons per 100,000 residents in Idaho are incarcerated which was 16<sup>th</sup> in the nation following Nevada and Michigan. In 2009, Idaho had the 4<sup>th</sup> highest suicide rate, 67% higher than the national average, and in the 2011 Youth Risk Behavior Survey, 15.4% of high school youth seriously considered suicide. According to the 2011/2012 National Survey of Children's Health, less than 37.1% of Idaho children in households earning less than 200% of FPL had a medical home, and 27.9% of Idaho children had experienced two or more adverse childhood experiences. In the same years, 37.4% of mothers indicated that either physical or mental or both were not good or excellent. Social and geographic isolation such as those indicators reported by Idaho's families are risk factors for poor maternal and child mental health.

By December 2013, approximately 815 young children and their families will be enrolled in the 13 home visiting programs in Idaho in approximately thirteen counties. Of the more than 118,000 young children, more than 64,000 live in families earning less than 200% of the Federal Poverty Limit. In 2013, less than 1.3% of low-income young children and their families will have access to home visiting services in Idaho. The landscape of home visiting in Idaho is very sparse. Very little is known about the home visiting workforce, quality of services, coordination with community partners, and outcomes of home visiting participants in Idaho. In recent years, there have not been systematic efforts to advance high quality home visiting in Idaho as an effective strategy to prevent child abuse and neglect, promote school readiness, maternal and child health, positive parenting, and family economic self-sufficiency.

Through the Expansion Grant, the MIECHV program intends to increase access to high quality home visiting to pregnant women, infants, young children and their families by implementing home visiting programs in seven new target communities and expanding the scale of home visiting programs to increase enrollment in four existing target communities to total 11 target communities. The 11 counties include three frontier counties (less than 15,000 residents), four rural counties (15,001 – 100,000 residents), and four urban counties (greater than 100,000 residents). Implementing

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 high quality home visiting programs in frontier, rural, and urban settings will increase access to services in hard-to-reach communities. Idaho proposes to roll-out expansion and implementation home visiting contracts with community-based organizations, including the districts (PHDs). The MIECHV program will support capacity development of home visiting programs to implement EBHV programs with fidelity to the model.

The MIECHV program intends to evaluate the community context of the home visiting programs as it relates to model fidelity, access to resources and supports, and program quality. Additionally, the MIECHV program proposes to conduct a comprehensive two-phase workforce study to better understand the home visiting workforce and inform development of professional development and training systems. This research is critical in build a baseline of information to inform home visiting systems building considering community context, professional development, and organizational capacity in Idaho. The MIECHV program recognizes the critical importance of supporting infrastructure for quality implementation of EBHV programs. The MIECHV program developed this proposal with understanding that organizations and systems are on a continuum of capacity and readiness to implement and support evidence-based interventions with fidelity in their community.

### *Programmatic Emphasis*

The MIECHV program will address several areas of emphasis outlined for the Expansion Grant.

- **Emphasis 1:** Improvements in Maternal, Child, and Family Health
  - Engaging health service providers in at-risk communities to encourage identification and referral of pregnant women, young children, and families to home visiting programs.
  - Provision of mental health services
  - Linkage of families with a medical home
- **Emphasis 2:** Effective implementation and expansion of EBHV programs or systems with fidelity to the evidence-based model selected
  - High-quality Supervision
  - Building strong local organizational and management capacity for implementation
- **Emphasis 3:** Development of a statewide or multi-state home visiting programs
  - Implementation home visiting program through a cross-state collaboration to reach frontier communities and build capacity to implement EBHV
  - Integrated home visiting data systems
  - Centralized intake systems
  - Integration of home visiting services with public health services through PHDs
- **Emphasis 4:** Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum.
  - Coordinated early childhood workforce and professional development systems that include home visitors
  - Centralized intake and referral systems to facilitate coordinated strategic planning and service delivery to improve the community environment and support positive child and family health, learning, and development outcomes.
- **Emphasis 7:** Outreach to families in rural or frontier communities

Because of Idaho's limited home visiting programs and systems, the MIECHV program is implementing innovative approaches to reach hard to reach populations and communities.

**Needs Assessment**

The MIECHV program’s Needs Assessment conducted in response to the “MIECHV Program Supplemental Information Request (SIR) #1” in September 2010 analyzed risk factors at the PHD (PHD) level as the “community” and unit of analysis. The seven PHDs are arranged around the seven population centers across the state. Additionally, the PHDs are commonly utilized for statewide public health services and activities. Much of the statewide health information including vital statistics, the Idaho Behavioral Risk Factor Surveillance System (BRFSS), and Idaho Pregnancy Risk Assessment Tracking System (PRATS) are available at the PHD level. In each of the seven PHDs, an autonomous health department provides local public health services including, but not limited to: surveillance, health inspections, health preparedness, immunizations, family planning, WIC, STD clinics, and medical home coordination. Given the initial definition of “communities” as PHDs, three “communities” were identified as at-risk. The following is a nine-step summary of the methodology used for the SIR #1 - Needs Assessment submitted in September 2010.

1. Gathered prevalence data for each of the thirteen required indicators at the county level,
2. Calculated the statewide mean and standard deviation for each indicator using the county level prevalence data (Note: statewide mean differs from statewide prevalence),
3. Compared Z-score method for each county to the statewide mean to determine number of standard deviations (SD) from statewide mean (Z-score of 1 = 1 SD greater than mean),
4. For Z-scores greater than 1, counties got “1 point” for each indicator,
5. Summed “points” to create county risk score (Note: counties could have “1 point” for each indicator” for a potential total of “13 points”),
6. Calculated the “Sum Risk Score” for each PHD by adding each county risk score,
7. Calculated a risk index while controlling for the number of counties per health district. The Risk Index (“Sum Risk Score”/ 13 \* Number counties per PHD),
8. Ranked risk index for each PHD from highest to lowest,
9. Determined three highest ranked PHD’s “at-risk communities.”

**Table 4: Community Risk Index and Risk Ranking SIR #1 – Needs Assessment**

“Communities”	PHD 2	PHD 1	PHD 5	PHD 3	PHD 4	PHD 6	PHD 7
<b>Risk Index</b>	21.5%	18.5%	18.3%	16.7%	15.4%	11.5%	10.6%
<b>Risk Ranking</b>	1	2	3	4	5	6	7

*Note: These percentages are proportions of risk and are not expected to total 100%*

The Needs Assessment identified PHDs 2, 1, and 5 as the “at-risk communities.” However given the scope, nature, and cost of the intervention, Idaho’s geography, existing home visiting infrastructure and guidance in the SIR #2 – Updated State Plan Guidance, it was necessary to narrow focus and target fewer “communities” and smaller geographic areas. After submitting SIR #1 – Needs Assessment, the MIECHV program conducted a second round of analysis to narrow the definition of “community at-risk.” The second round of analysis utilized the same data set for counties within the three at-risk PHDs identified in the SIR #1 – Needs Assessment. The goal of the second round of analysis was to analyze the 13 risk indicators to a smaller geographic unit at the county level. The following is a summary of the methodology for the second analysis, which included only counties within the previously identified “communities at-risk.”

1. **Method 1:** Compare county prevalence within each “at-risk” PHD to PHD median (i.e., county prevalence in District 1 compared to District 1 median)
2. **Method 2:** Compare county prevalence to median across “at-risk” PHDs (i.e., counties in Districts 1, 2, and 5 were compared to each other)

3. **Method 3:** Compare county prevalence to statewide prevalence (i.e., county’s prevalence in Districts 1, 2, and 5 compared to the statewide prevalence)

The second round of analysis indicated that 10 counties were at greater risk than the other counties within the three “at-risk communities.” Those counties at high (at risk after three methods) and moderate risk (at risk after two methods) in the second round of analysis included:

- Bonner
- Kootenai
- Shoshone
- Clearwater
- Jerome
- Twin Falls

For Formula Grants, the MIECHV program identified four of these six moderate to high risk counties to implement EBHV: Kootenai, Shoshone, Twin Falls, and Jerome counties (see Graphic 1). In these counties, the MIECHV program is contracting with five organizations to deliver EHS, PAT, and NFP (see Table 3 in the Introduction). For the Expansion Grant, the MIECHV program proposes to expand EBHV services into all PHD regions in which a MIECHV home visiting program does not exist. The MIECHV program conducted a third round of analysis of the needs assessment data to determine the at-risk counties in the remaining PHDs: 3, 4, 6, and 7. The third round of analysis reflected the same methodology used in the second round of analysis to determine the greatest risk counties in the remaining PHDs.

The third round of analysis indicates that nine counties were at greater risk than the other counties within the four PHDs or “at-risk communities.” Of those nine counties, seven scored highest and two scored moderately, while four counties scored low risk and 16 counties scored the lowest to no risk. Based on the second and third rounds of analysis, the MIECHV program identified seven additional target communities to implement EBHV, in addition to the existing four target communities: Nez Perce, Clearwater, Canyon, Ada, Bannock, Power, and Bonneville counties (see Table 6: Characteristics of Target Communities). These seven counties have risk indicators related to child abuse and neglect, crime, intimate partner violence, low educational attainment, poverty, smoking, and substance abuse.

*Current Communities Served*

Between February and April 2012, the MIECHV program successfully executed contracts with five agencies to implement four EBHV programs in four target communities, including a cross-state collaboration to implement NFP. The first three months of the contracts provided pre-implementation and planning time to allow the local implementing agencies to prepare for service delivery. The local implementing agencies began delivering services to families in target communities in June 2012. Table 5 presents the home visiting models, expected enrollment, actual enrollment, number of completed home visits to-date, and the cost per family by the target counties.

**Table 5:** 2013 Idaho’s Local MIECHV Program Enrollment (As of May 2013)

Target Communities (Counties)	FY10 & FY11 MIECHV programs	Expected Enrollment	Actual Enrollment	# of Home Visits Completed	Annual Cost per Family
Kootenai & Shoshone	ICARE: PAT	40	38	213	\$4,212
	Panhandle Health District: NFP* (with Spokane)	50	36	325	\$7,457

	<i>Regional Health District)</i>				
	Mountain States Group: EHS Home-Based	11	11	273	\$17,478
Twin Falls & Jerome	Community Council of Idaho: EHS Home-Based*	18	18	132	\$10,252
	<b>Total</b>	<b>119</b>	<b>103</b>	<b>943</b>	<b>\$7,818</b>

\* Indicates an agency establishing a new home visiting program

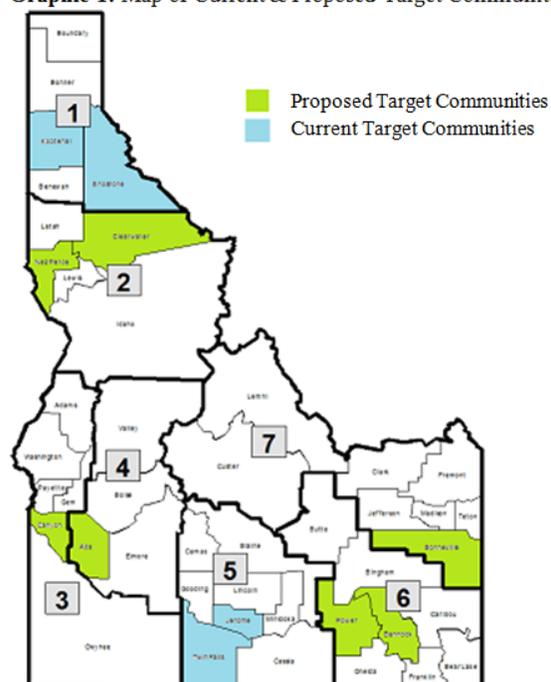
The cost per family was calculated by determining the total contract costs for each local implementing agency for the 12-month period since service delivery began (June 2012-May 2013). The total contract costs included the agency’s personnel, operating, supplies, travel, and indirect costs. The total contract cost was divided by the number of enrolled families as of May 2013 to determine the annual cost per family. It is important to note that the cost per family per agency is expected to decrease in coming years as this was the first year of service delivery and agencies will become more efficient in providing services. The cost per family calculation does not include the state program’s personnel or administrative costs. The MIECHV program will continue to support building strong agency organization and management capacity for implementation at the local level.

### Selected communities

As previously discussed, the MIECHV program identified four target communities for the Formula Grants to implement EBHV and integrate high quality home visiting into early childhood systems. For the Expansion Grant, the MIECHV program will target seven additional counties, adding Nez Perce, Clearwater, Canyon, Ada, Bannock, Power, and Bonneville counties to the Kootenai, Shoshone, Twin Falls, and Jerome program service areas (see Graphic 1). The Expansion Grant will enable the PHDs or community-based agencies to deliver services to priority populations in the target communities in the following 11 target areas:

- Kootenai and Shoshone counties
- Twin Falls and Jerome counties
- Nez Perce and Clearwater counties
- Canyon county
- Ada county
- Bannock and Power counties
- Bonneville county

Graphic 1: Map of Current & Proposed Target Communities



The MIECHV program will also increase contract amounts with local implementing agencies in the existing target communities to expand enrollment. The existing four target communities are

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 considered two contiguous two-county service areas. Similarly, Clearwater and Nez Perce counties and Bannock and Power counties will be considered contiguous two-county service areas. Ada, Canyon, and Bonneville counties will be single-county service areas.

The addition of the new and expanded program sites in the target communities will result in up to approximately 375 new enrollment slots across all home visiting programs (MIECHV and non-MIECHV sites). The addition these slots would increase coverage of home visiting services to approximately 1.2% of the birth to five population in the target communities (see Table 6).

**Table 6:** FY2013 Home Visiting Program Estimated Capacity by Target Community

	PAT	EHS	NFP	HFA	Total	2011 Birth-5 Population	% Birth-5 Population Served
Kootenai	40	162	42	0	<b>244</b>	9,079	2.7%
Shoshone	5	12	8	0	<b>25</b>	620	4.0%
Twin Falls	0	95	0	40	<b>135</b>	6,419	2.1%
Jerome	0	8	0	10	<b>18</b>	2,204	0.8%
Nez Perce	0	30	0	40	<b>70</b>	2,219	3.2%
Clearwater	0	0	0	10	<b>10</b>	346	2.9%
Bannock	0	0	0	40	<b>40</b>	6,716	0.6%
Power	0	0	0	10	<b>10</b>	734	1.4%
Bonneville	40	0	0	50	<b>90</b>	9,927	0.9%
Canyon	45	70	100	0	<b>215</b>	16,801	1.3%
Ada	0	64	0	50	<b>114</b>	27,653	0.4%
<b>All Target Communities</b>	<b>130</b>	<b>441</b>	<b>150</b>	<b>250</b>	<b>971</b>	<b>82,718</b>	<b>1.2%</b>

The MIECHV program is dedicated to providing high quality home visiting to legislatively defined priority populations. The 11 target communities represented approximately 69% of the total births to Idaho residents in 2011. Table 7 indicates that the communities varied greatly in population characteristics. Bonneville, Jerome, and Power counties had the highest birth rates in 2011. Kootenai and Shoshone counties had higher rates of substantiated child abuse, Medicaid births, unemployed citizens, poverty, and smoking during pregnancy than the statewide average. Nez Perce and Clearwater had a lower percentage of the population with a bachelor's degree and higher prevalence of smoking during pregnancy, and substantiated reports of child maltreatment. Canyon county had a greater population of young children, more Medicaid births, a higher Hispanic population, poverty, higher teen births, and higher child abuse rates. Twin Falls and Jerome counties had higher prevalence of young children, poverty, Hispanics, and teen births. In 2011, Shoshone, Jerome, and Canyon counties had higher rates of inadequate prenatal care than the state population. Canyon and Jerome counties have high rates of birth to women below the age of twenty. These risk-factors closely map to the MIECHV program priority populations and desired outcomes including low income families, pregnant women under the age of 21, low academic achievement, tobacco users in the home, and current or prior interaction with child welfare.

**Table 7:** 2011 Characteristics of Target Communities

	Statewide	Ada	Bannock	Bonneville	Canyon	Clearwater
Population	1,584,985	400,842	83,691	105,772	191,694	8,702

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% Population Aged Birth to 5	7.50%	6.8%	8.0%	9.4%	8.8%	4.0%
# of Births	22,311	5,151	1,320	1,878	3,019	62
Birth Rate per 1,000	14.1	12.9	15.8	17.8	15.7	7.1
% Medicaid Births	39.3%	34.1%	40.9%	39.5%	45.8%	46.8%
% Population with Bachelors	24.6%	35.2%	27.0%	26.7%	16.5%	14.2%
% Population Hispanic	11.5%	7.3%	7.0%	11.8%	24.1%	3.3%
% Population <100% FPL	14.3%	11.2%	14.6%	10.6%	18.1%	10.3%
% Inadequate Prenatal Care	13.1%	8.3%	13.0%	10.2%	15.4%	21.0%
% Smoked During Pregnancy	10.6%	10.3%	12.2%	10.4%	9.5%	35.5%
# of Births to 15-19 year olds	1,584	228	68	122	303	10
Rate Substantiated Maltreatment for Children < 18 per 1,000*	3.7	4.0	2.7	2.7	4.5	10.8

	Jerome	Kootenai	Nez Perce	Shoshone	Twin Falls	Power
Population	22,682	141,132	39,543	12,672	78,005	7,766
% Population Aged Birth to 5	9.7%	6.4%	5.6%	4.9%	8.2%	9.5%
# of Births	390	1,648	444	105	1,157	126
Birth Rate per 1,000	17.2	11.7	11.2	8.3	14.8	16.2
% Medicaid Births	56.9%	42.6%	43.2%	57.1%	50.2%	49.2%
% Population with Bachelors	12.4%	23.1%	19.7%	12.9%	17.3%	15.9%
% Population Hispanic	32.0%	4.0%	3.1%	3.4%	14.1%	30.6%
% Population <100% FPL	17.1%	12.8%	11.3%	16.5%	13.8%	17.1%
Inadequate Prenatal Care	22.9%	12.0%	14.4%	20.2%	13.6%	16.7%
% Smoked During Pregnancy	10.0%	14.7%	18.7%	24.8%	13.2%	11.1%
Births to 15-19 year olds	51	120	39	12	107	18
Rate Substantiated Maltreatment for Children < 18 per 1,000*	5.0	4.0	10.2	9.6	8.9	5.5

Source: US Census Bureau, 2011 Idaho Vital Statistics Report, Idaho FOCUS System Report

\*2009 data reported

### Estimated Families Served

The Expansion Grant would potentially double to triple the existing capacity of the MIECHV program to provide much needed services in the target communities. Through Formula Funds, the MIECHV program will serve 119 families at full capacity (see Table 8). Through Expansion Funds, three of the existing local implementing agencies would receive additional funding to increase enrollment by approximately 38%. Additionally, a new four-nurse Nurse Family Partnership (NFP) team would be introduced to the local PHD in Canyon county and five local PHDs would be given the option to implement PAT, EHS, or a new model to Idaho, HFA. Depending upon the model chosen by each PHD, service delivery capacity would be increased by 226 to 376 families per year

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 (see Table 9). Across Formula and Expansion Funding, the MIECHV program would serve between 345 and 495 families annually.

**Table 8:** Families Continued to be Served with Formula Grant

<b>MIECHV Programs: Formula Grant Years 1 &amp; 2</b>			
<b>Programs</b>	<b>Agency</b>	<b>Families</b>	<b>Counties</b>
EHS	Mountain States Group	11	Kootenai & Shoshone
PAT	St. Vincent de Paul ICARE	40	Kootenai & Shoshone
EHS	Community Council of Idaho	18	Twin Falls & Jerome
NFP	PHD 1 - Panhandle Health District	50	Kootenai & Shoshone
<b>Total</b>		<b>119</b>	

**Table 9:** Estimated Families to be Served per Year of Expansion Grant

<b>MIECHV Programs: Expansion Grant Years 1 &amp; 2</b>				
<b>Programs</b>	<b>Agency</b>	<b>Families</b>	<b>Counties</b>	<b>Cost per Family</b>
<b>Expansion</b>				
EHS	Mountain States Group	4	Kootenai & Shoshone	\$12,500
PAT	St. Vincent de Paul ICARE	15	Kootenai & Shoshone	\$3,333
EHS	Community Council of Idaho	7	Twin Falls & Jerome	\$7,142
<b>Implementation</b>				
NFP	PHD 3	100	Canyon	\$5,200
HFA, EHS, or PAT	PHD 2	20-50	Nez Perce & Clearwater	\$5,000-\$12,500
HFA, EHS, or PAT	PHD 4	20-50	Ada	\$5,000-\$12,500
HFA, EHS, or PAT	PHD 5	20-50	Twin Falls & Jerome	\$5,000-\$12,500
HFA, EHS, or PAT	PHD 6	20-50	Bannock & Power	\$5,000-\$12,500
HFA, EHS, or PAT	PHD 7	20-50	Bonneville	\$5,000-\$12,500
<b>Total</b>		<b>226-376*</b>		<b>\$5,100-\$8,500</b>

\*Number of families served is dependent upon selection of home visiting model by PHD

For the Expansion Grant, the cost per family would depend upon the program implemented in a target community. On average, cost per family would range from \$5,100 to \$8,500 per family across all models and target communities. See Table 9 for further breakdown of cost per family.

### *Programmatic Emphasis*

The MIECHV program is currently and will continue to address several areas of emphasis outlined in the Expansion Grant, including some related to programs and systems improvement. The proposed evaluation will assess the how these emphasis areas are being addressed through programmatic and participant evaluation. Table 10 demonstrates the alignment between the areas of emphasis and the MIECHV program goals.

**Table 10:** FY13 Expansion Grant Goals and Programmatic Emphasis Areas

<b>Desired Program Outcomes</b>
<i>FY13 Expansion Grant Goals</i>
<b>Goal 1:</b> Conduct a two-phase workforce study to understand the home visiting workforce and develop

Desired Program Outcomes
<i>FY13 Expansion Grant Goals</i>
<p>recommendations for a coordinated training and professional development system.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 2:</b> Effective implementation and expansion of EBHV programs or systems with fidelity to the evidence-based model selected               <ul style="list-style-type: none"> <li>○ High-quality supervision.</li> <li>○ Building strong local organizational and management capacity for implementation.</li> </ul> </li> <li>● <b>Emphasis 4:</b> Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum.               <ul style="list-style-type: none"> <li>○ Coordinated early childhood workforce and professional development systems that include home visitors.</li> </ul> </li> </ul>
<p><b>Goal 2:</b> Increase implementation capacity for EBHV in target communities and integrate home visiting services into family-centered medical home and public health services.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 1:</b> Improvements in Maternal, Child, and Family Health               <ul style="list-style-type: none"> <li>○ Engaging health service providers in at-risk communities to encourage identification and referral of pregnant women, young children, and families to home visiting programs.</li> <li>○ Provision of mental health services</li> <li>○ Linkage of families with a medical home.</li> </ul> </li> <li>● <b>Emphasis 2:</b> Effective implementation and expansion of EBHV programs or systems with fidelity to the evidence-based model selected.               <ul style="list-style-type: none"> <li>○ High-quality supervision.</li> <li>○ Building strong local organizational and management capacity for implementation</li> </ul> </li> <li>● <b>Emphasis 3:</b> Development of a statewide or multi-state home visiting programs.               <ul style="list-style-type: none"> <li>○ Implement a home visiting program through a cross-state collaboration to reach frontier communities and build capacity to implement EBHV</li> <li>○ Integrated home visiting data systems.</li> <li>○ Centralized intake systems.</li> <li>○ Integration of home visiting services with public health services through PHDs.</li> </ul> </li> <li>● <b>Emphasis 7:</b> Outreach to families in rural or frontier communities</li> </ul>
<p><b>Goal 3:</b> Include study of maternal stress and depression into existing evaluation of effect modifiers and implementation drivers.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 1:</b> Improvements in Maternal, Child, and Family Health               <ul style="list-style-type: none"> <li>○ Engaging health service providers in at-risk communities to encourage identification and referral of pregnant women, young children, and families to home visiting programs.</li> <li>○ Provision of mental health services</li> <li>○ Linkage of families with a medical home.</li> </ul> </li> </ul>
<p><b>Goal 4:</b> Partner with agency to coordinate and provide training, technical assistance, and consultation for the local MIECHV programs.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 2:</b> Effective implementation and expansion of EBHV programs or systems with fidelity to the evidence-based model selected.               <ul style="list-style-type: none"> <li>○ Building strong local organizational and management capacity for implementation</li> </ul> </li> </ul>
<p><b>Goal 5:</b> Continue to develop and build cross-model data system.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 3:</b> Development of a statewide or multi-state home visiting programs               <ul style="list-style-type: none"> <li>○ Integrated home visiting data systems.</li> <li>○ Centralized intake systems.</li> </ul> </li> </ul>
<p><b>Goal 6:</b> Partner with Early Childhood Comprehensive Systems work at state and local levels to integrate and advance home visiting into early childhood.</p> <ul style="list-style-type: none"> <li>● <b>Emphasis 4:</b> Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum.</li> </ul>

<b>Desired Program Outcomes</b>
<i>FY13 Expansion Grant Goals</i>
<ul style="list-style-type: none"><li>○ Coordinated early childhood workforce and professional development systems that include home visitors.</li><li>○ Centralized intake and referral systems to facilitate coordinated strategic planning and service delivery to improve the community environment and support positive child and family health, learning, and development outcomes.</li></ul>

## ***Methodology***

### ***Home Visiting Model Selection***

In November 2010, the MIECHV program began to research and review home visiting models likely to be considered evidence-based models according to the legislative definition of “evidence-based.” Convened by the MIECHV program leadership, the MIECHV program planning steering committee reviewed research for eleven home visiting models. The planning steering committee is comprised of the required concurrency partners. The planning steering committee participated in a model ranking activity according to relevance to Idaho’s at-risk communities. Through a collaborative effort, the committee ranked home visiting models on eight domains evidenced through research as critical components for high-quality, outcomes-driven home visiting programs (*Zero to Three: Home Visiting Past, Present, Future 2010*). After discussion and consensus, building the committee identified four models as relevant to the needs of Idaho’s communities, target populations, program outcomes, and current systems of care. The following home visiting models, in rank order, emerged as most relevant options for EBHV programs for the MIECHV program:

1. HFA
2. NFP
3. PAT
4. EHS

Given the factors of risk within the target communities, existing infrastructure, and model strengths, the following EBHV models were identified for implementation by the MIECHV program for the Formula Grant:

1. NFP
2. PAT
3. EHS

With the Expansion Funds, Idaho proposes to bring a new EBHV model to the state. Based on the results of the MIECHV steering committee’s ranking of relevant models, Idaho will bring HFA to the local PHDs as an option for implementation in eight target communities. The local PHDs may also choose PAT or EHS. The MIECHV program will also continue implementation of the three existing EBHV programs.

HFA is designed for parents facing challenges such as poverty, abuse, and substance use. The model also requires that all families be linked to a medical provider to assure optimal health and development (e.g. timely immunizations, well-child care, etc.). Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters. Based on the needs assessment

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 data and the MIECHV program’s goal to integrate home visiting services into medical home coordination and public health services, HFA aligns with the program goals and needs of the target communities. The MIECHV program also intends to implement a new four-nurse NFP team in Canyon county. Through the implementation of the cross-state collaborative effort to establish an NFP two-nurse team in Kootenai and Shoshone counties, the MIECHV program has established a state contract with the NFP National Office, gained experience working with the NFP model, and intends to apply the successes and lessons learned in the Canyon County NFP implementation. Table 11 provides justification for implementation of a four-nurse NFP team in Canyon county.

**Table 11: Population Justification for NFP in Canyon County**

	Average Births 2008-2010	2010 Births	% Smoke Pre-Pregnancy	% Smoke through Pregnancy	% Medicaid Births	2010 Births to Women Age < 24	Potential Participants
<b>Clearwater</b>	71	58	26.3%	15.8%	44.8%	28	3
<b>Nez Perce</b>	458	462	22.1%	13.0%	37.8%	169	17
<b>Canyon</b>	3,296	3,156	15.1%	8.8%	44.0%	1,232	<b>145</b>
<b>Twin Falls</b>	1,252	1,261	18.3%	10.7%	46.7%	494	58
<b>Jerome</b>	435	425	12.2%	8.5%	51.1%	193	22
<b>PHD 2</b>	1,201	1,166	19.6%	12.0%	35.9%	390	43
<b>PHD 3</b>	4,122	3,937	16.1%	9.7%	42.9%	1,550	176
<b>PHD 5</b>	3,057	3,018	14.5%	8.1%	44.5%	1,179	135

*Note: NFP algorithm for determining potential number of clients in community: Average Births \* Medicaid Births \* 40% (First Time Moms) \* 50% (recruit) \* 50% (eligible)*

### Goals and Objectives

The MIECHV program goals and objectives describe the vision for building onto the Formula Grant by bolstering capacity to implement EBHV and strengthening the systems of support for high quality home visiting in Idaho. The guiding principles of the MIECHV program are promulgating EBHV services in communities, integrating home visiting as an integral component of the continuum of care and supports provided across disciplines and sectors, particularly in the health care community, and building strong community networks. The MIECHV program seeks to promote collaboration, build sustainability, and strengthen support for quality and fidelity to achieve positive outcomes for children and families. Idaho’s goals and objectives are set within a timeframe that acknowledges challenges a new program in a state with a modest home visiting system may face. Finally, the goals articulated below are aligned to the extent possible with the goals and priorities outlined in Idaho’s Title V Maternal and Child Health Block Grant Needs Assessment for 2010 and the Comprehensive Early Childhood Plan for 2009-2012. Please see Attachment 6 for a detailed description of the activities to achieve each objective, as well as responsible staff and the timeframe to complete activities.

**Goal 1:** With the Expansion Grant, the MIECHV program will partner with a University-based partner to conduct a two-phase workforce study to assess state of and needs for professional development and training of home visiting programs across Idaho by July 2015.

*Objective 1:* The University partner will conduct a workforce study to provide a comprehensive view of the home visiting workforce in Idaho including issues related to: recruitment, training, retention, skills needed, Adverse Childhood Experiences (ACEs), and salary by January 2015.

*Objective 2:* The university partner will analyze and disseminate information collected in the workforce study as a basis for development of a professional development system including career ladders and training systems, in coordination with existing early childhood professional development systems (such as Idaho STARS) by July 2015.

**Goal 2:** The MIECHV program will establish expansion and implementation contracts for four home visiting models in 11 target communities to increase capacity to implement EBHV and provide training to implementing agencies about the integration of home visiting services into family-centered medical home and public health services by February 15.

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*Objective 1:* The MIECHV program will increase the funding (expansion) of three existing local MIECHV contractors in four existing target communities to support increased access to services by February 2014.

*Objective 2:* The MIECHV program will establish six new contracts (implementation) with six PHDs to implement EBHV in seven new (urban, rural, and frontier) and two existing target communities by April 2014.

*Objective 3:* The MIECHV program will support PHDs implementing an EBHV program to link and integrate home visiting services with medical and public health services offered through the PHD, including medical home coordination.

**Goal 3:** The MIECHV program will continue partnership with Boise State University, Center for Health Policy (BSU CHP) and expand current evaluation activities, which include: studying effect modifiers and implementation drivers, such as relationship quality and continuous quality improvement; study implementation of models in target communities; and survey and analysis of prevalence of maternal stress and depression in home visiting participants by September 2015.

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*Objective 1:* The BSU CHP evaluation team will study three program characteristics correlated with participant outcomes including: content (curriculum and core activities), relationship (participant to home visitor and home visitor to supervisor), and dosage (number of home visits and length of participation) by September 2015.

*Objective 2:* The BSU CHP evaluation team will assess the relationships between organizations, participant outcomes, and access to community resources and supports by September 2015.

*Objective 3:* The BSU CHP evaluation team will study and analyze organizational processes and performance related to model fidelity, organizational priorities, and continuous quality improvement at all local MIECHV programs through September 2015.

*Objective 4:* The BSU CHP evaluation team will assess the prevalence of maternal stress and depression for participants enrolled in the local MIECHV programs by September 2015.

*Objective 5:* The BSU CHP evaluation team will develop a study design to compare each implemented home visiting model to assess community context of the local MIECHV programs as an influential factor in program implementation and effectiveness by September 2015.

**Goal 4:** The MIECHV program will partner with an organization to become the Idaho Home Visiting Training and Implementation Center charged with coordinating and providing training, technical assistance, and consultation to local MIECHV programs in topics related to both content and implementation such as: local early childhood systems building, infant and early childhood mental health, implementation science, domestic violence and childhood trauma, continuous quality

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 improvement, data collection and use, and other topics to support organizations in all implementation stages (exploration, installation, initial implementation, and full implementation) by August 2014.

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*Objective 1:* Provide local MIECHV programs access to technical assistance, consultation and training to support implementation through the Idaho Home Visiting Training and Implementation Center with fidelity by August 2014.

**Goal 5:** The MIECHV program will continue to develop and build a cross-model data system to facilitate collection, maintenance, reporting, and connectivity for local MIECHV programs by June 2014.

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*Objective 1:* Build capacity within the MIECHV program Efforts to Outcomes data management system to capture and maintain data for all local MIECHV programs by March 2014.

**Goal 6:** The MIECHV program will continue to work with the Early Childhood Comprehensive Systems (ECCS) project and the Early Childhood Coordinating Council (EC3) newly formed Home Visiting and Parent Education committee to develop vision and goals, awareness of high quality home visiting, and development strategic partnerships to advance the systematic effort for high quality home visiting as an integral component of early childhood in Idaho by September 2015.

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*Objective 1:* Through the EC3 Home Visiting and Parent Education committee develop a common understanding, vision, and objectives of high quality home visiting as it fits within the service delivery system serving families and young children in Idaho by December 2014.

*Objective 2:* The MIECHV program will partner with the Regional Early Childhood Coordinating Council (RECC) that serves Kootenai and Shoshone counties to understand and better integrate home visiting into local early childhood systems. The MIECHV program will support the RECC to conduct an early childhood needs assessment and systems analysis to inform strategic planning for the local early childhood systems by September 2015.

### ***Work Plan***

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The implementation plan for the MIECHV program is designed to fit within the *Lifecourse Perspective* and *Strengthening Families* frameworks. These frameworks suggest that factors such as intergenerational experiences and environmental and community factors influence health and wellbeing over the lifespan. Each framework is supported by scientific and social research that consistently indicates that early years of life are a critical period; a window of opportunity to set the trajectory of a child's life and support families to create the best beginning to life. Occurrence of adverse childhood experiences during the early years increases the likelihood of negative impacts on health, development and wellbeing. Factors such as poverty, low educational attainment, low birth weight and exposure to family violence are associated with negative impacts in children's outcome later in life. The *Strengthening Families* framework suggests that a number of protective factors, if present or cultivated, can mitigate or reduce the impact on adverse events in early childhood. Evidence indicates that supporting protective factors by empowering communities and families provides the foundation for positive child development. The implementation plan intends to build the Idaho's MIECHV program through the lens of the *Lifecourse Perspective* and *Strengthening Families* frameworks.

### ***Collaborative Partners***

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In November 2010, the MIECHV program convened partners to form a planning steering committee. For the first year, the planning steering committee met monthly to provide guidance to the development plans for the MIECHV program. Starting in January 2012, the planning steering committee began meeting every other month to inform program roll-out and implementation. (See also Attachment 9 – Memoranda of Concurrence.) The planning steering committee includes the following required partners:

- Title V, Maternal and Child Health
- Idaho Child Welfare (Title IV-B/IV-E)
- Idaho Agency for Substance Abuse
- Idaho Early Childhood Comprehensive Systems Project
- Idaho Temporary Assistance to Needy Families (TANF)
- Idaho Children's Trust Fund (Title II - CAPTA)
- Idaho IDEA Part B Section 619
- Idaho Food Stamp Program
- Idaho Head Start Collaboration Office
- Idaho Child Care and Development Fund

These partners have been critically important to the development and implementation of the MIECHV program. Planning steering committee members have been involved with:

- Selection of EBHV models and identification of target communities
- Review of evaluation proposals from University partners
- Review of RFP responses by community-based organizations to EBHV in target communities
- Information and data sharing across programs and agencies
- Training local MIECHV programs at the MIECHV Orientation
- Coordination of communication between local MIECHV programs and local Department staff

## **Implementation Plan**

### *Community Engagement*

To date, the MIECHV program has implemented a number of strategies to engage community partners. This proposal outlines activities to continue and enhance work to engage community partners through community meetings, local MIECHV program contract requirements, evaluation activities, and local home visiting and early childhood systems building. In June 2011, the MIECHV program announced four upcoming community meetings in the four target communities through a press release issued by the Department of Health and Welfare. The community meetings were well attended by interested stakeholders and partners who provided MIECHV program staff context of their community and existing systems. Following the community meetings, the MIECHV program issued organizational capacity assessments for interested organizations to provide information about organizational capacity for the MIECHV program to inform the request for proposals (RFPs). Community involvement is critical throughout program implementation and evaluation.

Similar to the community engagement, the MIECHV program will host community meetings in the seven newly identified target communities to inform and engage stakeholders in January 2014 to discuss the home visiting models, MIECHV goals and objectives, implementation and planning for EBHV contracts, and community resources and concerns. Prior to the meeting, the MIECHV will publish meeting an announcement through a press release targeted to the target communities. The objectives of the community meetings are:

1. Generate a shared understanding of the MIECHV program,
2. Identify relationships between potential community partners, and
3. Develop an understanding of community strengths and needs respective to this opportunity

The Idaho MIECHV plans to continue to develop relationships at the local level throughout the initial years of planning, implementation, and evaluation. Ongoing partnerships and relationship-building are critical to the long-term sustainability and adoption of an evidence-based program in the target communities. The cycle of ongoing community engagement will likely be replicated during years three through five of the MIECHV grant program. The MIECHV program recognizes there are several important principles in community development and organization around early childhood systems building. Community development requires hosts to organize organizations in a community to achieve something for the common good of the community. In the coming years, the MIECHV program will employ strategies to develop local MIECHV program leadership to engage stakeholders in home visiting and early childhood systems building. The MIECHV program support local MIECHV programs by (see also Attachment 6 – Timeline):

1. Organizing MIECHV program to inform community stakeholders
2. Convene stakeholders in community meetings
3. Conduct an early childhood needs assessment and systems analysis
4. Facilitate a strategic planning process through the RECC in North Idaho as a pilot
5. Host a home visiting and early childhood summit to gather input from local stakeholders
6. Compile feedback from stakeholders and share with local MIECHV programs

#### *Monitoring, Assessment, and Technical Assistance*

The MIECHV program has established a foundation for ongoing monitoring and assessment with local MIECHV program. These elements are will continue to be refined and are applicable to the Expansion Grant work plan. Key elements of this foundation include: specific contract requirements, pre-implementation planning period built into the contract, MIECHV program manual including training request forms, technical assistance through webinars hosted by MIECHV program staff, program readiness assessments, monthly reports, and annual on-site monitoring visits.

The MIECHV program carefully outlined requirements for model fidelity, participation in evaluation, reflective supervision, staff and participant ratios, and much more in the request for proposals (RFPs). Contracts established through the RFPs reflected the scope of work outlined in the RFPs. Contractors were allowed 120 days for pre-implementation planning for their organizations to scale-up and build capacity to meet contract requirements. During the 120 pre-implementation planning phase, the MIECHV program developed a “Contractor Manual” detailing policies, expectations, forms, and reports. The Contractor Manual was developed to operationalize the contract requirements. Additionally, the MIECHV program convened all local MIECHV implementing agencies (contractors) for a day-and-a-half orientation. At the orientation, local MIECHV implementing agencies went over the manual, reports, benchmark data collection, cost analysis study design, state partners from Child Welfare, Early Intervention, Substance Abuse, as well as previewed the MIECHV program Efforts to Outcomes (ETO) data management systems. MIECHV program staff also hosted two webinars to provide an overview screening and assessment tools and introduction to the MIECHV program data system and data collection forms and requirements.

At the close of the planning phase, MIECHV program staff conducted on-site readiness assessments. The readiness assessments were to ensure that local MIECHV programs were meeting baseline contract requirements and had capacity to begin service delivery and program implementation. Local MIECHV programs submit monthly reports describing enrollment, major activities, successes, and barriers. Monthly reports are a critical component of ongoing monitoring of challenges and successes local MIECHV programs encounter. Finally, the MIECHV program will conduct at least annual on-site monitoring visits to ensure that local MIECHV programs are meeting contract requirements (including model fidelity). MIECHV program staff and BSU CHP evaluation team staff monitor data quality in the Efforts to Outcomes performance data system on an ongoing basis throughout service delivery and implementation.

For the additional programs established through the Expansion Grant, the MIECHV program will implement similar activities to monitor and assess local MIECHV program capacity and implementation. Additionally, the MIECHV program proposed to establish an Idaho Home Visiting Training and Implementation Center. This Center will be charged with coordinating and providing training, technical assistance, and consultation to local MIECHV programs in topics related to both content and implementation such as: local early childhood systems building, infant and early childhood mental health, implementation science, domestic violence and childhood trauma, continuous quality improvement, data collection and use, and other topics to support organizations in all implementation stages. Local MIECHV programs will be able to submit technical assistance requests to the Idaho Home Visiting Training and Implementation Center. The Center may have internal capacity to respond to technical assistance requests or may subcontract with another entity to provide the requested technical assistance.

The MIECHV program has begun cultivating relationships with national model developers to generate plans to partner in monitoring model fidelity. There are no representatives from the national models in Idaho. National model developers have the unique ability to ensure programs are adhering to their model requirements and maintaining model fidelity. The MIECHV program submitted a technical assistance request to the MIECHV Technical Assistance Coordinating Center (TACC) to assist the MIECHV program develop a partnership and plan with the Office of Head for monitoring of the local MIECHV program's implementing EHS Home-based. The MIECHV program will continue to work with the Office of Head Start to refine plans for monitoring model fidelity. The MIECHV program will submit similar requests to develop plans for monitoring in partnership with PAT, NFP, and HFA.

### *Professional Development and Training*

The MIECHV program recognizes the importance of training to assure high quality, competent service delivery, to adhere to model requirements, and organizational expectations. Training includes pre-service training, ongoing training and professional development. Each home visiting model developer has outlined standards related to personnel training. Local MIECHV programs are contractually obligated to adhere to model-specific standards as well as MIECHV program required training. The MIECHV program developed a training request form for local MIECHV programs to submit to request training at any time throughout the contract term.

*EHS* - Head Start Program Performance Standards (HSPPS) for staff qualifications and development outline the content of training that must be provided to home visiting staff. HSPPS do not specifically outline the number of professional development or training hours required to achieve the standard.

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The MIECHV program will partner with local contractors to identify goals and opportunities for pre-service, ongoing training and professional development for staff. Training content should be related to:

- structured child-focused visits that promote parent ability to support child development;
- strengths-based parent education with methods to encourage parents as child's first teacher;
- early childhood development with respect to children from birth through age three;
- methods to help parents promote emergent literacy in their children, including use of research-based strategies to support skill development children who are limited English proficient;
- working with providers of health and developmental services to eliminate gaps in service by offering annual health, vision, hearing, and developmental screening for children, when needed;
- strategies for helping families coping with crisis; and
- relationship of health and well-being of pregnant women to prenatal and child development.

*PAT* - Parent educators and supervisors are expected to complete “Foundational Training” and “Model Implementation Training” prior to conducting home visits, which provide a foundation for home visiting methodology and guidelines for quality assurance. Additionally, parent educators must complete competency-based training and professional development according to the following:

- Year 1: 20 clock hours of professional development
- Year 2: 15 clock hours of professional development
- Year 3 and beyond: 10 clock hours of professional development

*NFP* - Core Education for nurse home visitors and supervisors includes face -to-face and long distance education. Nurse home visitors and supervisors must complete the core education prior to enrolling clients and conducting home visits. The National Service Office established requirements for nurse home visitors, supervisors and data entry staff to have computers in order to participate in educational offerings. In addition, nurse home visitors must stay current on professional licensure requirements for continuing education. Nurse home visitors are expected to participate in clinical and reflective supervision, case and team meetings as a means of continuing education and professional development.

*HFA* - Requires Core Training for all direct service staff and their supervisors/program managers within six months of hire. Core Training provides training and direction to staff in their specific roles and must be delivered by certified HFA trainers. Core Training includes the following modules:

- Assessment Core Training - Intensive training provided to all program staff that will administer HFA assessment tools and provide supervisory support. The training focuses on building skills to engage parents in the assessment process, learning how to gather comprehensive information from parents in regard to their strengths and needs using a conversational style, and obtaining guided practice from a certified user to ensure the tool is administered in a standardized and reliable manner.
- Home Visitor Core Training - An in-depth, formalized training consisting of four full days for the home visitor, plus an additional fifth day for supervisors and program managers, the training outlines the specific duties of the home visitor in their role within HFA.
- Wraparound Training - Complements other core training modules and covers the additional training topics necessary to support home visitation staff in their duties. Twelve online self-paced modules are available to all program staff and provide 35 hours of training on important

topics, including keeping babies healthy and safe; fostering infant and child development; addressing domestic violence; preventing child abuse; recognizing substance abuse; responding to relationship issues; and promoting mental health.

The MIECHV program has been working with the local programs to identify and respond to training needs in addition to assessing current training and professional development opportunities available through various training initiatives. Training request forms, on-site readiness assessment, and ongoing communication indicate that current training needs include:

- Training on assessing and addressing domestic violence in the home
- Home visitor safety – developed online module for home visitors in May 2012
- Continuous Quality Improvement (data quality and data use) – planned for September 2013
- Mandatory reporting – in collaboration with Child Welfare staff – completed face to face training in May 2012
- Developmental Parenting – Home Visiting Observation Rating Scale (HOVR-S)
- Infant mental health and reflective supervision in partnership with the Idaho Association for Infant and Early Childhood Mental Health

In addition providing traditional training opportunities, the MIECHV program intends to partner with a University to conduct a comprehensive, two-phase workforce study (see Methodology Goals and Objectives and Attachment 6 Project Timeline). The objectives of the workforce study are to gain an accurate understanding of the home visitor workforce. In the first phase, the University partner will complete a comprehensive assessment of all home visitors in Idaho to gather information on the following factors:

- Demographic information (Age, Gender, Ethnicity/Race)
- Academic preparation (pre-service training/education)
- Professional development (in-service training)
- Tenure in job and field
- Salary and benefits (including recent increases/decreases in pay)
- Supervision (frequency/quality)
- Skills/competencies needed
- Job satisfaction and future plans
- Adverse Childhood Experiences
- Level of support and job security with organization

In the second phase of the workforce study, the University partner will analyze the information collected, inform stakeholders of the results, and begin to formulate recommendations for an integrated training and professional development system for home visitors. To date, there has not been a similar study completed for the home visiting workforce in Idaho. This workforce study will provide a baseline of information lend credibility to field of home visiting and open a window of opportunity to advance the field of high quality home visiting in Idaho. By the end of the two year project period, the MIECHV program will have a framework for integrating training and professional development into systems of early childhood training and professional development.

### *Staffing and Contracting*

The home visiting workforce is comprised of professionals and paraprofessionals with knowledge and skills related to early childhood, family dynamics, social work, health and development. Relationships between home visitors and families, as well as relationships between home visitors and program supervisors, are critical to participant outcomes.

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Local MIECHV programs were and will be required to develop a staffing plan including recruitment and retention in response the MIECHV program request for proposals and update them prior to the readiness assessments. The plans outlined interviewing techniques, such as role play or case presentation, employed identify qualified home visitors able to build trusting relationships with program participants, objectives for staff retention, and plans for professional development and training.

*EHS* - outlines home visitor expectations based on these qualifications: “Home visitors must have knowledge and experience in child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics. They must be skilled in communicating with and motivating people. They must have knowledge of community resources and the skills to link families with appropriate agencies and services” (Head Start Program Performance Standards (HSPPS) 1304.52). The HSPPS also provide requirements for staff training and development to promote staff retention.

*PAT* - indicates in the 2011 Quality Assurance Guidelines that PAT 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 or parents. The Quality Assurance Guidelines recommend that parent educators have at least a bachelor’s or four-year degree in early childhood or a related field. The Quality Assurance Guidelines describe a hiring priority for parent educators who demonstrate effective communication and interpersonal skills, with a commitment to professional growth.

*NFP* - expects organizations to recruit and hire bachelor’s prepared nurses unless there is not workforce available. Model Element 8 underscores the importance of organizational commitment to hire qualified staff to meet NFP standards. Nurse home visitors should integrate the Standards of Nursing Practice into the NFP intervention and maintain therapeutic relationship, set boundaries, and achieve program outcomes. Organizations should provide an environment supportive of retention of qualified nurse home visitors by compensation, supervision, and learning opportunities.

*HFA* - requires all staff to complete mandatory HFA training but does not require that direct service staff meet specific educational requirements. Rather, it recommends that staff have experience working with families with multiple needs. In addition, it recommends selecting staff based on their personal characteristics, including their experience working with or providing services to children and families; an ability to establish trusting relationships; acceptance of individual differences; their experience working with culturally diverse communities; their knowledge of infant and child development; and their ability to maintain boundaries between personal and professional life. Supervisors are required to have a minimum of a baccalaureate degree, and a master’s level with clinical and reflective background is preferred.

The MIECHV program has awarded contracts with five organizations to provide EBHV services in four target communities. A Request for Proposal (RFP) process was used to establish contracts with three of the five local implementing agencies, and two of the contracts were established through a direct contracting process (i.e., exempt from competitive bidding) with PHDs in accordance with the Idaho Department of Health and Welfare’s contracting policies and procedures as well as the U.S. Department of Health and Human Services Grant expectations for the MIECHV program. For the Expansion Grant, the MIECHV program intends to contract with five PHDs in the specified target

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 communities to implement home visiting programs. As public agencies, the PHDs are exempt from a formal bidding process to establish contracts for services. PHDs serve as the primary service delivery providers for most public health programs that are administered at the state level. If a PHD declines the opportunity to implement a home visiting program, the MIECHV program will utilize a competitive RFP process to identify and establish a contract with a community-based organization. The RFP and subsequent contracts will outline MIECHV program requirements, including staffing, implementation, participant recruitment, model fidelity, continuous quality improvement, community collaboration, and more. Please see Attachment 6: Timeline for a detailed description of the program's proposed contracting processes.

### *Recruiting and Retaining Participants*

The MIECHV program required local MIECHV program contractors to develop plans for participant recruitment and retention. Non-public agency applicants described recruitment and retention plans in response to the RFP, and the PHDs agree and abide by contractual requirements set forth by the MIECHV program. Local MIECHV program contractors are charged with adhering to model specific participant eligibility requirements, organizational priority populations, and MIECHV program legislatively mandated priority populations. Each local MIECHV program developed plans according to their model, organization, community, and MIECHV priority populations. The MIECHV program will employ the same requirements for the Expansion Grant.

A number of factors contribute to participant retention in home visiting programs. Research indicates that the intensity and duration of programs influence the attrition rates of both staff and participants. As the level of frequency and duration increase, participant engagement and benefits also increase (Center on the Developing Child, 2007 and Daro, D., 2006). Participant retention is centered in the relationship between the home visitor and participant and connections with community resources. Applications, on-site discovery visits, and readiness assessments local MIECHV programs indicated that the relationship between the participant and the home visitor is the most critical factor in participant retention. The MIECHV program will support local contractors to monitor participant recruitment and retention and encourage collaboration between programs to share challenges and solutions.

*EHS* - Head Start Program Performance Standards outline recruitment expectations (CFR 1305.5) which may include advertisements, news releases, or other forms of outreach to recruit the target population for services. Recruitment process should occur before the beginning of the enrollment year. Participants in EHS develop family partnership agreements that include goals for each family member and are encouraged to participate in roles of leadership in the program.

*PAT*- The PAT Affiliate Plan indicates affiliates identify current or proposed recruitment materials, such as print, personal contact, informal meetings, signage, web postings or other. Affiliates should have a clear, written plan for offering and promoting PAT services and reducing participant attrition. In the Affiliate Plan, affiliates identify strategies to encourage continued participation, such as text reminders of upcoming visits, phone or text messages between visits, incentives for completed visits and books appropriate for the topic of the visit.

*NFP*-Nurse supervisors and program administrators are expected to establish relationships with community resources to build a resource and referral network. Client recruitment typically occurs through resource and referral networks such as WIC, schools, or community health clinics. Clients

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 are enrolled when first visit occurs and forms are completed, with only one pre-enrollment visit. Participant retention is based on nurse home visitor relationship, support, and education provided on such topics as prenatal health behaviors and child's neurodevelopment. NFP encourages programs to recruit women early in pregnancy as data indicate earlier entry is related to longer participation.

*HFA*- Service providers must receive training related to services in their community. Sites utilize creative outreach to connect with families. Sites select specific characteristics of the target population they plan to serve in alignment with model requirements and require that all families complete a comprehensive assessment to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences. HFA sites utilize assessment process to reach out to families and build holistic family-centered relationships with families.

### *Continuous Quality Improvement*

Successful implementation of an evidence-based practice or program hinges on a number of factors including the organizational, staffing, community, and leadership of the implementing program (Fixsen, D., Naoom, S.F., Blase, D.A., Friedman, R.M., Wallace, F., 2005). Further, the following factors impact implementation: organizational capacity, fit to organization and community, need of community, resource availability, evidence of efficacy and intervention readiness for replication (NIRM, 2009). The MIECHV program recognizes the importance of comprehensive and ongoing monitoring and continuous quality improvement (CQI) at all levels of program implementation to understand how the aforementioned factors are influencing quality implementation of the evidence-based home program.

The MIECHV program identified a four-step CQI strategy to evaluate processes and outcomes and identify performance improvement opportunities on an ongoing basis to inform service delivery and monitor model fidelity. The Plan-Do-Check-Act method measures processes and outcomes to support data-driven decision-making, policies and practices, analysis of model fidelity, monitoring of local MIECHV program progress towards contractual objectives, assessment of program implementation, identification of training opportunities, and revision of processes to improve performance. As CQI is new for the MIECHV program, the program will seek external support through technical assistance and consultants during implementation to assist with CQI activities. During initial service delivery, local MIECHV programs establish a baseline of data that may be used for CQI over time. With baseline data, the MIECHV program and local MIECHV programs will prioritize constructs for performance improvement using the Plan, Do, Check Act Method. The following is an example timeline of a CQI process:

- 0-6 months: Establish a baseline for data collection
- 6-12 months: Assess initial trends within data set
- 12-18 months: Prioritize data for improvement, research variables influencing indicator
- 18-24 months: Introduce training, resources, activities or strategies to improve indicator(s)
- 24-36 months: Assess trends, variables, and performance improvement and set new goals

The MIECHV program will partner with model developers to assure state monitoring activities are in conjunction with monitoring conducted by the model developer as an important information source for CQI. In addition to collaborating with model developers, the MIECHV program plans to assemble a CQI team that will guide assessment and decision-making. The team will consist of partners from across the home visiting programs including, but not limited to, a home visitor, a

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family participant, supervisor, evaluator, program managers, program directors, and model developers. The MIECHV program understands that buy-in from all levels of the program is instrumental in creating a culture of quality.

Local MIECHV programs are contractually obligated to participate in CQI to assess implementation processes and performance. Local MIECHV programs are required to submit a bi-annual CQI report detailing indicators identified for improvements and steps taken according to the Plan-Do-Check-Act framework. Based on findings from on-site discovery visits in March 2012 and local implementing agency feedback, CQI has emerged as an important training and technical assistance. Although some local MIECHV programs use data to assess some components of service delivery and program operations, much additional CQI training and technical assistance is needed in over the course of the coming project periods related to data quality, data use, and CQI. Through the formula grant, the MIECHV program has worked with national TA providers to develop and provide a series of trainings and technical assistance to support the local MIECHV programs to integrate CQI into their regular work. Of note, the program has developed a data orientation and CQI training to be delivered to local agencies during the fall of 2013. With the Expansion Funds, the MIECHV program will expand the training to include new implementing agencies in the spring of 2014.

*1. Identification of Performance Indicators* - A performance indicator is a measure used as a tool that quantitatively describes the degree to which a process or outcome is meeting desired expectations. For the MIECHV program, many CQI performance indicators will align with constructs in the benchmark plan. Some of the indicators that may be assessed during the CQI process include:

- Prenatal care
- PPD screening
- Breastfeeding behaviors
- Well-child visits
- Injury prevention education
- Domestic violence screening
- Referrals for domestic violence
- Number of MOU's within community
- Number of completed referrals
- Number of incomplete visits

*2. Assessment* - Data will be collected utilizing a variety of methods including program, participant, and administrative data. Data will be aggregated and analyzed, and assessed for differences between current performance and desired performance based on indicator targets. Data reports for CQI indicators will be built into the Performance management system for local MIECHV program use in CQI. Those processes or outcomes not meeting target expectations will be flagged and prioritized for follow-up with Plan-Do-Check-Act process with MIECHV program staff, local MIECHV program staff, model developers and CQI team.

*3. Initiative* - Performance indicators identified as falling short of desired expectations will be considered as opportunities for performance improvement. The MIECHV CQI team will address performance improvement opportunities using the "Plan-Do-Check-Act" framework, which provides a methodical approach to identify performance problems and possible causes, then outline and prioritize corrective actions. The MIECHV program will provide technical assistance to local MIECHV programs related to the PDCA approach for CQI, and provide tools to assist in identifying problems and solutions. Local MIECHV programs are required to report on performance indicators bi-annually. The CQI team will determine which reports and partners are responsible for performance interventions. Performance interventions will be documented and monitored by the CQI team for improvement in specified processes and outcomes, as well as adherence to model standards.

4. *Evaluation* - The MIECHV program requires local MIECHV programs to submit an annual performance evaluation. The performance evaluation should summarize the goals and objectives of the CQI plan, progress made toward goals and objectives, adherence to model-specific standards, and performance improvement interventions conducted over the year, including the performance indicators, data analysis results, targets, and specific initiatives implemented in response to the PDCA approach.

#### *Model Fidelity*

The MIECHV program has identified three initial strategies to monitor and maintain model fidelity in partnership with national model developers and local MIECHV programs.

1. Technical Assistance from National Model Developers
2. On-site monitoring of local MIECHV programs
3. Ongoing analysis of MIECHV program ETO data

Local MIECHV programs are contractually obligated to implement the home visiting program in adherence with national model requirements to maintain model fidelity. Each local MIECHV program must adhere to model standards and MIECHV program standards. However, the MIECHV program understands that there are a multitude of factors that affect implementation and may influence organization ability to implement to model fidelity. In order to effectively assess adherence to model fidelity and support organization's to achieve and maintain model fidelity, the MIECHV program will utilize three strategies.

First, the MIECHV program will partner with model developers to understand model fidelity requirements, align state monitoring activities with model developer, and define roles in monitoring for fidelity. In March 2012, the MIECHV program submitted a Technical Assistance request seeking support and assistance in planning and executing monitoring for model fidelity for the EHS Home-Based Model. Each national model has some form of monitoring local program adherence to model requirements. MIECHV program seeks to work with national model developer to align national model and MIECHV program monitoring activities and avoid duplication. Secondly, the MIECHV program will conduct annual on-site monitoring visits. On-site monitoring visits review local MIECHV program adherence to MIECHV program contract requirements, which include maintaining model fidelity. The final component of monitoring model fidelity is ongoing review and analysis of data entered into the MIECHV program ETO system. MIECHV program staff will develop several reports for each local MIECHV program that include indicators of model fidelity (number of home visits, assessments, staff to participant ratio, supervision, and more).

*EHS* - The Office of Head Start published Monitoring Protocol for FY11, outlining the monitoring requirements for on-site visits. The Monitoring Protocol provides a framework for review of quality, program management and compliance to the HSPPS and regulations. The Monitoring Protocol is a tool to measure compliance in a framework of critical indicators meant to assess achievement of 11 required components. The Office of Head Start expects EHS programs to participate in major on-site monitoring every three years to assess performance, quality and management of HSPPS, and in the interim, as necessary. The Office of Head Start contracts with teams to conduct on-site monitoring.

*PAT* - According to the Covenantal Agreement with PAT affiliates, PAT National Office intends to conduct quality assurance visits through a Regional Technical Assistance structure to assess

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*NFP* - Integrates fidelity and quality assurance measures for every model element into its web-based information system. The NFP National Service Office monitors implementing agencies’ program fidelity, the quality data collection and provides feedback as needed.

NFP has identified more than 20 indicators for model fidelity and supports states and implementing agencies in collecting and analyzing data for every phase of implementation.

*HFA*- Established through a comprehensive accreditation process for implementing agencies. Accreditation is monitored by the HFA National Office to ensure agencies are implementing the 12 research-based critical elements of the model. The HFA National Office encourages implementing agencies to seek technical assistance throughout the planning process to ensure that the HFA critical elements are reflected in planning efforts. Program planning and assistance are available from a variety of sources, such as HFA state leaders, HFA state trainers, existing HFA sites, local community experts, and local or state HFA partners.

#### *Legislatively Mandated Benchmarks*

The MIECHV program intends to demonstrate measurable improvement in at least half of the constructs for each of the required benchmark areas. In April 2013, the MIECHV program benchmark plan was approved for implementation. The benchmarks plan maps out data elements that all local MIECHV programs, for all home visiting models, will be required to collect throughout program implementation. Local MIECHV programs are contractually obligated to collect data elements outlined in the benchmarks plan. Local MIECHV programs established through the Expansion Grant will be subject to the same requirements. The MIECHV program contractor manual includes an appendix with a one page description of each construct. The MIECHV program will continue to provide training and technical assistance to assure local MIECHV programs adhere to data collection requirements. Local MIECHV program are required to collect data for all constructs for all participating families. The MIECHV program has developed four standard data forms for local MIECHV programs to collect demographic and benchmark data not including standardized assessment/screening tool data. Local MIECHV programs will utilize the following standardized assessment/screening tools:

- Edinburgh Postnatal Depression Scale
- Relationship Assessment Tool
- Ages and Stages Questionnaire – 3<sup>rd</sup> Edition
- Ages and Stages Questionnaire – Social Emotional
- Protective Factors Survey
- Everyday Stressors Index
- Home Observation and Measurement of the Environment Inventory

The MIECHV program established an Intra-Agency Memorandum of Agreement with the Idaho Child Welfare Program in the Division of Family and Community Services to share state administrative data for child abuse and neglect. The MIECHV program received the first data file to

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 establish a pre-implementation baseline in March 2012. The MIECHV program recognizes the importance of participant privacy and protection given the rigorous data collection and reporting requirements. The MIECHV program developed client protection forms including: informed consent form, client rights and grievances procedures form, client consent to release information form, and client notice of confidentiality form. The MIECHV program will assure training is provided on an annual basis to all home visitors, data support staff, and supervisors on data collection integrity, maintenance and security. Local MIECHV programs are required to train staff on HIPAA, ethics, and assure privacy protections within their organizations. PAT, NFP, EHS, and HFA also require training regarding client privacy, rights and ethical conduct. Additionally, the MIECHV program will assure that data and server systems are secure and compliant with state and national privacy requirements, including HIPAA and FERPA.

The MIECHV program has purchased a license for the Social Solutions Efforts to Outcomes (ETO) product to house Idaho's MIECHV program data. The web-based system has been configured for Idaho went live in September 2012. MIECHV program staff will work with Social Solutions to build additional "sites" into the MIECHV program site to support the additional local MIECHV programs funded through the Expansion Grant. The Social Solutions ETO system will allow Idaho for the first time to have some cross model, standard data to assess participant and program outcomes.

Despite the intention to collect high quality data and demonstrate improvement in programs and participants lives, demonstrating measurable improvements are the product of a complex set of factors related target population, model, staff capacity, technology, environment, relationships, measurement tools and many others. Some of challenges include the discord between the legislatively mandated benchmarks and the research and evidence for each home visiting model. The expected outcomes for the required priority populations of the MIECHV program have not all demonstrated successful outcomes in high quality research on the evidence-based models.

#### *Coordination with Other Entities*

As the first state-administered home visiting program in Idaho, the MIECHV program staff have been working diligently to develop partnerships within various disciplines, agencies, and communities to develop understanding and awareness of the program. Partnerships continue to grow and develop (please see Attachment 10 – Memoranda of Concurrence). The MIECHV program planning steering committee has been actively involved throughout the grant development, planning, and implementation. The MIECHV program anticipates continued growth of partnerships and program coordination through the duration of program implementation. Since program inception, the MIECHV program has presented quarterly program updates to Idaho's Early Childhood Coordinating Council (EC3), part of the State Early Childhood Comprehensive System. Idaho's Home Visiting State Plan has been aligned with Idaho's Comprehensive Early Childhood Plan 2009 – 2012, to the extent possible. Through the Expansion Grant, the MIECHV program plans to strengthen systems building efforts, which include integration of a professional development and training system into existing early childhood systems and development of an early childhood home visiting strategic plan at the local and state level.

#### *State Administrative Structure*

The Idaho Department of Health and Welfare was designated as lead agency for the MIECHV program. The program will be managed within the Maternal and Child Health (MCH) Program, Bureau of Clinical and Preventive Services (BOCAPS), Division of Public Health. The Chief of the Bureau of Clinical and Preventive Services serves as the Title V, MCH Director for the state of Idaho. The MIECHV program is within the state MCH structure. The MCH Program Manager serves as the state Children with Special Health Care Needs (CSHCN) Director.

Jacquie Watson is the Program Manager of the MCH Program and manages the MIECHV program within the context of other MCH services for children and families. Ms. Watson supports partnerships, provides budget oversight, and manages professional and support staff. Ms. Watson assures and supports program grant writing and reporting. Ms. Daniel reports directly to the Title V, MCH Director, Kris Spain, MS, RD, LD; Chief of the Bureau of Clinical and Preventive Services. Ms. Spain supports and assures administration of the MIECHV program within the context of the Division of Public Health and Department of Health and Welfare.

The MIECHV program is directly managed at the state level by a lead Health Program Specialist (currently in process of filling vacancy), under the direct supervision of Ms. Watson. The lead position works directly with local MIECHV program contractors, national model developers, data system administration, Boise State evaluation team, steering committee members, vendors, contractors, and other partners as home visiting infrastructure develops within the state. This person works to assure model fidelity and availability of training and technical assistance. The lead is responsible for assuring program implementation, model fidelity and evaluation. In addition to the lead Health Program Specialist, the home visiting program plans to hire a “limited service” Health Program Specialist who will assist in the implementation/expansion of the home visiting program in Idaho. This limited service position will be full-time, for two years. The limited service position will support local MIECHV program contractors, manage the workforce study and assist in on-going training and technical support to contractors. The lead position and limited service position are supported by 0.5 FTE of an administrative assistant and a .5 state temporary Health Program Specialist. Kristin Bergeson is the state temporary Health Program Specialist. Ms. Bergeson is primarily responsible for the data system management and data reporting components of the MIECHV program. All staff will work closely with Mr. Ward Ballard, located in the Bureau of Vital Records and Health Statistics, Community Services in the Department of Health and Welfare.

#### *Incorporation of Program Goals, Objectives, and Activities into Ongoing Work*

The MIECHV program’s proposal for the Expansion Grant includes several components of early childhood and home visiting systems building in addition to implementation of EBHV. The proposal outlines one goal for implementation of EBHV programs in target communities and five goals related to home visiting systems building. The MIECHV program intends to develop public awareness and stakeholder buy-in through the activities associated with the systems building goals. Public awareness is critical in advancing the field of home visiting in Idaho. Currently, there are very few home visiting programs providing services in Idaho and systems building work is in its infancy. Successful execution of the goals and demonstration of success of the state and local MIECHV programs will support long term sustainment of program goals, objectives, and activities.

Since the MIECHV program inception, the program has sought to engage key partners through the planning steering committee, presenting program updates at the Regional and State Early Childhood Coordinating Councils. Additionally, local MIECHV programs are required to establish community advisory to engage key community stakeholders in the implementation of the MIECHV programs. These activities coupled with those proposed for the Expansion Grant will encourage long term incorporation and sustainment of the goals, objectives, and activities of the MIECHV program.

### *Logic Model*

The MIECHV program has developed a logic model depicting the proposed resources, inputs, outputs, outcomes, and assessment of the outcomes. The logic model was developed for the Expansion Grant and can be found in attachment 8.

### *Resolution of Challenges*

The MIECHV program presents an opportunity to initiate dialogue about strategies to advance high quality home visiting programs and systems. The MIECHV program anticipates confronting some challenges while implementing the activities outlined in the work plan of this proposal. Some of the challenges that the MIECHV program anticipates are: length of time to establish contracts, lack of awareness of the home visiting as an intervention, lack of a home visiting system, partners working autonomously of each other, lack of experience with continuous quality improvement (CQI), lack of understanding of “model fidelity,” and understanding the purpose of high quality data collection and use. Because of the frontier and independent nature of Idaho’s communities, there may be challenges in community buy-in, participant recruitment, and retention. Similarly, there may be challenges related to adequate community resources, frequency and duration of home visits, and coordinated referrals.

To address challenges related to timeliness of contract execution, the MIECHV program will utilize contract templates developed for the formula grant and PHDs to expedite the contracting process. The MIECHV program will assist local implementing agencies in building relationships with community partners and resources to build awareness of home visiting. The MIECHV program plans to facilitate a home visiting awareness campaign that engages local implementing agencies, state partners, and community members. In the campaign, the benefits of a home visiting program will be highlighted, along with outreach and referral to program partners. The challenge of partners working autonomously is on-going. Internal and external partners are being engaged in grant applications, public input, referral services, and emphasis is being placed on ensuring public health and home visiting, as applicable, are represented at critical discussions being held with stakeholders.

CQI is a critical component of the MIECHV program as discussed previously. The MIECHV program has developed a CQI plan to evaluate processes and outcomes and identify performance improvement opportunities on an ongoing basis to inform service delivery and monitor model fidelity. Ensuring program partners understand the meaning of model fidelity will assist in program adherence to the design and implementation that was intended. This is viewed as vital to achieve positive home visiting results for children and families of Idaho.

Given the frontier-nature of Idaho’s composition, home visiting in isolated, frontier communities will require careful monitoring to assure families receive a sufficient level of service. Geographic barriers may exist in very rural and frontier areas, thus making data collection challenging. The independent

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 nature of Idaho’s populous may present a challenge in collecting data on all families served by the MIECHV program. Maintaining data collection of implementation and service delivery of each home visiting model will allow the program to identify targeted improvement efforts and progress toward model fidelity. To monitor successes and challenges, local agencies are required to submit monthly reports that include number served, home visits, successes and challenges, and community collaboration updates. To assist with model fidelity, the MIECHV program will develop and provide training and technical assistance to local implementing agencies related to data collection, data quality, data use, CQI, referrals tracking, and formal community partnerships.

***Evaluation and Technical Support Capacity***

***Evaluation Methodology and Plan***

In September 2011, the MIECHV program established a contract with the Boise State University (BSU) Center for Health Policy (CHP) to conduct the evaluation of the MIECHV program. Between 2011 and 2013, the BSU CHP evaluation team developed seven evaluation goals with evaluation methods to support each evaluation goal. Data collected in 2012 and 2013 captured information on the three EBHV (EBHV) models (EHS, NFP, and PAT) currently implemented in the state, helping guide statewide system building and service delivery in different types of communities in Idaho. For the Expansion Grant, the MIECHV program and BSU CHP evaluation team propose to expand the evaluation plan to include Implementation of one new EBHV model – HFA; Expansion of the MIECHV program to six additional implementation sites not currently involved in the MIECHV program; and Two additional evaluation components focused on assessing maternal stress and depression and community context. If the Expansion Grant is awarded, the BSU CHP will apply for IRB approval of the evaluation design and comparison group in October, 2013 through BSU. As necessary, the MIECHV program will also apply for IRB approval through the Department of Health and Welfare in October 2013.

**Evaluation Goal 1:** After three years of MIECHV program implementation, the evaluation should illuminate the program factors associated with participant outcomes. Program factors of evaluation interest include: dosage (number of home visits and length of participation), content (curriculum and core activities), and relationship (participant to home visitor and home visitor to supervisor).

**Table 12:** Evaluation Goal 1 Dosage Variable

<b>What is dosage?</b>	<ul style="list-style-type: none"> <li>• Expected frequency of home visits</li> <li>• Expected duration of home visits</li> <li>• Expected length of home visits</li> </ul>
<b>Why measure dosage?</b>	<ul style="list-style-type: none"> <li>• Is the program being implemented with fidelity to the model?</li> <li>• Does the study assess effectiveness of model as conceptualized by model developers?</li> <li>• Interpret the evaluation results</li> <li>• Identify implementation issues and find solutions</li> </ul>
<b>Tools to measure dosage</b>	<ul style="list-style-type: none"> <li>• Home Visiting Encounter Form (at every visit)</li> <li>• Family/Child Program Exit Form (at exit)</li> </ul>

**Table 13:** Evaluation Goal 1 Dosage Requirements

<b>EBHV Program Model</b>	<b>Expected Duration</b>	<b>Expected Frequency</b>	<b>Expected Length</b>
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<b>EHS</b>	Birth or prenatal through the child's third birthday	Weekly home visits (minimum of 48 visits per year), semi-monthly socialization activities (minimum of 22 group socializations per year)	Minimum of 90 minutes
<b>HFA</b>	Birth or prenatal through the child's fifth birthday	Weekly home visits for at least the first six months; dosage may be adjusted based on family needs after this time	Minimum of 60 minutes
<b>NFP</b>	During pregnancy and through the child's second birthday	Weekly for the first month after enrollment, and then every other week until birth, weekly for the first six weeks after birth, then every other week until child is 20 months old, and then monthly until the child is two years old	60 to 90 minutes
<b>PAT</b>	Birth or prenatal through child's fifth birthday	Minimum monthly home visits and group visits	50 to 60 minutes

Paulsell et al. (2010) suggest that the content of home visiting is influenced by whether a program uses a specific curriculum or a more general approach. They note that information pertaining to how to use the model-specific curriculum (as envisioned by the model developers) is usually delivered to the home visitors and supervisors through training sessions and manuals. The curriculum typically identifies tools that home visitors can use with families during home visits. These tools include assessment of children's development and families' strengths and needs, visit-by-visit activity plan, and educational materials to leave with families (Paulsell et al., 2010).

**Table 14:** Evaluation Goal 1 Content Variable

<b>What is content?</b>	<u>Program-specific curriculum:</u> <ul style="list-style-type: none"> <li>• Assessment of child's development</li> <li>• Assessment of family's strengths and needs</li> <li>• Visit-by-visit activity plan</li> <li>• Educational material to leave with families</li> </ul>
<b>Why measure content?</b>	<ul style="list-style-type: none"> <li>• Is the program being implemented with fidelity to the model?</li> <li>• Do activities carried out during home visiting reflect the program model's guidelines?</li> <li>• Does the information provided to the family reflect the program model's guidelines?</li> <li>• Whether and to what extent content varies over the course of a family's enrollment</li> <li>• Whether and to what extent content varies across families enrolled in particular program</li> <li>• Identify topics associated with positive parent and child outcomes</li> <li>• How well was the content covered and how well did the parents understand the material?</li> </ul>
<b>Tools</b>	<ul style="list-style-type: none"> <li>• EBHV Home Visiting Encounter Form (at every visit)</li> </ul>

The relationship between the home visitor and the program participant is the aspect that is often described as the 'heart' of home visiting (Paulsell et al., 2010). There are two key components of relationship quality: the relationship between the home visitor and the program participant, and the relationship between the home visitor and the supervisor.

**Table 15:** Evaluation Goal 1 Relationship Variables

<i>Home Visitor – Parent Relationship Quality</i>	
<b>HV - Parent relationship</b>	<u>Implementing a strengths-based approach:</u> <ul style="list-style-type: none"> <li>• Developing rapport and trust</li> </ul>

<b><i>Home Visitor – Parent Relationship Quality</i></b>	
<b>quality</b>	<ul style="list-style-type: none"> <li>• Assessing strengths and needs regularly</li> <li>• Establish honest and respectful communication</li> <li>• Focus on empowering clients to identify solutions and actions</li> </ul>
<b>Why measure relationship quality?</b>	<ul style="list-style-type: none"> <li>• Is the program being implemented with fidelity to the model?</li> <li>• How well are home visitors able to develop a meaningful relationship that facilitates the delivery of program content?</li> <li>• Does the quality of the relationship between the HV and the parent influence the extent and quality of parent engagement and involvement in the program?</li> <li>• Does higher quality relationship contribute to more positive child and family outcomes?</li> </ul>
<b>Tools</b>	<ul style="list-style-type: none"> <li>• Observation of home visitor-family interaction during home visits:                             <ul style="list-style-type: none"> <li>➢ Home Visit Rating Scales-Adapted (HOVRS-A) consists of two subscales:                                     <ul style="list-style-type: none"> <li>○ Home Visitor Strategies (four scales that focus on the quality of the home visitor’s strategies)</li> <li>○ Participant Engagement (three scales that focus on how engaged the parent is with the home visitor and the child and how engaged the child is with the activities of the home visitor)</li> </ul> </li> </ul> </li> <li>• Home visitor and participant report about relationship quality                             <ul style="list-style-type: none"> <li>➢ Working Alliance Inventory (WAI) is completed periodically by both the home visitor and the parent                                     <ul style="list-style-type: none"> <li>○ Assesses how home visitors and participants rate their level of collaboration and the extent to which they have similar goals and similar visions for the home visiting services provided</li> </ul> </li> </ul> </li> </ul>
<b><i>Home Visitor – Supervisor Relationship Quality/Reflective Supervision</i></b>	
<b>HV - Supervisor relationship quality</b>	<p><u>Can be accomplished during regular one-on-one and group sessions</u></p> <ul style="list-style-type: none"> <li>• Attending to the interpersonal nature of the work (including feelings about interactions with families)</li> <li>• Reflecting on experiences</li> <li>• Discussing the challenges of working with high-need families</li> </ul>
<b>Why measure relationship quality?</b>	<ul style="list-style-type: none"> <li>• Provide guidelines on content and monitor the alignment of home visit content to the program curriculum and fidelity standards</li> <li>• Support the home visitor in strengthening relationships with families</li> <li>• Identify barriers to building strong relationships and completing home visits</li> <li>• Reduce staff burnout and turnover</li> </ul>
<b>Tools</b>	<p><u>Reflective Tool/Reflective Supervision Implementation Process Plan</u>                      Evaluation-related section of the Reflective Tool addresses the “How is RS going?” question and includes the following items:</p> <ul style="list-style-type: none"> <li>• When will staff have the opportunity to provide feedback about RS?                             <ul style="list-style-type: none"> <li>○ How often will this opportunity be provided (annually, monthly)?</li> </ul> </li> <li>• What form will these feedback sessions take?                             <ul style="list-style-type: none"> <li>○ Occur during staff meetings?</li> <li>○ Occur via anonymous surveys?</li> </ul> </li> <li>• Does the staff feel RS is helpful?                             <ul style="list-style-type: none"> <li>○ Do they like the: (1) format, (2) supervisor, and (3) frequency?</li> </ul> </li> <li>• Do they feel the need for any change? If yes, what?</li> <li>• How does the staff feel about options currently under consideration?</li> <li>• How is your organization going to incorporate the staff’s feedback?</li> </ul> <p><u>Leadership Self-Assessment Tool</u></p>

**Evaluation Goal 2:** After three years of the MIECHV program implementation, the evaluation should provide information on participant outcome variation across home visiting models. Model factors of evaluation interest include: professional credentials, target population, training, and staffing ratios.

The evaluation will seek to identify subcomponents of each program that are associated with specific outcomes, identify components of individual programs that are most effective in improving the outcomes for program participants, and compare different program outcomes. Model factors of evaluation interest for the four models implemented in Idaho are summarized in Table 16. Program factors of evaluation interest include:

- Target population characteristics
- Staffing ratio:
  - Supervisor to home visitor (each supervisor’s current caseload of home visitors)
  - Home visitor to supervisor (each home visitor’s current caseload; average hours or one-to-one supervision provided to each home visitor)
- Qualifications of home visitors
- Training in program implementation (date of completion of model-specific training)

**Table 16:** Evaluation Goal 2 Model-Related Variables

<b>EBHV Program Model</b>	<b>Target Population</b>	<b>Staffing Ratio</b>	<b>Qualifications of Home Visitors</b>
<b>EHS</b>	<p>Low-income (at or below the FPL) pregnant women and families with children birth to age 3 years</p> <p>At least 10 % of family enrollment available to children with disabilities</p> <p>Each individual EHS-Home Visiting program is allowed to create specific program eligibility criteria</p>	<p>Home visitors maintain an average caseload of 10 to 12 families, with a maximum of 12 families</p>	<p>Home visitors must have knowledge and experience in: child development, early childhood education; child health, safety, nutrition; adult learning principles; family dynamics</p> <p>Home visitors must be able to communicate effectively with the families with no or limited English proficiency. They can serve families either directly or through an interpreter. Home visitors must be sensitive to familiar with ethnic background and culture of families</p>
<b>HFA</b>	<p>Low-income pregnant women or families enrolled prenatally or at birth; services are available up to child’s fifth birthday</p>	<p>Home visitors have maximum of 15 families receiving weekly visits or 25 families receiving less frequent visits</p>	<p>Home visitors are recommended to have experience working with families with multiple needs. All staff are required to complete mandatory HFA training</p> <p>Home visiting supervisor required to possess a minimum of a baccalaureate degree; master’s level with clinical and reflective</p>

			supervision background is preferred
<b>NFP</b>	First-time, low-income mothers and their children  (Enroll first-time mothers between 16 to 28 weeks of gestation, and offer a first home visit no later than the end of the woman's 28th week of pregnancy; services are available until the child is two years old)	A full-time nurse home visitor carries a caseload of no more than 25 clients	Nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing  Nursing supervisors should preferably hold a master's-level degree in nursing
<b>PAT</b>	Income based criteria Families at risk for child abuse Teen parents First-time parents Immigrant families Children with special needs Parents with mental health or substance abuse issues	Essential requirements are based on expected number of visits conducted each month per parent educator *Full-time parent educators should complete no more than 60 visits per month *New parent educators (those working for PAT less than one year) should conduct no more than 48 visits per month	Parent educators must have a High school diploma or GED and a minimum of two years of previous supervised work experience with young children and/or parents At least a four-year degree in early childhood education or a related field <b>OR</b> at least a two-year degree or 60 college hours in early childhood or a related field

**Evaluation Goal 3:** After three years of the MIECHV program implementation, the evaluation should provide information on relationship of reflective supervision (RS) and home visitor staffing. Supervision factors of evaluation interest include: staff retention, frequency of supervision, group and individual reflection, supervisor training and qualifications.

In respect to the implementation of RS, Heller (2010) recommends that the organizational atmosphere (such as the level of trust and open communication) needs to be ripe for RS implementation, and that organizations should not rush the implementation of RS (training of the staff needs to occur before RS can be implemented and members from all levels of organization should be involved in the planning process). Heller suggests that the persons responsible for RS implementation need to realize the depth of RS before implementing it (2010). Heller further suggests these questions be asked to supervisors prior to RS, the evaluation team will utilize these questions with supervisors as a pre- and post-survey:

1. In your own words, describe the mission of your program.
2. Briefly describe RS and its purpose.
3. How do you see RS supporting your agency's mission?
4. What benefits do you hope RS will provide your program?
5. What benefits do you hope RS will provide your staff?
6. What challenges will need to be addressed in the implementation of RS in your program?
7. What fears or concerns do you have about implementing RS in your program?
8. What fears or concerns do you think your staff will have?
9. What are the first steps you want to take to move this forward in your program?
10. What are you looking forward to when RS gets under way within your agency?

**Evaluation Goal 4:** After three years of the MIECHV program implementation, the evaluation should provide information on the relationship between organizations and participant outcomes and access and barriers to community resources and supports. Factors of evaluation interest regarding community resources and supports include: availability/accessibility to community resources (cost and location), perception of community supports, coordination of community resources and home visiting organizations.

FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP) has developed a self-assessment tool for assessing the level of community collaboration efforts of EBHV programs (from EBHV study) (Winkle et al., 2011). The purpose of this self-assessment tool is to be used by the implementing agency to assess their agency's position in the community, to help programs evaluate "their ability to work cooperatively with other organizations, their knowledge of available community resources, and their ability to access those resources, as appropriate" (Winkle et al., 2011, p. 43). The program administrators will complete this self-assessment tool during the pre-implementation phase and then every six months thereafter to document changes that occur over the course of implementation.

The Family Support Program Outcome Survey (FSPOS), also developed by FRIENDS, will serve as an outcome evaluation tool to assess the level of improvement in child and family outcomes related to several preventive factors (such as access to and understanding of formal and informal support systems and ability to meet basic needs). Most items on this survey ask parents to evaluate the changes they have experienced over time as a function of participating in the home visiting program and receiving family support services by rating a number of statements twice ("before" and "today"). The survey also includes two qualitative items asking participants to provide suggestions for improvement and to explain what they liked the most about the program. Finally, the FSPOS provides an option to develop and add program-specific items. These additional items will be developed in collaboration with the local MIECHV programs during the initial implementation stage. The FSPOS will be administered annually and at exit to determine to what extent parents experience change in accessing formal and informal support systems as a result of participating in the home visiting program.

**Evaluation Goal 5:** Throughout the MIECHV program implementation, the evaluation should provide information and insight on organizational processes and performance related to model fidelity, organizational priorities, and continuous quality improvement. Process and performance factors of evaluation interest include: indicators of model fidelity, training in data analysis and utilization, administrative staffing and supports, and organizational communication.

This goal encourages the evaluation of three separate, though interrelated, constructs: 1) program (or model) fidelity; 2) organizational priorities; and 3) continuous quality improvement (CQI). In their evaluation of 17 EBHV grantees from Rhode Island to Hawaii, Koball and her colleagues (Koball et al., 2009) at Mathematica Policy Research, Inc. and Chapin Hall at the University of Chicago highlighted the importance of measuring program fidelity in any evaluation of HV programs. Differentiating between initial fidelity (pre-implementation organizational capacity, training, compliance with model requirements, data collection, recruitment, and referral plans) and ongoing fidelity (caseloads, staffing, supervision, and quality and quantity of HV services), Koball et al.

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(2009, pp. 37-39) created a matrix of initial and ongoing fidelity indicators they considered key to capture in order to understand the level of overall fidelity of EBHV programs. These fidelity indicators were grouped into five domains, including: 1) program-level descriptive data; 2) staff characteristics; 3) program-level service data; 4) participant characteristics; and 5) participant-level service data. The evaluation team will collect information on each of these domains and indicators. To gain a better understanding of model fidelity, the evaluation team will study the following additional variables:

- Collect information on parent-home visitor relationship not captured by the WAI, including:
  - A systematic assessment of participants' needs
  - Individualized or responsive practice based on a family's assessed needs
  - Participants' involvement in decision making and encouraging participants to ask questions and raise concerns
  - Cultural relevance/sensitivity
- Construct key fidelity indicators for data collected in Table 17. Key fidelity indicators include:
  - Participants' dosage, duration of services, and reasons for service termination
  - Home visitors' training, education, and experience, average caseload, and reasons for termination among their caseload
  - Ratio of supervisors to home visitors and the ratio of clients served to program capacity
- Reporting of key fidelity indicators in two ways, including:
  - The actual level of the indicator (for participant's dosage, calculate the number of home visits participant received)
  - Whether the indicator met the model standards (participant received the number of home visits required by the national guidelines)
- Aggregation of key fidelity indicators over time, to balance or control for monthly variation
- Aggregation of key fidelity indicators up to the service delivery location to facilitate comparisons (average participant dosage)
- Group aggregate location-level measures by key subgroups, such as by local MIECHV program, program model, primary target population, or geographic area, to better understand the patterns of fidelity across locations (Koball et al., 2009, pp. 38-39)

**Evaluation Goal 6:** By the third year of program implementation, the MIECHV program will assess and evaluate the prevalence of maternal stress and depression of participants.

Maternal depression can have a profound negative impact on a mother's parenting, child attachment, and child development. Depressed mothers are less attentive to children's needs and emotional cues when in the depressive state and even when depressive state is abated. Rates for maternal depression vary among racial and ethnic groups as well as individuals of different socio-economic status. Socio-demographic variables typically associated with disadvantaged populations such as low-income, ethnic or racial minority, unmarried, and low educational attainment are also associated with high rates of maternal depression. Individuals with one or more of these characteristics are often targeted by early childhood home visiting programs, and the MIECHV program is no exception. There is an emerging body of research on the prevalence, impact, and treatment of maternal depression in the context of early childhood home visiting programs. Recent research findings indicate a high rate of maternal depression among mothers participating in early childhood home visiting programs (Ammerman, 2010).

Because maternal depression appears to have a significant effect on outcomes related to child development and whether or not mothers access available community resources, this evaluation goal seeks to understand the prevalence of maternal depression in participants in the MIECHV program. The evaluation team will study the following four primary variables to understand the prevalence of maternal depression in participants in the MIECHV program:

- Scores from the Edinburgh Postnatal Depression (EPDS) Scale at 45 days, six months, and 18 months postpartum
- Scores from the Everyday Stressors Index (ESI) at intake and every 12 months thereafter
- Survey of mental health resources and supports available to participants within the local MIECHV program organization and the community
- Referral and referral follow-ups for mental health services for participants

Local implementing agencies working with the MIECHV program are required to screen all mothers using the EPDS at 45 days postpartum. The six and 18 months postpartum screens will be added with the Expansion Grant. The ESI assesses problems commonly faced by low-income mothers with young children such as financial stress, role overload, employment problems, parental worries, and interpersonal problems. Local implementing agencies working with the MIECHV program are required to screen all mothers using the ESI at intake and annually thereafter. Screening and referral data will be extracted from the MIECHV program ETO data system. The evaluation team will utilize information elicited from CBCAP community collaboration survey and key informant interviews to collect information related to mental health resources and supports available to participants within the organization and the community.

**Evaluation Goal 7: By the third year of program implementation, the MIECHV program will assess and evaluate the community context as it relates to model fidelity and program implementation.**

Recent EBHV research efforts have been largely focused on three key aspects of implementation including fidelity, community context, and professional development (Yowell, 2012). The MIECHV program is particularly interested in assessing one of these three key aspects: *community context*. Even though nearly all EBHV activities take place through interactions between home visitors and participating families in the participating families' homes, their effectiveness is not purely contingent on the home environment of individual families enrolled in the program or the quality of home visitation services provided by home visitors. The EBHV services occur within the community setting in which both the home visiting program and the participating families reside.

There is an increasing interest amongst researchers to understand how implementation relates to outcomes (Durlack & DuPre, 2008; Wanderman et al., 2008). In their recent study, Durlak and DuPre (2008) examined the relationship between implementation and outcomes and identified community context as one of the five categories that could influence the effectiveness of dissemination and implementation. For the purposes of this evaluation goal, the MIECHV program and evaluation team will examine two levels of community: 1) The organizational community context, and 2) The context of the wider community in which the program is being implemented

At the level of the organizational community context, the evaluation will compare the three EBHV models implemented in Kootenai and Shoshone counties (NFP, PAT, and EHS). These three models differ in several ways; one way in which they are different is the degree of 'flexibility' of each model in terms of adapting to the local community context and the needs of the clients. Limiting this

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At the level of the wider community context, we propose to conduct a within-community comparison to assess the level of community readiness in the initial stages of implementation, one year later and two years later. Additionally, the evaluation intends to assess the level of awareness about the presence of home visiting programs and community members' perception of the purpose of these programs in each community. The study design will be a multiple case study to identify some factors that exist in each community that positively or negatively influence implementation of EBHV programs. The study will be a prospective research design with several data collection points and multiple methods of data collection including: community collaboration self-assessment tool, survey of community members, and focus groups and/or interviews with key stakeholders.

*Evidence of organizational experience and capability to coordinate, plan, implement, and evaluate*

As the primary research arm of the COHS at BSU, the CHP has been involved for over a decade in conducting needs assessments, program evaluations, and policy- and health care-related research for organizations throughout Idaho and the United States. Some of the organizations are non-profits (including the American Lung Association, Healthwise, Idaho Housing and Finance Association, Idaho Primary Care Association, Maine Primary Care Association, Terry Reilly Health Services, University of Wisconsin, Wyoming Health Resources Association), and several are large state agencies. The BSU CHP is prepared to expand its work with the MIECHV program, as it has completed similar projects such as numerous studies of factors related to the recruitment and retention of rural family physicians, and studies of family planning initiatives, and insurance options for low-income Idahoans. The BSU CHP manages multiple contracts per year. In fiscal year 2013, the BSU CHP managed 20 different contracts, in excess of \$1.5 million. It has a full staff of faculty and graduate students with a broad range of expertise and experiences. The BSU CHP is an established research partner with a large and varied group of clients with a capable base of operational support.

***Organizational Information***

*Mission, structure, and scope of activities related to home visiting and early childhood systems*

The Idaho Department of Health and Welfare (the Department) has designated the Bureau of Clinical and Preventive Services, Division of Public Health, as the entity responsible for carrying out the MIECHV program planning, evaluation and implementation activities. The Department is charged with management of a multitude of public programs including: Medicaid, Welfare, Substance Abuse, Mental Health, Public Health, Temporary Assistance for Needy Families, Child Care, and Food Stamps. The mission of the Department is to promote and protect the health and safety of Idahoans. The Department programs and services are designed to help people live healthy and be productive; strengthening individuals, families and communities from birth throughout life. The Department operates with a goal of helping people become self-reliant, working with them to identify issues and solutions to their problems. The Department has nine Divisions:

- Medicaid
- Public Health
- Behavioral Health
- Family and Community Services
- Welfare
- Operational Services
- Information and Technology
- Licensing and Certification
- Support Services

The purpose of the MIECHV program closely aligns with the Department's mission and goals to promote health, economic self-reliance, and strengthen individuals and families. These are similar goals of the MIECHV program to promote maternal and child health, strengthen families and parenting practices, and improve family economic self-sufficiency. At the Department there is no

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013 other early childhood home visiting programs with the exception of the Early Intervention – Infant Toddler Program (IDEA Part C), which provides home-based services and care coordination using evidence-based practices for young children with developmental delay. The Infant Toddler Program is housed within the Division of Family and Community Services. The Early Childhood Comprehensive Systems Grant is also administered in the Division of Family and Community Services. The MIECHV program works closely with both the Infant Toddler Program and the Early Childhood Comprehensive Systems Grant.

#### *Home Visiting Infrastructure to Support Program Goals*

The Division of Public Health supports the goals and activities of the MIECHV program, including collaboration with other Divisions within the Department. The MIECHV program needs to continue building awareness of the benefit and outcomes of high quality home visiting programs for women, infants, young children, and their families. The MIECHV program will continue to develop partnerships, engage critical stakeholders, compile data and information, and build support systems for home visiting programs in Idaho to strengthen the infrastructure to support high quality home visiting.

#### *Culturally and Linguistically Sensitive Services*

The Department of Health and Welfare and the Division of Public Health serve nearly all Idahoans through public health infrastructure, health, and welfare services. The Department seeks to develop a culturally informed and aware workforce through trainings and professional development opportunities. The Division of Public Health administers the rural health, refugee health, WIC program, Children’s Special Health Program, AIDS/HIV program, and the immunization program which serve culturally and linguistically diverse populations. The MIECHV program will utilize these resources and seek additional supports to ensure service delivery is culturally sensitive and supportive of improved health literacy for local MIECHV programs, home visiting staff, and participants.

#### *Assessment of Target Population and Communities*

The MIECHV program reviews county, public health, and state-level population data including, birth, child abuse and neglect, and health behaviors data using data managed in the Divisions of Public Health in the Bureau of Vital Records and Health Statistics. The MIECHV program has established an intra-agency Memorandum of Agreement with the Child Welfare program in the Division of Family and Community Services to share administrative child abuse and neglect data throughout the duration of the MIECHV program. The MCH Program has a designated analyst within the Bureau of Vital Records and Health Statistics who supports data analysis for program planning and evaluation. The MIECHV program will analyze program and participant data maintained in the MIECHV program ETO data system to assess unique needs of target populations.

#### *Resources after Project Period Ends*

There are no other state, federal, or private resources supporting the MIECHV program. Local MIECHV programs are charged with developing a sustainability plan including developing community partnerships during the contract term. The materials and relationships developed during the project period will continue beyond the program.

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**BOISE STATE UNIVERSITY**  
CENTER FOR HEALTH POLICY

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Ms. Odjidja Boateng:

Please accept this letter in support of the Idaho Maternal, Infant and Early Childhood Home Visiting (MIECHV) program's application for the Affordable Care Act - Maternal, Infant and Early Childhood Home Visiting Program Expansion Grants to States for FY13 on behalf of the Boise State University Center for Health Policy. The Center for Health Policy (CHP) is a research unit within the College of Health Sciences that conducts health science research and collaborates in the development of innovative health policy in Idaho. CHP is comprised of faculty and students from the College of Health Sciences and other academic units of the university. In addition, CHP also partners with governmental agencies, non-profits and the private sector in conducting health science research.

In September 2011, the Center for Health Policy was awarded a contract (HC734500) with the Idaho Department of Health and Welfare MIECHV Program to design and implement evaluation and cost analysis plans for the program. The initial evaluation design developed by CHP focused on five goals related to participant outcomes and implementation factors. Throughout the past two years (a second yearlong contract was signed in September 2012), the evaluation team has worked diligently to develop the benchmarks, cost analysis, and evaluation plans, support development of the data system, and perform evaluation activities including data collection and analysis. If the Idaho MIECHV program is awarded an expansion grant, the CHP is committed to continue evaluation and implement the additional components outlined in the grant proposal.

We support the Idaho MIECHV program to add two evaluation components focused on assessing prevalence of maternal stress and depression and community context, implement a new evidence-based home visiting model, and expand the implementation of home visiting programs to six additional sites. Additional funding for evaluation would support research staff time, evaluation activities, and travel to local MIECHV program sites.

Sincerely,

Ed Baker, Ph.D, Director  
Boise State University Center for Health Policy  
The Ron & Linda Yanke Family Research Park  
220 E. Parkcenter Blvd.  
Boise ID 83706-1830

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**Public Health**  
Prevent. Promote. Protect.

Idaho Public Health Districts

## IDAHO ASSOCIATION OF PUBLIC HEALTH DISTRICT DIRECTORS

June 24, 2013

Angela Odjidja Boateng, JD, MHS  
Health Resources and Services Administration  
Maternal and Child Health Bureau  
Parklawn Building, Room 10-86  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Odjidja Boateng:

As the current Chair for the Idaho Association of Public Health District Directors, I welcome the opportunity to provide this letter of support for Idaho's application by the Maternal and Children's Health (MCH) Program for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program Expansion Grant. The goals of Idaho's MCH programs are to ensure the health, safety and well-being of the state's mothers, children and families. Local Public Health collaboration with programs such as the MCH/MIECHV programs help support the state's work in fulfilling this goal.

The Local Public Health Districts in Idaho are committed to partnering with the MCH program to support MIECHV activities and promote collaboration within the Division of Public Health. We are actively engaged in every county in our state, providing Public Health services to our population. We have a longstanding track record of working collaboratively with the Division of Public Health in MCH programs. This ongoing communication and collaboration will be critical for successful outcomes for children and families of Idaho.

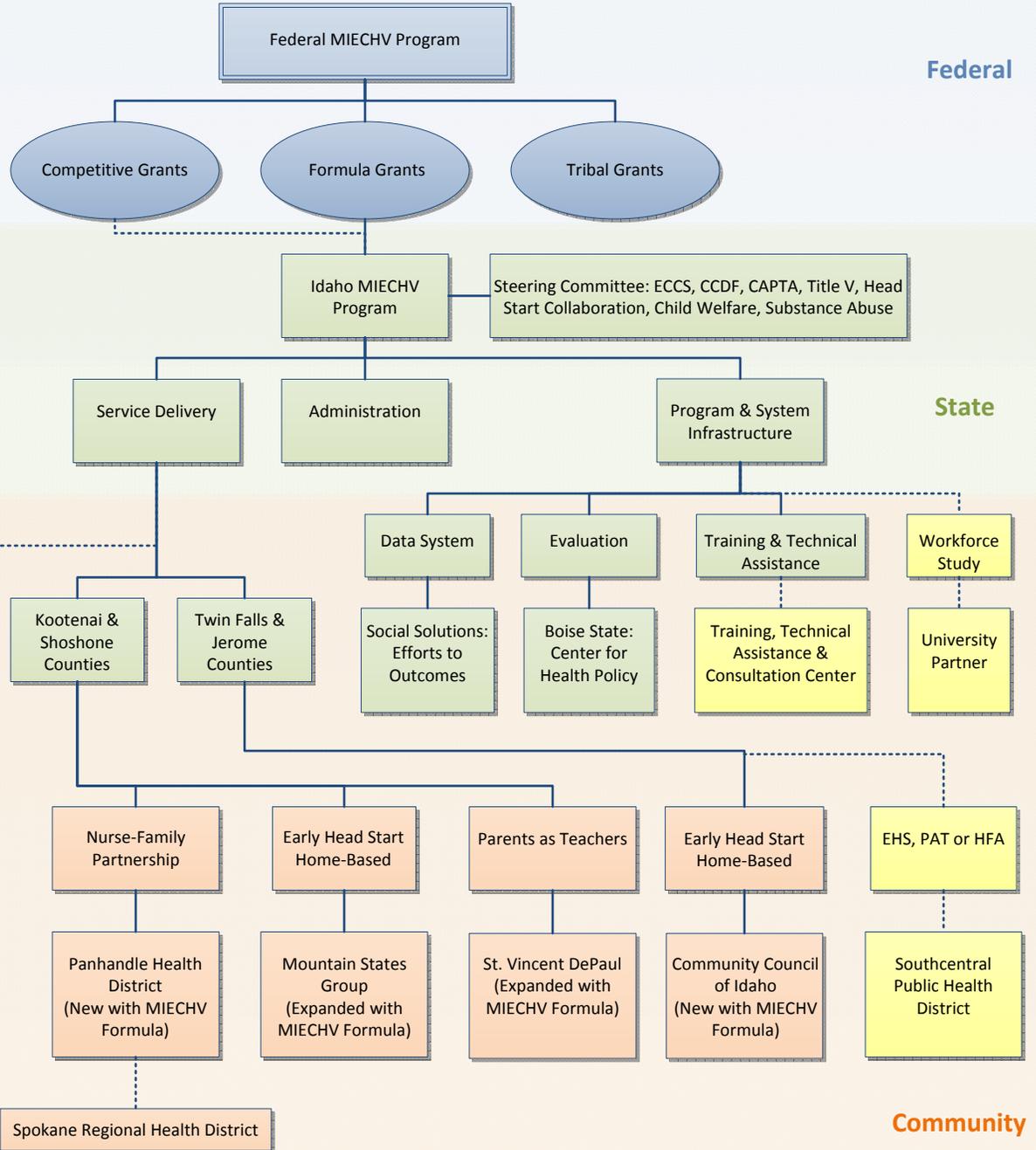
Again, the Seven Local Public Health Districts offer our enthusiasm and support for the MCH program's application for expansion funding for MIECHV activities in Idaho.

Sincerely,

Carol M. Moehrle  
Chair, IAPHDD

# Idaho's Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program

Announcement Number: HRSA-13-215  
 Idaho Department of Health and Welfare  
 Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Expansion Grants FY 2013



**Key:**  
 Proposed with 2013 Expansion Grant:  
 Shapes: Yellow  
 Lines: - - - - -  
 EHS = Early Head Start, Home Based  
 PAT = Parents as Teachers  
 HFA = Healthy Families America

**ATTACHMENT 6: Work Plan and Project Timeline**

Activity	Input	Timeframe	Person Responsible	Output
<b>Goal 1:</b> With the Development Grant, the Idaho MIECHV program will partner with a university-based partner to conduct a two-phase workforce study to assess state of and needs for professional development and training of home visiting programs across Idaho by July 2015.				
<i>Objective 1: Conduct workforce study to provide a comprehensive view of the home visiting workforce in Idaho including issues related to: recruitment, training, retention, skills needed, Adverse Childhood Experiences (ACEs), and salary by January 2015.</i>				
Develop contract requirements including purpose, scope of work, performance metrics, reports, and cost and billing for the workforce study	Project Staff	November 2013	State Lead Program Specialist	Contract requirements agreed upon by program and university partner
Establish a contract with a university partner to carry out the activities of the Idaho home visiting workforce study	Project Staff University Partner	December 2013	Program Manager State Lead	Two-year contract with university partner
Collaborate with university partner to incorporate an ACEs component in the workforce study	Project Staff University Partner ACE Research	April 2014	State Lead Program Specialist	Comprehensive study design including ACEs component
Partner with university partner to ensure the first phase of the workforce study is completed	Project Staff University Partner Local MIECHV Programs	September 2014	State Lead Program Specialist	Completed home visiting workforce study
<i>Objective 2: Analyze and disseminate information collected in the workforce study as a basis for development of a professional development system including career ladders and training systems in coordination with existing early childhood professional development systems (such as Idaho STARS) by July 2015.</i>				
Collate and analyze information collected in the workforce study as a basis for development of professional development and training system	Workforce Study University Partner Other State Examples	December 2014	University Partner Program Specialist	Outline for professional development and training systems
Research examples of other integrated State early childhood and home visiting professional development systems	University Partner Other State Examples	February 2015	University Partner Program Specialist	Options for profession development and training systems
Convene appropriate stakeholders to share workforce study and research plans to outline plan for development of coordinated professional development system for home visiting in Idaho	University Partner Stakeholders Workforce Study Other State Examples	June 2015	University Partner Program Specialist	Initial plan for integrated home visiting and early childhood training and professional development systems
<b>Goal 2:</b> The Idaho MIECHV program will establish expansion and implementation contracts for four home visiting models in 11 target communities to increase capacity to implement evidence-based home visiting and provide training to implementing agencies about the integration of home visiting services into family-centered medical home and public health services by February 15.				
<i>Objective 1: Increase the funding (expansion) of three existing local MIECHV contractors in four existing target communities to support increased access to services by February 2014.</i>				

<b>Activity</b>	<b>Input</b>	<b>Timeframe</b>	<b>Person Responsible</b>	<b>Output</b>
Partner with three existing local MIECHV programs to ensure capacity to scale-up	Local MIECHV Programs Project Staff	February 2013	State Lead	Enrollment of additional families
Amend existing contracts to increase the funding available in the second contract year for three existing local MIECHV programs	Local MIECHV Programs Project Staff	March 2014	Program Manager State Lead	Increased funding for three local agencies' contracts
<i>Objective 2: Establish six new contracts (implementation) with six local public health districts to implement evidence-based home visiting in seven new target counties (urban, rural, and frontier) and two existing target counties by April 2014.</i>				
Host community meetings in the seven newly identified target communities to engage community partners and build awareness around the MIECHV program goals and objectives	Project Staff Stakeholders Local Public Health Districts Department Facilitator Prior Community Meetings	December 2013 - January 2014	Program Manager State Lead Program Specialist	Community meetings in Nez Perce and Clearwater, Canyon, Ada, Bannock and Power, and Bonneville counties
Develop contract requirements to implement a four nurse, Nurse-Family Partnership program in Canyon County	Project Staff Existing NFP contract Contract Team	April 2014	State Lead Program Specialist	Contract for four-nurse NFP Team in Canyon County
Work with Southwest District Health Department to develop and complete a Nurse-Family Partnership Implementation Plan	Project Staff NFP Program Support Southwest District Health	May 2014	State Lead Program Specialist	Completed NFP Implementation Plan
Work with the Health Families America National Office to become a HFA Affiliate and support local implementing agencies that select HFA to complete the affiliation application and process and ensure adherence to quality assurance, technical assistance, and evaluation.	Project Staff HFA National Office Local Implementing Agency HFA Affiliate Application	March 2014	Program Manager State Lead Program Specialist	Completed HFA Affiliate Applications
Host planning and start-up meetings with local public health districts and community stakeholders to discuss implementation of Early Head Start Home-Based, Parents as Teachers, or Healthy Families America in target communities	Project Staff Local Public Health Districts Stakeholders Model-Specific Requirements	February 2014	Program Manager State Lead Program Specialist	EBHV Models identified by each local public health district serving Nez Perce, Clearwater, Twin Falls, Jerome, Ada, Bannock, Power, and Bonneville counties
If any of the local public health districts decline the option to implement home visiting services in a target area, conduct a competitive Request for Proposal (RFP) to identify a local community-based	Project Staff Community-based organizations Contract Team	February 2014	State Lead Program Specialist	Community-based organizations identified to implement PAT, EHS, or HFA in Nez Perce,

<b>Activity</b>	<b>Input</b>	<b>Timeframe</b>	<b>Person Responsible</b>	<b>Output</b>
organization to provide Early Head Start Home-based, Parents as Teachers, or Healthy Families America in target communities according to State procurement requirements	Prior RFP Model-Specific Requirements			Clearwater, Twin Falls, Jerome, Ada, Bannock, Power, and Bonneville counties
Develop contract requirements to implement the chosen home visiting models in target communities with the local public health districts or community-based agency as identified by the RFP process	Project Staff Local Public Health District Community-Based Org Contract Team Model-Specific Requirements	March 2014	State Lead Program Specialist	Contract requirements agreed upon by program and contractors
Establish contracts with the local public health districts or community-based agencies	Project Staff Local Public Health District Community-Based Org Contract Team	May 2014	Program Manager State Lead	Two-year contracts with local implementing agencies
Provide orientation, training, and technical assistance to contracted agencies to meet MIECHV program requirements and model requirements	Project Staff MIECHV Program Manual Webinars	April 2014 – September 2015	State Lead Program Specialist	Equipped local MIECHV programs
<i>Objective 3: The Idaho MIECHV program will support local public health districts implementing an evidence-based home visiting program to link and integrate home visiting services with medical and public health services offered through the public health district, including medical home coordination.</i>				
Include contractual requirements for public health districts 6 and 7 that are implementing a maternal and child health medical home demonstration project to link families receiving home visiting services with the medical home coordinator when appropriate	Project Staff Local Public Health District Contract Staff Medical Home Staff	May 2014	Program Manager State Lead	Contractual requirements for home visiting program and medical home program co-located within the health district to coordinate services for commonly eligible families
Host two joint trainings with public health districts 6 and 7 for home visiting and medical home staff to discuss the integration of home visiting services as part of the medical home model, provide education about each other's roles, common goals, methods for communication, benefits of coordination between programs, and a formal plan on how to link eligible families with each program's services	Project Staff Local Public Health District Home Visiting Staff Medical Home Staff Trainer/Faciliator Program-Specific Information	by December 2014	Program Manager State Lead Program Specialist	Mutual understanding and formal plan between home visiting and medical home programs to link eligible families to respective services

Activity	Input	Timeframe	Person Responsible	Output
Coordinate three facilitated regional trainings for public health districts and other implementing agencies across the state to discuss the integration of home visiting services across other public health services including family planning and interconception care and counseling, tobacco cessation, WIC, and other services relevant to home visiting, including the benefits of home visiting, common goals across programs, a formal plan on how to link and refer eligible families to each program’s services	Project Staff Local Public Health Districts Home Visiting Staff Public Health Program Staff Trainer/Faciliator Program-Specific Information	February 2015	Program Manager State Lead Program Specialist	Mutual understanding and formal plan between home visiting and local public health programs co-located together to link and refer eligible families to respective services
<b>Goal 3:</b> The Idaho MIECHV program will continue partnership with Boise State University, Center for Health Policy (BSU CHP) and expand current evaluation activities, which include: studying effect modifiers and implementation drivers such as relationship quality and continuous quality improvement respectively; to include identification and inclusion of an appropriate comparison group for study of additional implementation sites; and survey and analysis of prevalence of maternal stress and depression in home visiting participants by September 2015.				
<i>Objective 1: The BSU CHP evaluation team will illuminate program characteristics correlated with participant outcomes: content (curriculum and core activities), relationship (participant-home visitor and home visitor-supervisor), and dosage (number home visits and participation length) by September 2015.</i>				
Analyze frequency, duration, and length of home visits using data entered into the Idaho MIECHV program data system throughout service delivery	MIECHV Program Database Local MIECHV programs Evaluation Team	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on program dosage
Assess content of home visits including curriculum, assessments, activity plan, and materials provided to participants by reviewing and analyzing the home visit encounter forms	MIECHV Program Database Local MIECHV programs Evaluation Team	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on program content
Assess quality of relationships between participants and home visitors by implementing and analyzing results of the Working Alliance Inventory (WAI) and the Home Visit Rating Scales-Adapted (HOVRS-A)	MIECHV Program Database Local MIECHV programs Evaluation Team HOVRS-A and WAI	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on relationship quality
Assess and analyze the quality of relationships between home visitors and supervisors by conducting ongoing reflective supervision (RS) surveys and administering a standardized leadership self-	MIECHV Program Database Local MIECHV programs Evaluation Team	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on relationship quality

<b>Activity</b>	<b>Input</b>	<b>Timeframe</b>	<b>Person Responsible</b>	<b>Output</b>
assessment tool with supervisors	RS Surveys and Self-Assessment Tool			
<i>Objective 2: The BSU CHP evaluation team will assess the relationships between organizations, participant outcomes, and access to community resources and supports by September 2015.</i>				
Administer FRIENDS National Resource Center for CBCAP self-assessment tool to assess community collaboration of local MIECHV programs	Local MIECHV programs Evaluation Team CBCAP Self-Assessment	May 2015	Evaluation Team State Lead Program Specialist	Information on community collaboration
Administer the FRIENDS National Resource Center Family Support Program Outcome Survey with a sample of program participants	Local MIECHV programs Evaluation Team Family Support Outcome Survey	May 2014 – May 2015	Evaluation Team State Lead Program Specialist	Information on family outcomes and perceptions of program
Analyze and communicate results of the community collaboration self-assessment tool and Family Support Program Outcome Survey	Evaluation Team Family Support Outcome Survey	May 2015 - September 2015	Evaluation Team State Lead Program Specialist	Stakeholders informed of evaluation results
<i>Objective 3: The BSU CHP evaluation team will study and analyze organizational processes and performance related to model fidelity, organizational priorities, and continuous quality improvement at all local MIECHV programs through September 2015.</i>				
Adapt research on model fidelity from the Evidence-Based Home Visiting Grantees to assess pre-implementation fidelity and ongoing fidelity for program-level descriptive data, staff characteristics, program-level service data, participant characteristics, participant-level service data	Evaluation Team Research from Mathematica Policy Research, Inc., and Chapin Hall at the University of Chicago	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Ability to monitor and evaluate model fidelity
Conduct interviews with local MIECHV programs to understanding organizational priorities prior to and during implementation	Local MIECHV programs Evaluation Team	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on organizational priorities
Assess integration of continuous quality improvement into practice through key informant interviews and administering the FRIENDS National Resource Center's Peer Review in CBCAP Tool	Local MIECHV programs Evaluation Team Peer Review Tool	May 2014 - September 2015	Evaluation Team State Lead Program Specialist	Information on CQI practices
<i>Objective 4: The BSU CHP evaluation team will assess the prevalence of maternal stress and depression for participants enrolled in the local MIECHV programs by September 2015.</i>				
Conduct baseline and ongoing assessments for local MIECHV programs to assess prevalence of maternal stress and depression among participants	Local MIECHV programs Evaluation Team Edinburgh Postnatal Depression Scale	January 2014-June 2015	Evaluation Team State Lead Program Specialist	Prevalence data for maternal stress and depression

Activity	Input	Timeframe	Person Responsible	Output
	Everyday Stressors Index			
Conduct surveys and key informant interviews with local MIECHV programs and to determine available resources and supports within the organization related to maternal stress and depression	Local MIECHV programs Evaluation Team	June 2014- December 2014	Evaluation Team State Lead Program Specialist	Internal resources and supports for maternal depression
Assess community resources available within target communities to local MIECHV programs for maternal stress and depression including use of screening tools, eligibility for mental health and supportive services, location of services and resources, and accessibility of services and resources.	Local MIECHV programs Evaluation Team Local service providers CBCAP Community Collaboration Tool	January 2015- September 2015	Evaluation Team State Lead Program Specialist	Understanding of available community resources to provide context for outcomes
<i>Objective 5: The BSU CHP evaluation team will develop a study design to include a comparison group to assess community context of the local MIECHV programs as an influential factor in program implementation and effectiveness by September 2015.</i>				
Examine organizational community context within which each program is implemented for three home visiting models in Kootenai and Shoshone counties	Local MIECHV programs Evaluation Team	October 2014 - September 2015	Evaluation Team State Lead Program Specialist	Insight into influence of organizational context on outcomes
Examine context of wider community in which the program is being implemented for three home visiting models in Kootenai and Shoshone counties	Local MIECHV programs Evaluation Team	October 2014 - September 2015	Evaluation Team State Lead Program Specialist	Insight into influence of community context on outcomes
<b>Goal 4:</b> The Idaho MIECHV Program will partner with an organization to become the Idaho Home Visiting Training and Implementation Center charged with coordinating and providing training, technical assistance, and consultation to local MIECHV programs in topics related to both content and implementation such as: local early childhood systems building, infant and early childhood mental health, implementation science, domestic violence and childhood trauma, continuous quality improvement, data collection and use, and other topics to support organizations in all implementation stages (exploration, installation, initial implementation, and full implementation) by August 2014.				
<i>Objective 1: Provide local MIECHV programs access to technical assistance, consultation and training to support implementation through the Idaho Home Visiting Training and Implementation Center with fidelity by August 2014.</i>				
Develop contract requirements for the Idaho Home Visiting Training and Implementation Center to provide consultation, technical assistance, training	Project Staff	June 2014	Program Manager State Lead	Establish Idaho Home Visiting Training and Implementation Center
Partner with contracted organization to plan for develop and communicate availability of consultation, technical assistance, and training	Project Staff Home Visiting Training and Implementation Center	August 2014	Program Specialist State Lead	Training, Consultation, and Technical Assistance Plan
Survey local MIECHV programs to understand and confirm stage of implementation and needs for technical assistance, consultation, and training	Project Staff Home Visiting Training and Implementation Center	October 2014	Program Specialist	Understanding of Training and TA Needs for local MIECHV

Activity	Input	Timeframe	Person Responsible	Output
associated with this stage of implementation				programs
Provide ongoing training, technical assistance, and consultation according to the results of the survey of local MIECHV programs	Home Visiting Training and Implementation Center	June 2014 – September 2015	Program Specialist State Lead	Trained and equipped local MIECHV programs
<b>Goal 5:</b> The Idaho MIECHV Program will continue to develop and build a cross-model data system to facilitate collection, maintenance, reporting, and connectivity for local MIECHV programs by June 2014.				
<i>Objective 1: Build capacity within the Idaho MIECHV Program Efforts to Outcomes data management system to capture and maintain data for all local MIECHV programs by March 2014.</i>				
Work with the Social Solutions Efforts to Outcomes to modify the existing Idaho MIECHV program ETO enterprise to include six additional program sites	MIECHV Program Database Program Staff	January 2014	State Lead	Access to Idaho MIECHV ETO site for all local MIECHV programs
Provide user training to all local MIECHV program staff to develop understanding of functionality of the Idaho MIECHV program ETO data system	MIECHV Program Database Program Staff	March 2014	State Lead Program Specialist	Local MIECHV program staff equipped to enter and use database
Develop custom reports to assist local MIECHV program staff to understand and interpret data to inform service delivery and decision making	MIECHV Program Database Program Staff	May 2014	State Lead Program Specialist	Access to meaningful information for local MIECHV program staff
Continue to develop and refine the central intake program within the Idaho MIECHV Program ETO data system to include local MIECHV and non-MIECHV programs in all target communities	MIECHV Program Database Program Staff Local MIECHV Programs	August 2014	State Lead Program Specialist	Functional, automated centralized intake in the Idaho MIECHV ETO
<b>Goals 6:</b> The Idaho MIECHV Program will continue work with Early Childhood Comprehensive Systems (ECCS) project and Early Childhood Coordinating Council (EC3) newly formed Home Visiting and Parent Education committee to develop vision and goals, awareness of high quality home visiting, and development strategic partnerships to advance the systematic effort for high quality home visiting as an integral component of early childhood in Idaho by September 2015.				
<i>Objective 1: Through the EC3 Home Visiting and Parent Education committee develop a common understanding, vision, and objectives of high quality home visiting as it fits within the service delivery system serving families and young children in Idaho by December 2014.</i>				
Identify consultant to guide visioning process for EC3 Home Visiting and Parent Education committee	EC3 HVPE Committee Project Staff	January 2014	Program Specialist	Consultant to lead planning
Develop vision, goals, and activities of EC3 Home Visiting and Parenting Education committee	EC3 HVPE Committee Project Staff	June 2014	Program Specialist	Strategic Plan for the HVPE Committee
Present initial vision, goals, and activities to the Early Childhood Coordinating Council for review, feedback, and recommendations	EC3 HVPE Committee Project Staff	September 2014	Program Specialist	Stakeholder buy-in for the Strategic Plan

<b>Activity</b>	<b>Input</b>	<b>Timeframe</b>	<b>Person Responsible</b>	<b>Output</b>
Plan, coordinate, and host Early Childhood Home Visiting Summit to convene partners and stakeholders to present information about effects of home visiting, data from MIECHV program, share vision, goals, activities of HVPE Committee to build awareness and visibility of home visiting in the state	EC3 HVPE Committee Project Staff EC3	November 2014	Program Specialist	Stakeholder buy-in for the high quality home visiting and HVPE Strategic Plan
Continue work with consultant to finalize EC3 Home Visiting and Parent Education vision, objectives, and activities including determining accountability and timeframes for activities outlined in the plan	EC3 HVPE Committee Project Staff EC3	November 2014 - March 2015	Program Specialist	HVPE Committee Strategic plan
Carryout and monitor activities outlined in the EC3 Home Visiting and Parenting Education committee vision, objectives, and activities	EC3 HVPE Committee Project Staff Stakeholders	November 2014 - September 2015	Program Specialist	Home visiting systems change
<i>Objective 2: The Idaho MIECHV Program will partner with the Regional Early Childhood Coordinating Council (RECC) that serves Kootenai and Shoshone counties to understand and better integrate home visiting into local early childhood systems. The Idaho MIECHV Program will support the RECC to conduct an early childhood needs assessment and systems analysis to inform strategic planning for the local early childhood systems by September 2015.</i>				
In partnership with RECC in Northern Idaho, identify a consultant to facilitate development of vision, goals, and activities	RECC Local MIECHV Programs Project Staff	March 2015	Program Specialist	Home visiting and early childhood systems planning
Partner with RECC in Northern Idaho as a pilot for conducting an early childhood systems needs assessment and systems analysis	RECC Local MIECHV Programs Project Staff	June 2015	Program Specialist	Local early childhood needs assessment and systems analysis
Convene stakeholders to review the results of the Northern Idaho RECC early childhood systems needs assessment and system analysis and present information to community partners	RECC Local MIECHV Programs Project Staff Consultant	March 2015	Program Specialist	Stakeholder awareness and buy-in for results of needs assessment and systems analysis
Host a local Early Childhood Home Visiting Summit with diverse stakeholders to gather feedback and incorporate action steps into the goals and activities of the Northern Idaho RECC to advance the early childhood systems	RECC Local MIECHV Programs Project Staff Local Stakeholders	November 2015	Program Specialist	Community driven strategic planning process for home visiting and early childhood
Define accountability and implement action steps identified at the local early childhood summit. Continue to follow-up and gather stakeholders to review the goals, activities, and action plan	RECC Local MIECHV Programs Project Staff	September 2015	Program Specialist	Local home visiting and early childhood strategic plan



a program of Prevent Child Abuse America

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June 20, 2013

Jacquie Watson  
Program Manager  
Maternal and Child Health Program  
Idaho Department of Health and Welfare  
450 West State Street, 4<sup>th</sup> Floor  
Boise, ID 83720

**Re: Documentation of Approval to Utilize the HFA Model**

Dear Ms Watson:

This letter is in response to the requirement of HRSA's Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) Expansion grant opportunity to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding the potential implementation of the Healthy Families America (HFA) model in Idaho and any intentions to implement adaptations to the HFA model.

**This letter outlines the approval from the HFA National Office at Prevent Child Abuse America to use the HFA model in Idaho (herein referred to as "the State").** Approval to make adaptation to the model has not been granted as adaptations have not been proposed at this time. Should any adaptations be proposed at a later time, the HFA National Office will review them on a case by case basis to determine if any shall be granted.

Currently, HFA is present in 40 states, D.C. and 5 U.S. territories. There are currently no HFA sites in the state of Idaho. We understand that given the funding available through the MIECHV Expansion grant, the State has proposed that additional funding resources will be used to establish contracts with five local public health districts in the north central, central, south central, south eastern and eastern regions of Idaho to implement evidence-based home visiting in target communities of each respective health district. Each local public health district may choose from implementing one of three evidence-based models: Parents as Teachers, Early Head Start-Home Based, or Healthy Families America. The new target communities (i.e., counties) in these regions include:

- Nez Perce
- Clearwater
- Ada
- Bannock
- Power
- Bonneville



Prevent Child Abuse America

The State agrees to require that any new program site choosing to implement the HFA model will complete the application process to affiliate with HFA. Should any additional HFA sites be established in Idaho at a later time, those sites will also be required to affiliate with the HFA National Office. The State has agreed to insure programs will pay the required annual fees (\$1,450 in 2013), and obtain necessary HFA training for program staff utilizing HFA certified trainers. The State has indicated its intent to work in partnership with the HFA National Office to obtain model specific technical assistance and support related to site planning, development, implementation, and accreditation. Technical assistance will be made available to you from the HFA National Office's Western Region Director at no cost via phone and email, and at a cost of \$1,250 per day plus travel for on-site technical assistance

In order to maintain HFA affiliation and the right to use the Healthy Families America name and to insure model fidelity, the State agrees that within the first 3 years of site affiliation, each HFA site will complete the accreditation process and again every 4 years thereafter. The State also agrees to complete, or to require that each site complete, an annual site survey (distributed by PCA America on an annual basis), and to utilize a data management system to better provide information to the National Office. It is PCA America's intention to affiliate individual program sites and multi-site systems and to authorize use of the name "Healthy Families" and use of variations of the name (*i.e.*, Healthy Families Place, County, or City), provided they are committed to the best practice standards identified by PCA America through research. Should there be any instance that would impede the program's ability to implement the critical elements (such as a loss of funding, etc.), it is understood that it is the program's responsibility to notify PCA America immediately. It is also understood that PCA America is the sole grantee of the right to use the HFA name and/or affiliation with the HFA initiative. PCA America reserves the right to revoke use of the name, and/or affiliation with the Healthy Families initiative, at any time before, during, or after the community/program enters the HFA Accreditation process. Finally, once entering the HFA Accreditation process, it is understood that the program will be subject to the policies and procedures of that process.

We are pleased to grant approval to the Idaho Department of Health and Welfare to implement the HFA model and we support participation in any HHS efforts to coordinate evaluation and programmatic technical assistance. If you would like to discuss this further, I can be reached at [kstrader@preventchildabuse.org](mailto:kstrader@preventchildabuse.org) or 248.988.8990. I applaud your commitment to Idaho's children and families and the HFA National Office looks forward to working together in partnership with you.

Sincerely,



**Kathleen Strader, MSW, IMH-E® (IV)**  
Director, Quality Assurance and Accreditation  
Healthy Families America National Office

Cc: Satya Kline, M.Ed.  
Cydney M. Wessel, MSW



Prevent Child Abuse America



June 24, 2013

Jacquie Watson  
Program Manager  
Maternal and Child Health Program  
Idaho Department of Health and Welfare  
450 West State Street, 4<sup>th</sup> Floor  
Boise, ID 83720

Dear Ms. Watson:

Based on the information provided to your Program Developer, Lauren Platt, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your FY13 expansion grant proposal submission to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Specifically:

- NFP NSO verifies that we have reviewed **Idaho's** proposed emphasis areas and scope, and that the application includes the specific elements required in the FY13 FOA; and
- NFP NSO is supportive of **Idaho's** participation in the national evaluation and any other related HHS efforts to coordinate evaluation and programmatic technical assistance.

As part of our ongoing partnership to support **Idaho's** implementation of the MIECHV program, we look forward to continuing to work together as revisions to that plan unfold, including the level of support your state may need from our staff at NFP NSO. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment. Lauren Platt will continue to be your direct contact as this work continues, and she will guide you through the requirements so that any of your funded agencies are in the best position to implement NFP with fidelity to the model. In order to further assist you, we have a set of [online resources](#) that can serve as additional resources for our continued work together.

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

Sincerely,

Erika Bantz  
Director of Program Development  
Nurse-Family Partnership National Service Office

1900 Grant Street, Suite 400 | Denver, CO 80203-4304  
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226  
[www.nursefamilypartnership.org](http://www.nursefamilypartnership.org)

**ATTACHMENT 7: Model Developer Approval Letters**



**Parents as Teachers**

July 23, 2012

Laura DeBoer, MPH  
Idaho Department of Health and Welfare  
Division of Public Health  
Bureau of Clinical and Preventive Services  
Children's Special Health Program  
450 West State Street, Fourth Floor  
Boise, ID 83720

Dear Ms. DeBoer:

This letter serves as the approval to the Idaho state plan for the implementation of Parents as Teachers under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Competitive funding opportunity for Fiscal Year 2012.

We look forward to the potential expansion to Parents as Teachers in Nez Perce and Clearwater Counties and the phased expansion in the existing PAT MIECHV funded site serving Kootenai and Shoshone. The national office is especially pleased with the attention to fidelity, professional development and continuous quality assurance. As the model developer, we stand ready to assist the state office, the Home Visiting Coordinator, affiliates and program staff with training needs and technical assistance, which are critical to yielding good outcomes. Compliance with Essential Requirements is important.

As indicated before, we look forward to a long and rich relationship with the State of Idaho. Please feel free to engage us in any meetings or discussions related to the MIECHV and Parents as Teachers. This is a true partnership indeed on behalf of all the children and families that will be served by this effort. Again, thank you.

Sincerely,

Cheryle Dyle-Palmer, M.A.  
Executive Vice President & Chief Operating Officer

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2012-2013**

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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ADMINISTRATION FOR CHILDREN AND FAMILIES  
Office of Head Start  
8th Floor Portals Building  
1250 Maryland Avenue, SW  
Washington, DC 20024

Laura DeBoer-Alfani, MPH  
Health Program Manager  
Maternal, Infant and Early Childhood Home Visiting Program  
ID Department of Health and Welfare  
450 West State Street  
Boise, Idaho 83702

Dear Ms. DeBoer-Alfani,

Thank you for providing an update on your state's Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program FY 2011 competitive grant application to the Office of Head Start (OHS).

As Director of the Office of Head Start (OHS), I am pleased to give you approval for implementing the Early Head Start (EHS) Home-Based Model including the priority element enhancement(s). OHS requests a list of new selected EHS sites be provided prior to implementation for final approval. We have reviewed and approved your state's updated competitive grant summary. Further, OHS supports your state's participation in the national evaluation and other related efforts to coordinate evaluation and programmatic technical assistance through the U.S. Department of Health and Human Services (HHS).

To ensure full compliance with all Head Start Program Performance Standards and model fidelity, the Office of Head Start requires each state to direct all questions and needs for technical assistance to OHS. All EHS grantees implementing the MIECHV program must submit federal reports and will be monitored. This will help OHS to facilitate ongoing communication and support to your state.

We look forward to continuing to work with your state and its partners in implementing the EHS Home-Based Option.

For additional questions, please contact Angie Godfrey at [angie.godfrey@acf.hhs.gov](mailto:angie.godfrey@acf.hhs.gov).

Sincerely,

Yvette Sanchez Fuentes  
Director

**Idaho MIECHV Program Logic Model: Expansion Grant FY13**

**Program Vision:** Increase capacity, quality, and visibility of organizations to provide evidence-based (EB) home visiting (HV) programs through the MIECHV by 2015 in Idaho, which will improve coordination of community supports and improve lives of Idaho's young children and their families to achieve optimal health, well-being, and development.

**Population Served:** Pregnant women, infants, young children, and their families until the child turns five or enters kindergarten.

**Population Needs to be Addressed by Services:** The Idaho MIECHV program enrolls high-risk populations including low-income, pregnant women, families with histories of child abuse and neglect, substance abuse, tobacco use, low academic achievement, developmental delay, or in the armed forces in need of family support, parenting skills, understanding of child development, and connection to additional services in target communities.

**Services	Resources	Outcomes	Short/Long Term	Indicators	Measurement
Evidence-based home visiting services using:  Early Head Start Home-Based (weekly home visits, playgroups, and resource and referral services)	<i>State MIECHV Program:</i> Staff, Training, Technical Assistance, Data System, Evaluation	Participants know how to access formal support systems in their communities.	Short Term	<ul style="list-style-type: none"> <li>Participants demonstrate knowledge of the array of services available to them in the community.</li> <li>Participants demonstrate knowledge of the government entitlement programs for which they qualify and where to go to apply for them.</li> </ul>	<ul style="list-style-type: none"> <li>Protective Factors Survey (PFS)</li> <li>Family Support Program Outcome Survey</li> </ul>
		Participants know how to manage child behavior in a nurturing and effective manner (behavior management, discipline).	Long Term	<ul style="list-style-type: none"> <li>Participants demonstrate knowledge of the importance of positive role modeling.</li> <li>Participants demonstrate knowledge of the importance of consistency in setting and maintaining rules.</li> </ul>	<ul style="list-style-type: none"> <li>Home Observation for Measurement of the Environment (HOME) Inventory</li> </ul>
Parents as Teachers (at least monthly home visits, group socialization, and resource and referral services)	<i>Local MIECHV Programs:</i> Home visiting program staff, curriculum, community relationships, parent engagement materials	Participants understand typical development.	Short Term	<ul style="list-style-type: none"> <li>Participants identify developmental milestones and the age range when the milestones generally occur.</li> </ul>	<ul style="list-style-type: none"> <li>(ASQ) Ages and Stages Questionnaires – 3<sup>rd</sup> Ed.</li> </ul>
		Participants understand the need for and know how to foster cognitive, academic, and literacy development.	Short Term	<ul style="list-style-type: none"> <li>Participants identify developmentally appropriate materials and activities they can provide their children to encourage learning.</li> </ul>	<ul style="list-style-type: none"> <li>ASQ - 3<sup>rd</sup> Ed.</li> <li>HOME Inventory</li> </ul>
		Participants know how to access prenatal care.	Short Term	<ul style="list-style-type: none"> <li>Participants have contact information for local medical care providers who provide prenatal care.</li> </ul>	<ul style="list-style-type: none"> <li>Maternal Health Form</li> </ul>
Nurse-Family Partnership (at least bi-weekly home visits and resource and referral services)		Children use pro-social behaviors to communicate their needs.	Long Term	<ul style="list-style-type: none"> <li>Children use positive methods to initiate interactions with others.</li> </ul>	<ul style="list-style-type: none"> <li>ASQ -3<sup>rd</sup> Ed.</li> <li>ASQ - SE</li> </ul>
		Participants provide appropriate supervision according to the developmental stages of children.	Long Term	<ul style="list-style-type: none"> <li>Participants have child-safe inside and outside play areas that meet their children's developmental levels and individual needs.</li> </ul>	<ul style="list-style-type: none"> <li>HOME Inventory</li> </ul>
Healthy Families America (at least weekly visits for six months postnatal, then based on family need and resource and referral services)		Participants access formal support systems in their communities when they need them.	Short Term	<ul style="list-style-type: none"> <li>Participants complete the necessary paperwork and/or interviews necessary to qualify for services.</li> </ul>	<ul style="list-style-type: none"> <li>Protective Factors Survey (PFS)</li> <li>Family Support Program Outcome Survey</li> </ul>
		Participants manage family life to promote self-sufficiency, safety, and stability.	Long Term	<ul style="list-style-type: none"> <li>Participants access adult education and job services as needed.</li> <li>Participants obtain safe and affordable housing.</li> </ul>	<ul style="list-style-type: none"> <li>Referral Follow-up Tracking</li> </ul>
		Participants understand how to care for themselves (self-care) so they can gain/maintain emotional well-being.	Long Term	<ul style="list-style-type: none"> <li>Participants demonstrate knowledge of how to effectively advocate for themselves</li> </ul>	<ul style="list-style-type: none"> <li>Protective Factors Survey (PFS)</li> </ul>
		Participants understand the effects of domestic violence (physical and emotional) on children.	Short Term	<ul style="list-style-type: none"> <li>Participants demonstrate knowledge of the emotional effects on children who witness domestic violence.</li> </ul>	<ul style="list-style-type: none"> <li>Relationship Assessment Tool</li> </ul>
		Participants access help when their emotions (depression, anxiety, anger, fear, etc.) interfere with their ability to parent well.	Short Term	<ul style="list-style-type: none"> <li>Participants use community resources (respite programs, anger management classes, mental health counseling, parent support groups, etc.) for help when they are experiencing stressors such as anxiety, anger, depression, and fear.</li> </ul>	<ul style="list-style-type: none"> <li>Protective Factors Survey (PFS)</li> <li>Edinburgh Postnatal Depression Scale (EPDS)</li> <li>Everyday Stressors Index</li> </ul>

**\*\* Service Assumptions:** Evidence-based home visiting programs, when implemented with as a relationship-based intervention and with fidelity, have been shown to improve child health, parenting skills, school readiness, economic self-sufficiency, more.

**ATTACHMENT 10: Letters of Support**

**Idaho MIECHV Program**

<b>Letters of Support</b>		
<b>Agency</b>	<b>Required Program</b>	<b>Letter Dated</b>
Bureau of Clinical and Preventive Svcs Division of Public Health Idaho Department of Health & Welfare	Title V Agency	June 27, 2013
Idaho Children’s Trust Fund	Title II – CAPTA	June 24, 2013
Division of Family & Community Svcs Idaho Department of Health & Welfare	Child Welfare Agency (Title IV-E and IV-B)	June 20, 2013
Division of Behavioral Health Idaho Department of Health & Welfare	Substance Abuse Services	June 27, 2013
Statewide Self Reliance Programs Idaho Department of Health & Welfare	Child Care and Development Fund	June 21, 2013
Division of Family & Community Svcs Idaho Department of Health & Welfare	Head Start Collaboration	June 25, 2013
Division of Family & Community Svcs Idaho Department of Health & Welfare	Early Childhood Comprehensive System	June 21, 2013
Division of Medicaid Idaho Department of Health & Welfare	Medicaid/Children’s Health Insurance Program (EPSDT)	June 27, 2013
<b>Memoranda of Concurrence</b>		
<b>Agency</b>		<b>Letter Dated</b>
Idaho Department of Health & Welfare – <ul style="list-style-type: none"> <li>• Division of Family and Community Services</li> <li>• Division of Behavioral Health</li> <li>• Idaho Children’s Trust Fund</li> <li>• Head Start Collaboration Office</li> <li>• TANF/Child Care/Community Action</li> <li>• Division of Medicaid</li> <li>• Division of Public Health</li> </ul>		July 23, 2012
Idaho Department of Health & Welfare – Idaho Infant Toddler Program		July 23, 2012
Idaho Department of Insurance State Advisory Council on Early Childhood Education and Care		July 23, 2012