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INTRODUCTION

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.), by adding Section 511, which establishes the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). The California Department of Public Health, Maternal, Child, and Adolescent Health (CDPH/MCAH), was designated by the Governor's office in 2010 as the single State entity authorized to apply for and administer HRSA and ACF home visiting program funds on behalf of California. CDPH/MCAH formed the California Home Visiting Program (CHVP) which seeks funding for FY 2011 ACA MIECHV Program Formula Grant. CHVP seeks these funds, in response to FOA HRSA-187, to continue the effective implementation of an evidence-based, coordinated, comprehensive statewide home visiting program in 13 at-risk communities who have a demonstrated high need and a readiness to implement.

The ACA MIECHV program provides an opportunity for collaboration at the federal, state and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) intend that the funds will result in a coordinated system of early childhood home visiting in every state that has the capacity and commitment to ensure high-quality, evidence-based practice. The new program plays a crucial role in a national effort to build quality, comprehensive, statewide early childhood systems. Ultimately these systems will improve health and developmental outcomes for pregnant women, parents and caregivers, and children from birth to eight years of age.

The mission of CHVP is to provide leadership for integrated, collaborative, high-quality, maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse families throughout California. To achieve this mission, CHVP will continue to work closely with federal, state, and local partners in addition to the various stakeholders to implement a comprehensive, evidence-based home visiting program.

In response to FOA HRSA 11-187 CHVP provides the following in this application: Identification of the State's Targeted At-Risk Communities; Goals and Objectives, including a Logic Model; Description of the Selected Models and How they Meet the Needs of the At-Risk Communities; an Implementation Plan; Description of How Benchmarks will be Met; an Administration Plan; a Continuous Quality Improvement Plan; Anticipated Technical Assistance Needs; and an Update on Reporting Requirements.

SECTION 1: NEEDS ASSESSMENT AND IDENTIFICATION OF THE STATE'S TARGETED AT-RISK COMMUNITIES

1. Identification of "At-Risk Communities"

California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) developed a statewide Home Visiting Needs Assessment for Supplemental Information Request-1 (SIR 1) using the set of required indicators. Results from the Needs Assessment indicated considerable need across the state whereby 54 of 58 counties had rates or percentages worse than the corresponding statewide median for six or more indicators. All 58 counties were defined as "at-risk communities."

California's approach for refining the Supplemental Information Request-2 (SIR 2) Updated State Plan (USP) was to supplement results from the initial Needs Assessment with further quantitative data, and to incorporate a framework for leveraging local expertise. A multipronged approach was developed that included both quantitative and qualitative data collection and analysis. Quantitative information used to assess need included a geospatial hot-spot analysis of families living in poverty based on 2005-2009 American Community Survey estimates. Local Health Jurisdictions (LHJ) were also provided thematic maps of eligible clients for Nurse-Family Partnership (NFP) and Healthy Families America (HFA) programs, and county profiles with indicators from the Needs Assessment to assist local efforts assessing needs. Further qualitative information was gained from the California Home Visiting Program - Request for Supplemental Information (CHVP-RSI). Released to all 61 LHJs, the CHVP-RSI requested information about areas and populations in need, cross-agency coordination and collaboration, current infrastructure, timeline for program implementation, strength of referral systems, data experience, and continuous quality improvement. LHJs were asked to provide firsthand knowledge to: (1) identify and describe the community(ies) and population(s) with the highest need; and (2) identify the evidence-based home visiting model, either NFP or HFA, that would best meet the identified needs and fill any gaps in early childhood services.

CDPH/MCAH developed a five-step process to review and categorize qualitative information from responses to the CHVP-RSI and quantitative data from the hot-spot analysis in order to identify a set of communities as having considerable need and the best likelihood to improve health outcomes of families targeted with home visiting services. Communities were reviewed for: need and likelihood of achieving minimum enrollment estimates within the community; readiness and timeline to implement; potential for impact; and capacity at both the community and LHJ level.

CDPH/MCAH also recognized the importance of funding communities that could expand an existing HFA or NFP program, as well as those without an existing home visiting program. This approach of selecting communities with varying programmatic experience allows CHVP to establish best practices and lessons learned for implementing home visiting programs in areas that currently do not administer HFA or NFP. CDPH/MCAH

identified 32 at-risk communities with considerable need and the best likelihood to improve health outcomes of families targeted with home visiting services. Due to the limited availability of funds, a priority funding order was developed based on level of need and capacity. For the CHVP USP, 13 communities were targeted for funding under ACA MIECHV formula grant funding. Community risk factors, characteristics and needs of the potential participants are provided towards the end of Section 1. See *Section 3 for community strengths*.

2. Existing Mechanism for Screening, Identifying, and Referring Clients

California is currently implementing a statewide home visiting program; however, no centralized statewide mechanism for identifying, screening, and referring potential clients is in place. The model for integrating existing programs and services will follow procedures established by the home visiting model's curriculum and the Strengthening Families Framework, which is an approach currently used at the local level by several existing programs. Strengthening Families (SF) will help align recruitment methods across home visiting models. At the local level, there are numerous existing mechanisms for screening, identifying, and referring clients that are specific to the particular region and reflect the diversity that exists within the at-risk communities; these mechanisms are described in Section 3.

3. Referral Resources Currently Available and Needed in the Future

The CHVP-RSI asked each LHJ to identify existing referral resources for each of the following domains: health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services, and to provide an operational plan for coordinating among these referral resources for referring clients to and from the newly established home visiting program. See *Section 3 for referral resources currently available*. Referral resources needed in the future are listed by community towards the end of Section 1.

4. Coordination of Early Childhood System of Care

CDPH/MCAH identified organizations, institutions, and individuals to begin discussions on the implementation of the CHVP. The process included consultation and collaboration with stakeholders, local MCAH Directors, and CDPH partner programs such as the California Departments of Education, Social Services, Health Care Services, Alcohol and Drug Programs, as well as public health educators and organizations concerned with the well-being of California's at-risk communities. Members of these agencies will collaborate and their activities will be aligned with the work of the California ECCS Advisory Council, the California Early Learning Advisory Council, the California Statewide Screening Collaborative, California Project LAUNCH, and Help Me Grow. These partners will engage in strategic planning to create an administrative structure that encourages stronger collaboration across health and early care and education settings. Through this coordinated structure, agencies will be better positioned to promote a common set of outcomes for children, enhancing efforts to track outcomes through improved data linkages.

5. At-Risk Communities for MIECHV Formula Grant Program FY 2011

The following information was provided by the LHJs in response to the CHVP-RSI and has been truncated by CDPH/MCAH, and summarizes community characteristics and risk factors, as well as referral resources needed in each of the 13 communities selected for funding. At-risk communities not selected for funding due to funding limitations are listed towards the end of Section 1. *See Section 3 for details on strengths and existing home visiting services in the communities.*

Alameda (East/ West Oakland)

Approximately 120,000 people live in East/West Oakland; over 80% are African American or Latino. East/West Oakland and their residents experience a disproportionate burden of morbidity and mortality. There are approximately 800 first-time births annually in East/West Oakland with 42% women under the age of 21 and 63% births paid by Medi-Cal. Sixty percent or more of the families with children under age 5 living below 185% of the Federal Poverty Level (FPL) in Alameda reside in East/West Oakland. First time mothers in East/West Oakland have among the highest rates of low infant birth weight in the County. In particular, 13.2% and 10.5% of infants born to African American mothers in East and West Oakland, respectively, are born with low birth weight, compared to 8% in the County as a whole. Referral resources needed include housing support, child care services, and early childhood programs.

Butte (Paradise Ridge/ Southern Butte)

Butte County was ranked 6th out of 58 counties for “Percentage of Residents of All Ages Living in Poverty” in the California Home Visiting Statewide Needs Assessment, placing Butte in the > 90th percentile for poverty. According to the Butte County Profile, Butte ranks between the 75th and 89th percentile for the child maltreatment indicator. Rate of substantiated cases of child maltreatment for 2009 was 17.0 per 1000 children, which is higher than California’s rate of 9.1 per 1000. Butte County ranked 4th with a rate of 13.1 per 1000 children for children ages 0-17 in Child Welfare Supervised Foster Care compared to the state rate of 6.0 per 1000 children. Butte ranks at >90th percentile for illicit drug use, 75th-89th percentile for binge alcohol use and non-medical pain reliever use, and 50th-74th for marijuana use. Referral resources needed include mental health resources for pregnant and postpartum women, substance abuse treatment options, and additional perinatal programs.

Contra Costa (East/ West/ Central)

Contra Costa County has the 9th largest population of all California counties, with an estimated 1,042,804 residents (2007), an increase of 9.9% since 2000. In 2007, people of color comprised 43.3% of the County’s population. There are disproportionate rates of teen births among Hispanic (49.7 per 1000) and Black (43.6 per 1000) teens which together accounted for 75% of teen births. African American women had the highest rate of low birth weight (LBW) infants (12.4 per 100 live births); a rate nearly two-fold greater than the overall county rate (6.7 per 100 live births). African American mothers had the highest rates of LBW in San Pablo (15.2 per 100 live births), Richmond (14.4 per 100 live births), Pittsburg (12.8 per 100 live births), Concord (12.3 per 100 live births), and Antioch (11.4 per 100 live births). These are also the areas with the most LBW infants. Referral resources needed include a high quality accessible and culturally

appropriate health care system; a responsive child welfare system that includes families as part of the solution; early childhood programs that support parent-child attachment and child development; and a mental health system that provides a broad spectrum of services.

Imperial (El Centro/ Imperial/ Holtville/ Seeley/ Heber)

This at-risk community has a statistically higher percentage of families with children under age 5 living below 185% FPL compared to California overall and more families living in poverty than any other area in Imperial County. Imperial County also has a higher overall crime rate (3770 per 100,000 population) than the statewide rate (3320 per 100,000). This at-risk community also has a significantly higher percentage of first-time mothers on Medi-Cal. In 2008, 14.4% of all births to women aged 15-44 had a birth less than two years before, a slightly higher percentage than the statewide median. Imperial County has one of the lowest rates of prenatal care initiation during the first trimester (59.7% compared to 82.4% statewide). Imperial County has a higher rate of substantiated child maltreatment cases (9.9 per 1000 children) than California as a whole (9.1 per 1000 children). Needed referral resources include education, support, and referrals for basic living skills and breastfeeding; education on keeping to immunization schedules; alternative and temporary shelter services, and assistance for housing, clothing, baby supplies, transportation, and utilities.

Kern (Countywide)

Kern County's Hispanic/Latino population is growing faster than other segments of the population. According to California Data, in 2009 the Hispanic population in Bakersfield was 139,406 (43.0%) in comparison to 132,712 White (40.9%) and 25,997 African American (8.0%). The U.S. Census American Community Survey ranked Kern County 20th out of all counties across the United States in overall poverty level over a 12-month period. According to the 2008 American Community Survey, 27% of Kern County children (63,718) lived in families with incomes below the FPL. The percentage of births paid for by Medi-Cal ranged from 46.6% in Western Kern to as high as 82.7% in Southern Kern. Needed referral resources include increased screening efforts for postpartum depression and prenatal substance use, stronger links to and availability of mental health and substance abuse services to ensure women receive the support they need.

Los Angeles Service Planning Areas (SPA) [SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); SPA 7 (East L.A.)]

The targeted community includes the San Fernando Valley Service Planning Area 2 (SPA 2), the San Gabriel Valley (SPA 3), and East Los Angeles (SPA 7). Together SPAs 2, 3, and 7 account for over 36,000 births each year to women who are pregnant for the first time and living in poverty. SPA 2 has a population of 559,233; the population is noted for its high crime areas and high poverty (16% of children live below the FPL). SPA 2 had 28,229 live births in 2008 of which 48% (13,471) were to first-time mothers receiving prenatal care funded by Medi-Cal. There were 135 infant deaths. SPA 3 is one of the largest service planning areas, home to 29 cities, and 32 separate school districts. SPA 3 had 24,927 live births of which 46% (11,448) were to first-time mothers on Medi-Cal funded prenatal care. There were 142 infant deaths. Nearly 90% of

residents age 5 years or older speak a language other than English at home; and over one-quarter of the population is children and youth under age 17 years old. SPA 7 had 20,834 live births of which 57% (11,900) were to first-time mothers using Medi-Cal funded prenatal care. The rate of low birth weight births is 68.8 per 1000 births and there were 104 infant deaths. More referral resources are needed to Magnolia Place in SPA 4, accessible to residents in SPAs 2, 3, and 7. Magnolia Place offers employment referrals, day care, medical services, and peer support groups. Additional referrals are needed to a new Resource Center in SPA 2, assisting residents with health and social issues and providing employment opportunities.

Los Angeles Unified School District (LAUSD)

Los Angeles Unified School District (LAUSD), the second largest school district in the U.S., offers free public education to a diverse, largely urban, ethnic minority (72.8% Hispanic, 11.2% African American, 8.9% White) and lower socio-economic (70% enrolled in free lunch program or <133% of federal poverty line) student populations from pre-school through grade 12 (>1 million students). Despite declining rates over the years, more than 40% of teen girls still get pregnant at least once before age 20. The L.A. teen birth rate is 38.5 per 1000 births that accounts for 14,733 births to teens yearly. LAUSD school specific teen birth rates range from fewer than 55 to 89.6 per 1000 population. The latter rate would mean a school of 2500 female students (15-19 years old) would have 224 live births per year. Needed referral resources include a greater need to develop community referral systems composed of schools, public and private agencies, and faith-based organizations.

Madera (Western Madera County)

In 2008, the estimated percentage of “California Residents of All Ages Living in Poverty” in Madera County was 18.2% compared to the state’s 13.3%. Madera had 13.7% (50th-74th percentile) unemployment compared to California (11.9%). In 2008, Madera had the 5th highest ranking for preterm births; 11.9% of Madera County births were preterm (>90th percentile) compared to California’s 10.7% and the statewide county median (9.8%). The 2008 teen birth rate for ages 15-19 years was 56.9 per 1000, ranking Madera 4th highest for teen births in the State. All 10-14 year old births for 2005-2008 were to Hispanic mothers. According to the US Census Bureau, 65.4% of Madera County persons age 25 years or older have a high school diploma or equivalent compared to 76.8% of all Californians. Only 12% of Madera County persons age 25 years or older have a bachelor’s degree or higher compared to 26.6% of Californians. Madera County’s percentile ranking was 50th–74th for child maltreatment. For substantiated cases of child maltreatment, the Madera County rate per 1000 children was 11.8, ranking Madera 22nd (from high to low). This is higher than California (9.1 per 1000) and the statewide county median (9.75 per 1000). Needed referral resources include improved resource access and improved assistance for navigating community resource systems; an improved tracking system; support for parents of toddlers; case managers for MCPHD MCAH Programs with Behavioral Health Services backgrounds; more support with mental health issues; support and mentorship from parents; improvements in communication and sharing between agencies and professionals or agencies and policy makers; and public transportation in rural areas.

North Coast Tri Consortium (Del Norte/Humboldt/Siskiyou County)

Humboldt, Del Norte, and Siskiyou Counties were found to have indicators above the 90th percentile in the areas of perinatal substance use, children with special needs, juvenile crime, illicit drug use, prenatal care, foster care, short birth intervals, domestic violence, child maltreatment, poverty, premature births, and low birth weight. Needed referral resources include increased access to public transportation; safe and affordable housing; an improved economy and job market; increased access to family planning services and medical providers; continued after-school programs and day care providers; continued perinatal substance abuse prevention programs; increased mental health services for low income adults and children; substance abuse recovery programs; employment training and opportunity; and dental providers who accept adults on Medi-Cal.

Sacramento (South Sacramento communities)

In 2000, the racial composition of this region was 41.1% Caucasian, 29.9% Hispanic, 18.6% Asian and Pacific Islander, 15.3% African American, and 1.7% American Indian. In 2008, there were 1496 first-time mothers in these South Sacramento Communities. Medi-Cal was the payment source for 843 (56.4%) first-time mothers, a rate 35.5% higher than the rest of Sacramento County. The 2008 prematurity rate in this region was 13.7% higher than the rate for Sacramento County. During the same year, approximately 307 (7.5%) live births were of low birth weight; a rate 15.4% higher than the rate for Sacramento County. The birth rate for teens aged 15 to 19 years was 37.8% higher than the birth rate for Sacramento County. From 2004 to 2008, 590 infant deaths occurred in Sacramento County; of these, a total of 129, or 21.8%, occurred in the South Sacramento Communities. Sacramento County Public Health analyses revealed Oak Park as having the third highest infant mortality rate among all California zip codes with at least 20 deaths. Needed referral resources include affordable and safe housing; programs targeting fathers, specifically programs that promote positive parental involvement, and support to fathers and their families; transportation; and payment programs for pre-schools and child care centers.

Shasta (Shasta Lake/ Redding/ Anderson/ Burney)

From 2005-09, 28% of the families with children under age five in the at-risk community had incomes below the poverty level compared to 18% statewide. Many of the births, and especially first births, are to moms who are young, single, and with low educational attainment. In 2009, 39% of births to residents in this community were to first-time mothers and 16% were to women under age 21. From 2006-08, the rate of women with a diagnosis of alcohol or drug use was more than four times the statewide rate (54.3 per 1000 labor and delivery hospital discharges versus 11.9 per 1000) and was the second highest among all the counties in California. Needed referral resources include mental health resources for the uninsured, underinsured, and/or Medi-Cal recipients, and coordination with existing resources to meet the mental health needs of women.

San Diego (North Inland-Coastal Expansion (NICE) - Oceanside/ Vista/ San Marcos/Escondido/ Carlsbad)

From 2005 to 2009 American Community Survey estimates show nearly half of all families in the NICE region with children under age five (48.5%) are below 185% of

poverty (compared to 32.1% countywide). There are also pockets of concentrated poverty throughout the large rural and frontier areas and in neighborhoods in suburban communities. One in five NICE families (21.4%) is headed by a single mother and almost a third of these families live in poverty (31.6%). Averaging 2007 through 2009 data in NICE, a quarter of infants were born to young mothers each year – 554 were to girls under 21, and 436 (78.7%) of these were to first-time mothers. About half the area's births (49.6%) were to mothers who were foreign-born. More than one in four (27.0%) NICE residents at least five years of age speak English less than "very well." Between 2007 and 2009, nearly one out of four babies (24.8%) was born to a mother who did not receive prenatal care until after the first trimester. Needed referral resources include improved health factors, environmental access factors, social/education services, and political engagement.

San Francisco (Bayview Hunter's Point)

There were 8437 births to San Francisco mothers in 2010, of which over half (53%) were to first-time mothers. Approximately 22% of first-time mothers were insured through Medi-Cal. Eighty-five percent (85%) of women were from four non-white groups: Hispanic (41%), Asians (28%), Black (11%), and Pacific Islander (5%); 14% of the women were White. The Child Abuse Unit received 564 felony child abuse cases in FY 09/10; 515 (91%) merited investigation. This represents a 3-year high for felony child abuse cases; up 13% from FY 08/09. The most common types of abuse were general neglect (30%) and physical abuse (29%). Thirty-seven percent (37%) of San Francisco residents are foreign-born, compared to 26% statewide, according to the 2000 Census. While children comprise only 15% of the total San Francisco population, children represent 31% of San Francisco's public housing residents. Needed referral resources include transportation for clients (e.g. bus or taxi vouchers) and homeless families in accessing health and social service appointments. Transportation also helps these clients to be visited by NFP PHNs at an alternate location.

6. At-Risk Communities Proposed for Competitive Expansion Grant Funds (HRSA 11-179)

Fresno (Southeastern Fresno); Merced (Countywide); Nevada (Countywide); Northern Los Angeles SPA 1 (SPA 1- Antelope Valley); Sacramento (North Sacramento communities); San Mateo (North/ Central/ South Counties); Solano (Countywide); Stanislaus (Countywide).

7. Additional Communities Identified as At-Risk but Not Selected Due to Limited Funding

Long Beach (The City of Long Beach); Marin (San Rafael/ Novato/ Marin City); Northern Tri Consortium (Colusa/Glenn/Tehama County); Orange (Countywide); Riverside (Perris/Moreno Valley); Santa Barbara (North County); Santa Clara (Countywide); Santa Cruz (Countywide); Sonoma (Sonoma County Hwy 101 Corridor); Tehama (Countywide); Yolo (Countywide).

SECTION 2: HOME VISITING PROGRAM'S GOALS AND OBJECTIVES

CHVP will establish an effective, comprehensive, early childhood system that supports health and well-being across the life course. In collaboration with stakeholders and other state agencies, the following Goals and Objectives have been determined:

Goal: Promote maternal health and well-being

Objectives:

- a. Increase receipt of early and adequate prenatal care
- b. Increase the proportion of women with health insurance and a medical home (pediatric primary care team) just before pregnancy and for 2 years postpartum
- c. Decrease maternal Emergency Department visits
- d. Decrease parental use of alcohol, tobacco, and/or illicit drugs
- e. Decrease the proportion of women with a subsequent birth within 2 years postpartum
- f. Increase the proportion of women screened and referred for maternal depression
- g. Increase the proportion of women breastfeeding through 3 months postpartum
- h. Increase the proportion of women provided domestic violence and reproductive coercion information and resources

Goal: Improve infant and child health and development

Objectives:

- a. Increase the proportion of children with health insurance and a medical home (pediatric primary care team)
- b. Decrease child Emergency Department visits
- c. Decrease parental use of alcohol, tobacco, and/or illicit drugs
- d. Increase breastfeeding
- e. Increase the proportion of children who complete the schedule of well-child visits
- f. Decrease incidence of child injuries requiring medical treatment
- g. Decrease suspected and substantiated child abuse and neglect reports

Goal: Strengthen family functioning

Objectives:

- a. Increase the number of families receiving information on preventing child injuries and providing a safe home environment
- b. Decrease parental use of alcohol, tobacco, and/or illicit drugs
- c. Increase the proportion of families demonstrating high-quality parenting behavior and parent-child relationship in support of children's learning and development
- d. Increase parental emotional well-being and decrease parental stress
- e. Increase the number of families that promote positive child development through comprehensive social, emotional, and developmental screening and referrals for early intervention
- f. Increase the proportion of families effectively screened and referred for domestic violence including development of a safety plan
- g. Increase the proportion of parents improving employment status or educational attainment

Goal: Cultivate strong communities

Objectives:

- a. Increase identification and referral of families in need of services
- b. Enhance existing, and increase the number of formal agreements with community social service agencies across the home visiting continuum
- c. Increase maternal and early childhood referral systems and number of completed referrals

Goal: Provide leadership for the coordination of maternal and early childhood systems and supports to advance federal, state, and local efforts to improve health and well-being for families in California.

Objective:

- a. Establish a home visiting network continuum of services based upon maternal, family, and child needs for children 0-5, reducing duplication of services across home visiting programs.

1. Comprehensive, High-Quality Systems to Promote Maternal, Infant, and Early Childhood Health

CHVP provides a leadership role in cross-systems work at the state level in an effort to promote the health of the maternal, child, and adolescent populations. CHVP plans to use the Strengthening Families framework to bring together multiple partners around a common set of goals to support the CHVP mission and vision.

CHVP embraces the Strengthening Families framework to guide the development of a comprehensive, high-quality maternal and early childhood system throughout California that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships. This approach is centered on five protective factors for working with children and families in different settings, including the home visiting arena. The five research-based protective factors have been linked to the reduction of child abuse and neglect, and the increase of optimal development in children. A focus on strengths and protective factors is promoted among California MCAH programs as a strategy to address social determinants of health and health inequity, thus promoting health across the life course. Focusing on protective factors helps to develop circumstances that promote health behaviors and decrease the chance children will engage in risky behaviors as they grow up. The five protective factors outlined in the Strengthening Families approach are:

Parent resilience: The ability to constructively cope with and bounce back from all types of challenges. Parental resilience is about creatively solving problems, building trusting relationships, maintaining a positive attitude, and seeking help when it is needed.

Social connections: Whenever a family is isolated from family or community, the children are more at-risk. Many parents may naturally develop friendships with other parents, but others may need help in establishing social connections. Building trusting relationships with all families and helping isolated families connect with other parents strengthens parenting skills and protects the children.

Knowledge of parenting and child development: Parents with knowledge about parenting and their own child's development have more appropriate expectations for their behavior and knowledge of alternate discipline techniques. Early childhood professionals have a wealth of knowledge about child development that they can share with parents, whether through an informal conversation, in a class, or by sharing brochures and other written information.

Social and emotional competence: Children who receive high quality early care get support for healthy social and emotional development in many ways. They learn how to identify their feelings, empathize with the feelings of others, share emotions appropriately, and problem solve with peers and adults.

Concrete supports in times of need: When families are in crisis, the children are more protected if the family gets access to the resources they need relatively quickly. Early childhood professionals may not be able to personally provide those resources, but they can provide appropriate referrals and follow-up to families who need immediate support.

2. California Strategies for Program Integration

CHVP will utilize strategies for integrating with other programs and systems in California that are related to maternal and child health, early childhood health, child development and well-being by integrating home visiting into the ECCS guidelines. This involves the key early childhood system components of health care/medical home, early care and education, social and emotional development, family support, and parenting education. Approaches such as:

- Establish linkages to existing collaboratives and initiatives to support the integration of program services into wider state systems of care
- Integrate home visiting as one component of a continuum of services for children
- Improve and expand timely and early identification of children with, or at-risk for, developmental delays and provide early intervention to help children reach full potential
- Develop interagency partnerships to address barriers to services for children who fall through the cracks due to lack of insurance or ineligibility to entitlement services
- Improve effective prevention and early intervention services and provide information, education and training to parents, professionals and decision makers, and others
- Address common barriers that limit a parent's ability to parent and work from a strength-based perspective
- Streamline and improve services through cross-departmental planning and governance that builds on existing initiatives and services
- Work to ensure that services are continuous for children, especially during transition from home visiting to other services, and for those with special needs
- Improve cross-agency coordination between home visiting and early childhood programs to strengthen referral mechanisms to services that are part of the broader linked system of care
- Develop MOUs to promote formalized linkages and coordination among public and private sector partners and to ensure that interagency and cross-systems protocols and practices are effectively implemented and evaluated

SECTION 3: SELECTION OF PROPOSED HOME VISITING MODELS AND HOW THE NEEDS OF THE TARGETED COMMUNITIES ARE MET

1. Selection of the California Home Visiting Models

CHVP selected two notable evidence-based home visiting (EBHV) models for implementation in California: Nurse-Family Partnership (NFP) and Healthy Families America (HFA). Selection of these two models was based on findings from the Home Visiting Evidence of Effectiveness Review (HomVEE) Study funded by HRSA, which distinguished NFP and HFA as having the most favorable ratings for primary and secondary outcomes in the benchmark areas. CDPH/MCAH also completed an internal review on primary service strategy home visiting models in October 2010 that agreed with the findings from HomVEE. Both models reflect an ecological and empowerment approach that incorporates aspects of developmental, psychosocial, systems, and attachment theories to create change in the lives of families and their young children. As part of the CHVP-RSI process the LHJs engaged the local at-risk communities to select the models that would address the needs of the communities. *See Section 8 for Model Developer approval letters.* CHVP will disseminate a targeted survey to LHJs to glean information on promising practices (e.g., locally developed home visiting programs). The survey will provide CHVP with a more in-depth review of promising approaches (PA) as well as determining the interest and capacity of the participating LHJs to implement a PA. For those LHJs that choose to participate, the survey will elicit information that will identify and describe the PA, its newly identified at-risk community and how the PA meets their needs; the national organization or institution of higher learning affiliated with the model; LHJ's current and prior experience and capacity for implementing the PA; an evaluation plan specifying how the proposed PA will be evaluated using a well-designed and rigorous process; a plan for ensuring implementation with fidelity to the PA model; and the overall plan for quality assurance, anticipated risks and challenges, and technical assistance needs.

2. High-Risk Communities Submitted for Competitive Expansion Grant Funds

CDPH/MCAH is requesting competitive expansion grant program (HRSA 11-179) funds to develop strategies to reach high-risk, hard-to-engage populations in eight additional communities: Fresno (Southeastern Fresno); Merced (Countywide); Nevada (Countywide); Northern Los Angeles SPA 1 (SPA 1- Antelope Valley); Sacramento (North Sacramento communities); San Mateo (North/ Central/ South Counties); Solano (Countywide); and Stanislaus (Countywide).

3. Experience with Implementing the Selected Models and Support Capacity

While there was no coordinated statewide home visiting program prior to 2011, there are multiple national, and some locally developed, home visiting models operating in California. The two selected models, NFP and HFA, as well as the other HomVEE-recognized models have been implemented and well-established in California at the local level. CHVP has the capacity to develop, implement, and administer a comprehensive statewide home visiting program, in conjunction with the NFP and the HFA models. CHVP is currently using this capacity to develop a comprehensive plan to

ensure adequate state-level staffing with expertise specific to program development, oversight of contractual and fiscal agreements, information technology, including data system development, and policy and strategic planning.

Nurse-Family Partnership: In California, a total of 14 counties report using NFP and serve approximately 3096 families annually. Thirteen counties have a current Agency Funding Agreement (AFA) in place with the NFP National Service Office and serve approximately 2458 families annually. These include: Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Diego, San Luis Obispo, Santa Clara, Solano, Sonoma, and Tulare. One county, Madera, is using NFP without an AFA in place and serves approximately 638 families annually.

Healthy Families America: Currently in California, a total of 12 counties report using HFA. Seven counties have a current AFA in place with HFA National Office. These include: Butte, Nevada, Los Angeles, Riverside, San Diego, Napa, and Yolo. Five counties that are using HFA without an AFA in place are: Contra Costa, Humboldt, Lassen, Los Angeles, and Santa Barbara. The affiliated HFA programs do not use waiting lists; however, they find other resources and referrals for families in a timely fashion.

4. Quality and Program Assurance to Maintain Model Fidelity

As a mechanism for overseeing home visiting quality assurance, CHVP is developing workgroups to promote interagency coordination, shared accountability, and support model fidelity. Workgroup membership will include CHVP staff, national NFP and HFA representatives, and experienced local MCAH Directors who will provide experience and expertise in collaboration with other programs within their LHJ/communities. The consistency of model fidelity rests with the NFP model elements and HFA critical elements combined with best practices for effective, quality program implementation as described below. Quality Improvement teams will be established at the state and LHJ/community level. Mechanisms for feedback and information exchange will be created and maintained through the CHVP workgroups.

CHVP's approach to home visiting quality assurance, program assessment, and support of model fidelity is to oversee a system that ensures the primary components of evidence-based home visiting program quality are in place and continuously monitored. Scopes of Work and policies and procedures will be developed. These will include clear protocols for monitoring staff development, training, program implementation, evaluation and reporting requirements, data collection and analysis, and continuous quality improvement (CQI). The primary structural components of program effectiveness and quality include: 1) Clear and Specific Goals and Objectives; 2) Content and Focus of Visits; 3) Curriculum and Activities; 4) Training, Supervision, and Administrative Support; 5) Family Engagement, Cultural Consonance; 6) Program's Ability to Deliver Appropriate Services to High-risk Families; 7) Linkage to Quality and Diverse Services; and 8) Evaluation Component. In addition, as an overarching supportive mechanism to reinforce home visiting services, CHVP will utilize the Strengthening Families framework.

5. Anticipated Challenges and Risks to Maintaining Quality and Fidelity		
Area	Challenges/Risks to Fidelity	Response/Plan
Program Design	Inflexible/traditional work schedules for staff may have a negative effect on client enrollment and retention.	Use a 'flexible framework' allowing staff to plan their work schedules to include weekend, evening, and early morning schedules, can improve client enrollment/retention.
Caseload	Caseload "creep": increasing caseloads over recommendations.	Work with counties/communities to maintain their commitment to limiting caseloads.
Staff	<u>Turnover, burnout, indifference</u> : not feel vested in the program's principles; uninformed/misinformed about program components. <u>Consortia and/or rural areas</u> : supervisory logistics (i.e., one supervisor covering large geographical areas) and access to timely training	Routinely review/revise training calendar. Cross train staff in the event of a turnover. Ensure all staff are able to give feedback. Track volume of high need clients. Track progression and enrollment status. Share weekly individual/group reflective supervision. Ensure qualified congenial staff are hired. Provide regular opportunities for skill building. Offer fair wages/benefits. Involve staff in CQI efforts. <u>Consortia and/or rural areas</u> : Supervisory logistics should be included in scheduling training.
Clients	Motivated by "incentives" only; not interested in services; forced to be in program; rigid or irregular work schedules and non-English-speaking; not recognizing their own risk behaviors	Train staff to actively engage clients with prompt follow-up, especially early in recruitment process. Reassure families that program is strictly voluntary. Flexible work hours - convenient to the clients. Assess client's states of change and educate about risk behaviors. Bi-lingual staff will be hired to meet clients' needs.
Attrition	Family hesitates to follow through though they want/need the support; family moves without leaving a forwarding address	Allow a "holding" period (e.g., 3 months) when families are having difficulty keeping HV appointments. Utilize a signed release of information with community partners to track down lost clients.

Area	Challenges/Risks to Fidelity	Response/Plan
Local & State Agencies / Community Partners	Lack of commitment and/or interest in supporting services; Staff turnover Lack of buy-in for the programs; Referring families for services who are outside the target area	Secure buy-in by having partners sign MOUs. Provide refresher presentations to keep partners engaged. Ensure participating staff are trained quickly and well. Establish and maintain an advisory group. CHVP will help educate community and state partners regarding the program parameters. Offer referrals to partner programs.
Data	Not obtaining quality data; Missing data	Ensure staff training for all aspects of data collection, management and utilization of data and reports. Ensure staff recognition of data importance. Complete regular reviews of local data, data collection, and data management field operations.

6. Anticipated Challenges/Risks of Selected Program Models		
Issue	Challenges/Risks Model-Specific	Response
Cost of Program and Staff Retention	NFP is a costly model. PHN's education and experience increases the salaries. HFA may have retention issues due to lower wages and intensity of job.	An internal implementation workgroup will explore ways to identify, assess, and sustain funding sources and advocate at the State level.
Recruitment of Competent Staff in view of time constraints	NFP PHN shortages creates a challenge hiring NFP staff, especially in rural areas. HFA HV FSWs are selected on personal characteristics (open-mindedness, compassion, maturity), rather than formal education. Curriculum is flexible, so very well trained FSWs are needed.	NFP support nursing recruitment by coordinating with baccalaureate nursing programs in California. PHNO of CA ensures that LHJs adopt competitive salary ranges. HFA FSWs recruitment should ensure correct candidates are recruited and not hired in haste due to external or internal pressures.
Client participation and attrition	NFP/HFA Engagement and retention of families, especially those populations at the highest risk.	Use NFP and HFA program's effective strategies to minimize attrition rates. Troubleshoot with communities to identify solutions specific to their program.

Issue	Challenges/Risks Model-Specific	Response
Model Design	<p>PIPE curriculum has not yet been purchased from NFP. HFA has no requirements or protocol for using a specific curriculum, which has raised concern about model implementation, consistency in data collection statewide, and possible difficulty interpreting results.</p>	<p>NFP NSO contract with CDPH is pending. HFA CHVP sees the varying needs of LHJs/communities and the importance of addressing these through the appropriate resources and curricula. CHVP will work with HFA sites to help them determine the most fitting curriculum for their program that meets the CHVP standards.</p>
Evaluation and Benchmark Reporting	<p>NFP has allowed limited access to measurement tools. Selection of HFA curriculum has not been decided for LHJs/communities.</p>	<p>CHVP has submitted a Proprietary Property letter to NFP NSO. HFA curriculum will be determined once the USP award is public knowledge and the LHJs/communities can be contacted.</p>

7. How Models Meet the Needs of Targeted Communities

The following information is derived from the LHJs in response to the CHVP-RSI. The tables include the 13 counties/communities that are funded for FFY 2010-2011; CHVP requests continued formula grant funding for these communities during FFY 2011-2012. CHVP will continue to engage the LHJs/communities on an ongoing basis throughout the duration of the program. The following describes how the NFP and HFA models meet the needs of the targeted communities in the implementation period and outlines the existing strengths and resources that ensure a good fit with the NFP or HFA model. The benefits of selected models are numerous as are the strengths and resources. Selected examples of model capacity to meet community needs and their respective strengths/resources are delineated below.

Alameda (East/West Oakland)-- NFP New

Targeted high-risk community: East/West Oakland

How the model meets the community needs and service gaps:

- NFP will address the gap of unmet need due to the significant number of Medi-Cal births to first-time mothers and the decreasing capacity of home visitors to serve them;
- NFP meets a gap in its provision of nurse-based services: East/West Oakland has a high rate of low birth rates to first-time moms who need intensive programming to achieve greater impact;
- NFP will address the 32% (almost a third) of first-time mothers between the ages of 15-19; and
- NFP will help address the limited availability of home visiting services; most caseloads are full and there is a shortage of services for pregnant women as many focus on the post-partum period.

Strengths and Resources:

- NFP was implemented in this community in the late 1990's, and although discontinued, many NFP components were well received and have been adopted by existing home visiting programs;
- An available cadre of culturally responsive public health nurses with decades of experience, high familiarity with the challenges faced by the populations, levels of need and existing services;
- Alameda County Public Health Department (ACPHD) is active in several initiatives to increase health and wellness and develop working partnerships with people and organizations; and
- Multiple programs exist with home visiting components providing regular contact with the community, and a streamlined referral and assessment process for eligible families.

Butte (Paradise Ridge/Southern Butte)--HFA Expansion (Currently called Butte Baby Steps (BBS))

Targeted high-risk community: Community of Paradise Ridge (Town of Paradise and Magalia) and parts of Southern Butte County (SBC).

How the model meets the community needs and addresses service gaps:

- HFA will address SBC's need for more pregnancy, parenting, and family support resources, including the need for substance abuse recovery services, especially for pregnant women;
- This program will meet the challenges of access to appropriate health care due to transportation issues, cultural isolation, and quality of health care;
- HFA will meet the need of the high number of children and parents with developmental delays, mental disease and/or disabilities; and
- HFA intensive, flexible services will target the poorest, most isolated geographic regions in the County.

Strengths and Resources:

- Early Head Start, Department of Social Services, WIC, Oroville Hospital, Better Babies, healthcare providers, and others benefit from regular contact with BBS staff;
- Feather River Hospital has a wealth of prenatal and pediatric medical programs and services;
- Youth For Change offers family reunification services, group home and family resource services; and
- CareNet is a non-profit community program that provides assistance to young pregnant mothers.

Contra Costa (East/West/Central)--NFP New

Targeted high-risk community: County ZIP codes in the cities of Richmond, San Pablo, Concord, Pittsburg, Bay Point, Antioch, Oakley, and Brentwood

How the model meets the community needs and service gaps:

- NFP will add to and fill gaps in the existing continuum of services by providing an intensive intervention for higher risk families, including earlier during pregnancy;
- NFP helps the need for broad, sustained efforts to create support systems that strengthen families;

- This program will address the inadequate services for substance abusing pregnant and postpartum women; and
- Fill gaps in mental health, substance abuse, transportation, and shelter for women and children.

Strengths and Resources:

- Established evaluation unit specializes in data management and analysis, assessment, planning, and evaluation of the Family, Maternal and Child Health (FMCH) Programs and other programs;
- Contra Costa Health Services integrated health care delivery provides full scope of services;
- First 5 Contra Costa Family Resource Centers are located in five of the hot-spot zip codes; and
- Building Blocks for Kids partners with over 30 agencies to support healthy development and education for children and self-sufficiency for families by engaging the community, block by block.

Imperial (El Centro/Imperial/Holtville/Seeley/Heber)--HFA New

Targeted high-risk community: Central Imperial Valley: includes incorporated cities of El Centro, Imperial and Holtville and the unincorporated cities of Seeley and Heber

How the model meets the community needs and addresses service gaps:

- HFA would fill a need for programs that address alcohol, drug, and tobacco use among pregnant and parenting women;
- HFA works with the family at the intensity level needed for up to 3-5 years which is significantly longer and more effective than the short-term interventions in place;
- HFA will enhance local efforts to improve access and integration of social services, reduce red tape and duplication of efforts, and improve efficiency by collaborating with family support organizations; and
- HFA will fill the gap for the large portion of non-English speaking families who have limited access to health care.

Strengths and Resources;

- Strong collaboration within the Imperial County Public Health Department between Social Services and Imperial County Office of Education;
- Structure in place that provides a solid approach to working with children and families in early education centers, child welfare departments, and health-care programs;
- Strong sense of community among families, neighbors, schools, support systems; and
- Long history of working with Promotoras community-based organizations.

Kern County--NFP Expansion

Targeted high-risk community: Low Income Pregnant Women and/or Families with Children Birth to Age 2; Bakersfield, Northwest and Southeast corner of Kern.

How the model meets the community needs and service gaps

- This program will fill the gap of existing NFP with its current limited services due to the large geography and high numbers of referrals;
- NFP will improve the possibility of prospective participants currently on the NFP waiting list to be served;

- NFP builds on and fills gaps of outreach efforts to other medical providers who recruit first trimester, pregnant women; and
- NFP targets pregnant teens at risk for complications, such as premature labor, anemia, and high blood pressure.

Strengths and Resources:

- Community Action Partnership provides comprehensive information and referral services to this community;
- Search and Serve provides services to children with disabilities and works with the Department of Mental Health, schools, Regional Centers, and community agencies;
- Alliance Against Family Violence and Sexual Assault is a 24-hour hotline nonprofit organization in the community; and
- The Medically Vulnerable Infant Workgroup and Children's Assessment Center identifies gaps in services by carefully reviewing individual infant cases on medical and social needs.

Los Angeles Unified School District (LAUSD)--NFP Expansion

Targeted high-risk community: Los Angeles Unified School District (LAUSD)

How the model meets the community needs and service gaps:

- NFP will fill the void of hundreds of eligible young women who remain underserved by any home visitation or family strengthening program, especially within the geographical area of LAUSD;
- NFP will target areas that have high numbers of first-time mothers who are economically disadvantaged, and receive Medi-Cal paid prenatal care;
- The existing partnership with NFP-LA allows referrals to be received district-wide and shared; this complimentary relationship will allow LAUSD to expand NFP services within the school system, filling a major gap; and
- NFP will fill the gap in services provided to pregnant young females/teens.

Strengths and Resources:

- Department of Public Health's NFP program has provided services within the LAUSD boundaries for the last 11 years. The program has achieved outstanding outcomes with high-risk pregnant youth;
- "Linkages" is a statewide initiative currently sponsored by the Child & Family Policy Institute of California with the goal of effectively integrating CalWORKs and Child Welfare Services;
- LAUSD School Nurses are viewed as confidants and sources of trustworthy information. They have universal access to students and every K-12 school has a School Nurse at least once a week; and
- LAUSD provides foster care counselors offering case management and counseling services to students and their families and works with children's social workers to ensure school stability.

Los Angeles Service Planning Areas (SPA)--NFP Expansion

Targeted high-risk community: SPA 2 (San Fernando Valley); SPA 3 (San Gabriel Valley); and SPA 7 (East Los Angeles)

How the model meets the community needs and service gaps:

- NFP expansion will address the significant poverty, fetal, and infant/child deaths by becoming a presence in these high-risk communities;
- NFP will fill the gap in services for pregnant youth in these communities;
- This model will assist in addressing the reduced services funding (loss of funding 2003-04) in the SPA 3 area;
- NFP will address the gap in limited resources for foster children in the SPA 7 area.

Strengths and Resources:

- NFP partners with the Children's Law Center, Los Angeles, The Alliance for Children's Rights, and several other law firms that can and will provide legal support for NFP teens in need;
- NFP-LA has formed a partnership with Homeboy Industries, Inc., a gang-diversion program which has provided several trainings to the NFP-LA nurses;
- SPA 2: L.A. Universal Preschool and Valley College has a variety of programs designed both to build the early care workforce and support families with children under age three; and
- SPA 3: Presence of Edelman's Children's Court representing the first children's court in the nation dedicated to the health and welfare of abused and neglected children and their families.

Madera County Western Madera County (WMC)--HFA New

Targeted high-risk community: Western Madera County (WMC)

How the model meets the community needs and service gaps:

- HFA will fill the gap left when Cal-Learn (CalWorks non-home visiting program for pregnant and parenting teens) was discontinued June 30, 2011;
- HFA will address the expansion of HVP services to children 2-5 years of age;
- HFA would help children in WMC receive early intervention if developmental delays are detected; and
- This program will fill the service gap of first-time mothers, age 19 and under, who receive Medi-Cal.

Strengths and Resources:

- Madera Rescue Mission, Doors of Hope, Madera Ministerial Association, and other organizations work to provide a network of food, clothing, and furniture banks to serve those in WMC in poverty;
- WMC is a strength-based, family-centered community with an emphasis placed on parenting;
- MCPHD HVP has a culturally and linguistically competent staff for Latino/Hispanic populations; and
- MC's Children's Hospital Central California was the first children's hospital west of the Rockies to receive Magnate Nursing Designation.

North Coast Tri Consortium--NFP New

Targeted high-risk community: Humboldt (HC), Del Norte (DNC) and Siskiyou (SC) Counties

How the model meets the community needs and service gaps:

- NFP fills the void left by HC's adapted HFA wait-list and helps extend fully into DNC where the need for a home visiting program is great;
- Current gaps exist in the ability of the Early Head Start home visiting model to effectively meet the needs of the community, address generational dysfunction, addiction, and mental health conditions;
- NFP would offer what current HVPs don't in SC and DNC (professional home visitors with comprehensive skills and experience and the ability to show effective measurable outcome improvements); and
- NFP will address challenges with intergenerational poverty, substance abuse, domestic violence, and child abuse and neglect in a large geographical area.

Strengths and Resources:

- HC Department of Health and Human Services (DHHS) integrated Public Health, Mental Health and Social Services into one department and along with HC educators, and the business community are working together to create a "ready and willing, able and capable" workforce initiative;
- SC and DNC join HC in the MCAH Northern Association of Perinatal Advocates, First 5 Northern Region, and the California Center for Rural Policy focus area;
- Remoteness creates small, close-knit communities that are self-sufficient and adopt family support and grass-roots programs supporting the high-risk community; and
- Nurturing Parenting classes, tailored to the needs of the community, are offered throughout SC.

Sacramento (South Sacramento Communities)--NFP Expansion

Targeted high-risk community: Sacramento (Florin, Fruitridge, Oak Park, Parkway and South Sacramento)

How the model meets the community needs and service gaps:

- NFP will target and meet the needs of low-income, first-time mothers, teenage mothers, and those with poor birth outcomes;
- This model will address the services needed to decrease the high rates of prenatal substance abuse and high school dropout rates;
- NFP will address the gap in services for pregnant women using marijuana and/or alcohol; and
- The model will assist women wanting to attend education/vocational schools.

Strengths and Resources:

- Sacramento NFP has a well-established and extensive referral network of service providers;
- Three Family Resource Centers provide free services from parenting to anger management classes;
- Women Escaping a Violent Environment (WEAVE) provides domestic violence counseling and services; and
- Strong partnership with the County of Sacramento's Alcohol and Drug Unit, Sacramento County Office of Education, the MCH Advisory Board, and the Public Health Advisory Board.

San Diego (North Inland-Coastal Expansion (NICE))--NFP Expansion

Targeted high-risk community: North Inland-Coastal Expansion (NICE). MSSA 156d and 156e. NICE overlaps with Oceanside, Vista, San Marcos, Escondido and Carlsbad and the County's unincorporated area

How the model meets community needs and service gaps:

- NFP will help serve the waiting list of mothers who are enrolled in NFP, but have not yet been served;
- NFP will address the service needs due to violence disparities, high rate of teen births, low education, and limited access to healthcare;
- Transportation is a barrier for many families accessing health care and social services and NFP can assist in eliminating this obstacle; and
- NFP can help meet the needs of the large Hispanic population who have great difficulty accessing services due to language, financial, and cultural barriers.

Strengths and Resources:

- Community-based approach of service delivery using public-private partnerships;
 - Diverse representation from public and private alliances (government, education, health care, faith-based, grass-root, councils, schools, and other associations);
 - Integrated health care system of 2 community clinics, 2 hospitals, and other private medical providers; and
 - Collaborative partners are in conversation to explore Strengthening Families (SF) as a platform to strengthen cross-collaborations. San Diego NFP currently addresses the five SF Protective Factors.
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San Francisco (Bayview Hunter's Point)--NFP New

Targeted high-risk community: San Francisco (SF)

How the model meets community needs and service gaps:

- NFP presents the opportunity to engage SF community partners and stakeholders in ways that strengthen the safety net for services to the most vulnerable families. The NFP program-required advisory board closes this gap and helps build an integrated system of care for the client;
- NFP will improve SF's focus and coordination in promoting healthy pregnancies and infants and provide an evidence-based home visiting arm among its programs directed at families with children;
- NFP targets first-time mothers and fills the gap in services to them; and
- NFP, whose primary participants are mothers, will target and meet the needs of SF mothers who live in poverty, have high rates of domestic violence, child abuse and neglect, are non-English speaking, and have histories of substance abuse.

Strengths and Resources:

- Many low- income, first time mothers already have connections to social services prior to their pregnancy. This builds a high level of familiarity and trust with social service and health agencies;
- SF has many nationally-regarded governmental programs including Community Behavioral Health Services, Department of Children, Youth and Families, and a network of primary health clinics;

- SF is home to outstanding research and teaching universities and a powerful financial and high technology economy; and
- The Strengthening Families approach was incorporated into San Francisco's Preschool for All (PFA) Program guidelines, and is the overarching vision for high quality early childhood programs.

Shasta (Shasta Lake/Redding/Anderson/Burney)--NFP New

Targeted high-risk community: Shasta County (SC) Regional Population Centers. The four communities include Cities of Anderson, Redding, Shasta Lake, and Burney.

How the model meets community needs and service gaps:

- NFP will fill the gap identified by Shasta County Health and Human Services Agency (SCHHSA) Stakeholders who identified the need for Perinatal Home Visitation Services, case management, self-sufficiency and getting people off HHS services;
- NFP will address the need for services to prevent child abuse and/or neglect;
- This model will fill the gap in services for pregnant women in need of smoking cessation; and
- NFP would fill a major gap in the lack of any medical care for high-risk women who are pregnant or have infants living in the home.

Strengths and Resources:

- SCHHSA has the infrastructure and foundation in place to meet NFP's implementation timeline;
- Referral resources are available, such as Breastfeeding Peer Counselors, Medi-Cal and CalFresh application assistors, and immunization nurses all located within the same regional office;
- SC "PREVENT Team" is dedicated to addressing prevention of child maltreatment in SC County; and
- Expansion of the 4 P's Plus Substance Use Screening program includes mental health screening and referral services for physicians seeing pregnant women suspected of substance use.

SECTION 4: IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

Implementation of the statewide home visiting program has commenced at the state level; implementation activities will commence at the local level upon receipt of FFY 2010 funds. CHVP is in the process of developing an Implementation Team to focus on organizational readiness, create communication and feedback loops, and define roles and responsibilities. CHVP will work closely with the leadership in selected communities, as well as other state agencies and collaborative partners, to build local infrastructure and to support the adoption, implementation, and long-term sustainability of the home visiting program throughout California.

1. Engaging the At-Risk Communities and Identifying Organizations, Institutions

California's proposed USP for a statewide home visiting program describes how CDPH/MCAH engaged LHJs by requesting local information via the CHVP-RSI (See *Section 1 for details*). The CHVP-RSI allowed local MCAH Directors to: identify key local

stakeholders who provide services and resources within their LHJs/community; identify local health priority needs by engaging local public agencies, service providers, non-profit organizations, and families or clients; and formulate responses pertaining to the at-risk LHJs/communities. Information provided by local MCAH Directors on behalf of their identified at-risk LHJ/community is incorporated throughout CDPH/MCAH's implementation plan for CHVP.

Beginning in February 2010, CDPH/MCAH began collaboration with multiple organizations, institutions, and individuals, including local MCAH Directors, state agencies, evidence-based home visiting models National offices, Maternal and Child Health Bureau, ACF and the Region IX Project Officer on the implementation of a statewide home visiting program in California. The California Home Visiting State Partners Collaborative (Collaborative) began formal monthly in-person meetings in December 2010. The Collaborative membership includes representatives from First 5 California, California Departments of Education, Social Services, Health Care Services, Alcohol and Drug Programs, Mental Health, and Developmental Services. *See Section 6 for descriptions of these organizations.* The Collaborative is tasked with the provision of ongoing recommendations to CHVP for the role of home visiting in improving the health and well-being for California families; providing oversight to increase efficiency and effectiveness, recommending coordination with other agencies on service delivery, and sharing pertinent research, information, and resources.

Additional partner organizations involved in the overall planning and implementation process include: California Conference of Local Health Officers; County Health Executives Association of California; Early Childhood Comprehensive Systems; California Project LAUNCH; Early Learning Advisory Council; California Statewide Screening Collaborative; Help Me Grow; Preconception Health Council of California; and CDPH/MCAH Perinatal Substance Abuse Prevention Program. *See Section 6 for descriptions of these organizations.*

2. CHVP Approach to Policy and Standards

CDPH/MCAH, lead entity for management of the Title V Block Grant, has experience in setting policy and standards for the multiple programs it oversees; this expertise continues to be used in setting the policies and standards for the newly formed CHVP. CDPH/MCAH is in the process of integrating the CHVP into existing comprehensive early childhood systems in California. CHVP works towards using resources efficiently, and shaping policies that will bring a cohesive approach to the use of data systems, coordinated administration and planning throughout various state agencies. Key policy objectives will provide: alignment of outcome objectives with intervention strategies with the Logic Model; coordination of a network of early childhood services to address the various needs of at-risk families and provide linkages to service strategies; reduction in duplication of services by ensuring coordination and collaboration with partner agencies at the national, state, and local levels; and promotion of quality and adherence to fidelity for the national model developers.

3. Working with National Model Developers: Description of TA and Support

Contractual agreements with the NFP National Service Office and the HFA National Office are under development. Once approved, a comprehensive plan including technical assistance and support for CHVP and the LHJ/communities will be finalized. NFP will work with CHVP and LHJ/community staff to: prepare for implementation and plan for sustainability of CHVP programs; train Public Health Nurses (PHN), nurse supervisors, nurse consultants, and administrators using a competency-based instruction model that builds on their education and experience and provide consultation on NFP operations, nursing practice, successful practices, implementation challenges and support, resources, and ongoing professional development of educational opportunities. HFA will provide staff training, technical assistance, and quality assurance support and offer assistance to counties/communities in building infrastructure with advocacy, funding, training, quality assurance, and evaluation.

4. Timeline for Obtaining Curricula or Other Materials

CHVP anticipates obtaining model curriculum for NFP and HFA programs based on the funding and implementation timeline and the development of contractual agreements with NFP and HFA national offices. All curriculum materials will be received prior to staff training, counties/communities referral expansion and establishment, and outreach to targeted communities. *See Attachment 2 for the implementation timeline.*

5. Initial and Ongoing Training and Professional Development Activities

CHVP will require formal mechanisms to ensure trainings for staff are appropriate to the NFP and HFA models. Each LHJ/community will provide a professional growth plan for staff with individually tailored opportunities for additional training. CHVP will create a detailed training calendar which will outline ongoing monthly, semi-annual, and annual training and professional development activities to be provided for the home visiting programs. State-level trainings will address progress reporting, data system usage, scope of work, and fiscal accountability and will be delivered via webinar, teleconference, and in-person as needed. CHVP will collaborate with the national NFP and HFA models to ensure Technical Assistance and Training opportunities are explored and delivered on a timely basis and will utilize internal workgroups to ensure that best practices are inherent in the CQI process.

6. A Plan for Recruiting, Hiring, and Retaining Appropriate Staff for all Positions

CHVP will monitor the recruitment, hiring, and retention of staff through consistent and systematic feedback with NFP and HFA national model developers, as well as the LHJ/community-level management structure. CHVP will ensure that each LHJ/community has the county infrastructure to perform targeted outreach to identify appropriate staff.

7. Subcontracts

CHVP will not directly subcontract but instead provide funding through established funding provisions. CHVP will utilize an existing allocation process as the basis for disseminating funds. Once the plan receives approval, the selected LHJs will be

awarded their CHVP allocation. Some LHJs may enter into subcontract agreements with Community Based Organizations (CBO) or other local agencies.

8. Assurance of High Quality Clinical Supervision and Reflective Practice

CHVP recognizes high quality clinical supervision and reflective practice are mission-critical for successful home visiting programs. Both NFP and HFA national models adhere to high quality supervision and reflective practices and this will be reflected in the implementation and ongoing operation of all CHVP LHJ/communities.

Nurse-Family Partnership Clinical Supervision and Reflective Practices

In keeping with NFP model element #14, ensuring high quality clinical supervision and reflective practice, CHVP Nurse Supervisors will monitor and ensure that appropriate methodologies, standards, procedures and guidelines are followed by all staff.

Healthy Families America Clinical Supervision and Reflective Practices

Reflective practice is woven throughout the HFA Critical Elements and is a crucial component to the success of HFA. High quality clinical supervision and reflective practice for all FSWs, FAW, and Supervisors will be part of a formal plan.

9. Identifying and Recruiting Participants, Minimizing Attrition Rates, Number of Families Served, and Estimated Timeline to Reach Maximum Caseload

Identification and Recruitment Prior to identifying participants, a Local Home Visiting Planning Committee (LHVPC) will be established. It is critical to unify a cross-section of community members who represent the interests of the community and who will provide the service supports for clients with young children to be enrolled in CHVP. The LHVPC may be a new group or an existing collaborative; they will establish linkages to connect clients to home visiting services. Additional strategies for the identification of participants: using networks with access to Healthcare Advisory Councils organized by public district hospitals in the targeted community may be used for recruiting clients; and referrals from community agencies such as Adolescent Pregnancy and Parenting Programs, WIC, First 5, Black Infant Health Programs, Adolescent Family Life Program and Early Head Start.

Minimizing Attrition Rates for Participants Enrolled in the Program: CHVP will adhere to NFP and HFA standards for minimizing attrition rates for participants enrolled in home visiting programs. CHVP recognizes that some existing NFP and HFA home visiting programs have effective plans in place for minimizing attrition rates. Best practices from these highly effective attrition plans will be replicated at all expansion and new home visiting sites in California.

Estimated Timeline to Reach Maximum Caseload of Families

The CHVP USP required a minimum of 100 families to be served by either new or expanding home visiting programs. For LHJs/communities to reach the minimum caseload of 100, timelines are dependent on the following factors: (1) whether it is a new home visiting program or an expansion; (2) ability of the LHJ/community to hire qualified staff; (3) experience in managing data collection; and (4) the level of LHJ/community support for maximizing outreach and improving the network of referral linkages.

In general, all NFP LHJs/community sites, new or expansion, will reach the maximum caseload of 100 families by 15 months. All HFA LHJs/community sites, new or expansion, will reach the maximum caseload of 100 families by 18 months. HFA site's longer timeline is due to HFA accreditation guidelines and Critical Element #8, which defines a leveling system that determines the intensity of services families will receive. The leveling system ensures the quality of services provided to families is not compromised and FSWs do not become burned out from having entire caseloads of families all needing intensive services at once.

See Attachment 2, the Implementation Timeline, for more detail.

10. Coordination Between the Proposed Home Visiting Programs and Other Existing Services

CHVP will utilize the Strengthening Families framework (*see Section 2 for more details*) for the coordination of home visiting programs with other existing resources within each community; this will ensure a common set of outcomes and contribute to strategic planning efforts at the state level. To further influence coordination between the home visiting programs and other existing resources within each community, CHVP is in the process of developing workgroups to promote interagency coordination and shared accountability. Workgroup membership will include CHVP staff, national NFP and HFA representatives, and experienced local MCAH Directors who will provide experience and expertise in collaboration with other programs within their communities. Additional workgroup members at the state level will include representation from health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services within CHVP communities. CHVP will also include non-traditional partners in the workgroups as appropriate. Workgroups will include: Continuum of Care Workgroup, Public Awareness and Advocacy Workgroup, and a Program Performance Workgroup.

11. Data Systems for Ongoing Continuous Quality Improvement (CQI)

By incorporating home visiting program data into a larger, coordinated data system, better use can be made of the data to measure progress, make decisions, and track outcomes. CHVP will identify a new data system, or modify an existing data system, to support CQI efforts in the implementation process and beyond. *Section 5 describes how CHVP will provide the functionalities to ensure collection of data and ongoing CQI. Section 7 describes how data will inform ongoing CQI.*

12. CHVP Approach to Monitoring, Assessing, and Supporting Implementation with Fidelity to the Chosen Models and Maintaining Quality Assurance

CHVP will establish procedures and protocols for monitoring the overall implementation structure with regard to model fidelity within the State's CQI plan. CHVP will require adherence to research-based quality standards of practice such as staffing requirements, ongoing training and professional development, stringent reporting requirements, and continuous improvement at the program level. This will be achieved through strong data collection systems that will track outcomes and help to better target deficiencies in service. As noted in the CQI plan, fidelity and quality assurance measures at the program level will be monitored in three areas: program characteristics,

including home visitor/supervisor characteristics; participant characteristics; and participant experiences or service delivery. *Section 7 provides further detail about maintaining model fidelity and quality assurance.* CHVP will work closely with NFP and HFA to ensure that national and state quality improvement activities are complementary. To ensure that these efforts are coordinated, CHVP will consult with NFP and HFA to ensure ongoing dialogue and planning activities at the state level.

13. Anticipated Challenges to Maintaining Quality/ Fidelity, Proposed Response

See Section 3 for further details on anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues.

14. Collaborative Public and Private Partners

See Section 6 for a detailed explanation of all public and private partners.

15. How California Integrates CHVP into the Early Childhood System

Section 2 and Section 6 describe how Strengthening Families provides an overarching frame for building collaborations across the maternal and early childhood system.

16. Assurances

Designed to Result in Participant Outcomes as Noted in the Legislation: The CHVP USP provides details on data collection, analysis, and evaluation which assures that the home visiting program will be designed and implemented to result in participant outcomes as noted in the legislation by working closely with HRSA, as well as the National Model Developers.

Individualized Assessments will be Conducted of Participant Families and Services will be Provided in Accordance with those Assessments: CHVP adheres to the mission, goals and objectives, as well as the individualized assessment procedures and standards established by NFP and HFA, all California-funded home visiting programs will be required to conduct individualized assessments of participant families. Home Visiting Services provided to participating families will be in accordance with the individual assessments and quality standards, which will be monitored and reviewed by CHVP on an ongoing basis.

Services will be Provided on a Voluntary Basis: CHVP will adhere to NFP and HFA National Home Visiting Model standards by providing services on a voluntary basis.

California will comply with the Maintenance of Effort Requirement: CHVP assures that the home visiting program will be designed and implemented to comply with the MOE Requirement as specified in the ACA language (Sec. 2951).

Priority will be given to Eligible Participants: CHVP assures that through continuous monitoring and adherence to model fidelity, priority will be given to those eligible participants who:

- Have low incomes
- Are pregnant women who have not attained age 21
- Have a history of child abuse or neglect or had interactions with child welfare services

- Have a history of substance abuse or need substance abuse treatment
- Are users of tobacco products in the home
- Have, or have children with, low student achievement
- Have children with developmental delays or disabilities
- Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

SECTION 5: MEETING LEGISLATIVELY-MANDATED BENCHMARKS

1. Process for Developing Proposed Benchmark Construct Measures

Development of individual construct measures was an iterative process based upon review of information published by HRSA/ACF and its contractors regarding screening tools and constructs; review of published peer reviewed studies of screening tools; review of home visiting program evaluation reports conducted by other states and also published in the peer reviewed literature; and review of technical documentation from the model developers. Input and technical assistance was also obtained from a variety of stakeholders and subject matter experts, including those from HRSA/ACF, HFA and NFP model developers, MCAH program staff, data system developers, and epidemiologists in other states.

2. Coordination with Other Relevant State or Local Data Collection Efforts

Whenever possible, CHVP selected individual construct measures that were consistent or similar to other data collection efforts currently underway in communities or in other programs. The use of the 4Ps and 5Ps prenatal substance use screening tools in many local health jurisdictions contributed to the selection of the 5Ps tool for the CHVP. Lastly, questions or reporting timeframes consistent with population-based surveillance systems, such as the Maternal and Infant Health Assessment survey, American Community Survey, and the California Birth Statistical Master File were considered.

3. Defining Measures of Improvement

When possible, CHVP selected *outcome* measures to assess program impact, such as health behavior change or access to services. However, many constructs were more appropriately assessed using *process* measures or were required by the federal guidelines to report a process measure (e.g., referrals to domestic violence services). Two types of comparisons will be used in defining improvement in CHVP construct measures: (1) *Individual* comparisons or a comparison of the measure at two time points for the same individual; and (2) *Cohort* comparisons or a comparison of all program participants in one program year to all program participants in a subsequent program year. The assumption for most of the cohort comparisons is that the performance of the home visitors and the program itself will improve over time.

4. Data Management

Infrastructure: In collaboration with local and national HFA and NFP providers, CHVP will implement processes and provide the necessary infrastructure to support data collection. Local agencies will be required to provide adequate infrastructure to support program implementation and data collection processes, including desks, computers,

lockable filing cabinets, and other necessary components. They will also be required to provide minimum staffing for activities supportive of data collection and entry tasks.

Data Collection and Entry: No sampling strategies with independent data gathering efforts are being proposed. Data collection for the vast majority of constructs will be based upon the regular ongoing data collection efforts of the home visitor that are necessary to implement the program. Data for these items will be collected initially on the paper- client assessment and administrative forms used by the home visitor. Data collection for constructs will be based upon client self-report to the home visitor, or home visitor observation of the parent's interaction with the child. A few other constructs, such as the number of MOUs, will be based on the local agency summarizing and reporting their administrative data. All these data will be collected at regular intervals and at least on an annual basis. Minimum data collection timetables for each construct are referenced in the Benchmark tables towards the end of this section. Depending on local agency preferences, caseload, and capacity, sites may elect to hire a program technician to enter data or use their home visiting or supervisory staff to perform this task.

5. Data Management and MIS

Data for the mandated constructs will be entered into a computerized management and information system (MIS) at the local agency level. The NFP data collection MIS is based on the Efforts to Outcomes (ETO) software developed by Social Solutions. This is a web-based program that allows for local data entry, automatic data transmission via secure Internet to a central server, and the generation of standardized ("canned") and query-based reports. CHVP is investigating the use of ETO, other MIS solutions already in use at CDPH/MCAH, and other commercial off the shelf (COTS) data systems for possible use with the HFA program. The MIS will support CQI efforts in the implementation process and beyond by providing the following functionalities: standard reports for CQI and fidelity monitoring; ad hoc query capability for special analyses including CQI; vertical and horizontal control of membership for permissions to enter, modify, or query data, and data quality reports tracking percentage of form completion, field completion and process timelines. Data quality reports will be available at multiple levels, including the statewide program, and at each site, which includes management, staff and family or individual client. A singular statewide CHVP MIS is intended for implementation by CDPH/MCAH in order to centralize the receipt and analysis of CHVP data, and to do so with greatest operational efficiency.

All local agencies for the respective models will have their data stored in a single database at a central server. Local agencies will have restricted access to data from the centralized server so that they will only be able to access their own local agency data. Pending final selection of software used for HFA and terms of the contractual arrangement for use of ETO for NFP, these data will be available from the central server to the State MCAH program for analysis by scientific staff. CHVP intends to serve as Administrator of the MIS over both evidence-based models (NFP and HFA). Serving as Administrator will allow CHVP to implement uniform data standards and quality checks, California-specific CQI indicators in a standardized and uniform manner, flexible modification of the MIS based on revision of existing forms or addition of new forms as

necessary, and “canned” data reports that will contribute to managing program Scope of Work and process evaluations. The Administrator role may be shared with national offices for NFP and HFA where Administrative access will be limited to the evidence-based model of the national office and those areas of the MIS that are standardized by the model.

6. Staff Qualifications and Plan for Data Safety and Monitoring

State staff managing and analyzing the statewide data will be Master’s or Doctoral level trained public health scientific staff operating under the supervision of a Doctoral level Research Scientist Supervisor. They will all have taken information security training and orientation classes in accordance with information security policies required by the CDPH. The Budget Narrative provides time estimated for data collection related activities by personnel classification.

Local programs will be required to demonstrate appropriate knowledge and skill level of analytic staff via information provided in their Annual Report in fulfillment of their Scope of Work. LHJ/community staff will also receive analytic technical assistance from CDPH/MCAH on an as-needed basis. LHJ/community staff will receive training by their respective models on procedures for maintaining client confidentiality. Statewide home visiting program data will be stored on a secure server available for use only by EAPD Branch Staff directly involved in the analysis of these data.

According to documentation provided by the NFP, MIS data safety standards of the ETO software include:

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

Data safety standards of the statewide CHVP MIS, and HFA, will follow these same standards.

7. Data Quality Assurance

Data quality assurance efforts will be implemented at multiple levels, including training of home visiting staff in data collection procedures, establishment of data entry protocols, ensuring functionality of the MIS in support of minimizing data errors, implementation of data quality assurance reports, and creation of a data-driven culture at the local and state levels that values collecting reliable and timely data. Home visiting

staff will be trained in the use and proper administration of the screening tools, referral tracking forms and other data collection processes. The HFA and NFP programs both have their own training and orientation processes for home visitors to ensure data collection quality and operating procedure fidelity related to the implementation of forms, evaluation tools and related activities. CHVP will require the MIS to have a built-in functionality that identifies out-of-range values for relevant data elements to help prevent data entry errors. The MIS will also allow local agencies to track form and field completeness to ensure data quality and to generate missing data reports. Data quality assurance reports will be developed at the state level. These reports will be shared with local agencies as a quality improvement and assessment tool and as a means to compare local agency data collection efforts to the statewide quality benchmarks.

8. Plan for Analyzing Data at the Local and State Level

Data will be analyzed at both the state and local levels. Programs at the local level will be able to use the MIS software to produce quality improvement and other reports on the clients enrolled in the program. CDPH-MCAH will ensure the MIS has a functionality that stratifies data by sub-groups (e.g., client demographics, case worker, etc.) at the local level to understand the impact the home visiting program is having on different types of clients. State staff within the MCAH program will have access to the statewide client level data in order to conduct in-depth analyses. Analyses will be conducted on an ongoing basis to monitor program implementation, quality improvement activities, and program outcomes, including progress toward improving Benchmarks. Analyses will be conducted to assess: client characteristics, client risk profiles, service utilization, and outcomes.

A number of program client characteristics and service use data will be collected in order to support program implementation, monitor progress of key subgroups, and assist in the evaluation of program activities. Selected examples include: age, education, income, marital status, race/ethnicity, employment status, living arrangement, number of persons in household, primary language, among others, as well as number of visits, length of visits, content of visits, referrals made, referrals completed, time enrolled in program, among others.

9. Benchmarks and Continuous Quality Improvement

The CHVP Continuous Quality Improvement (CQI) plan will incorporate the federally required benchmark data, as well as the NFP and HFA specifically mandated data and additional data elements. Virtually all of the benchmark measures lend themselves well to use in CQI activities. Consequently most, if not all, will be used for both purposes. The CHVP CQI plan will be implemented and monitored at the state and LHJ/community level. LHJ/communities will use CQI data to monitor maternal and early childhood systems for quality improvement priorities and opportunities and will provide leadership in rectifying local level gaps in services and linkages. For CQI purposes, demographic data will be used to determine if the CVHP target population is being reached, assure cultural consonance with the home visitor, and to stratify other data elements in order to analyze differences in attrition rate, missed visits, etc. Programmatic data such as caseloads, staff stability, quality of supervision, participant engagement, frequency and duration of services provided, and participant provider

relationships will be used for CQI and to ensure model fidelity for both CHVP models. Technical assistance will be provided to enable local program staff to identify areas for improvement and to design an improvement plan.

Benchmark Table

The following table delineates each Benchmark area and respective constructs. These constructs are further categorized to address and clarify the overall plan for assessing the impact of home visitation on client outcomes.

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric
Prenatal Care <i>(individual or cohort outcome)</i>	Proportion of women receiving prenatal care. (Increase)	Client self-report from assessment forms	Questions have been formatively tested by evidence-based home visiting programs (EBHVs) ¹	Pregnant women. Questions will be available in both English and Spanish	Maternal entry point and routine prenatal care in each trimester	Numerator: number of women who received prenatal care Denominator: number of women enrolled during pregnancy.
Parental Use of Alcohol, Tobacco, or Illicit Drugs <i>(individual outcome)</i>	Proportion of women who drank alcohol, used drugs, or smoked during pregnancy. (Decrease from in-take to the 3 rd trimester of pregnancy.)	Client self-report using NFP-developed questions or the 5 P's Plus in HFA	Based on 4P's Plus screening tool, which has been validated across a variety of diverse populations. 83% sensitivity and 80% specificity. The positive predictive value (PPV) 50% and negative predictive value (NPV) 95%. ²	5P's focus on pregnant women and its non-threatening approach makes it appropriate for this population. Available in both English and Spanish	At in-take and during the 3 rd trimester of pregnancy	Numerator: number of women who drank alcohol, used drugs, or smoked during pregnancy. Denominator: number of women enrolled during pregnancy.
Preconception Care	Proportion of women with a medical	Client self-report from assessment	Questions have been formatively tested by MIHA	Pregnant and postpartum women.	At in-take and one year post-	Numerator: number of women with a medical

¹ Li R, Scanlon KS, Serdula MK. The validity and reliability of maternal recall of breastfeeding practice. *Nutr Rev.* 2005 Apr;63(4):103-10.

² Chasnoff IJ, Weels AM, McGourty RF, Bailey L. Validation of the 4P's Plus screen for substance use in pregnancy. *Journal of Perinatology* 2007;27:744-748; Kennedy C, Finkelstein N, Hutchins E, Mahoney J. Improving screening for alcohol use during pregnancy: The Massachusetts ASAP program. *Maternal and Child Health Journal* 2004;8(3):137-147.

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
<i>(individual outcome)</i>	home. (Increase from just before pregnancy to one year post-partum)	forms		Questions will be available in both English and Spanish	partum	home (regular medical provider that is not an ER). Denominator: number of women enrolled in the program.
Inter-Birth Intervals <i>(cohort outcome)</i>	Proportion of women with a subsequent birth within two years post-partum. (Decrease)	Client self-report from assessment forms	Questions have been formatively tested by EBHVs	Postpartum women. Questions will be available in both English and Spanish	Date of subsequent birth	Numerator: number of women having a subsequent birth within two years post-partum. Denominator: number of women enrolled in the program at two years post-partum.
Screening for Maternal Depressive Symptoms <i>(cohort outcome)</i>	Proportion of women screened for the presence of depressive symptoms. (Increase)	Client screened using EPDS	The widely used EPDS has an internal consistency reliability of .87 with a sensitivity of 95% and a specificity of 93%. ³	EPDS was developed specifically for use with women 6-8 weeks postpartum. Available in both English and Spanish.	Six to eight weeks postpartum	Numerator: number of women screened for depressive symptoms Denominator: number of women still enrolled in the program at six to eight weeks postpartum.

³ Matthey S, Elliott CH, Barnett B. (2006). Variability in use of cut-off scores and formats on the Edinburgh postnatal depression scale – implications for clinical and research practice. Archives of Women’s Mental Health, 9, 309-315.

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
Breastfeeding <i>(cohort outcome)</i>	Proportion of women who exclusively breastfeed their infants through 3 months postpartum. (Increase)	Client self-report from assessment forms	Questions have been formatively tested by evidence-based home visiting programs	Postpartum women. Questions will be available in both English and Spanish	At regular home visits through 3 months post-partum	Numerator: number of postpartum women with infants aged 3 months or older who were breastfed exclusively through 3 months of age. Denominator: number of postpartum women with infants aged 3 months or older.
Well-Child Visits <i>(cohort outcome)</i>	Proportion of children who receive the recommended schedule of well-child visits. (Increase)	Client self-report from assessment forms	Questions have been formatively tested by evidence-based home visiting programs	Children. Questions will be available in both English and Spanish	At initial home visit and then at regular home visits coinciding with the recommended schedule of well-child visits	Numerator: number of infants that received all recommended well-child visits for their age. Denominator: number of infants enrolled in the program.
Maternal and Child Health Insurance	Proportion of women and children with	Client self-report from assessment	Questions have been formatively tested by evidence-	Women and children. Questions will be	At in-take (about coverage	Numerator: number of women and children

BENCHMARK AREA I. IMPROVED MATERNAL AND NEWBORN HEALTH						
Status <i>(individual outcome)</i>	health insurance coverage. (Increase from just before pregnancy to one year post-partum)	forms	based home visiting programs	available in both English and Spanish	during the time just before pregnancy) and at one year post-partum	reporting having any type of health insurance. Denominator: number of women and children enrolled in the program. (women and children analyzed separately)

BENCHMARK AREA II. CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric
Visits for Children to Emergency Department from All Causes <i>(individual or cohort outcome)</i>	Average number of times children visit the emergency room. (Decrease)	Client self-report from assessment forms	Questions have been formatively tested by EBHVs	Children. Questions will be available in both English and Spanish	At least once quarterly starting at birth	Average number of emergency room visits for children.

BENCHMARK AREA II. CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT						
Visits of Mothers to Emergency Departments from All Causes <i>(individual or cohort outcome)</i>	Average number of times mother visits the emergency room. (Decrease)	Client self-report from assessment forms	Questions have been formatively tested by EBHVs	Women. Questions will be available in both English and Spanish	At least once quarterly starting postpartum	Average number of emergency room visits for mothers.
Information Provided Or Training Of Participants On Prevention Of Child Injuries <i>(cohort outcome)</i>	Proportion of families who are provided information regarding the prevention of child injuries. (Increase)	Home visitor report	Questions have been formatively tested by EBHVs	Women. Questions will be available in both English and Spanish	Curriculum topics addressed during home visits reported after each visit	Numerator: number of families provided information on child injury. Denominator: number of participating families.
Incidence of Child Injuries Requiring Medical Treatment <i>(individual or cohort outcome)</i>	Average number of times children received medical treatment for injuries. (Decrease)	Client self-report from assessment forms	Questions have been formatively tested by EBHVs	Children. Questions will be available in both English and Spanish	At least once quarterly starting at birth	Average number of times children received treatment from a medical professional for injuries.

BENCHMARK AREA II. CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT						
Reported Suspected Maltreatment for children in the program <i>(individual or cohort outcome)</i>	Proportion of cases of suspected maltreatment of the target child. (Decrease)	Home visit interview & CPS administrative data	Questions have been formatively tested by EBHVs	Children. Questions will be available in both English and Spanish	At least once a month starting at birth	Numerator: number of cases of suspected maltreatment. Denominator: number of participating families.
Reported Substantiated Maltreatment for children in the program <i>(individual or cohort outcome)</i>	Proportion of cases of substantiated maltreatment of the target child. (Decrease)	Home visit interview & CPS administrative data	Questions have been formatively tested by EBHVs	Children. Questions will be available in both English and Spanish	At least once a month starting at birth	Numerator: number of cases of substantiated maltreatment. Denominator: number of participating families.
First-Time Victims of Maltreatment for Children in the program <i>(individual or cohort outcome)</i>	Proportion of target children who were victims of first time maltreatment. (Decrease)	Home visit interview & CPS administrative data	Questions have been formatively tested by EBHVs	Children. Questions will be available in both English and Spanish	At least once a month starting at birth	Numerator: number of victims of first time maltreatment. Denominator: number of participating families.

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric
Parent Support for Children's Learning and Development <i>(individual outcome)</i>	Proportion parents who demonstrate high-quality (KIPS score \geq 4 on 5- point scale) parenting behavior. (Increase)	Home visitor observation using NFP developed interview and observation or KIPS for HFA	The KIPS instrument was field tested and showed high internal consistency (alpha=0.95) and high (cont.)	KIPS is a structured observational assessment of parenting quality that involves a 20-minute observation of free-play between (cont.)	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families
Parent Knowledge Of Child Development And Of Their Child's Developmental Progress <i>(individual outcome)</i>	Proportion parents who demonstrate high-quality (KIPS score \geq 4 on 5-point scale) parenting behavior. (Increase)	Home visitor observation using NFP developed interview and observation or KIPS for HFA	Inter-rater reliability (92.4%) on scoring by professionals and paraprofessionals ⁴	Caregiver and a child. It includes 12 criteria to measure parent-child relationship and adult behaviors related to children's development.	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families
Parenting	Proportion	Home visitor	See KIPS	See KIPS	Once when	Numerator:

⁴ Comfort M, Gordon PR, A, Naples D. (2011). KIPS: an evidence-based tool for assessing parenting strengths and needs in diverse families. *Infants & Young Children*, 24, 56-74.

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS						
Behaviors and Parent-Child Relationship <i>(individual outcome)</i>	parents who demonstrate high-quality (KIPS score \geq 4 on 5-point scale) parenting behavior. (Increase)	observation using NFP developed interview and observation or KIPS for HFA	explanation above	explanation above	child is 3 months and again when child is 12-14 months	number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families
Parent Emotional Well-Being or Parenting Stress <i>(individual outcome)</i>	Proportion parents who demonstrate high-quality (KIPS score \geq 4 on 5-point scale) parenting behavior. (Increase)	Home visitor observation using NFP developed interview and observation or KIPS for HFA	See KIPS explanation above	See KIPS explanation above	Once when child is 3 months and again when child is 12-14 months	Numerator: number of families that demonstrate high-quality parenting behavior. Denominator: number of participating families
Child's Communication, Language, and Emergent Literacy <i>(cohort process)</i>	Proportion of target children who receive developmental assessments at least once every 6 months. (Increase)	Client self-report using ASQ3	The internal consistency coefficient alpha for each individual developmental area (cont.)	The ASQ-3 is a general developmental screening tool that focuses on asking (cont.)	At least every 6 months starting at birth	Numerator: number of families that received all scheduled assessments. Denominator: number of participating families.
Child's General Cognitive	Proportion of target children who receive	Client self-report using ASQ3	Ranged from .51 to .87. Its test-retest reliability ranged	parents about the child's specific	At least every 6 months	Numerator: number of families that received all

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS						
Skills <i>(cohort process)</i>	developmental assessments at least once every 6 months. (Increase)		from .75 to .82. The overall sensitivity (cont.)	developmental skills rather than their developmental (cont.)	starting at birth	scheduled assessments. Denominator: number of participating families
Child's Positive Approaches to Learning Including Attention <i>(cohort process)</i>	Proportion of target children who receive developmental assessments at least once every 6 months. (Increase)	Client self-report using ASQ3	Was 86.1%; the overall specificity was 85.6% ⁵	Concerns. The ASQ may be completed at home by the parent or during a home visit in approximately 15 minutes.	At least every 6 months starting at birth	Numerator: number of families that received all scheduled assessments Denominator: number of participating families
Child's Social Behavior, Emotional Regulation, and Emotional Well-Being <i>(cohort process)</i>	Proportion of target children who receive developmental assessments at least once every 6 months. (Increase)	Client self-report using ASQ-SE	The overall internal consistency coefficient alpha was .82. The overall positive predictive value was 26.8%. The overall test-retest agreement was 94% ⁶	The ASQ-SE screens infants and young children for possible social-emotional and behavioral concerns that might require further evaluation. The ASQ-SE	At least every 6 months starting at birth	Numerator: number of families that received all scheduled assessments Denominator: number of participating families

⁵ Squires J, Twombly E, Bricker D, Potter L. (2009). Ages and Stages Questionnaire, Third Edition. Accessed from www.agesandstages.com on May 25, 2011. See pages 1, 3, and 4.

⁶ Paul H. Brookes Publishing. (Undated) Technical Report on ASQ:SE. Accessed from www.agesandstages.com on May 25, 2011. See pages 8, 15

BENCHMARK AREA III. IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENTS						
				has seven subscales: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.		
Child's Physical Health and Development <i>(cohort process)</i>	Proportion of target children who receive developmental assessments at least once every 6 months. (Increase)	Client self-report using ASQ3	See ASQ3 explanation above	See ASQ3 explanation above	At least every 6 months starting at birth	Numerator: number of families that received all scheduled assessments Denominator: number of participating families

BENCHMARK AREA IV: CRIME OR DOMESTIC VIOLENCE (DOMESTIC VIOLENCE)						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric

BENCHMARK AREA IV: CRIME OR DOMESTIC VIOLENCE (DOMESTIC VIOLENCE)						
<p>Screening for Domestic Violence</p> <p><i>(cohort process)</i></p>	<p>Proportion of women who were screened for domestic violence at recommended intervals. (Increase)</p>	<p>Client self-report using NFP develop-ed interview or the WEB for HFA</p>	<p>The WEB scale has been validated to assess domestic violence with high sensitivity (86%) and specificity (91%)⁷</p>	<p>The WEB scale is a self-report instrument related to experiences of domestic violence. It is a 10-item questionnaire that is non-threatening and easy to administer.</p>	<p>At enrollment, birth, 3 months, 6 months, 12 months, and 24 months</p>	<p>Numerator: number of women who received the domestic violence (DV) screen at all required intervals. Denominator: number of women enrolled in the program.</p>
<p>Of Families Identified For The Presence Of Domestic Violence, Number Of Referrals Made To Relevant Domestic Violence Services</p> <p><i>(cohort process)</i></p>	<p>Proportion of women receiving at least one referral to a relevant DV service following every positive screen for DV. (Increase)</p>	<p>Home visitor report</p>	<p>Questions have been formatively tested by evidence-based home visiting programs</p>	<p>Women in this construct. Questions will be available in both English and Spanish</p>	<p>Whenever a screen is positive for DV</p>	<p>Numerator: number of women who received at least one referral to a relevant DV service every time she had a positive screen. Denominator: number of women screened at every required interval, and who had at least one positive screen.</p>

⁷ Smith PH, Earp JA, DeVellis R. Measuring battering: development of the Women’s Experience with Battering (WEB) Scale. Women’s Health, winter 1995, 1(4):273-288.

BENCHMARK AREA IV: CRIME OR DOMESTIC VIOLENCE (DOMESTIC VIOLENCE)						
Of Families Identified For The Presence Of Domestic Violence, Number Of Families For Which A Safety Plan Was Completed	Proportion of women completing or revisiting a safety plan following every positive screen for DV. (Increase)	Home visitor report	Questions have been formatively tested by evidence-based home visiting programs	Women in this construct. Questions will be available in both English and Spanish	Whenever a screen is positive for DV	Numerator: number of women who completed or revisited a safety plan every time she had a positive screen for DV. Denominator: number of women screened at every required interval, and who had at least one positive screen.
<i>(cohort process)</i>						

BENCHMARK AREA V: FAMILY ECONOMIC SELF-SUFFICIENCY						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric
Household Income and Benefits	Total household income and benefits. (Increase)	Client self-report from assessment forms	Questions have been formatively tested by evidence-based home visiting programs ⁸	Women in this construct. Questions will be available in both English and Spanish	At least every 6 months starting at in-take	Household income will be reported in dollars. Benefits will be reported in dollars or by category where dollar amount is not applicable.
<i>(individual outcome)</i>						
Employment or Education	Employment: number of paid	Client self-report from	Questions have been	Women in this construct.	At least every 6	• For employment, number of adult

⁸ United States Census Bureau, American Community Survey, 2011 Questionnaire. <http://www.census.gov/acs/www/Downloads/questionnaires/2011/Quest11.pdf>

<p>of Adult Members of the Household <i>(individual outcome)</i></p>	<p>hours worked plus unpaid hours devoted to care of an infant. (Increase) Education: educational attainment - completion of academic degrees or training certification programs. (Increase)</p>	<p>assessment forms</p>	<p>formatively tested by evidence-based home visiting programs</p>	<p>Questions will be available in both English and Spanish</p>	<p>months starting at in-take</p>	<p>household members employed during the month, and average hours per month worked by each adult household member. • For education, educational attainment achieved for each adult household member, number of adult household members participating in educational activities since the previous interview, and hours per month spent by each adult household member in educational programs.</p>
<p>Health Insurance Status</p>	<p><i>See Benchmark area I, maternal and child health insurance status</i></p>					

BENCHMARK AREA VI: COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS						
Construct	Description of Measure (Definition of Improvement)	Measure Source	Validity / Reliability / Justification	Population Assessed and Appropriateness	Data Collection Schedule	Measurement Metric
Number of Families Identified for Necessary Services <i>(cohort process)</i>	Proportion of families receiving intake assessments. (Increase)	Client self-report from intake assessment form	Assessment forms developed for low-income, perinatal populations based on previous experience with this population.	Family and household members. Forms used successfully in low-income, perinatal populations	At participant intake	Numerator: number of families that received an intake assessment. Denominator: number of families enrolling in the California Home Visiting Program.
Number of Families that Required Services and Received a Referral to Available Community Services <i>(cohort process)</i>	Proportion of families identified with a need who receives a referral to available community resources. (Increase)	Home visitor referral tracking form	Referral forms developed by programs with previous experience with this population.	Family and household members. Forms used successfully in low-income, perinatal populations	Ongoing throughout program starting at intake	Numerator: number of families enrolled in CHVP who received referrals. Denominator: number of families enrolled in the program that needed services.
Number of Memorandum of Understanding	Number of MOUs or other formal agreements between each	Local program activity/ progress	Standard interagency reporting	Local home visiting program and local service agencies	At program initiation, annually thereafter	Summary of meeting notes and attending agencies will be

BENCHMARK AREA VI: COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS						
<p>ing or Other Formal Agreements with Other Social Service Agencies in the Community</p> <p><i>(program process)</i></p>	<p>local program and local social service agencies. (Increase)</p>	<p>report</p>				<p>compiled by each local program. The measure will be expressed as a count/number.</p>
<p>Information Sharing</p> <p><i>(program process)</i></p>	<p>Number of agencies with an advisory committee meeting at least quarterly. (Increase)</p>	<p>Local program activity/progress report</p>	<p>Standard interagency reporting</p>	<p>Local home visiting program and local service agencies</p>	<p>At program initiation, annually thereafter</p>	<p>Summary of meeting notes and attending agencies will be compiled by each local program. The measure will be expressed as a count/number.</p>
<p>Number of Completed Referral</p> <p><i>(cohort process)</i></p>	<p>Proportion of completed referrals. (Increase)</p>	<p>Home visitor referral tracking form</p>	<p>Referral forms have been developed by programs with previous experience with this population.</p>	<p>Family and household members. Forms used successfully in low-income, perinatal populations</p>	<p>Ongoing through-out program starting at intake</p>	<p>Numerator: number of referrals completed by CHVP families. Denominator: number of referrals given to CHVP families.</p>

SECTION 6: STATE ADMINISTRATION OF THE STATE HOME VISITING PROGRAM

1. Lead Agency

CDPH/MCAH is the lead agency for the State Home Visiting Program. CDPH/MCAH administrative structure has the internal capabilities in place to support the CHVP by providing an overarching statewide strategy to ensure and promote the effectiveness of an evidence-based home visiting program, and provide accountability for public funds.

2. Collaborative Public and Private Partners

CHVP will collaborate and coordinate with the following private and public sector partners to develop cohesive strategies, gain access to services, and seek referrals to promote home visiting program quality and effectiveness: (1) California Department of Mental Health (CDMH); (2) California Department of Social Services (CDSS); (3) California Department of Developmental Services (CDDS); (4) California Department of Alcohol and Drug Programs (ADP); (5) California Head Start State Collaboration Office (CHSSCO) of the California Department of Education (CDE); (6) MCAH Local Health Jurisdictions (LHJs); (7) First 5 California; (8) California Department of Health Care Services (DHCS); (9) Futures Without Violence (FWV); (10) California Conference of Local Health Officers (CCLHO); (11) County Health Executives Association of California (CHEAC); (12) Early Childhood Comprehensive Systems (ECCS); (13) Early Learning Advisory Council (ELAC); (14) California Project LAUNCH (CPL); (15) California Statewide Screening Collaborative (CSSC); (16) Preconception Health Council of California: (PHCC); and (17) CDPH/MCAH Perinatal Substance Abuse Prevention Program.

3. California Home Visiting Management Plan

CHVP management is comprised of CDPH Executive Management, as well as the CDPH/MCAH management team which includes programmatic, epidemiologic, administrative, and fiscal administration. The management plan has been organized with both manager and line staff responsible for ensuring the successful systems implementation. CHVP Technical Assistance (TA) teams have been designated to provide direct support to LHJs along with coordination with the NFP and HFA home visiting models to ensure that LHJs are on pace to meet required benchmarks, guide responses to time-sensitive deadlines and ensure that local level staff are operating in fidelity with the model. CHVP TA teams will be minimally comprised of a Nurse Consultant III, Health Program Specialist II, Health Program Specialist I, and Research Scientist I, plus other supporting staff for fiscal and administrative responsibilities. Each team will serve as the subject matter expert to a specific model, and will be the state-level liaison to the LHJ and the model developer. The CHVP TA teams will be fully immersed in training for each model, and will work with developers to implement and clarify fidelity measurements, as well as develop data collection strategies with the programs. *Attachment 3 provides the organizational chart; Attachment 4 provides detailed job duties and responsibilities.*

Leadership and Organizational Capacity

CDPH/MCAH has designated key personnel to implement and provide leadership to CHVP. In addition to the onsite CHVP management team, CHVP is supported by other Division-level management, the CDPH Director's Office, as well as the California Health and Human Services Agency for the State of California. CHVP meets the legislative requirements by employing highly educated, well-trained, competent staff. Professional staff all hold Masters Degrees or above and are well established in the Public Health field. High quality supervision will be provided through a combination of managerial staff experience and education. Strong organizational capacity to implement activities is supported by the following interagency CDPH infrastructure: Human Resources Branch, Program Support Branch, Financial Management Branch, Office of Leadership and Workforce Development, Information Security Office, and the Office of Legal Services. At the Division level, MCAH provides Information Technology support; Contracts and Grants Management, Accounting and Business Operations; Epidemiology, Evaluation and Data Operations, as well as Surveillance, Assessment and Program Development.

4. Related Evaluation Efforts of Home Visiting Programs in California

Rady Children's Hospital-San Diego (RCHSD): The Safe Kids California Project (SKCP), under the leadership of the Chadwick Center for Children and Families (CCCCF), will "cascade" SafeCare®, an evidence-based home visitation (EBHV) model, across multiple California counties.

5. Referral and Service Networks

CHVP selected two home visiting models and each funded LHJ/community will support only one model for implementation. Therefore, a plan for coordinating referrals across models is not necessary. CHVP will utilize the following referral and service networks: California Project LAUNCH; Early Childhood Comprehensive Systems (ECCS); Early Learning Advisory Council (ELAC); and Help Me Grow (HMG).

See Section 3 and Section 4 for further details on referrals

6. Coordinated Efforts

CHVP will utilize strategies for integrating the home visiting program with other programs and systems in California that are related to maternal and child health and early childhood health, development and well-being by integrating home visiting into the ECCS efforts involving the key early childhood system components of health care/medical home, early care and education, social and emotional development, family support, and parenting education. Specifically, approaches will be developed to: establish linkages to existing collaboratives and initiatives to support the integration of program services into wider state system of care; integrate home visiting as one component of a continuum of services for children; improve and expand timely and early identification of children with developmental delays or at risk of delays and provide early intervention to help children reach full potential; develop interagency partnerships to address barriers to services for children who fall through the cracks due to lack of insurance or ineligibility to entitlement services; streamline and improve services through cross-departmental planning and governance that builds on existing initiatives

and services; and promote better communication and coordination between county and private agencies serving children and their families.

7. Monitor Model Fidelity

CDPH/MCAH will monitor the fidelity of program implementation to ensure services are delivered pursuant to the selected models, through TA Teams. The TA Teams will be comprised of experts in a specified model, knowing exactly what is required of the model to be successful. CHVP will incorporate Management Information Systems (MIS) to measure progress, make decisions, and track outcomes. The CHVP CQI plan will ensure fidelity to the NFP and HFA models by applying the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative (EBHV Initiative).

Prerequisites for Implementation

CHVP will comply with HFA implementation requirements as follows:

Staffing Requirements: All California HFA home visiting sites will have three primary staff positions: (1) FSW who conducts home visits with families; (2) FAW who conducts family and child assessments and sometimes screens families for enrollment in the program; and (3) program managers/supervisors who oversee program operations, funding, quality assurance, evaluation, and supervision of staff. **Supervision**

Requirements: CHVP will comply with the national HFA recommendation of one supervisor for every five staff persons. CHVP HFA programs will recommend program managers/supervisors spend a minimum of 1.5 to 2 hours per employee each week on formal supervision and additional shadowing the FSWs and FAWs to monitor and assess their performance and provide constructive feedback and development. **Staff**

Ratio Requirements: CHVP will comply with the national HFA recommendation of one FSW serving up to 15 families. In some instances, the caseload may need to be reduced to accommodate families with multiple needs or to accommodate communities in which there are long distances between home visits. **Data Systems/Technology**

Requirements: CHVP will incorporate the Program Information Management System (PIMS) into our existing computerized data collection, management, and reporting systems. By incorporating home visiting program data into a larger, coordinated data system, better use can be made of the data to measure progress, make decisions, and track outcomes. CHVP is in the process of identifying new data systems, or modify existing data systems, to support CQI efforts in the implementation process and beyond. **Staff Education and Experience:** While HFA does not provide specific educational requirements for direct-service staff, the California HFA program will recommend selecting staff based on their personal characteristics; their willingness to work in, or experience working with, culturally diverse communities; their experience working with families with multiple needs. CHVP HFA programs will comply with the national HFA mandatory training.

CHVP will comply with NFP implementation requirements as follows:

Staffing Requirements: CHVP will require two primary staff positions which are consistent with the national NFP recommendation: (1) nurse home visitors who conduct home visits with families, and (2) nursing supervisors who supervise nurse home

visitors. Additionally, an administrative assistant is required to manage data entry and other administrative tasks. **Staff Education and Experience:** Consistent with NFP NSO, CHVP will require that nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing. **Supervision Requirements:** Consistent with NFP NSO, CHVP will require that a full-time supervisor provides supervision to no more than eight individual nurse home visitors. CHVP funded nursing supervisors will provide nurse home visitors clinical supervision with reflections, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role. Supervisory activities include one-on-one clinical supervision, case conferences, team meetings, and field supervision. **Staff Ratio Requirements:** In compliance with NFP NSO, CHVP will require that a full-time home visitor carry a caseload of no more than 25 clients.

SECTION 7: STATE PLAN FOR CONTINUOUS, QUALITY IMPROVEMENT

1. The California Home Visiting Program Continuous Quality Improvement Plan

The CHVP continuous quality improvement (CQI) plan will ensure fidelity to the NFP and HFA models by applying the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative (EBHV Initiative). The EBHV Initiative was a cross-site evaluation of five EBHV models, including NFP and HFA that resulted in a framework for assessing fidelity. The framework identified structural and dynamic criteria that define high-quality implementation includes: consistency in practice, including relatively low caseloads for home visitors; stability of home visitors and supervisors; strong supervision; adequate participant engagement rates among families referred for services; and maintenance of a set standard for home visiting duration and dosage. An additional criterion is the participant-provider interaction, defined by careful family assessment, responsiveness of the home visitor, and respect for the family.⁹

CHVP will use the process outlined in the Plan-Do-Check-Act cycle (PDCA) to structure its data-driven (CQI) plan. Briefly, the four steps of the PDCA cycle include planning what needs to be accomplished, doing a small-scale test of the plan, checking the results, and acting on the results, which may include standardization of the plan or revision and re-testing. Its flexibility allows for coordination with other CQI tools, such as those currently in place at local agencies. Importantly, both the CHVP implementation and CQI plans are anchored to the regular use of data, which supports the early identification of areas in need of improvement. The CHVP CQI plan will be incorporated into the foundation of the implementation process. In order to address the unique cultural and contextual needs of California's diverse communities, some local home visiting (HV) programs may identify potential adaptations to national models. CHVP will carefully evaluate requests for adaptations in coordination with NFP or HFA, with attention to maintaining core components of the evidence-based models.

⁹ Daro, D. Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity. Mathematica Policy Research, Inc. Chapin Hall at the University of Chicago. December 2010.

The flexibility of the PDCA cycle allows easy incorporation of elements, such as the EBHV Initiative framework criteria and the multiple additional indicators required by the federal guidance and the national NFP and HFA models. Importantly, CDPH/MCAH has fostered an ongoing dialog with the national offices of NFP and HFA. CHVP will continue to collaborate with the national models in order to meet fidelity criteria and integrate the CQI requirements of each model into the CHVP CQI plan.

2. California’s Plan for Fidelity Monitoring and Quality Improvement

The CHVP CQI plan requires three levels of involvement across the public health system: the Program level, which includes participants and HV staff; the LHJ level, which includes the local system for maternal and early childhood providers; and the state level, which provides overall leadership and coordination across sites. In addition, close collaboration with the national models will be required at each level and is vital to the overall success of the implementation and ongoing process of quality improvement. Both NFP and HFA require local programs to adhere to stringent principals of model fidelity and quality. CHVP will define fidelity and quality standards and corresponding indicators that will be regularly monitored based on federal guidance, NFP and HFA recommended or required CQI indicators, and input from experts, local programs, and stakeholders. An overview of the CQI processes and indicators for NFP and HFA as they relate to the CHVP CQI plan are described below.

Nurse-Family Partnership: Quality assurance measures are built into NFP; the program focuses on client interactions, program implementation, and outcome achievement. CHVP will require all local agencies to follow NFP’s 18 Model Elements, undergo any necessary certification processes, and comply with CHVP-specific HV program policies and procedures, and scopes of work. CHVP will ensure fidelity to the program model by maintaining national NFP guidelines in monitoring, assessing, and supporting implementation.

Example NFP Guidelines Indicators of Implementation Fidelity

<u>Client Characteristics/Quality of Care</u>	<u>Agency Level</u>
<ul style="list-style-type: none"> • Voluntary participation • First-time mother status • Low-income criteria • Percent of referrals enrolled in the program and referral source 	<ul style="list-style-type: none"> • Nurse home visitors and supervisors are registered nurses • Clinical staff attends Nurse-Family Partnership training • Clinical staff employs methods promoted by the program • Clinical staff FTE status; a full-time nurse home visitor carries a caseload of no more than 25 active clients; a full-time nurse supervisor provides supervision to no more than eight individual home visitors

Healthy Families America: HFA requires accreditation to ensure participating programs abide by the commitment to deliver the highest quality services possible to families and children. The Self-Assessment Tool (SAT) for programs serves as the program’s guide to maintaining quality throughout implementation. The SAT is also used to determine

the program’s current state of quality. The State will require all local agencies to adhere to HFA’s self-assessment and accreditation process. Local programs will be required to follow HFA’s 12 Critical Elements and comply with California-specific HV program policies and procedures, and scopes of work. CHVP will maintain national HFA guidelines in monitoring, assessing, and supporting implementation which ensures fidelity to the program model.

Example of the HFA SAT recommends monitoring and analyzing the following factors to assure adherence to national HFA guidelines:

<p><u>Programmatic Factors</u></p> <ul style="list-style-type: none"> • Target population • Referral sources • Staffing issues (patterns & trends among assessment staff) • Number of days between referral and assessment 	<p><u>Demographic Factors</u></p> <ul style="list-style-type: none"> • Gender • Age • Race & ethnicity • Marital status <p><u>Social Factors</u></p> <ul style="list-style-type: none"> • Assessment score • Working or in school • Socio-economic status • Family or friend support
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3. Role of the Local Program in Fidelity and Quality Improvement

The CHVP CQI approaches will be integrated into all aspects of the at-risk communities to support fidelity, empower home visitors and supervisors to continually improve practices, and ensure achievement of participant outcomes. Importantly, the at-risk communities contribute expertise to the overall CHVP CQI effort. Local programs are the best able to identify barriers to implementation, solutions to problems, and strategies to better address the needs of participating families. Each at-risk community will be required to establish a CQI Team based on the guidelines provided by the national model and the CHVP scopes of work. The CQI Team will have responsibility for leading local efforts. Inclusion of participating families in the CHVP CQI process will occur at the community level. Examples at the LHJ level include:

- Capture and routinely monitor CQI indicators as required by CHVP and HFA or NFP to track quality and fidelity of implementation.
- Identify and address CQI measures which do not meet the performance standard set by NFP, HFA or CHVP.
- Choose at least one quality indicator per quarter to improve upon; document corresponding new knowledge and practices.
- Document resulting changes and improvements and report to CHVP.

4. LHJ Role in Fidelity and Quality Improvement

At the LHJ/community level, the CQI activities will include monitoring of the LHJ/community, with a specific emphasis on supporting a strong maternal and early childhood system of services. LHJ leadership, including the MCAH Director, will be involved in monitoring CQI indicators that inform systems of care, such as completed referrals and access to care. LHJ CQI activities would then address gaps in local services, enhancing collaboration among local agencies, and prevention of duplication

of LHJ/community services with other programs. In addition, the LHJ will be involved in identifying contextual factors that inform success or serve as challenges to model implementation. LHJ leadership will be involved in assessing the need for and implementing model adaptations.

5. CHVP Role in Fidelity and Quality Improvement

CHVP will establish overall leadership for the CQI plan and ensure a coordinated process across local HV program, LHJ, and State levels. Guidance to LHJ and local HV programs will be provided through scopes of work and program standards documents, training, and ongoing technical assistance. Emphasis will be placed on integrating the CQI process throughout all aspects of program implementation and soliciting input from local HV programs and LHJs to ensure the CHVP achieves benchmarks. In addition, CHVP will establish a state-level CQI Team that will be responsible for developing required CQI measures, standards, and reporting timelines; identifying/selecting data sources and measurement tools; providing necessary training, and managing CQI data systems. CVHP will be responsible for ensuring overall focus on model fidelity and quality, in coordination with the national models. CHVP is also responsible for supporting communication across sites, developing statewide training and technical assistance resources, and addressing systems-level factors that impact quality, such as ensuring a strong network of services.

SECTION 8: STATE TECHNICAL ASSISTANCE NEEDS

California anticipates needing technical assistance from HRSA in the following areas:

- Provide effective strategies for ongoing sustainability of CHVP.
- Facilitate connection to other state ECCS partners as appropriate for collaboration.
- Provide best practice exchange with other states.
- Identifying strategies for ensuring the cultural competency of evidence-based home visiting program models.
- Share nationwide models used for integrating HV with early childhood systems in addition to providing consultation on integrating HV programs at the local level into a seamless system of services and supports.
- Share best practices in structuring a data system to collect information required for model fidelity and for MIECHV benchmarks.
- Share other states models for training and supporting local programs on CQI.
- Share best practices for recruitment and retention of hard to reach communities.

SECTION 9: STATUS OF MEETING REPORTING REQUIREMENTS

CDPH/MCAH provides assurance that CHVP will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program activities. The following summarizes progress to date as an example of content that will be provided in future reports:

1. CHVP Goals, Objectives, and Logic Model

Progress made to date has focused on Logic Model “inputs” designed to facilitate progress toward CHVP Goals and Objectives. Activities include: strategic planning efforts around implementation; development of processes to meet reporting requirements, including details of any barriers and all progress made during the HRSA-specified reporting period; monthly meetings with the CHVP State Partners Collaborative; and staff attendance at *Strengthening Families, Building Protective Factors* trainings.

The CHVP Goals and Objectives remain the same as presented in the USP. The Logic Model has been revised to indicate short-term and long-term outcome objectives and to incorporate efforts to better engage and retain high-risk and hard-to-engage populations. An implementation timeline has been created (see *Attachment 2*). The CHVP Logic Model provides an effective method for charting progress towards meeting outcome objectives, from initial and short-term outcomes towards intermediate and long-term outcomes. The Logic Model focuses program strategies on those activities intentionally designed to impact the desired outcomes toward a comprehensive high-quality, early childhood system. The CHVP Logic Model explicitly captures ACA intent by incorporating benchmarks into the model objectives. See *Attachment 1 for Logic Model*.

2. Implementation of Home Visiting Program in Targeted At-Risk Communities

CHVP updates regarding planning and implementing NFP and HFA in selected communities are described below. CHVP is planning several site visits to existing California NFP programs (Solano, Contra Costa and Fresno Counties) and an HFA program (Butte County) throughout July and August 2011. The site visit objective is to learn strategies for successful implementation of home visiting programs into early childhood systems and to seek local perspectives that will inform development of CHVP policies and procedures and scopes of work. CHVP’s progress on implementation at the local level is pending the announcement of the USP award.

3. Progress Towards Meeting Legislatively Mandated Benchmarks

Currently, there are no significant changes to the USP benchmarks proposal. Based on feedback from HRSA regarding benchmarks, a few constructs and their definitions of improvement have been clarified and further operationalized. CHVP will continue to provide updates and clarifications on all benchmark related activities. *Section 5 provides detailed information on the benchmarks and constructs.*

4. CHVP Continuous Quality Improvement (CQI) Efforts

CHVP is developing the format (e.g., creating forms) for data collection for CQI reporting. Site visits to existing home visiting programs will provide an opportunity to observe how CQI is utilized and to glean successful strategies. When available, CHVP will provide updates regarding the planning and implementation of CQI efforts for the home visiting program.

5. Administration of State Home Visiting Program

No updates to the CHVP organization chart, key personnel, and resumes have occurred. CHVP is in the process of attending Strengthening Families trainings,

developing policies and procedures, and examining the steps needed to ensure referral and service networks.

Expansion Grant Update: CDPH/MCAH is requesting \$9,430,000 under the ACA MIECHV FFY 2011 competitive expansion grant program (HRSA 11-179) to develop strategies around engagement and retention to reach diverse, at-risk populations in eight new LHJs/communities. CHVP will expand using Nurse-Family Partnership in six communities and Healthy Families America in two communities. Section 4 provides additional details.

6. Technical Assistance Needs

CHVP site visits scheduled for July 2011 will help inform CHVP on technical assistance needs for implementation and development of a statewide early childhood system.