

California Home Visiting Program Request for Supplemental Information

BACKGROUND AND PURPOSE

Background

The Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) has operated as a Federal-State partnership to improve the health and welfare of women, children and families since 1935. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA of 2010 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 (MIECHV) Program. The goals of the MIECHV Program are to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The California Department of Public Health, Maternal, Child and Adolescent Health Program (CDPH/MCAH) was designated by Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer MIECHV Program funds on behalf of California. The process for fulfilling requirements by HRSA includes three steps: (1) submission of an application for funding; (2) submission of a Statewide Needs Assessment, also referred to as the first federal Supplemental Information Request (SIR-1); and (3) submission of an Updated State Plan, also referred to as the second federal Supplemental Information Request (SIR-2).

On February 8, 2011, the HRSA and ACA MIECHV Program released the federal SIR-2 <http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf>. The requirements for the SIR-2 to develop the Updated State Plan include:

- Section 1: Identification of the State's Targeted At-Risk Community(ies)
- Section 2: State Home Visiting Program Goals and Objectives
- Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of Targeted Community(ies)
- Section 4: Implementation Plan for Proposed State Home Visiting Program
- Section 5: Plan for Meeting Legislatively-Mandated Benchmarks
- Section 6: Plan for Administration of State Home Visiting Program
- Section 7: Plan for Continuous Quality Improvement
- Section 8: Technical Assistance Needs
- Section 9: Reporting Requirements

The States are expected to submit their Updated State Plans within 90 – 120 days from the release of SIR-2.

Purpose

The purpose of the California Home Visiting Program Request for Supplemental Information (HVP-RSI) is to obtain information from local partners about the community(ies) and population(s) that local officials believe have the highest need, and to identify the evidence-based Home Visiting model that will best meet the identified needs.

One of the core values of the CDPH is collaboration. CDPH fosters collaboration both internally to empower and engage staff, and externally, by reaching out to diverse groups and external stakeholders. Echoing our Department's values, CDPH/MCAH is committed to engaging stakeholders in administering programs under the Title V MCH Services Block Grant. No single agency has the resources, access and relationships to address the multiple needs of at-risk families; CDPH/MCAH views the involvement of partners as essential to addressing the complex needs of California's population.

Central to CDPH/MCAH's philosophy of involving external stakeholders is our ability to leverage the local relationships and systems expertise of Local Health Jurisdictions (LHJs) in order to ensure broad and diverse stakeholder input. CDPH/MCAH's model for incorporating local expertise is to have LHJs obtain input from other local public agencies, service providers, non-profit organizations, and families or clients in order to shape local assessment of health status and capacity, and to identify local priority health needs. This extensive local input gets communicated to CDPH/MCAH which in turn informs statewide priorities. California recognizes that local input is also crucial to the success of the California Home Visiting Program.

Information submitted from LHJs will be combined with quantitative data already available to CDPH/MCAH. These quantitative data are U.S. Census American Community Survey 5-year aggregate data of families below 185% Federal Poverty Level with any children under 5 years. Qualitative information from this HVP-RSI and quantitative data will be used, together, to identify the highest need communities in California where Home Visiting programs, when implemented, will have the greatest impact. Through this process, CDPH/MCAH estimates that 25 to 35 "High Risk Communities" in California will be selected for MIECHV Program implementation, although the exact number of funded programs will be determined by future federal funding levels.

INSTRUCTIONS FOR COMPLETION OF THE REQUEST FOR SUPPLEMENTAL INFORMATION

In the *California Statewide Home Visiting Needs Assessment*, all 58 counties were designated High Risk Communities. A contributing factor in designating all counties was the availability of data below County level. Federal requirements in the federal SIR-1 for the Statewide Needs Assessment specified the use of indicators mostly available at the County and Regional levels. Quantitative data from the U.S. Census American

Community Survey available to the State for refining the “High Risk Communities” allows for sub-county designations. Therefore all 61 LHJs should respond to this HVP-RSI and provide the qualitative information that will be combined with these quantitative data.

Responses

Responding to questions in this HVP-RSI is necessary in order to be considered for receipt of funds under the California Home Visiting Program. Responses to this HVP-RSI will get submitted to CDPH/MCAH by the LHJ Maternal, Child and Adolescent Health Director in collaboration with the Local Department of Social Services (Title II, CAPTA, Title IV-E and IV-B), Local Department of Education (Child Care and Development Fund and Head Start Office), Local Department of Alcohol and Drug Programs, other appropriate agencies and organizations potentially associated with a Home Visiting Program, and members of the identified “High Risk Community”. Responses to this HVP-RSI will be strengthened by collaborative involvement and input from these agencies and organizations as well as groups and members of the “High Risk Community”.

Due Date

Responses to this HVP-RSI are due no later than 5:00 PM Pacific Time on Thursday, April 14, 2011. Information for each question will be submitted in the space provided within the electronic version of the HVP-RSI.

Technical Assistance

CDPH/MCAH will host two conference calls to answer questions about completing the HVP-RSI on Wednesday, March 16, 2011 at 10:00 AM Pacific Time and Tuesday, March 29, 2011, at 9:00 AM Pacific Time. Call in number: 877-972-6022; and Participant Code: 8473930 to access the conference call. CDPH/MCAH will post responses to questions on the MCAH website no later than 12:00 noon on Monday, March 21, 2011 and will update this document as further questions are received and answered. (<http://www.cdph.ca.gov/programs/MCAH/Pages/default.aspx>).

Structure of the RSI

The contents of this HVP-RSI are organized into two parts, *PART A, LHJ Level Information* and *PART B, Community Level Information*. Information provided in *PART A* should focus on the LHJ level instead of a specific population or community within the LHJ. Information provided in *PART B* will provide the opportunity to specifically address at least one population/community within a LHJ or a LHJ consortium.

Each LHJ will complete *PART A* once, and will be asked to submit responses to *PART B* for at least one Community within the LHJ. Some LHJs will have an opportunity to provide information for more than one Community based on estimated number of potential eligible clients that would voluntarily enroll in the California Home Visiting Program. Each MCAH Director can access information (<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>) from

CDPH/MCAH that specifies the maximum number of “High Risk Communities” for which they can provide responses. A separate *PART B* will be completed for each “High Risk Community.” For example, a LHJ identifying two “High Risk Communities” will submit two separate *PART B*’s.

The California Home Visiting Program has defined the minimum required enrollment to be 100 families per program. Each MCAH Director can access information from CDPH/MCAH (<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>) that provides an estimate of the population size in their LHJ likely to enroll in a Home Visiting Program. LHJs where the estimated population size is below 100 are encouraged to develop consortia with a neighboring LHJ(s). LHJs where the estimated population size is below 100 may respond to this HVP-RSI without developing a consortia, but the process for funding California Home Visiting Programs will consider the likelihood to meet minimum enrollment. When responding to this HVP-RSI as part of a consortium, each LHJ should complete their own *PART A* and *PART B*; responses to *PART B* should focus on the population that will receive services within that community.

Some LHJs may determine that the needs of a specific community will be best addressed by expanding an existing Home Visiting Program already using an evidence-based model. In these instances, LHJs must ensure a minimum of 100 additional families will be voluntarily enrolled to supplement, not supplant, the existing Home Visiting Program.

Questions in *PART B* will identify which evidence-based Home Visiting model will best meet the needs of the identified “High Risk Community”. Only one evidence-based Home Visiting model should be specified in each submitted *PART B*. Mathematica Policy Research completed a systematic review of Evidence-Based Home Visiting (EBHV) models for the Home Visiting Program established by the ACA of 2010. This review, referred to as the Home Visiting Evidence of Effectiveness Review (HomVEE) Study, identified seven models that meet the criteria for evidence base. The HomVEE Study distinguished two models with the most favorable ratings for primary and secondary outcomes in the benchmark areas. These two models are Nurse Family Partnership (NFP) and Healthy Families America (HFA). In *PART B*, LHJs will choose from either NFP or HFA. Results of the HomVEE Study are available at the following website: <http://homvee.acf.hhs.gov/>.

Please provide your responses directly within the HVP-RSI document using the space provided for each question. Please use 12 point Arial font for your responses. Save the file with your responses using the following convention:

PART A: “{LHJ Name} HVP RSI PART A]”; example: “Sacramento HVP RSI PART A”

PART B: “{LHJ Name} {Community Name} HVP RSI PART B]”; example: “Sacramento Midtown HVP RSI PART B”

Submit your responses electronically by attaching the files to an email sent to stefanie.lee@cdph.ca.gov no later than 5:00 PM Pacific Time on Thursday, April 14, 2011. You may submit responses to *PART A* along with responses to *PART B* by affixing multiple attachments to a single email. Please use the following as the “Subject” line of your email: “[SECURE] {LHJ Name} HV HVP RSI”; example: “[SECURE] Sacramento HV HVP RSI”. Placement of “[SECURE]” in the subject line will encrypt the file in transport to CDPH/MCAH.

ENCLOSED MATERIALS AND LINKS TO ADDITIONAL INFORMATION

CDPH/MCAH has assembled various sources of information to assist in completion of this HVP-RSI. Links to additional information that MCAH Directors and partner organizations will find useful are found in this section. A brief description of materials included as Appendices to this HVP-RSI and materials that will be posted on the CDPH/MCAH website are also in this section.

Summary of Nurse Family Partnership and Healthy Families America

In *PART B* of this HVP-RSI, you will be asked to identify which of NFP or HFA would best address the needs of the identified “High Risk Community”. CDPH/MCAH has provided as Appendices an overview of these two evidence-based models and a summary of research for each model. A summary for NFP is located in Appendix A and a summary of HFA is located in Appendix B.

Existing Early Childhood Home Visiting Programs from Section IV of the *California Statewide Home Visiting Needs Assessment*

This HVP-RSI asks that LHJs provide a list of programs and services available in their LHJs and in the identified “High Risk Community”. Recognizing that some of this information was already provided by counties to CDPH/MCAH in response to the August 2010 *California Maternal, Infant & Early Childhood Home Visiting Survey*, this HVP-RSI asks that LHJs identify programs and services not already identified to CDPH/MCAH. To help complete the HVP-RSI requirements, each MCAH Director can access what information was already provided to CDPH/MCAH by reviewing Section IV of the *California Statewide Home Visiting Needs Assessment* (September 2010), “Information on the Quality and Capacity of Existing Programs/Initiatives for Early Childhood Home Visitation in At Risk California Communities”.

<http://www.cdph.ca.gov/programs/mcah/Documents/MO-HVP-FinalCaliforniaStatewide-HV-NA.pdf>

Minimum Number of Clients

Using methods provided by NFP and HFA, CDPH/MCAH has estimated the number of eligible clients likely to volunteer and enroll in NFP and HFA for each of California’s 61 LHJs. Each MCAH Director will have access to information

(<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>) that will include

a table providing these estimates. Appendix C provides the location of the estimated number of clients on the *Home Visiting Program Supportive Data and Information Table*.

Number of “High Risk Communities” Within Your LHJ

Each LHJ responding to this HVP-RSI will provide information, using *PART B*, for at least one “High Risk Community”. Some LHJs will have an opportunity to provide information for more than one Community based on estimated number of potential eligible clients that would voluntarily enroll in the California Home Visiting Program. Each MCAH Director will have access

(<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>) to a table providing the maximum number of “High Risk Community(ies)” for their LHJ. Appendix C provides LHJs an example of how CDPH/MCAH is informing them of the maximum number of “High Risk Communities” on the *Home Visiting Program Supportive Data and Information Table*.

Summary of Home Visiting Needs Assessment Indicators for Each County

The *California Statewide Home Visiting Needs Assessment* included a set of indicators reported at the State and County levels. These indicators were reported in Section I and Section III of the *Statewide Needs Assessment*, and included data for the following domains: newborn/infant health, child health, maternal health, family characteristics, community characteristics, and substance abuse. Each County was categorized as being in one of four quartiles for each of these indicators: 0-49th percentile; 50th-74th percentile; 75th-89th percentile; and 90th percentile and above. Each MCAH Director will have access (<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>) to a table providing their quartile ranking for each *California Statewide Home Visiting Needs Assessment* indicator. MCAH Director’s from LHJs are encouraged to use this information when determining population(s) of highest need in their LHJ. Appendix C provides the location of this indicator information on the *Home Visiting Program Supportive Data and Information Table*.

Geospatial and Thematically Mapped Data

CDPH/MCAH has completed a geospatial hot-spot analysis of children less than five years old living in families below 185% Federal Poverty Level. CDPH/MCAH selected this indicator because it represents the intended target population for the California Home Visiting Program, and because it is correlated with other indicators included in the *California Statewide Home Visiting Needs Assessment*. Geospatial hot-spot analyses identify clusters that are statistically significantly different than the statewide mean for that particular indicator. Significance is determined as being either above or below the statewide mean.

CDPH/MCAH has also developed several thematic choropleth maps of children less than five years old living in families below 185% Federal Poverty Level, estimated number of NFP clients, and estimated number of HFA clients. A separate map has been generated for each indicator and each LHJ.

Appendix D provides the statewide geospatial hot-spot analysis maps. Each MCAH Director will have access to their County specific thematic choropleth maps (<http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx>). MCAH Director's from LHJs are encouraged to use these maps when determining the geographic area(s) of their identified "High Risk Community(ies)".

RSI Review and Categorization Process

A multi-step process will be undertaken to categorize communities based on the need for home visiting and the capacity to implement a program. Quantitative information from the U.S Census American Community Survey will be combined with qualitative data from the HVP-RSI to identify communities with a high need for and capacity to implement a Home Visiting Program. Then an extensive review of responses to the HVP-RSI will provide insight for categorizing communities based on readiness, potential to succeed and overall capacity.

- Step 1: Need and Enrollment Minimum within the Community
- Step 2: Readiness and Timeline to Implement
- Step 3: Potential Impact
- Step 4: Community and LHJ Capacity
- Step 5: Programs to Fund

For a detailed description of this process, please see Appendix E.