

California Home Visiting Program Scope of Work

AUTHORITY

The Patient Protection and Affordable Care Act of 2010 established the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program to provide an opportunity for collaboration and partnership at the federal, state, and community levels to improve outcomes for families who reside in at-risk communities through evidence-based home visiting programs.

The Local Health Jurisdiction (LHJ) agrees to provide the services presented in this Scope of Work (SOW) from the California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division in collaboration with the California Home Visiting Program Branch for implementation of the California Home Visiting Program (CHVP). The funded LHJ/Agency is referred to as "LHJ site" in this SOW. The CHVP shall strive to develop collaborative community systems that protect and improve the health and developmental outcomes for California's pregnant women, parents, and families.

The purpose of the LHJ site SOW is to provide parameters for implementing or expanding an existing Nurse-Family Partnership (NFP) or Healthy Families America (HFA) home visiting program in accordance with Federal MIECHV and State requirements to achieve positive outcomes for each of the following five goals:

1. Provide leadership and coordinate maternal and early childhood systems and supports to advance federal, state, and local efforts to improve the health and well-being of families in California
2. Cultivate strong communities
3. Promote maternal health and well-being
4. Improve infant and child health development
5. Strengthen family functioning

Each LHJ site shall assure program integrity and fidelity to their selected evidenced-based model. The site shall comply with the terms of this SOW and its attachments, including CHVP Operational Requirements, in their entirety. These requirements include, but are not limited to, fulfilling all deliverables associated with benchmark constructs, attending required meetings and trainings, using a version of the Efforts to Outcome data system (referred herein as the "CHVP data system") to measure outcomes, perform continuous quality improvement, enter and submit timely data, and complete other required reports.

LHJ site agrees to abide by the Maintenance of Effort (MOE) as defined in the Affordable Care Act Section 295:

"Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood visitation programs or initiatives. The grantee must agree to maintain non-Federal funding (State General Funds) for grant activities at a level which is not less than expenditures for such activities as of the date of enactment of this legislation, March 23, 2010."

All activities in this SOW shall take place from receipt of funding, estimated to begin February 1, 2012, to June 30, 2013.

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Special Notice for \$50,000 Initial Allocation

CDPH/MCAH will allocate \$50,000 for one-time-use to each LHJ site for initial administrative functions associated with home visiting implementation activities. This amount must be used for activities required to implement CHVP. The initial allocation shall be used to hire qualified staff, provide the necessary equipment, training, and home visiting materials required by CHVP and either HFA or NFP model, affiliation or certification fees, and other administrative activities.

The table below summarizes a list of reports due to CHVP. Specifics related to the contents of reports are described further in this SOW and located under *Evaluation/Performance Measure* of each objective.

Deliverables	Due Date
Administrative Plan for \$50,000 One-Time Funding	Upon return of complete AFA packet
Orientation Attendance	April, 2012 or TBD
Staffing Report	May 31, 2012
Semiannual Progress Reports	See below
Supervisor Quarterly Reports	See below

Semiannual Progress Reports:

Reporting Period	From	To	Due Date
1) First Report	February 15, 2012	June 30, 2012	July 31, 2012
2) Second Report	July 1, 2012	December 31, 2012	January 31, 2013
3) Third Report	January 1, 2013	June 30, 2013	July 31, 2013

H. V. Supervisor Quarterly Reports:

Reporting Period	From	To	Due Date
1) Primary Administrative Report	February 15, 2012	June 30, 2012	July 31, 2012
2) Second Report	July 1, 2012	September 30, 2012	October 31, 2012
3) Third Report	October 1, 2012	December 31, 2012	January 31, 2013
4) Fourth Report	January 1, 2013	March 31, 2013	April 30, 2013
5) Fifth Report	April 1, 2013	June 30, 2013	July 31, 2013

See the following pages for a detailed description of the services to be performed.

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		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Administrative Plan			
1.1 Prior to CHVP implementation, sites will receive \$50,000 one-time allocation; sites will develop a summary of initial administrative functions associated with home visiting implementation activities.	1.1 The administrative plan must summarize administrative activities associated with CHVP implementation as follows: <ul style="list-style-type: none"> • Prioritization of activities required before program implementation (e.g., county approval to accept funds; obtaining site certifications/affiliations through NFP/HFA if needed; recruiting, hiring, orienting, and training staff, as well as for obtaining equipment and training materials. • Determine target dates for completion of each activity. • Names and contact information for the responsible staff who will be completing each activity. 		1.1 Submit a summary of administrative activities upon return of complete AFA packet.
MCAH Director Leadership			

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1.2 The LHJ Maternal, Child and Adolescent Health (MCAH) Director shall provide oversight of the LHJ site, including leveraging opportunities for coordination and integration of services to improve community linkages, reduce duplication of service, and foster seamless systems of services and supports for the target MCAH population.	1.2 The LHJ MCAH Director shall perform the following: <ul style="list-style-type: none"> • Provide authoritative advice, guidance, and assistance to LHJ site managers, supervisors, staff, and various nonprofit and private entities on all matters related to the development, implementation, operation, administration, evaluation, and funding for CHVP in their own local jurisdictions. • Designate self or an appropriate staff member as the central point of contact for CHVP in terms of program-related administration. • Participate in CHVP system of care improvement activities with specific emphasis on building local capacity to promote positive outcomes for children and families and addressing systems-level factors, such as ensuring a 	1.2.1a Submit a report on CHVP-related activities and accomplishments performed by the MCAH Director during the reporting period. 1.2.1b. Submit a report regarding discussion of the system of care improvement activities developed by LHJ sites and/or the Community Advisory Board during the reporting period. Required details of this report will soon be announced in a Program Letter.	

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	<p>strong network of community services; addressing gaps in local services and supports; enhancing cross agency coordination, collaboration and communication; integration of home visiting into the larger continuum of services for children and families; and prevention of service duplication.</p> <ul style="list-style-type: none"> Play a role in the state effort to build a high quality comprehensive and coordinated statewide early childhood system. 		
Program and Fiscal Management			
1.3 LHJ site will maintain program and fiscal management capability and will demonstrate that it is conducting CHVP activities as required in the CHVP established Policies and Procedures, Scope of Work and Fiscal Policies and	<p>1.3 LHJ site shall:</p> <ul style="list-style-type: none"> Semiannually review, revise and enhance internal policies and procedures for implementing CHVP. Implement CHVP according to HFA or NFP program fidelity 	1.3 Semi-annual progress reports to include a brief description of the LHJ policies reviewed during the reporting period, and a discussion of relevant policy changes during that period.	

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Procedures.	and CHVP requirements. <ul style="list-style-type: none"> Collect and electronically input data according to model and CHVP requirements. 		
MCAH Director Responsibilities			
1.4 By April 30, 2012, LHJ site will hire staff according to CHVP and model requirements.	1.4 LHJ site shall hire sufficient staff to serve 100 clients and adhere to their specific evidence-based model guidelines as follows: <p><u>NFP Model</u></p> <ul style="list-style-type: none"> Supervising Public Health Nurse Public Health Nurse Administrative / Clerical Support <p><u>HFA Model</u></p> <ul style="list-style-type: none"> Program Manager Supervisor Family Support Worker Family Assessment Worker 		1.4 Submit staffing report by May 31, 2012, that will include the following (see Attachment B): <ul style="list-style-type: none"> Staff recruitment status. Percentage of effort dedicated to CHVP. Submit organizational chart with names of staff hired by May 31, 2012.
Orientation			
1.5 By June 30, 2012, staff will complete required CHVP	1.5 LHJ staff shall participate in a CHVP-mandated "General Orientation" which will be face-	1.5 Submit a list of staff who attended CHVP-mandated	

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program orientation.	to-face (other details will be provided at a future date via an official Program Letter).	"General Orientation."	
Training			
1.6 LHJ sites will ensure that staff complete the required core trainings and ongoing training sessions required by the NFP National Service Office (NSO) or HFA model.	<p>1.6 LHJ site shall ensure that staff receive training in the following curricula, assessment tools, and other training modules:</p> <p>NFP Model</p> <ul style="list-style-type: none"> - Partners in Parenting Education (PIPE) - NCAST (Training assessment tool) - Ages and Stages Questionnaire (ASQ) - Keys to Caregiving - HOME Inventory - Other CHVP required trainings to be announced in a program letter <p>HFA Model</p> <ul style="list-style-type: none"> - Partners for a Healthy Baby (include latest versions of five modules: "Before Baby Arrives", Baby First 6 mo., Baby First 7-12 mo., Baby First 13-18 mo., Baby First 19-36 mo.) - Ages and Stages Questionnaire (ASQ) - Kempe Family Stress Checklist 	1.6 Submit a list of staff who completed trainings, including the dates taken and copy of successful completion of core educational requirements.	

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	- Other CHVP required trainings to be announced in a Program Letter		
Enrollment			
1.7.1 <u>NFP Expanded and New LHJ Sites</u> – 100 families will be enrolled within 9-15 months from date of program	1.7.1 Conduct outreach activities to at-risk groups, areas, and community agencies and other service providers to ensure that	1.7 List and report the following : <ul style="list-style-type: none"> • Outreach activities. • Number <u>and</u> contact information for all 	1.7 (HFA sites) At the end of each reporting period, submit a report on the average time to

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<p>implementation and maintained throughout the duration of the program, recognizing effects of attrition when number of enrolled clients may temporarily fall below 100.(+)</p> <p><u>HFA Expansion and New LHJ Sites</u> – 100 families will be enrolled by 15 months from date of program implementation and maintained throughout the duration of the program , recognizing effects of attrition when number of enrolled clients may temporarily fall below 100.(+)</p>	<p>appropriate, eligible clients are identified and referred to LHJ.</p> <p>1.7.2 LHJ site will assess and enroll eligible families for CHVP services and will link non-qualifying referred families and families referred after the program has reached full capacity to other community resources.</p>	<p>community groups, and other service providers contacted.</p> <p>Report the following:</p> <ul style="list-style-type: none"> • Number of enrolled families by month. • Number and source of incoming referrals to CHVP and number of newly enrolled families by month. • Number and type of outgoing referrals made to appropriate community resources for families not enrolled in CHVP by month. 	<p>assess and enroll families following the receipt of referrals. Within this report, submit information on the total number of contact attempts from referral to assessment and enrollment. (*)</p> <p>1.7 (NFP sites) At the end of each reporting period, submit a report on the average time from receipt of referral to first client contact and home visit intake. Within this report, submit information on the total number of contact attempts from referral to first client contact and home visit intake. (*)</p>

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Home Visiting Service			
1.8 Between May 1, 2012, and June 30, 2012, the LHJ site will begin the process of implementation for home visiting services under the condition that LHJ board approval and implementation plan approval are met.	1.8 Implement home visiting services following the NFP or HFA model and CHVP requirements. Appropriate staff shall complete documentation of home visiting notes within 24 hours of occurrence and enter information into the data management system as required by CHVP.	1.8.1 Report the number and length of home visitor contacts. 1.8.2 Report the number of clients that were maintained on the home visitor caseload and the time duration of home visits.	1.8 Of those enrolled families or clients, report completed visits and the number of scheduled visits.
Fidelity and Quality Assurance			
1.9 Assure program fidelity and quality of CHVP implementation.	1.9.1 LHJ Site Supervisors are required to manage staff activities using reflective supervision based on NFP and HFA model requirements. 1.9.2 Verify the accuracy, validity and completeness of data input into the data system.	1.9.1 LHJ Site Supervisor shall electronically submit a quarterly report to the CHVP State Nurse Liaison for NFP or HFA Statewide Nurse Consultant that will detail LHJ site's successes, challenges, and any need for technical assistance. 1.9.2 At the end of each reporting period, submit a statement of the method(s) used for	.

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	<p>1.9.3 Participate in model-specific quality assurance activities and any CHVP-directed Continuous Quality Improvement (CQI) activities to be developed.</p> <p>1.9.4 Identify areas in need of improvement and develop a plan to address deficiencies.</p> <p>1.9.5 Coordinate communication of quality assurance/improvement activities between the LHJ program and Community Advisory Board (CAB) or other community collaborative designated to address quality improvement needs.</p> <p>1.9.6 MIECHV Competitive Grant recipients will work with the CHVP external evaluators and ensure that all data is provided as needed under direction of the CHVP Branch.</p>	<p>verifying the integrity of the data.</p> <p>1.9.3 - 1.9.5 Electronically submit all required CQI reports, including plan and activities to CHVP Branch. Other specific requirements related to CQI will be announced by CHVP via a Program Letter.</p> <p>1.9.6 MIECHV Competitive Grant recipients will report required activities as defined in the attached Operational Requirements.</p>	

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		Process Measures	Outcome Measures
Data Collection			
1.10.1 Collect all information that will contribute to the 35 constructs that comprise the 6 legislatively-mandated benchmark domains, and any possible additional CQI and/or evaluation measures identified by CHVP in the CHVP Policies and Procedures Manual (to be released).	1.10.1 – 1.10.4 LHJs will use CHVP or NFP/HFA data forms and processes as defined in the CHVP Policies and Procedures Manual (to be released) or Program Letter. LHJs' appropriate staff shall collect and enter the data into the secure data management system on an ongoing basis and as required by CHVP and NFP or HFA.		
1.10.2 Collect participant demographic, process, quality improvement, and outcome data using the required tools through self-report and observation at each of the defined time intervals.			

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1.10.3 Collect home visitor and supervisor demographic, process, and quality improvement data at each of the defined time intervals. 1.10.4 Collect information on collaboration and systems of care from program staff using the required tools (TBA) at each of the defined time intervals. 1.10.5 Verify the accuracy, validity, and completeness of data collected and entered into MIS.	1.10.5 LHJ site in collaboration with the CHVP Evaluation Team Member will develop methods for verifying the integrity of these data.	1.10.5 LHJ shall electronically submit data by the end of each quarterly reporting period that meets all requirements set forth by the CDPH/MCAH in the Policies and Procedures Manual (to be released).	

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Goal 2: Cultivate strong communities.

The federally required benchmarks and constructs corresponding to Goal 2 include:

- Improvement in the coordination and referrals for other community resources and supports
 - Number of families identified for necessary services; Number of families that required services and received a referral to available community resources; Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community; Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies; Number of completed referrals.

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Community Advisory Board			
2.1 CHVP LHJ will form a Community Advisory Board (CAB)	2.1 CAB activities include: <ul style="list-style-type: none"> • Quarterly meetings. • Maintenance of meeting minutes, a list of membership to be made available by LHJ site to CHVP upon request. • Assist in informing program operation and implementation, quality assurance/improvement, child and family advocacy, and public awareness regarding home visiting. Establish or improve system of care improvements, interagency coordination, information sharing, and referral system. 	2.1 Briefly describe the activities and frequency of CAB meetings during the reporting period to enhance CHVP implementation and operation.	2.1.1 Submit a report of policy recommendations developed by CAB. 2.1.2 Submit a report of outcomes related to policy recommendations (guidance to be announced in a Program Letter). 2.1.3 Submit a report of accomplishments as related to each of the CAB goals and objectives (specific goals and objectives to be announced in a Program Letter).

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Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated			
Memoranda of Understanding (MOU) / Formal Agreements			
2.2 LHJ site will increase or enhance the number of MOUs or other formal agreements with other local social service agencies in the community. (+)	<p>2.2.1 Develop and/or maintain documented agreements (e.g., MOUs, letters of support or agreements) with community agencies and other service providers specified by CHVP.</p> <p>2.2.2 Develop community partnerships and facilitate coordination and integration of services among MCAH and other community programs/services.</p>	2.2.1 – 2.2.2 At the end of each reporting period, submit a report that lists, describes, and updates the types of agreements (e.g., MOUs, formal/informal agreements) with community agencies and other service providers involved in referral of potential clients.	2.2.1 – 2.2.2 Report the number of MOUs or other formal agreements with other local social service agencies.

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Collaborative Effort			
2.3 LHJ site will increase information sharing with other local social service agencies in the community. (+)	2.3.1 Develop collaborative relationships with local service agencies and hospitals in the community to effect strong referral resources and allow service integration. 2.3.2 The LHJ will develop a clear point of contact (person/s) with collaborating community agencies and share information on a regular basis as it relates to outreach, enrollment, referrals, care coordination, etc. 2.3.3 Outreach and education about CHVP.	2.3 The number of agencies with which the home visitor has a clear point of contact and with whom information is regularly exchanged.	2.3.1-2.3.2 System of care survey to be developed that will include measurement of number and types of interagency relationships.
Increase identification and referral of families in need of services for families already enrolled			
2.4 Home visitors screen mothers/children for needs at scheduled intervals (or whenever parent/caregiver/home visitor (HV) concerns arise) using identified screening/ assessment tools. (+)	2.4 Home visitor to administer screening/assessments (e.g. ASQ, ASQ-SE, <i>Edinburgh Postpartum Depression Scale</i> , etc.) at scheduled time periods or whenever parent/caregiver/HV concerns arise in accordance to CHVP requirements.	2.4 Submit report on the following: - The number of children/mothers screened for needs at each scheduled time period for each identified screening/ assessment tool. (*)	

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2.5 Home visitors shall provide appropriate referral(s) to available community resources for children and mothers with identified need(s) based on screening tools, clinical assessment, or parental concern. (+)	<p>2.5.1 For each identified concern, based on screening tools, clinical assessment, or parental concern, the mother and/or child receives a referral(s) to available community resources.</p> <p>2.5.2 Home visitor shall follow-up with the family regarding outcome of referral.</p> <p>2.5.3 Maintain access to, or develop an updated list of community referral resources/services including hospitals, health care providers, and community agencies. Domains shall include:</p> <ul style="list-style-type: none"> • Maternal, Infant, and Child Health • Mental Health • Early Childhood Development • Substance Abuse • Domestic Violence Prevention • Child Maltreatment Prevention • Child Welfare • Education • Other Social and Health Services <p>Note: Referrals include both internal</p>	<p>2.5.1 Submit report on the following:</p> <ul style="list-style-type: none"> - The number of identified needs (based on screening tools, clinical assessment, or parental concern) with and without a corresponding referral to available community resources. (*) <p>2.5.2 Submit a list of the number and type of referral resources/ services available and appropriate for the participants in the program regardless of whether LHJ uses a telephone access resource. (*)</p>	<p>2.5.1 Document and report on the number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion by obtaining a report of the service provided). (*)</p>

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California Home Visiting Program Scope of Work

Goal 2: Cultivate strong communities.

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Process Measures	Outcome Measures
	referrals (to other services provided by the local agency) and external referrals (to services provided in the community but outside of the local agency).	2.5.3 Document any changes or updates to the list of community referral resources.	

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Notations to Scope of Work:

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California Home Visiting Program Scope of Work

Goal 3: Promote Maternal Health and Well-being

The federally required benchmarks and constructs corresponding to Goal 3 include:

➤ Improved Maternal and Newborn Health

- Prenatal care; Parental use of alcohol, tobacco, or illicit drugs; Preconception care; Inter-birth intervals; Screening for maternal depressive symptoms; Breastfeeding; Well-child visits; Maternal and child health insurance status.

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Prenatal Care			
3.1 If enrolling during pregnancy, increase receipt of early and adequate prenatal care. (+)	3.1.1 Educate women regarding early and adequate prenatal care. 3.1.2 Refer to prenatal provider, and use Comprehensive Perinatal Services Program (CPSP) provider when available. 3.1.3 Identify and address barriers to keeping prenatal appointments.	3.1 Number of referrals to CPSP and other prenatal providers.	3.1 Report on the number of early and adequate prenatal care visits (*).
Maternal Health Insurance			
3.2 If enrolling during pregnancy, increase the proportion of women with health insurance during pregnancy. (+)	3.2 Make referrals and assist clients to enroll in Healthy Families, Medi-Cal, Access for Infants and Mothers (AIM), and other low cost/no cost health insurance programs for health care coverage.	3.2 Number of referrals to low cost/no cost health insurance programs for health care coverage.	3.2 Report the number and percent of women with health insurance at specified time frame intervals required by CHVP (to be announced in a Program Letter). (*)

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California Home Visiting Program
Scope of Work

Goal 3: Promote Maternal Health and Well-being

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
3.3 Decrease maternal Emergency Department (ED) visits. (+)	3.3 Educate women on appropriate use of ED and medical home for routine care.		3.3 Number of visits per mother at each reporting period. (*)
3.4 If enrolling during pregnancy, decrease maternal use of alcohol, tobacco, and illicit drugs during pregnancy. (+)	3.4 Assess mother for alcohol, tobacco, and illicit drugs and refer as appropriate.	3.4 Number of women with identified substance use receiving referrals to appropriate agencies for alcohol, tobacco, and illicit drug use.	3.4 Number of women who drink alcohol at/during specified times required by CHVP (to be announced in a Program Letter). (*) Number of women who use tobacco at/during specified times required by CHVP (to be announced in a Program Letter). (*) Number of women who use illicit drugs at/during specified times required by CHVP (to be announced in a Program Letter). (*)

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California Home Visiting Program
Scope of Work

Goal 3: Promote Maternal Health and Well-being

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Inter-birth Interval			
3.5 Decrease the proportion of women with a subsequent pregnancy within 18 months postpartum. (+)	3.5.1 Educate on family planning and use of different types of contraceptives and refer to appropriate agencies.		3.5 Number of women with confirmed subsequent pregnancy less than 18 months postpartum. (*)
Maternal Depression			
3.6 Increase the proportion of women screened for maternal depression and referred for services as appropriate.	3.6.1 Educate women on the signs and symptoms of maternal depression. 3.6.2 Screen women for maternal depression with the Edinburgh Postnatal Depression Scale at specified intervals required by CHVP (to be announced in a Program Letter), and refer to appropriate services as warranted. 3.6.3 Identify community partners with expertise in management of postpartum depression/perinatal mood disorders.	3.6 Number of women screened for maternal depression. (*)	3.6 Number of women at-risk who are referred and receive services for postpartum depression/perinatal mood disorders.

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California Home Visiting Program
Scope of Work

Goal 3: Promote Maternal Health and Well-being

Objective(s)	Intervention Activities to Meet Objectives	Evaluation/Performance Measures	
		Short, Intermediate, and Long-Term Measures to be Reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Breastfeeding			
3.7 If enrolling during pregnancy, increase proportion of women who plan prenatally to breastfeed. (+)	3.7.1 Educate women regarding the importance of breastfeeding for at least 6 months and of continued breastfeeding through one year postpartum.		3.7 Number of women who plan on breastfeeding their baby. (*)
3.8 Increase the proportion of women breastfeeding. (+)	3.8.1 Educate women regarding the importance of breastfeeding for at least 6 months and continued breastfeeding through one year postpartum.		3.8 Number of women who breastfeed at/during specified times required by CHVP (to be announced in a Program Letter). (*)
Postpartum Visit			
3.9 If enrolling before 10 weeks postpartum, increase proportion of women who had a postpartum visit with a medical provider.	3.9.1 Educate women regarding the importance of a postpartum visit with a medical provider.		3.9.1 Number of women who attend a 3-8 week postpartum visit with a medical provider. (*) 3.9.2 Number of women who attend an 8-12 week postpartum visit with a medical provider. (*)

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California Home Visiting Program Scope of Work

Goal 4: Improve Infant and Child Health and Development

The federally required benchmarks and constructs corresponding to Goal 4 include:

- Improved Maternal and Newborn Health
 - Prenatal care; Parental use of alcohol, tobacco, or illicit drugs; Preconception care; Inter-birth intervals; Screening for maternal depressive symptoms; Breastfeeding; Well-child visits; Maternal and child health insurance status
- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
 - Visits for children to the emergency department from all causes; Visits of mothers to the emergency department from all causes; Information provided or training of participants on prevention of child injuries; Incidence of child injuries requiring medical treatment; reported suspected maltreatment for children in the program; Reported substantiated maltreatment for children in the program; First-time victims of maltreatment for children in the program.
- Improvements in School Readiness and Achievement
 - Parent support for children's learning and development; Parent knowledge of child development and of their child's developmental progress, Parenting behaviors and parent-child relationship; Parent emotional well-being or parenting stress; Child's communication, language and emergent literacy; Child's general cognitive skills.

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Insured Children			
4.1 Increase proportion of children who have health insurance. (+)	4.1 Make referrals and assist parents to enroll children in Healthy Families, Medi-Cal, Access for Infants and Mothers (AIM), and/or other low cost/no cost health insurance programs.	4.1 Number of referrals to low cost/no cost health insurance programs for health care coverage.	4.1 Number of children that have any type of health insurance at specified time intervals required by CHVP (to be announced in a Program Letter). (*)

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Notations to Scope of Work:

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- (+) Health Resources and Services Administration (HRSA) required construct

All reports required under Evaluation Measures are to be submitted semiannually unless otherwise specifically indicated.

California Home Visiting Program Scope of Work

Goal 4: Improve Infant and Child Health and Development

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Child E.D. Visits			
4.2 Decrease child Emergency Department (ED) visits. (+)	4.2 Educate parents on appropriate use of ED and help establish medical home for routine care.		4.2 Number of child visits to the ED at a specified time interval required by CHVP (to be announced in a Program Letter). (*)
Well-Child Visits			
4.3 Increase the proportion of children who receive all recommended well-child visits from 0-2 years. (+)	4.3 Educate families to understand the importance of well-child visits and immunizations. Support parents to adhere to scheduled well-child visits.		4.3 Number of infants that received all recommended well-child visits for their age. (*)
Child Injuries			
4.4 Decrease the incidence of child injuries requiring medical treatment. (+)	4.4 Educate families regarding home safety measures and injury prevention.		4.4 Number of child injuries that required medical treatment at specified intervals required by CHVP (to be announced in a Program Letter). (*)

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Notations to Scope of Work:

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(+) Health Resources and Services Administration (HRSA) required construct

All reports required under Evaluation Measures are to be submitted semiannually unless otherwise specifically indicated.

California Home Visiting Program Scope of Work

Goal 4: Improve Infant and Child Health and Development

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Child Abuse			
4.5 Decrease suspected and substantiated child abuse and neglect. (+)	4.5.1 Provide resources to parents to prevent child abuse. 4.5.2 Model appropriate parenting skills and refer to parenting classes, counseling, or other support resources. 4.5.3 Provide emotional support to the family. 4.5.4 Look for signs of child abuse and/or neglect through observation at each home visit.	4.5.1 Number of referrals to support services for parents who are suspected of maltreatment and/or neglect. (*) Number of referrals to Child Protective Services (CPS) for suspected maltreatment and/ or neglect. (*)	4.5.1 Number of cases of suspected child maltreatment. (*) Number of cases of substantiated child maltreatment. (*)
Child Safety			
4.6 Home visitors provide women with information regarding child safety, safe home environment, and prevention of child injuries. (+)	4.6.1 Provide education and educational materials (e.g., brochures, videos) related to child safety, safe home environment, and injury prevention. 4.6.2 Administer the Home Safety Checklist according to CHVP requirements.	4.6.1 Document information provided on child injury and safe home environment.	4.6.1 Number of women provided information on child injury and safe home environment. (*) 4.6.2 Number of Home Safety Checklists administered. (*)

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California Home Visiting Program Scope of Work

Goal 5: Strengthen family functioning

The federally required benchmarks and constructs corresponding to Goal 5 include:

- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
 - Visits for children to the ED from all causes; Visits of mothers to the ED from all causes; Information provided or training of participants on prevention of child injuries; Incidence of child injuries requiring medical treatment; Reported suspected maltreatment for child in the program; Reported substantiated maltreatment for children in the program; First-time victims of maltreatment for child in the program.
- Improvements in School Readiness and Achievement
 - Parent support for children’s learning and development; Parent knowledge of child development and of their children’s developmental progress; Parenting behaviors and parent-child relationship; Parent emotional well-being or parenting stress; Child’s communication, language and emergent literacy; Child’s general cognitive skills.
- Domestic Violence
 - Screening for domestic violence; Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services; Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.
- Family Economic Self-Sufficiency
 - Household income and benefits; Employment or Education of adult members of the household; Health insurance status.

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long-Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
School Readiness			
5.1 Parents increase their support of their children's learning and development (e.g., having appropriate toys available, talking and reading with their child). (+) • Parents increase their	5.1 LHJ will integrate the Strengthening Families framework and protective factors to promote high-quality parenting behavior and the parent-child relationship. Protective Factors: <ul style="list-style-type: none"> • Parental Resilience • Social Connections • Concrete Support in Times of Need • Knowledge of Parenting and Child 	5.1 Submit a description of activities incorporating the five Protective Factors of “Strengthening Families Framework” in the Policies and Procedures Manual for home visiting service delivery. Administer tools	5.1 Number of families with improved scores on tools related to school readiness/ strengthening families as recommended/ required by CHVP (to be announced in a Program Letter).

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(+) Health Resources and Services Administration (HRSA) required construct

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California Home Visiting Program Scope of Work

Goal 5: Strengthen family functioning

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long-Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
<p>knowledge of child development and of their child's developmental progress. (+)</p> <ul style="list-style-type: none"> Parents have an improved relationship with their child (e.g., discipline strategies, play interactions). (+) <p>5.2 Screen target child for developmental progress using the Ages and Stages Questionnaire (ASQ) Version 3 and the Ages and Stages Questionnaire-Social Emotional (ASQ-SE) instruments.</p>	<p>Development</p> <ul style="list-style-type: none"> Social and Emotional Competence of Children www.strengtheningfamilies.net <ul style="list-style-type: none"> Assist families in improving the quality of the child's home environment and the extent of stimulation available to the child. Model appropriate parenting skills and refer to parenting classes and other support resources. <p>5.2.1 Provide anticipatory guidance and education regarding importance of developmental screening.</p> <p>5.2.2 Administer the ASQ-3 and ASQ SE at specified intervals required by CHVP (to be announced in a Program Letter).</p>	<p>related to school readiness/ strengthening families as recommended/ required by CHVP (to be announced in a Program Letter).</p> <p>5.2.1 – 5.2.2 Number of children that received all scheduled assessments. (*)</p>	
Parental Stress			
<p>5.3 Increase parental emotional well-being and decrease parental stress. (+)</p>	<p>5.3 Conduct assessment of family level stress, social support, and parental emotional well-being using CHVP required assessment tools.</p>		<p>5.3 Number of families with improved parental well-being and stress scores. (*)</p>

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California Home Visiting Program Scope of Work

Goal 5: Strengthen family functioning

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long-Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
Domestic Violence			
5.4 Home visitors screen mothers for domestic violence (DV) at appropriate intervals. If needed (either based on screening tools, clinical assessment, or mother's concern), home visitors refer mothers to DV services and assist them in developing a safety plan. (+)	<p>5.4.1 The home visitor will screen for relationship related issues and DV at specified intervals or as needed.</p> <p>5.4.2 The home visitor will refer women to DV services as needed (either based on screening tools, by clinical assessment, or mother's concern).</p> <p>5.4.3 Home visitor will assist women experiencing DV with the creation of a safety plan. Revisit/update the plan as needed.</p>	<p>5.4.1 The number of women who received DV screening during specified intervals required by CHVP (to be announced in a Program Letter). (*)</p> <p>5.4.2 The number of women who received at least one referral to a relevant DV service after a newly positive screen or disclosure of abuse. (*)</p> <p>5.4.3 The number of women who completed a safety plan after a newly positive screen or disclosure of abuse. (*)</p>	

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California Home Visiting Program
Scope of Work

Goal 5: Strengthen family functioning

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long-Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
5.5 Increase the proportion of women provided reproductive coercion information and resources.	5.5.1 Screen women for presence of reproductive coercion and provide information and resources. 5.5.2 Refer screen-positive women to providers to obtain coercion-resistant birth control methods and counseling. 5.5.3 Provide emotional support.	5.5.1 Number of at-risk (e.g., screen positive) clients referred for "coercion resistant" birth control methods and counseling.	
Employment and Education			
5.6 Increase the proportion of parents improving employment status or educational attainment. (+)	5.6 Assist parents to develop a plan to achieve educational and employment goals.	5.6 Describe activities performed to assist parents in developing educational and employment goals at specified intervals required by CHVP (to be announced in a Program Letter).	5.6 Number of households with increased parental employment status or education attainment. (*)
Household Health Insurance			
5.7 Increase proportion of household members with health insurance	5.7.1 Make referrals and assist families to enroll in Healthy Families, Medi-Cal, and other low cost/no cost health insurance programs for health care coverage.	5.7 Number of family members who received referrals to low cost/no cost health insurance	5.7 Number of household members insured at specified intervals required by CHVP (to be announced in a Program

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California Home Visiting Program
Scope of Work

Goal 5: Strengthen family functioning

Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Short, Intermediate, and Long-Term Measures to be reported in the Semiannual Progress Report or more frequently where indicated	
		Process Measures	Outcome Measures
coverage. (+)		programs for health care coverage.	Letter). (*)
Income			
5.8 Proportion of households with an increase in total household income and benefits. (+)	5.8 Assist parents in developing an economic self-sufficiency plan. Refer to community resources, job training, and employment events.		5.8 Number of households with an increase of combined household income and monetary benefits.

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