Supplemental Information Request #2 – Updated State Plan
Maternal, Infant and Early Childhood Home Visiting Program

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By the
Idaho Department of Health and Welfare
Division of Public Health
Bureau of Clinical and Preventive Services
Children's Special Health Program

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Introduction and Background

The Idaho Department of Health and Welfare has designated the Bureau of Clinical and Preventive Services within the Division of Public Health as the team responsible for carrying out the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program planning and implementation activities for the state of Idaho. The Department of Health and Welfare serves as the state agency charged with management of a multitude of public programs including, but not limited to: Medicaid, Welfare, Substance Abuse, Mental Health, Public Health, Temporary Assistance for Needy Families (TANF), Child Care, and the Idaho Food Stamp program. The Department of Health and Welfare services a state where the people are as diverse as the landscape.

As a frontier state, Idaho is subject to challenges not found in more highly populated, urbanized states. Idaho's geography, to a large extent, dictates the population dispersal and the lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating from these centers are numerous isolated rural and frontier communities, farms and ranches. Access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special health care needs, pregnant women and young children can be problematic. Local public health infrastructure has been established around the population centers, arranged in autonomous health departments across the state (see map on page 8). A careful balance of the needs of these populations and the viability of providing services within isolated communities requires a committed effort and continuous dialogue on between both local and state stakeholders. Additionally, Idaho's citizenry and leadership tend to emphasize the importance of individual and local control over matters involving livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans manifests in development of local programs and services through grassroots efforts rather than a centralized approach. This philosophy is present within the political leadership, which influences fiscal allocations to programs within state government, leading to important implications on all of Idaho's health care programs.

Demographics

The 2009 estimated population for Idaho is 1,545,801, ranking 40th in United States population. However, the population increased 19.5% from 2000 to 2009, more than double the national average of 9.1%. Rapid demographic shifts are occurring in the ethnic and geographic composition of Idaho, both in rural and urban areas. This population growth results in an average population density of 15.6 persons per square mile of land area. However, half of Idaho's 44 counties are considered "frontier," with *averages of less than seven persons* per square mile. In 2009, the national average for population density was 79.6 persons per square mile.

The US Census Bureau indicates that 8.1% of the total state population is under the age of 5, greater than the US median of 6.9%. Of Idaho's estimated 1,545,801 persons, approximately 123,200 are

children under the age of 5. In 2009, an estimated 53% of young children (0-5 years old) were living in low income households at 200% FPL or below. There were 21% of young children living in poverty (< 100% FPL or below) and 8% live in extreme poverty (< 50% FPL) (National Center for Children in Poverty, Retrieved from nccp.org on April 22, 2011). Economic recession has significantly impacted small business in Idaho in addition to some of the major industries including construction and logging. Unemployment has risen steadily and rapidly in the past three years, between September, 2007 when just 2.7% of the labor force was unemployed (not seasonally adjusted) to 10.4% in March, 2011 (U.S. Bureau of Labor Statistics retrieved on April 25, 2011).

According to the 2009 Idaho Vital Statistics Report, the mean age of all Idaho mothers was 26.8 years. For the 8,522 first-time mothers with known age, the mean age was 24.1 years in 2009 compared with 25.0 years for first-time mothers in the U.S. in 2007. In 2009, 37.0% of births were primarily covered by Medicaid compared with 32.9% in 2008. A total of 8.8% of births were paid by the mother or family, and a total of 3.5% of births were paid by other governmental agencies. In 2009, 71.5% of births were to mothers with a first prenatal visit in the first trimester compared with 69.4% in 2008. Overall, 2,847 (12.0%) live births were to Idaho mothers who reported smoking any time during pregnancy.

Between 2005 and 2009, there was an average of 24,230 births ranging from 23,064 to 25,156 per year. Of all the births in 2009, 15% (3,677) of births were to Hispanic mothers across the state. According to the U.S. Census Bureau, 92.1% of the population is white, non-Hispanic and 10.2% of the population is Hispanic. Given the rate of births to Hispanic mothers is 15% and the overall Hispanic population is 10.2%, this could be considered evidence of current demographic shifts in Idaho. In portions of the state, approximately 30% of all births were to Hispanic mothers in 2009. Less than 1% of the state population is African American (0.6%), Native Hawaiian or Other Pacific Islander (0.1%), and 1.1% of the population is Asian. There are six Native American tribes across the state with approximately 18,350 persons making up 1.2% of the population. The tribes are spread across the state and include the following: Kootenai, Shoshone-Bannock, Coeur d'Alene, Nez Perce, Northwest Band of Shoshone Nation, and Shoshone Paiute.

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 2009, the National Center for Farmworker Health, Inc. estimated that over 54,659 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. This is about 3.5% of population estimates for the state of Idaho. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain.

Access to Health Care

In addition to the geographic barriers, availability of primary care and specialty physicians and the lack of health insurance are major barriers to health care in Idaho. Nearly all of Idaho's counties are either population or geographic health professional shortage areas (HPSA) and considered medically underserved populations/areas (MUP/MUA). Currently, 96.7% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 93.9% in Dental Health, and 100% in Mental Health. According to the Association of American Medical Colleges (AAMC), 2009 State Data book, Idaho ranks 49th in active physicians with 181.8 per 100,000 compared to the median of 239.6 per 100,000. Idaho ranks 38th for active physicians over age 60 or older, with 22% of all active physicians over the age of 60. In 2008, there were 2,771 total active physicians, 1,003 primary care physicians, and 552 female physicians practicing in Idaho. Lack of available health care and isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. The counties often considered the most challenging to serve are the most isolated and those with the lowest populations such as Camas county, population 1,126, and Clark county, population 910.

Estimated uninsured rates for children and adults vary according to data source for citizens in Idaho. Kaiser State Health Facts estimated that in 2009, 21% or approximately 189,000 adults (19-64 years old) were uninsured. An estimated 10% or approximately 42,900 children (0-18 years old) were uninsured during the same time (retrieved from www.statehealthfacts.org on April 26, 2011). Idaho's Behavioral Risk Factor Surveillance System (BRFSS) 2009 Report indicates that 18.7% of respondents did not have health care coverage. Respondents with a high school education or below were three times more likely to report no health care coverage. Also, Hispanics were significantly more likely than their non-Hispanic counterparts to report no health care coverage, at 47.1% compared to 16.6%. Of the 2009 BRFSS respondents, 8.9% indicated their children under 18 years of age had no credible health care coverage.

In 2009, approximately 34% (158,298) of all children were enrolled in Medicaid, which is comparable to the U.S. population of approximately 33%. Of these children, 86% received some service paid for by Medicaid. Of the Early, Periodic, Screening, Diagnosis, and Treatment (EPDST) eligible Medicaid children aged 6 through 9 years old, only 7.2% received any dental services throughout the year. In Idaho, children living in households earning 135% of FPL are eligible for Medicaid and up to 185% of FPL for the state Children's Health Insurance Program (SCHIP), an expanded eligibility for Medicaid.

Title V Maternal and Child Health and Early Childhood Systems (MIECHV)

The purpose of the MIECHV Program is (1) to strengthen and improve the programs and activities carried out under Title V; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The Idaho MIECHV program intends to work with and within the Title V MCH program as well as early childhood programs and systems in Idaho. In Idaho, Title V MCH block grant supports a

number of state level programs that carry-out infrastructure building, population-based services, enabling services, and direct health care. After conducting the 2010 Five Year MCH Needs Assessment, the top seven priorities to promote maternal and child health in the coming five years were established. The work of the MIECHV program in Idaho will support many of these priorities, advancing progress and goals set forth by the Title V MCH program in Idaho.

1. **Reduce premature births and low birth weight.**
2. *Reduce the incidence of teen pregnancy.*
3. Increase the percent of women incorporating effective preconception and prenatal health practices.
4. **Improve immunization rates.**
5. *Decrease childhood overweight and obesity prevalence.*
6. Reduce intentional injuries in children and youth.
7. Improve access to medical specialists for Children with Special Health Care Needs.

Please note: MIECHV supported priorities are **bolded** for direct impact and *italicized* for indirect impact.

The Idaho MIECHV program is housed within the Title V MCH administrative structure. The activities of the MIECHV will bolster the priorities of Title V MCH. Additionally, it is the goal of the MEICHV program to embed and integrate activities within the Early Childhood Comprehensive Systems (ECCS) work in Idaho. Since 2005, work of the early childhood systems has been guided by the Idaho's Comprehensive Early Childhood Plan. In 2006, Executive Order 2006-12 was issued to establish the Early Childhood Coordinating Council to consolidate the Interagency Coordinating Council (Idaho Code Title 16, Chapter 1), and the Early Care and Learning Cross Systems Task Force (Executive Order No. 2004-01) in order to establish greater coordination, communication and efficiency of early childhood services and initiatives of the state of Idaho.

The Early Childhood Coordinating Council (EC3) has been charged with the advancement of the Comprehensive Early Childhood Plan through the work of its 22 members representing the public and private sector, multiple agencies, regional early childhood coordinating committees, early childhood programs, policy makers and many more. The members promote early childhood through a governance structure organized into four committees and four Ad Hoc committees. The four committees include: Membership, Finance, Public Awareness and Policy. Four Ad Hoc Committees, which in some cases also serve as the State Advisory board include: Head Start/Early Head Start, Infant Toddler Program (Part C), Standards and Early Childhood Home Visiting (established March, 2011).

The vision of EC3 is "All Idaho's young children are healthy, nurtured by families with quality learning opportunities and supported by community resources." A thorough, statewide needs assessment was conducted in 2008 to gather input on the needs of young children across Idaho. Six identified outcome areas encompass the service delivery system and the networks of support services for young children. The outcome areas are:

Health:

1. **Accessible and affordable health care**
2. **Comprehensive development screening and monitoring**
3. *Nutrition for young children*
4. **Immunization rates**
5. **Pre- and post-partum depression screening and referral**
6. Follow-up Newborn Hearing Screening

Infant and Early Childhood Mental Health/Social and Emotional Development

1. *Service delivery system for infant and early childhood mental health*
2. **Pre- and post-partum depression screening and referral**

Early Learning/Education and Care

1. Quality child care
2. *Integrated learning opportunities for children from birth to 5 years old*
3. Common language and understanding of child development

Parent Education

1. *Parent education - Common language and understanding of child development*
2. **Parent education resources**
3. *Education and resources for incarcerated parents*

Family Self-Sufficiency

1. *Supports for families of children with disabilities*
2. **Accessible and affordable health care**
3. Quality child care

Please note: MIECHV supported priorities are **bolded** for direct impact and *italicized* for indirect impact.

While the MIECHV program in Idaho is aligned with both the Title V MCH priorities and EC3 outcomes, the impacts will be more far reaching. The opportunities afforded by the MIECHV program in Idaho for families and communities are great. As the Idaho MIECHV program progresses, there will be many challenges and successes. By continuing to build partnerships within and beyond MCH and Early Childhood communities, the work is likely to continue beyond the duration of the MIECHV grant.

Since November 2011, the Idaho MIECHV program has been convening a "planning steering committee" of required concurrency partners to plan for the MIECHV program implementation. The "planning steering committee" has been meeting biweekly to monthly to identify evidence-based home visiting models appropriate for this program, target communities, and implementation options. During the planning meetings, committee members reviewed evidence-based home visiting models, discussed implementation plans, developed a community resource survey, and assisted with data collection. Please see the Attachment 1: MIECHV Program Planning Framework (page 88), Attachments 2: MIECHV Program Planning Timeline, Attachment 3: Model Ranking Activity and Attachment 4: Community Resource Survey (see pages 91-98).

Section 1: Identification of State's Target At-Risk Communities

Overview of Needs Assessment

For the purpose of the Needs Assessment, "communities" were defined as public health districts (PHDs). The PHDs are arranged around the seven distinct population centers across the state. Additionally, the health districts are commonly utilized for statewide public health services and activities. Much of the health data for the state is collected and analyzed at the PHD level, including Vital Statistics, BRFSS, and Idaho's Pregnancy Risk Assessment Tracking System (PRATS). Because the PHDs do not cut across county lines, non-health data collected at the county level can be analyzed at the PHD level. Within each of the seven PHDs, there are autonomous district health departments to conduct public health services including, but not limited to: surveillance, health inspections, health preparedness, immunizations, family planning, WIC, STD clinics and clinics for children with special health problems. Many programs within the Idaho Department of Health and Welfare contract with the district health departments to support and build local public health infrastructure. One example is the Children's Special Health Program (Idaho's CYSHCN program), which provides partial funding for specialty clinics in northern and eastern Idaho where physician specialists travel from neighboring states (Oregon and Utah) to provide services not otherwise available in those areas.

Figure 1: Map of Idaho's Public Health Districts

Ethnic Groups in the State of Idaho

The racial groups that comprised Idaho's population in 2009 were: white, 95.6%; black, 1.2%; Native American/Eskimo, 1.6%; and Asian/Pacific Islander, 1.4%. Similarly, the ethnic majority of the population of Idaho is considered non-Hispanic white (89.8%), with Hispanics comprising of 10.2% of the populous. Due to the agricultural nature, more than half of Idaho's Hispanic population resides in two PHDs, with 32.5% residing in PHD 3 and 20.4% in PHD 5. The majority of approximately 25,000 Native Americans reside on five reservations in northern, eastern and southern Idaho in PHDs 1, 2, 3 and 6. Notably, Idaho resettles the ninth most international refugees per capita in the United States. The majority of the refugees reside in PHD 4, the largest population center in the state. Currently, most of the incoming refugees are from the following conflict-ridden countries: Iraq, Myanmar (Burma), and the Democratic Republic of Congo.

Table 1, following, describes the distribution of population of Idahoan's across the "communities," as defined in the SIR #1 – Needs Assessment. The state population is rapidly changing, as evidenced by the 19.5% population growth during the past ten years. Both the Hispanic and non-Hispanic population continue to grow in Idaho. There are an estimated 123,400 children under the age of five years old in Idaho, with 15.6% of all births to Hispanic mothers. According to the National Center for Children in Poverty state profiles, approximately 53% of children under the age of five live in households below 200% of FPL in Idaho.

Table 1: Summary of Population by Public Health District, Idaho Population Estimates, March 1, 2009

	Total Population	% Total Population	5 Year Average Births	% Births to Hispanic Mothers	% Total Pop Hispanic	Est. children < 5 years (8%)	Est. Children <5 below 200% FPL
Idaho	**1,545,801**	100%	24,231	15.6%	10.2%	123,400	66,500
PHD 1	213,662	13.80%	2,509	3.7%	3.2%	17,100	9,200
PHD 2	104,496	6.80%	1,178	3.4%	2.6%	8,200	4,400
PHD 3	251,013	16.20%	4,325	28.7%*	19.8%	20,000	10,900
PHD 4	429,647	27.80%	6,273	9.6%	7.2%	34,500	18,600
PHD 5	179,994	11.60%	3,008	32.1%*	19.1%	14,300	7,700
PHD 6	167,290	10.80%	2,936	12.4%	9.4%	13,300	7,200
PHD 7	199,699	12.90%	4,002	12.2%	8.9%	15,800	8,500

Sources: U.S. Census Bureau, Internet release March 22, 2009, Idaho Vital Statistics Report 2009, National Center for Children in Poverty State Profiles 2009.
Note: Asterisk (*) indicates statistically significant difference compared to the state average

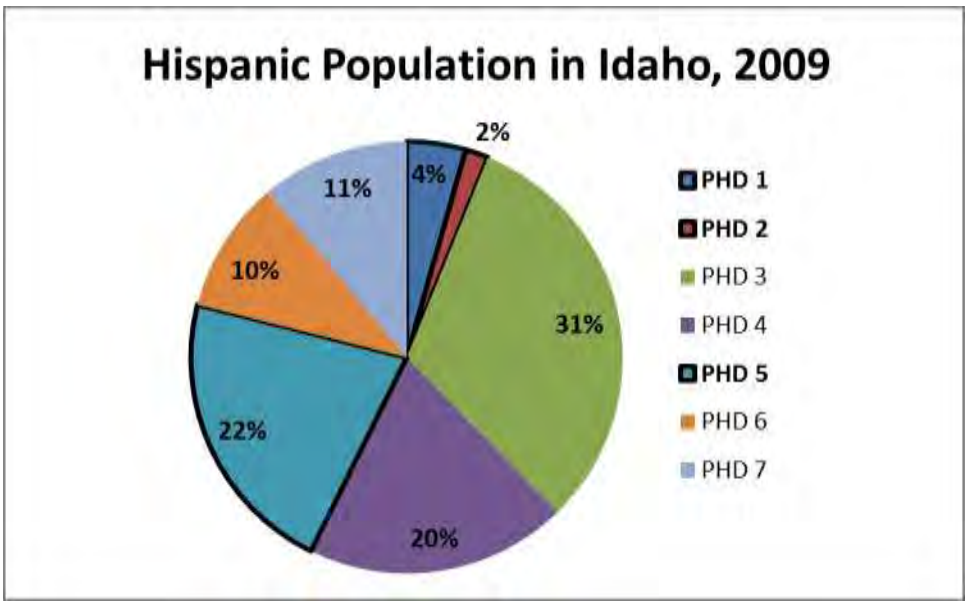
Table 2: Idaho Public Health District Population Totals by Race and Ethnicity, July 1, 2008

	Total	White	Black	American Indian	Asian/Pacific Islander	Non-Hispanic	Hispanic
Idaho	1,523,816	1,458,280	17,878	25,613	22,045	1,367,989	155,827
PHD 1	211,870	20,686	1,416	4,192	1,576	204,988	6,882
PHD 2	102,099	95,889	774	3,818	1,618	99,414	2,685

	Total	White	Black	American Indian	Asian/Pacific Islander	Non-Hispanic	Hispanic
PHD 3	248,000	238,041	3,251	3,322	3,386	198,858	49,142
PHD 4	426,283	402,555	8,479	4,379	10,870	395,662	30,621
PHD 5	176,400	171,929	1,129	1,907	1,435	142,739	33,661
PHD 6	164,357	154,760	1,365	6,563	1,669	148,847	15,510
PHD 7	194,807	190,420	1,464	1,432	1,491	177,481	17,326

Source: National Center for Health Statistics. Estimate of July 1, 2008 resident population from the Vintage postcensal series by state, county, year, age, sex, race and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau.
Note: *Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.

Figure 2: Distribution of Hispanic Population in Idaho, 2009



Source*: U.S. Census Bureau, 2009*
Note: Bolded borders denote communities at-risk in SIR#1 – Needs Assessment

Existing Home Visiting Capacity in Idaho

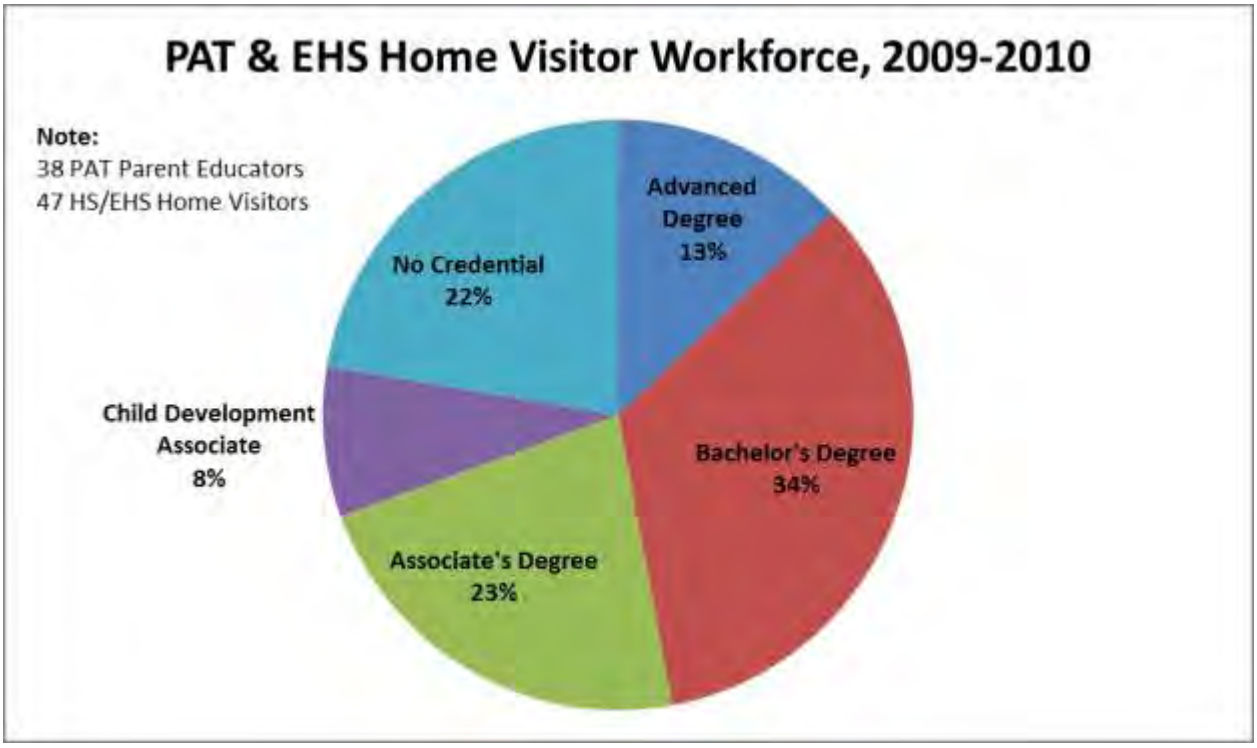
Given the seven evidence-based home visiting models listed in the Supplemental Information Request #2, two of the seven models are currently implemented in communities around the state. Early Head Start (EHS) Home-Based and Parents as Teachers (PAT) currently operate in multiple, independent locations across Idaho. Neither program has state-level administration, other than the Head Start Collaboration Office or the Idaho Head Start Association. Currently, there are eight affiliate PAT programs and five EHS Home-Based programs in the entire state, serving around 1,000 families combined. According to the Parents as Teachers 2009-2010 Annual Report of Idaho, 636 families and 1,020 children were served in eight affiliate PAT programs across the state of Idaho.

The 2009-2010 Head Start Program Information Report for Idaho indicates there were funded enrollments for 357 children and 45 pregnant women for all Early Head Start Home-Based programs across Idaho. Head Start programs report a significant waiting list (4,600 for any Head Start services, including Early Head Start Home-Based); and estimates indicate that only a fraction of eligible children receive Head Start services. Given estimates that approximately 53% of young children live in low income households, thousands of children likely eligible for Head Start and Parents as Teachers do not receive services.

Additionally, the Infant Toddler Program (ITP – IDEA Part C) provides early intervention services and service coordination in-home. The Infant Toddler Program coordinates the statewide early intervention system to identify and serve children birth to three years of age who have a developmental delay or a condition that may result in a developmental delay. This program serves as an umbrella over different agencies and service providers to link children with services that promote their physical, mental and /or emotional development and support the needs of their families.

According to the Head Start Program Information Report (PIR) for 2009 – 2010, of the 47 home visitors statewide, 40% of the home visitors had no credential, 34% had an Associate's degree or Child Development Associate, and 26% had a Bachelor's degree or higher. The Parents as Teachers 2009-2010 Annual Report indicates that among the 38 home visitors there are 16 full-time and 22 part-time parent educators. In the state of Idaho, there are currently 85 home visitors working in one of thirteen evidence-based home visiting programs. However, it should be noted that there are home visitors working within the Infant Toddler Program to provide early intervention services in-home.

Figure 3: Evidence-based Home Visiting Workforce in Idaho, 2009 - 2010



Sources: Parents as Teachers Annual Report for program affiliates, 2009 - 2010
Idaho Head Start Program Information Report, 2009 - 2010, printed Nov. 1, 2010

Needs Assessment Data Analysis Methods

Given the initial definition of "communities" as PHDs, three "communities" were identified as at-risk. A summary of the methodology for the SIR #1 - Needs Assessment submitted in September, 2010 is as follows.

1. Gathered prevalence data for each of the thirteen required indicators at the county level,
2. Calculated the statewide mean and standard deviation for each indicator using the county level prevalence data (Note: statewide mean differs from statewide prevalence),
3. Using a Z-score method, compared each county to the statewide mean to determine number of standard deviations from statewide mean (Z-score of 1 = 1 standard deviation greater than mean),
4. For every Z-score greater than 1, counties were given "1 point" then for each indicator the "points" were summed for a county risk score (Note: counties could have "1 point" for each indicator" for a potential total of "13 points"),
5. "Sum Risk Score" for each PHD was calculated by adding each county's risk scores,
6. Calculated a risk index, while controlling for the number of counties per health district. The Risk Index → ("Sum Risk Score"/ 13 * Number counties per PHD),
7. Ranked risk index for each PHD from highest to lowest,

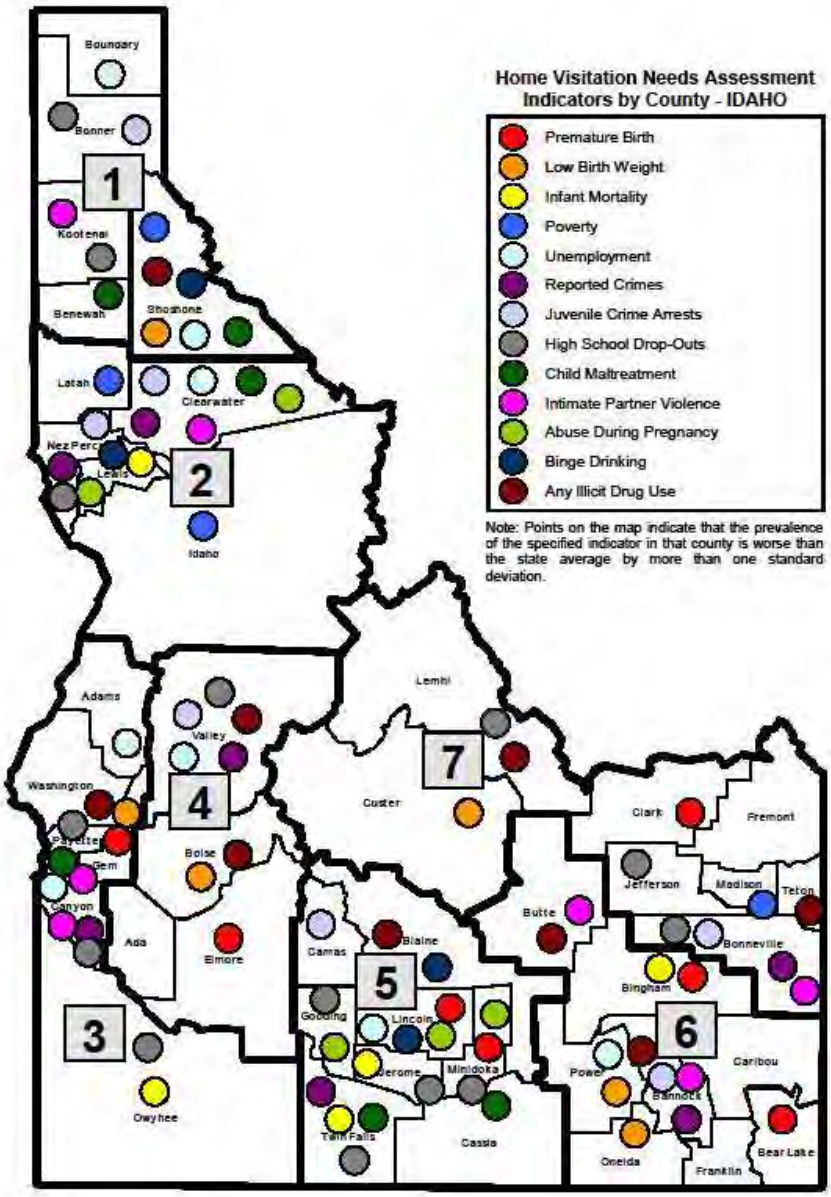
8. Determined three highest ranked PHD's "at-risk communities."

Table 3: Community Risk Ranking from SIR #1 – Needs Assessment

"Communities"	Risk Index	Risk Ranking
PHD 2	21.5%	1
PHD 1	18.5%	2
PHD 5	18.3%	3
PHD 3	16.7%	4
PHD 4	15.4%	5
PHD 6	11.5%	6
PHD 7	10.6%	7

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

Figure 4: Distribution of risk by indicator for Idaho



The Needs Assessment identified PHDs 2, 1, and 5 as the "at-risk communities." These communities had the highest concentration of risk factors, with prevalence of adverse indicators greater than one standard deviation from the statewide mean. Based on the SIR #2 – Updated State Plan Guidance, the cost of intervention and risk factors, it is necessary to target fewer "communities" and smaller geographic areas. After submitting SIR #1 – Needs Assessment, the Idaho MIECHV program conducted a second round of targeted analysis in order to narrow the definition of "community at-risk." The second round of analysis utilized the same data set for counties within the three at-risk PHDs identified in the SIR #1 – Needs Assessment. The goal of the second round analysis was to narrow the geographic area and scope of "community at-risk" for evidence-based home visiting intervention. The following is a

summary of the methodology for the second analysis, which only included counties within the previously identified "communities at-risk."

1. **Method 1**: Compare county prevalence within each "at-risk" PHD to PHD median (county prevalence in District 1 compared to District 1 median, county prevalence in District 2 compared to District 2 median, etc.):
    a. Conduct comparison for each county prevalence to PHD median prevalence for each indicator
    b. Score counties with prevalence greater than the PHD median as "1" for each indicator
    c. Sum scores for each county across indicators for "County Risk Score"
    d. Highest "County Risk Scores" considered "At-Risk Score = 1 point"
2. **Method 2**: Compare county prevalence to median across "at-risk" PHDs (i.e. counties in Districts 1, 2, and 5 were compared to each other)
    a. Conduct comparison for each county prevalence and median for all counties within the three "at-risk" PHDs
    b. Score counties with prevalence greater than the cross "at-risk" PHD median as "1" for each indicator
    c. Sum scores for each county across indicators for "County Risk Score"
    d. Highest "County Risk Scores" considered "At-Risk Score = 1 point"
3. **Method 3:** Compare county prevalence to statewide prevalence (i.e. county's prevalence in Districts 1, 2, and 5 compared to the statewide prevalence)
    a. Conduct comparison for each county prevalence to statewide prevalence for each indicator
    b. Score counties with prevalence greater than the statewide prevalence as "1" for each indicator
    c. Sum scores for each county across indicators for "County Risk Score"
    d. Highest "County Risk Scores" considered "At-Risk Score = 1 point"

Table 4 indicates the counties that are at greater risk than other counties within the "at-risk communities." The score indicates sum of risk rankings across methods.

TABLE 4: Analysis of Counties within "At-Risk Communities"

	Method 1	Method 2	Method 3	SCORE
District 1				
Benewah		X		1
Bonner	X	X		2
Boundary				0
Kootenai		X	X	2
Shoshone	X	X	X	3
District 2				
Clearwater	X	X	X	3

	Method 1	Method 2	Method 3	SCORE
Idaho				**0**
Latah				**0**
Lewis	**X**			**1**
Nez Perce				**0**
District 5				
Blaine				**0**
Camas				**0**
Cassia				**0**
Gooding				**0**
Jerome	**X**	**X**	**X**	**3**
Lincoln	**X**			**1**
Minidoka	**X**			**1**
Twin Falls	**X**	**X**	**X**	**3**

The second round of analysis indicates that 10 counties are at greater risk than the other counties within the three "at-risk communities." Of those 10 counties, four scored highest (3), two scored moderately (2), and four scored lowest risk (1), while eight counties were not at-risk (0). From the second round analysis, there are several counties that appear as the most "at-risk." Those counties at high and moderate risk in the second round analysis include:

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

Community Resource Survey

The Idaho MIECHV program recognizes the importance of qualitative data to support and clarify the results of the quantitative analysis. In order to learn more about communities across the state, Idaho's MIECHV program conducted a "Community Resource Survey" to gather information about services and networks in communities across Idaho. Over the course of several months the MIECHV planning steering committee (PSC) developed a community resources survey to collect information related to utilization of evidence-based programs, in-home services, community-based organizations, target populations, service areas and more. The PSC identified potential respondents from stakeholder groups, existing sampling frames and contacts lists. No complete sampling frame of community-based organizations exists that would allow for probability sampling. Without a complete sampling frame, the Community Resource Survey methodology is considered a non-probability, convenience sample. The survey sample included more than 550 potential respondents across disciplines, including social service, health, early learning, faith-based, education and community-based organizations. The original sample included 560 potential respondents, including more than 400 elementary principals. Both an

electronic fillable form (Microsoft Word) and Survey Monkey were developed in an attempt to accommodate respondents. After being available for three weeks, the survey closed on April 22nd and elicited 192 responses via Survey Monkey: 70 partial and 122 complete responses. Analysis began immediately, resulting in 162 responses sufficient for evaluation.

The objectives of the community resource survey were to:

1. Collect information on services that support women, children and families,
2. Capture a picture of local resources, community assets, and referral networks, and
3. Better understand how to support organizations that serve women, children and families.

In the coming months, the Idaho MIECHV program intends to continue analysis, with the goal of creating county profiles to be available on the MEICHV Web page and upon request. It is likely that additional reports will follow to support other early childhood programs as well. A following is a sample of the responses, which provides a snapshot of community networks according to referral sources. When organizations were asked to identify the top three referral sources, they responded:

Rank	Given	Received
1	School District	School District
2	Health and Welfare Regional Office	Self-referred
3	Counseling/Mental Health	Doctor's Office
4	Doctor's Office	Infant Toddler Program (ITP – Part C)

The following attachments provide additional information about the Community Resource Survey:

- Attachment 4: Community Resource Survey
- Attachment 5: Map of Community Resource Survey Respondents
- Attachment 6: Community Resource Survey - Basic Counts of Respondents

At-Risk, Target Communities

For the purpose of Year 1 of the MIECHV program in Idaho, four communities have been identified as target communities based on thorough analysis of multiple variables including: analysis of risk, geography, proximity, and infrastructure. These four counties will be eligible to apply for MIECHV program funding opportunities to implement evidence- based home visiting in accordance with MIECHV program requirements (*see implementation program for roll-out plan*). The four target communities are, in no order:

- Kootenai County (PHD 1) – 6 risk factors
- Shoshone County (PHD1) – 10 risk factors
- Twin Falls County (PHD 5) – 11 risk factors
- Jerome County (PHD 5) – 8 risk factors

According to the SIR #1 – Needs Assessment, each of the counties are "at-risk" for multiple indicators of risk. Table 5 indicates the prevalence of risk factors in the target communities. Table 6 outlines the characteristics of the target communities. Notably, the target communities had elevated prevalence of at-risk for high-school drop outs, child maltreatment and adult binge drinking. Additionally, the teen birth rate of each of these counties exceeds the statewide teen birth rate. Each of the communities had a lower proportion of residents with bachelor's degrees than the statewide estimate. The average percent of births covered primarily by Medicaid in each of the communities is greater than the statewide average (See Attachment 7 Map of Medicaid Births). The target communities represent 16.1% of the state population and 17.1% of all 2009 births in Idaho. The risk factors indicate supporting evidence-based home visiting programs with proven outcomes to address the following: school readiness, child abuse and neglect, and birth outcomes.

Table 5: Target Community Risk Factors

	Preterm Birth	Low Birth Weight	Infant Mortality	Poverty	Unemployment	Crime	Juvenile Crime	High School Drop Outs	Child Maltreatment	Intimate Partner Violence	Abuse During Pregnancy	Binge Drinking	Illicit Drug Use
Kootenai					●	●	●	●	●			●	
Shoshone	●	●	●	●	●			●	●		●	●	●
Twin Falls	●	●	●	●		●		●	●	●	●	●	●
Jerome	●	●	●	●			●	●	●			●	

Source: Idaho's SIR #1 – Need Assessment

Table 6: Characteristics of Target Communities

	Kootenai	Shoshone*	Twin Falls	Jerome	Idaho
Population	139,390	12,660	75,296	21,262	1,545,801
0-5 population	8,634	613	5,728	2,009	118,779
2009 Births	1,770	133	1,232	443	23,726
2009 Birth Rate	12.7	10.5	**16.4**	**20.8**	15.3
% of Births covered by Medicaid	**42%**	**53.9%**	**43.%**	**51.7%**	37%
% Population with Bachelors	**22%**	**11.9%**	**16.7%**	**11.9%**	23.7%
% Population Civilian Veterans	**14.2%**	**16.6%**	11.2%	10.2%	12.2%
% Population Below 100% FPL	8.4%	**13.0%**	**11.4%**	8.9%	9.5%
2009 Inadequate Prenatal Care	13.7%	**26.0%**	**15.4%**	**20.2%**	14.6%
2009 Birth Rate for 15 – 19 yr. old	**36.1**	**50.8**	**52.0**	**87.4**	35.8
2009 Rate Substantiated Maltreatment Children under 18	**4.0**	**9.6**	**8.9**	**5.0**	3.7

Sources: US Census Bureau 2009, Idaho Vital Statistics 2009, Idaho Department of Health and Welfare
*Note**: Shoshone is considered frontier

There is varied capacity of existing evidence-based home visiting programs in the target communities. There are two affiliated Parents as Teachers programs in Kootenai County, with a total of seven parent educators. One of the programs in Kootenai County was initiated March 11, 2011. There is one Early Head Start Home-based program in Kootenai County and one Early Head Start Home-based program in Twin Falls, serving approximately 200 participants in both programs. These programs may serve families in other communities as well.

Table 7: Estimated Capacity of Existing Evidence-Based Home Visiting Programs in Target Communities

	Parents as Teachers	Early Head Start	Total	0-5 Population	% 0-5 Population Served
Kootenai	105	119	224	8,634	2.6%
Shoshone	0	0	0	613	0%
Twin Falls	0	80	80	5,728	1.4%
Jerome	0	0	0	2,009	0%

The MIECHV program anticipates partnering with Parents as Teachers and Early Head Start model developers to further assess community and program readiness to implement the MIECHV program prior to issuing a funding opportunity announcement for local organizations. Model developers will be expected to partner with evidence-based home visiting programs to conduct a readiness self-assessment related to program reach, model fidelity, community connectedness and technological capacity.

Plan for Coordination among Existing Services

There are no known coordinated efforts to screen, identify and refer families into the evidence-based home visiting services anywhere in the state of Idaho, with the exception of early intervention services. Early Intervention services provided through the Infant Toddler Program identify families through developmental screenings available in print and online and participation in a developmental milestones program. Infant Toddler Program and Head Start programs also collaborate to assess transition and service plans for both programs. Additionally, the Department of Health and Welfare has mobilized staff navigators to facilitate family connection with the appropriate benefit programs offered through the state.

The state MIECHV program plans to facilitate connection between these existing screening and referral processes with subcontractors implementing the MIECHV program. In order to build the referral networks, coordinate services, and address gaps in services, the MIECHV program intends to support subcontracts by partnering with other evidence-based home visiting programs, early intervention and other services within the communities. It is likely that the Idaho MIECHV program will need to request technical assistance related to establishing centralized intake processes and service integration across

agencies. During year 1 of the MIECHV program, it is anticipated that state leaders will partner with subcontractors implementing the MIECHV program to assess the local landscape of community-based organizations serving young children and their families. Over time, the MIECHV program will provide tools, resources and technical assistance to facilitate community conversations to increase coordination among evidence-based home visiting programs and other child service organizations in target communities. (Please see also Implementation Plan and Anticipated Technical Assistance Needs.)

Integration of Home Visiting Services into the Early Childhood System

Early childhood services in Idaho include a variety of state and local programs and services including the Infant Toddler Program, Child Care, WIC, Head Start and Early Head Start, Parents as Teachers and preschool services for developmentally delayed children. At this time, service delivery integration is driven primarily by various state and local efforts. Replicating exemplary partnerships in the state in the context of an evidence-based home visiting program is critical in integration to the early childhood systems. The Infant Toddler Program and Head Start convene advisory councils within the governance structure of the Early Childhood Coordinating Council (EC3). The Children's Trust Fund and Child Care leaders have partnered to establish training curricula for child care providers connected with the Quality Rating System to promote protective factors through the Strengthening Families framework.

The MIECHV program intends to partner with the Early Childhood Coordinating Council through the newly established Early Childhood Home Visiting Ad Hoc Committee within the Early Childhood Coordinating Council. The EC3 provides a forum for state leaders to strategize and identify opportunities for collaboration and integration. Accordingly, the Early Childhood Home Visiting Ad Hoc Committee will act as a forum to optimize partnerships within the early childhood community and build home visiting infrastructure. Additionally, the MIECHV program intends to continue convening the planning steering committee and shifting focus to implementation, evaluation and diffusion of information during year 1 of MIECHV program implementation.

At-Risk, Non-Target Communities

The emphasis on program quality, fidelity and targeted intervention, and the results of the needs assessment has allowed the MIECHV program to identify four communities for year 1 of the Idaho MIECHV program. Fourteen counties identified as at-risk in the SIR #1 - Needs Assessment will not be targeted for year 1 of the MIECHV program. Twenty-six counties were not identified as at-risk in the SIR #1 - Needs Assessment and will not be targeted by the MIECHV program in year 1.

Table 8: All counties according to risk as identified in the Needs Assessment

MIECHV Program Year 1 Target Counties	Counties identified as at-risk in Needs Assessment	Counties not identified as at-risk
Jerome	Benewah	Ada
Kootenai	Blaine	Adams
Shoshone	Bonner	Bannock

Twin Falls	Boundary	Bear Lake
	Camas	Bingham
	Cassia	Boise
	Clearwater	Bonneville
	Gooding	Butte
	Idaho	Canyon
	Latah	Caribou
	Lewis	Clark
	Lincoln	Custer
	Minidoka	Elmore
	Nez Perce	Franklin
		Fremont
		Gem
		Jefferson
		Lemhi
		Madison
		Oneida
		Owyhee
		Payette
		Power
		Teton
		Valley
		Washington

Section 2: Home Visiting Program Goals and Objectives

The Idaho MIECHV program goals and objectives describe the broad vision for year 1 of the MIECHV program. Goals focus on the anticipated state level processes and outcomes, as well as collaboration with the EC3. The goals seek to support a definition for success in establishing a state administered evidence-based home visiting program. Goals address phases of program development including planning, implementation and evaluation and system's integration. Partnering with the EC3 and other early childhood systems initiatives is critical in advancing the goals of the Idaho MIECHV program.

The guiding principles of the Idaho MIECHV program are promulgating evidence-based home visiting services in communities, supporting a continuum of care and building strong community networks, while simultaneously seeking to integrate services across agencies and sectors at the local and state level. The MIECHV program seeks to promote collaboration, build sustainability, strengthen communication and support quality and fidelity to achieve positive outcomes for families. Idaho's goals and objectives are set within a timeframe that acknowledges the likely challenges and lessons learned that a program new to the state will face. Finally, the goals articulated below are aligned, to the extent possible, with

the goals and priorities outlined in the Title V Maternal and Child Health Block Grant Needs Assessment for 2010 and the Comprehensive Early Childhood Plan for 2009-2012.

Broad Idaho MIECHV program and systems goals are outlined here. Additionally, the Idaho MIECHV program has developed performance and outcome goals as outlined in the Benchmarks Plan. Performance and outcome goals in the Benchmarks Plan are designed to undergird and support the broad program goals.

Goal 1: Support community-based organizations to implement evidence-based home visiting programs in communities at-risk.

> *Objective 1.A*: By September 1, 2011 award implementation grants to two organizations to implement evidence-based home visiting programs in priority "at-risk communities."
>
> *Objective 1.B:* By June 1, 2012 support implementing organizations in identification of specific performance objectives and indicators for Continuous Quality Improvement.
>
> *Objective 1.C*: By September 20, 2012 collect and assess annual report from year 1 grantees to provide direction to years 2-5 of the MIECHV program.

Goal 2: Identify or develop a cross-model data system to facilitate collection, maintenance and reporting of performance and outcome indicators for the MIECHV program.

> *Objective 1.A*: By September 2011, convene home visiting data workgroup to identify common screening/assessment tools, process and outcome indicators and methods of collection.
>
> *Objective 1.B:* By December 2011, develop or implement a data system application relevant to multiple models to collect process and outcome indicators required by the SIR #2.

Goal 3: By September 2012, improve access to maternal health services for women receiving home visiting services.

> *Objective 3.A*: By September 2012, increase utilization of prenatal and preconception care to 90% of pregnant women receiving home visiting services.
>
> *Objective 3.B*: By September 2012, increase post-partum depression screening to 90% of mothers with children less than one year old receiving home visiting services.

Goal 4: By September 2012, increase training opportunities and assessments for home safety and injury prevention for home visitors employed by home visiting programs.

> *Objective 4.A*: By September 2011, assure that home visitors are equipped with training to assess home safety, car seat safety and promote injury prevention.

Objective 4.B: By September 2012, assure that 95% of all families participating will have received education related to home safety and injury prevention.

Goal 5: By September 2012, increase home visiting workforce capacity through training of home visitors and supervisors to prepare for scale up of evidence-based home visiting.

Objective 5.A: By December 2011, assure that all training requirements according to model standards and the MIECHV program are current for 100% of existing program staff and new hires (home visitors and supervisors).

Objective 5.B: By September 2012, assess all available training in the state that supports home visiting competencies to produce a systems analysis report of gaps and duplications.

Goal 6: By September 2011, assure MIECHV program participation in early childhood systems building efforts through the EC3 Early Childhood Home Visiting Ad Hoc Committee.

Objective 6.A: By September 2011, support the process to gather stakeholders and partners to begin systems building process.

Objective 6.B: By April 2012, lead activities to address three to four of the Ad Hoc Committee's identified system needs – such as common training opportunities, common intake forms and cross-model evaluation.

Logic Model

Idaho MIECHV program's logic model depicts anticipated program input, activities, outputs and outcomes for the program and system development.

Logic Model: Idaho's MIECHV Program

Planning – Implementation – Evaluation – Sustainability

Obstacle: Idaho's home visiting programs, network, and service delivery system silo-ed, under-supported and lack coordination. This inherently places families and young children at a disadvantage to receive optimal opportunities to succeed.

Goal/Mission: Increase capacity, quality, and visibility of evidence-based home visiting (HV) programs through the MIECHV by 2015 in Idaho to better provide community supports and resources for families and young children to achieve optimal development and lead healthy successful lives.

Inputs → Activities → Outputs → Outcomes → Impact

Resources:

- Early Childhood Coordinating Council (EC3)
- Idaho Children's Trust Fund: CAPTA Title II
- Idaho Head Start Collaboration Office
- Dept. of Health and Welfare
  - Division of Public Health: Title V
  - Division of Welfare: Title IV-E
  - Division of Welfare: CCDF
  - Division of Family and Community Services: Part C
  - Division of Behavioral Health: Substance Abuse Services
- Idaho State Department of Education
- Idaho Comprehensive Early Childhood Plan
- MIECHV Program

Rationale for results:

Idaho intends to build on existing partnerships to support existing home visiting structures, introduce new evidence-based models to increase quality and capacity, and strengthen home visiting systems

Work plan:

1. With guidance of planning steering committee, develop state plan outlining implementation and evaluation plan for MIECHV for year 1
2. Utilize results of needs assessment & community resource survey to develop comprehensive summary of assets, gaps, & barriers to implementing HV programs
3. Establish funding opportunities for community-based organizations to apply for the following funding support for EB HV implementation
4. Support home visiting systems building efforts through EC3 Early Childhood Home Visiting Ad Hoc Committee
5. Establish contract to support CQI and Evaluation for grantees implementing EB home visiting

Evaluation & Products:

- Support implementing agencies to conduct CQI and assure model fidelity partnering with model developer and evaluation partner
- Annual Progress Report: Lessons learned and accomplishments
- Assess intake process, identify referral networks, & intake tools
- Monitor participant outcomes for grantees
- Formal CQI, publish results and utilize them to inform future decisions
- Ongoing capacity assessment
- Coordinate policy recommendations and public engagement efforts via EC3 Ad Hoc committee

Short term:

Increased access to quality home visiting services in target at-risk communities, enhanced communication among models and service providers

Long term:

Increased: receipt of appropriate services supporting optimal child and family developmental outcomes.
Decreased: incidence of child maltreatment, gaps and duplication of home visiting services

Who:

Target population: Pregnant women, caregivers and young children 0-5 years of age

Extent:

Interventions targeted to at-risk communities, with significant technical assistance and evaluation support. Statewide system efforts to better coordinate programs statewide

External Factors: The following factors can influence planning, implementation and sustainability of the proposed activities in Idaho: national, state and local political climates; resistance to paradigm shift, lack of trust in government, deeply entrenched habits within professional communities; structural change within current home visiting delivery system, physical and cultural environments of families to participate in home visiting.

Section 3: Selection of Proposed Home Visiting Models to Meet Community Needs

Home Visiting Model Selection

In November 2010, the Idaho MIECHV began to research and review home visiting models likely to be considered evidence-based models according to the legislative definition of "evidence-based." Convened by the MIECHV program leadership, the planning steering committee reviewed research for eleven home visiting models. The planning steering committee participated in a model ranking activity according to relevance to Idaho's at-risk communities. Through a collaborative effort, the committee ranked home visiting models on eight domains evidenced through research as critical components for high-quality, outcomes driven home visiting programs (Zero to Three: Home Visiting Past, Present, Future 2010). Discussion and consensus building occurred over the course of time to identify four models as relevant to the needs of Idaho -- at-risk communities, target populations, program short- and long-term outcomes and current systems of care. (Please see Attachment 3 – Home Visiting Model Ranking Activity.) The following four home visiting models, in rank order, emerged as the most relevant options for evidence-based home visiting programs for the MIECHV program:

1. Healthy Families America (HFA)
2. Nurse Family Partnership (NFP)
3. Parents as Teachers (PAT)
4. Early Head Start – Home-Based (EHS)

As described in the identification of target communities, the SIR #1 – Needs Assessment indicated that public health districts 2, 1, and 5 were at most risk given the indicators of analysis. The second round of analysis indicated six counties at moderate to high risk, four of which have been identified as target communities for year 1, see Identification of Target Communities. Given the factors of risk within the target communities, existing infrastructure and model strengths, the following evidence-based home visiting models have been identified for implementation year 1 of the Idaho MIECHV program:

1. Early Head Start – Home-Based
2. Parents as Teachers

Table 9 is a crosswalk between the risk factors for the four target communities aligned with the research-based outcomes of Parents as Teachers and Early Head Start – Home-Based as reported on the Home Visiting Evidence of Effectiveness Study (retrieved from http://homvee.acf.hhs.gov on April 14, 2011). As indicated in the second round of analysis, 10 counties were at higher risk than the others within the three "communities at-risk" indicated in the SIR #1 - Needs Assessment. For year 1, Parents as Teachers and Early Head Start-Home-Based are the models identified for implementation to address needs of the counties most at-risk as indicated in Table 9. Please see Attachment 8 for expanded crosswalk with 10 counties.

Table 9: Evidence-Based Home Visiting Model Outcomes Crosswalk with Target Communities

County	Population	Indicator	Year 1	
			PAT	EHS
Shoshone	12,660	Low Birth Weight		
		Preterm Birth		
		Infant Mortality		
		DV in Pregnancy		
		Adult Binge Drinking	X	X
		Adult Illicit Drug Use		
		Poverty	X	X
		Unemployment	X	X
		High School Drop Out	X	X
		Substantiated Maltreatment		
Kootenai	139,390	Crime		
		Juvenile Crime		
		Adult Binge Drinking	X	X
		Unemployment	X	X
		High School Drop Out	X	X
		Substantiated Maltreatment		
Twin Falls	75,296	Preterm Births		
		Low Birth Weight		
		Infant Mortality		
		Crime		
		Intimate Partner Violence		
		DV in Pregnancy		
		Adult Binge Drinking	X	X
		Adult Illicit Drug Use		
		Poverty	X	X
		Substantiated Maltreatment		
		High School Drop Out	X	X
Jerome	21,1262	Preterm Birth		
		Low Birth Weight		
		Infant Mortality		
		Juvenile Crime		
		Adult Binge Drinking	X	X
		Poverty	X	X
		Substantiated Maltreatment		
		High School Drop Out	X	X

Community Involvement

The Idaho MIECHV program recognizes the need for community engagement in the program planning and development process. In April, Idaho's MIECHV program conducted a "Community Resource Survey" to gather information about services and networks in communities across Idaho. Over the

course of several months the MIECHV planning steering committee developed a community resources survey to collect information related to utilization of evidence-based programs, in-home services, community-based organizations, target populations, service areas, and more. The survey sample included more than 550 potential respondents across disciplines, including social service, health, early learning, faith-based, education and community-based organizations. The original sample included 560 potential respondents, including more than 400 elementary principals. Both an electronic fillable form (Microsoft Word) and Survey Monkey were developed in an attempt to accommodate respondents. After being available for three weeks, the survey elicited 192 responses via Survey Monkey: 70 partial and 122 complete responses, resulting in 162 responses sufficient for evaluation. The results of the survey will facilitate spatial analysis of community organizations for statewide planning. Ideally, the results will allow spatial analysis of service location compared to population in order to assess gaps and duplication in services.

The MIECHV program anticipates engaging communities and organizations in several ways in the coming months. In late May to early June 2011, the MIECHV program intends to publish a targeted news release announcing upcoming informational community forums regarding the MIECHV program in the target communities. The news release will be followed by newsletter inserts for partner organizations (see Attachment 11 – MIECHV Program News Release). In late June 2011, the MIECHV program plans to conduct informational community forums for organizations within target communities interested in learning more about the MIECHV program. These community forums will provide an opportunity for the MIECHV program administrators to engage community stakeholders in the target at-risk communities in dialogue, question and answer. In June to July 2011, the MIECHV program anticipates partnering with model developers to conduct a readiness assessment for organizations in target communities. The results of the readiness assessment will inform the funding opportunity and technical assistance requests during the initial stages of implementation. The MIECHV has identified a process and will identify activities for continued ongoing community engagement during years two through five of the MIECHV grant, recognizing the importance of community and stakeholder engagement. Please see Identification of Target Communities and Implementation Plan.

Demonstrated and Expected Capacity

The state of Idaho has no experience administering or implementing an evidence-based home visiting program, with the exception of early intervention through the Infant Toddler Program – IDEA Part C. Over the past several years, Idaho has had varying levels of home visiting programs in the State. Parents as Teachers and Early Head Start Home-Based are the two evidence-based home visiting models that exist in Idaho, through a total of 13 programs throughout the State. Community-based organizations funded by varying sources offer home visiting services in the Parents as Teachers and Early Head Start Home-Based models. For year 1, the Idaho MIECHV program has identified Parents as Teachers and Early Head Start Home-Based as the models to be implemented in target communities. Please see Implementation Plan for anticipated program roll-out for year 1. In outgoing years of the MIECHV program, Idaho anticipates conducting a feasibility study for implementation of other evidence-based home visiting models. Through significant monitoring and technical assistance, the Idaho MIECHV

anticipates strengthening capacity of community-based organizations to implement evidence-based home visiting programs.

Parents as Teachers:
At this time, eight affiliate Parents as Teachers programs operate throughout the state of Idaho. Two of the affiliate programs operate in the target communities. Two affiliate Parents as Teachers models exist in Kootenai County. In all of the programs across the state, 45 parent educators served 636 families in 2008-2009. There are seven parent educators working in Kootenai County for either of the Parents as Teachers affiliates. Parents as Teachers has had a significant presence in Idaho during the past two decades until major funding cuts occurred in 2006, diminishing capacity of the Parents as Teachers programs. Of the greater than 123,000 children ages 0 to 5 years old in Idaho, less than 1% was served by PAT in 2008-2009 (U.S. Census Bureau, 2010). Each PAT program reports waitlists of greater than 100 families. Currently, the majority of Parents as Teachers funding in Idaho is through the Parent Information and Resource Centers (PIRC) grant awarded through the US Department of Education.

Early Head Start:
There are five EHS Home-Based programs throughout the state of Idaho. Three of these programs operate in the "at-risk communities." EHS Home-Based operates in Twin Falls, Nez Perce, and Kootenai. In 2009-2010, in the EHS/HS Home-Based programs across the state, 47 home visitors served 357 children enrolled in HS/EHS Home-Based programs. Of those, 40% (19) are non-credentialed home visitors. In the three counties at-risk, there are 190 federally funded Early Head Start slots for children 0-2 and 23 slots for pregnant women. The 2010 Idaho Head Start Data Book reports that less than 5% of the eligible pregnant women, infants and toddlers are receiving Early Head Start services.

Nurse-Family Partnership:
No demonstrated capacity

Health Families America:
No demonstrated capacity

Anticipated Adaptations

There are no anticipated adaptations of either PAT or EHS during year 1 of implementation. Please see initial approval letters from both EHS and PAT model developers approving the plan to implement in Attachments 9 and 10. Although there are no anticipated adaptations for year 1, there may be required model adaptations to address sparsely populated areas and geographic challenges.

Plan to Ensure Model Fidelity

The Idaho MIECHV program anticipates supporting implementing organizations in a multitude of methods by building fidelity measures into an application process, developing and monitoring contract performance measures, coordinating training and technical assistance, data systems development or

procurement and development of resources and tools as necessary. The following outline indicates the steps to ensure fidelity to the evidence-based home visiting model. Please see Implementation Plan and Continuous Quality Improvement for additional description of maintaining model fidelity and continuous quality improvement.

1. Funding Opportunity:

The application for funding will require organizations to complete a brief organizational capacity assessment. Throughout the application process, there will be technical support available to applicants via teleconference, conference calls or webinars by the MIECHV program leadership. Applicants will be required to indicate plans to adhere to model specific requirements including, but not limited to:

- Target population
- Use of the program components and materials
- Proper settings
- Staff qualifications
- Staff training and supervision
- Number and length of home visits and service delivery
- Number of families per worker
- Quality of program delivery

Applicants will be provided with tools to support the application process including, but not limited to:

- Model Developer Contact information
- Logic model framework
- Friends National Resource Center's Tool for Critical Discussion

Applications for funding will be scored on a number of factors, including responses to model fidelity and fidelity indicators, organizational and community awareness. Applicants will have varying capacity to support model fidelity, thus the MIECHV program intends to provide ongoing support to successful grant applicants to adhere to required model components.

2. Contract Performance Measures:

The MIECHV program will establish a subcontract with successful applicants to provide evidence-based home visiting services. Contracts will require submission of quarterly and annual reports to the MIECHV program administrators providing process, performance and outcome data such as: number enrolled participants, missed visits, time spent per visit, training, and participant and staff retention. Additionally, the Idaho MIECHV program intends to develop or procure a management information system (MIS) or supplement existing organization MIS systems to track administrative and client data.

3. Ongoing Monitoring and Continuous Quality Improvement:

Organizations implementing will also be contractually obligated to participate in continuous quality improvement (CQI) to assess processes and performance. Please see the Continuous Quality Improvement Plan for additional details. Some of the indicators programs may assess in the CQI processes include:

- Prenatal Care
- Post-Partum Depression Screening
- Breastfeeding education
- Well-child visits
- Injury prevention education
- Domestic Violence screening
- Referrals made for families identified with Domestic Violence
- Number families identified for necessary services
- Number of families receiving referral to necessary referral
- Number Memorandums of Understanding (MOUs) within community
- Point of contact in agency responsible for connecting to other community-based organizations
- Number of completed referrals

Successful implementation hinges on a number of different factors including an understanding of the organizational, staffing, community and leadership drivers of the program (Fixsen, D., Naoom, S.F., Blase, D.A., Friedman, R.M., Wallace, F., 2005). Each of the following factors impacts the implementation with fidelity: organizational capacity to implement fit to organization and community, need of community, resource availability, evidence of efficacy and intervention readiness for replication (NIRM, 2009). The Idaho MIECHV Program recognizes the importance of ongoing monitoring of policy and practice at every level including the state, implementing organization and model developers to assure quality and fidelity to the evidence-based home visiting model. Please see the Implementation Plan for plan to partner with model developers in quality assurance, continuous quality improvement and monitoring activities.

Anticipated Challenges and Technical Assistance Needs

There are a number of challenges that may occur during implementation and evaluation of the MIECHV program. Currently, there are few existing evidence-based home visiting programs, with limited reach throughout the state. A systematic effort to support and advance multiple evidence-based home visiting programs will be a new experience for the state of Idaho. In addition to the geographic barriers, there may be political barriers to implementation of evidence-based home visiting systems. Because agencies that may be implementing the MEICHV program may be existing or new programs, technical assistance for both types of programs will be necessary. MIECHV program will likely need technical assistance in at least the following areas:

1. Continuous quality improvement
2. Domestic violence screening and referral

3. Establishing an effective referral network (community resources network)
4. Centralized intake processes
5. Program evaluation and data-driven decision-making

Section 4: Implementation Plan for Proposed State Home Visiting Program

The implementation plan for the Idaho MIECHV program is designed to align with tenants of the *Lifecourse Perspective* and the *Strengthening Families* framework. These frameworks suggest that factors such as intergenerational experiences and environmental and community factors influence health and wellbeing over the lifespan. Each framework is supported by scientific and social research that consistently indicates that early years of life are a critical period; a window of opportunity to set the trajectory of a child's life and support families to provide the best beginning to life.

Occurrence of adverse childhood experiences during the early years increases the likelihood of negative impacts on health, development and wellbeing. Risk factors such as poverty, educational attainment, low birth weight and exposure to family violence are associated with negative impacts on a child's outcome later in life. The *Strengthening Families* framework provides that a number of protective factors, if present or cultivated, can mitigate or reduce the impact on adverse events in a young child's life. Evidence suggests that supporting development of protective factors by empowering communities and families provide the foundation for positive child development. The implementation plan intends to outline the Idaho's MIECHV program through the lens of positive family and child development in the frameworks of *Lifecourse Perspective* and *Strengthening Families*.

The Idaho MIECHV program will release a funding opportunity to organizations for funding to implement evidence-based home visiting in target communities in the summer 2011. The funding opportunity will include the components outlined in the implementation plan and align with the *Lifecourse Perspective* and *Strengthening Families* Framework.

Community Engagement

Community engagement activities to date include the statewide community resource survey, proposed news release, community forums in target communities and community/organizational readiness assessments in target communities. Please see the *Target Community Identification* and *Model Selection* sections that provide a background on the community engagement to date. The news release is to be released on June 8, 2011 and targeted to the communities at-risk. The news release announces community forums to occur in two, two and one-half hour sessions in each two county area (Kootenai/Shoshone and Twin Falls/Jerome). Targeted communication and public notices will be sent mid-June to organizations who participated in the community resource survey. Regional Early Childhood Coordinating Councils will be assisting with meeting planning and set-up (see Attachment 11 - News release).

The Idaho MIECHV plans to continue to develop relationships at the local level throughout the first year of planning, implementation and evaluation. The MIECHV planning framework depicts proposed organizations and relationships of State and local stakeholders (please see Attachment 1).
Ongoing partnerships and relationship building will be critical to the long-term sustainability and adoption of an evidence-based program. As implementing organizations are identified, there will be ongoing assessment of organization and community needs. In a cyclical process, the Idaho MIECHV program intends to conduct the following activities in partnership with implementing organizations and community partners:

1. Data collection to document community need (such as community resource survey, capacity assessments, focus groups or key informant interviews)
2. Information sharing and consensus building (such as community meetings, teleconferences or conference presentations)
3. Targeted response to identified need (strategic action plan, continued monitoring, and development of tools or training)

The Idaho MIECHV program recognizes the need for ongoing community engagement. The community resource survey, news release and community forums are being employed as community engagement strategies during year 1 of the MIECHV program. The cycle of ongoing community engagement will likely be replicated during years two through five of the MIECHV grant.

Policies and Standards

The Idaho MIECHV program intends to support existing Maternal and Child Health and Early Childhood practices, policies and standards in Idaho.

In conjunction with the evaluation partner, the EC3 Early Childhood Home Visiting Ad Hoc Committee and the EC3 Standards Ad Hoc Committee state standards for home visiting will be developed over time. The state of Idaho or the Idaho MIECHV program has no precedent regarding state standards for home visitors outside of the IDEA Part C, Infant Toddler Program for professionals and paraprofessionals providing early intervention services. The Idaho MIECHV program intends to include the following standards within any implementation agreement. It should be noted that these six standards may change and evolve over time.

1. Frequency and duration of visits

   Idaho MIECHV program subcontractors should provide a plan to provide home visits in accordance with the respective evidence-based home visiting model standards. Additionally, these standards should be of sufficient frequency and duration to develop a trusting relationship between the home visitor and family. At a minimum the plan should:

- Address visits appropriate to family needs. The plan should include at least weekly home visits for the first six (6) months of the family's participation in the program, or a description of modified frequency based on the family's documented needs, circumstances and strengths. The plan for visit frequency should be reviewed every three months for the first year by the home visitor and supervisor and updated every six months during the first year of participation.
- Indicate services will be delivered based on family needs including visits during non-traditional working hours.
- Indicate services will be delivered in the family's home with plans for alternative locations, when appropriate, such as a school, child care setting, or other.

2. Appropriate curriculum for lifecourse stage

Idaho MIECHV program subcontractors should provide a plan to provide home visits in accordance with the respective evidence-based home visiting model standards. These standards should support State Maternal and Child Health priorities, emphasize strengthening protective factors, and recognize appropriate stages in the lifecourse. The curriculum should be interactive, flexible and focus on achievement of family driven goals. Curriculum should be culturally relevant to the home visiting program participants. Below are examples of appropriate topics for each lifecourse period encountered by families in the program:

- <u>Prenatal Visit Period</u>
  - Linkage to appropriate care for mother and child (primary, prenatal, urgent, etc.)
  - Education on impact of substance use (tobacco, alcohol, illicit drug use, etc.)
  - Breastfeeding education and support
  - Linkage to oral health services
  - Nutrition education and fetal growth and development
  - Depression and domestic violence screening and linkage to mental health services
  - Assistance accessing health insurance for mother and child
  - Referral to community resources assistance accessing community resources
  - Information on child development, attachment and newborn care

- <u>Postpartum and Infancy Period</u>
  - Information on home safety including safe sleep, injury and poison prevention and car seat safety
  - Assessment of maternal well-being including physical and mental health
  - Breastfeeding education and support
  - Anticipatory guidance regarding child development and birth spacing
  - Information on child growth and development, attachment and newborn care
  - Information on reportable abuse and neglect and nurturing positive parent-child interactions

- Education on early signs of illness and accessing appropriate levels of health care

- Toddler and Early Childhood
  - Education for age-appropriate behavioral expectations and appropriate discipline for children
  - Establish family-centered goals
  - Conduct family-centered assessments
  - Information about developmentally appropriate activities including promotion of emergent literacy and numeracy skills
  - Guidance through developmental curriculum that supports nurturing and responsive parent-child interactions

- Transition Period
  - Provision of referrals to community resources needed or desired by family
  - Facilitate linkages to community resources
  - Anticipatory guidance related to attainment of education and employment

3. Family recruitment, selection and enrollment

It will be the expectation of MIECHV program subcontractors to collaborate and partner with other community resources to conduct outreach to identify families in need and inform them of available home visiting services. In response to the funding opportunity, applicants will be required to outline a plan for family recruitment, selection and enrollment. The plan should describe specifically how families are recruited, screened, selected and enrolled in services. In their plan, applicants must establish partnerships with community resources for referrals and procedures for referrals from any other home visiting programs available within the service area. Additionally, the plan should describe how the home visiting program will establish referrals with health care providers, child protective services, homeless shelters and early intervention services. Applicants to the funding opportunity should indicate that priority for services will be given to pregnant women, with second priority for women enrolling prior to discharge from hospital at childbirth. The program should indicate plans to enroll women prior to the woman's 24th week of pregnancy. If applicable to the home visiting model, priority for enrollment should be given to the following populations:

- Pregnant woman under 21 years
- Families with prior interaction with child welfare services
- Families with a history of substance abuse
- Family members of the armed services

Participation in home visiting services must be voluntary, and families may withdraw from services at any point in service delivery. Home visiting services for the programs funded by the Idaho MIECHV program may begin prenatally and continue until the child's sixth birthday or kindergarten entry, whichever comes first. The plan should include a plan for timely initiation of services and provision for placement on a waiting list.

4. Home Visiting staff recruitment, selection, training and supervision

The home visiting workforce is comprised of professionals and paraprofessionals with knowledge and skills related to early childhood health and development. Relationships between home visitors and families, as well as relationships between home visitors and program supervisors, are critical in improving participant outcome. Home visitors must develop a strong rapport with participants by building trust over time. Evidence-based home visiting models vary in personnel standards in at least the following areas: recruitment, credentials and training. The MIECHV program personnel standards may also vary slighting from evidence-based home visiting model specific standards.

In the response to the funding opportunity for the MIECHV program, applicants will describe existing staff and outline a plan for recruitment for staff, training and supervision of home visitors. A home visitor should not have a caseload that exceeds 25 families, recognizing model specific standards may be lower than a 25 family caseload. In addition to caseload, the staffing plan should address the following personnel standards:

- Home Visiting Staff Selection:
  - Comportment – home visitors should be hired based on demonstrated competency to engage, establish trust, develop relationships and work with families with diverse backgrounds.
  - Cultural relevance – as necessary, bilingual staff should be available to provide culturally relevant services.
  - Observation – home visitors should be able to observe family functioning, strengths, needs and recognize problems related to substance abuse, domestic violence, child abuse and neglect.
  - Home visitors should understand the importance of confidentiality, privacy and code of ethics related to specific licensures.
  - Home visitors have various backgrounds including social workers, nurses, early childhood educators, psychologist, or other related fields.
  - Home visiting staff must undergo and pass a criminal background check before hire.

- Home Visiting Staff Training
  - Home visiting programs must have a training plan in place to assure compliance with model specific expectations of pre-service and ongoing training, including training of new hires within three months to both organization and model philosophies and goals.

  - Training should promote skill advancement, learning and cooperation among personnel, in addition to providing continuing education requirements for respective professional credentialing standards.
  - The MIECHV program may require additional training related to various topics that will facilitate improvement of home visiting outcomes.
  - Training should include organization and model specific records and data collection and maintenance techniques.
  - Training should include orientation to community resources, referral processes and protocols, and public assistance.

- Home Visiting Supervision
  - Home visiting supervisors should have an *advanced degree* in a health, education or human services field, a *bachelor's degree* in health, education or human services field and two years of experience working with children and families, or an *associate's degree* in health, education or human services field and four years of experience working with children and families.
  - Home visiting supervisors should maintain an appropriate number of supervisees in order to best support personnel in developing competencies and skills, and in accordance with model specific supervisor to supervisee ratios.
  - Home visiting supervisors should provide reflective supervision to home visitors at least twice monthly on an individual level and a minimum of two staff meetings monthly.
  - With home visitors, supervisors should review family records, curriculum, caseload and case complexity and status as the family progresses through the home visiting program.
  - Home visiting supervisors should assess training needs and ensure that supervisees are progressing with required training, conducting performance evaluations and providing case consultation. Supervisors should accompany new home visitors on home visits at least twice within the year of hire and then once annually in subsequent years.

5. Data collection and records

Maintenance of home visiting records should align with the organization's policies related to confidentiality and privacy, with protections for disclosure of confidential information and protocols for grievance procedures. Organizations will describe policies, procedures and practices that assure compliance with applicable privacy laws and regulations, such as HIPAA or FERPA in response to the MIECHV program funding opportunity.

Records should, at a minimum, contain the following:

- Intake information including demographic and contact information
- Release of information including purpose, dates and signatures
- Documentation of consent including dates and signatures
- Referrals made and completed including lack of available resources

- All completed assessments including date and assessor
- Description of services and education with time spent with each service or activity
- Discharge (transition) planning, closure summary, including reason for termination of services

The aforementioned minimum standards outline basic elements of an individual case record. There is recognition that in some cases these elements are not obtainable, for which explanation should always be provided. Additionally, there are a multitude of other elements that may also be kept with an individual case record. Organizations should detail a plan for data collection and management electronically, through an existing management information system or state identified software product. The plan should indicate assurance to collect all data outlined in the Benchmarks Plan (see Benchmarks Plan).

6. Program evaluation

In the response to the funding opportunity to implement evidence-based home visiting for MIECHV program, applicants should describe a plan for ongoing program evaluation which should include the monitoring of program implementation (including model fidelity through continuous quality improvement) and participant outcomes. Evaluation related to program implementation should include a plan to review indicators of model fidelity such as, but not limited to, percentage of completed home visits within appropriate service delivery timeframe, percentage of staff with successful completion of all training requirements or percentage of home visitors with current reflective supervision. These measures indicate program adherence to model and state practice standards.

The plan for evaluation must also include a description of the existing process or plan for assessing participant outcomes throughout service delivery. The plan should describe how home visitors and supervisors will work with families to develop a family-centered plan with goals, outcomes and timeframes. Programs should outline, in the plan, a systematic approach for evaluating progress towards the goals and outcomes including family centered assessments to identify participant strengths and risk factors. Programs should include a standardized process for conducting participant assessment. The evaluation plan should include assessment of family outcomes using appropriate instruments, such as the Life Skills Progression Tool, over time as one indicator of progress toward family-centered goals and child development.

Subcontractors (implementing organizations) will submit data to both the model developer and the state MIECHV program in order to comply with model-specific and MIECHV program reporting requirements. The state standards intend to align with evidence-based home visiting model standards, policies and requirements to the extent possible. In some cases, it is likely that the MIECHV program standards may be more or less rigorous than program standards. Applicants will be required to describe the intention to meet the standards in response to the funding opportunity. Implementing

organizations will be required to report on these standards, which will be incorporated into contract performance metrics bi-annually to facilitate continuous quality improvement and assurance of contract compliance.

The Idaho MIECHV program State lead will facilitate *policy development* at the state and local level to support adherence to home visiting standards with subcontractors. MIECHV program administrators will partner with subcontractors and potential subcontractors to develop a self-assessment to determine adherence to standards and identify existing policies meet the standards. Subcontractors should complete the self-assessment within six months of contract establishment and create a plan to address areas where standards are not being met.

Model Developer Technical Assistance

The Idaho MIECHV program held multiple question and answer calls with the Parents as Teachers national office and the Office of Head Start to inquire about model specific questions, including training and technical assistance. The Idaho MIECHV program intends to schedule ongoing calls with national model developers to coordinate monitoring, training and technical assistance with MIECHV program implementing agencies. Additionally, Parents as Teachers and Early Head Start model developers provided initial approval of the State Plan (please see Attachments 9 and 10).

Early Head Start
The Office of Head Start has established a sophisticated technical assistance system through Early Childhood Knowledge and Learning Center (ECLKC) and the Head Start National and Regional centers, which offer training and technical assistance to local Head Start programs. The technical assistance system has been arranged around the following topics:

- Cultural and Linguistic Responsiveness
- National Center on Health
- Parent, Family, and Community Engagement
- Program Management and Fiscal Operations
- Quality Teaching and Learning
- Early Head Start National Resource Center

It is anticipated that Idaho's MIECHV program will continue to communicate with the Office of Head Start and the Idaho Head Start Collaboration Office regarding Idaho's training and technical assistance needs to assure that subcontractors access appropriate training and technical assistance. Anticipated communications include inquiries related to subcontractor monitoring reports, technical assistance and accessing regional Head Start technical assistance staff expertise to coordinate technical assistance with Early Head Start implementing organizations. The Idaho MIECHV program intends to communicate with the Office of Head Start quarterly, or more frequently as needed.

Parents as Teachers

The Parents as Teachers technical assistance system is designed to support the quality and organizational capacity of Parents as Teachers affiliates, maximizing positive outcomes for children, families and the communities in which they reside, according to the Parents as Teachers Affiliate Plan. Technical assistance has been developed to address several topics:

- Design and Development – foundation for successful replication
- Initial Implementation – quality assurance planning
- Assessment and Refinement – quality validation
- Sustainability – fidelity and avoiding drift

In the Parents as Teachers Covenantal Agreement between Parents as Teachers national office and Parents as Teachers state offices, the national office describes a key function as supporting state offices in fulfilling their essential responsibilities, which include advocacy, collaboration, networking, communication, training and technical assistance, and fidelity and quality. When a state does not have a Parents as Teachers state office, such as Idaho, a regional technical assistance specialist is designated to carry out the state quality assurance activities, including quality validation visits.

It is anticipated that Idaho's MIECHV program will continue to communicate with the Parents as Teachers national office for technical assistance until assignment of a regional Technical Assistance specialist. The MIECHV program will collaborate with the Parents as Teachers national office to plan trainings and coordinate technical assistance for subcontractors that are implementing the Parents as Teachers model. Anticipated communication includes inquiries related to subcontractor's progress in achieving the Parents as Teachers essential elements, coordinating the Foundational and Model Implementation Training, and data collection and management. Idaho MIECHV program intends to communicate with the Parents as Teachers national office or regional Technical Assistance specialist quarterly, or as needed if more frequent.

Timeline for Obtaining Curriculum

The Idaho MIECHV program anticipates subcontracting with organizations with existing capacity to delivery evidence-based home visiting services in target communities and populations. Given the evidence-based home visiting models, the existing home visiting programs are primarily utilizing the Born to Learn ®, Creative Curriculum® and Partners for a Healthy Baby®. It is likely that the potential contractors are utilizing the following curricula:

- Parents as Teachers: Born to Learn ®
- Early Head Start: Creative Curriculum ®, Partners of a Healthy Baby ®

Early Head Start programs are not required to utilize one specific curriculum but define curriculum as child development goal setting, activities to achieve goals, and materials and support needed to achieve the goals. The curriculum utilized by MIECHV implementers adopting the Early Head Start Home-Based

model should be consistent with the Head Start Program Performance Standards and based in child development research and principles.

Training and Professional Development

The Idaho MIECHV program recognizes the importance of training to assure competent service delivery, addressing both model and organization expectations. Training includes pre-service training and ongoing training and professional development. Each home visiting model developer has outlined standards related to personnel training. Subcontractors will be expected to adhere to model-specific standards as well as Idaho MIECHV program required training.

Early Head Start
Head Start Standards for staff qualifications and development outline the content of training that must be provided to home visiting staff. Content for training should be related to:

- structured child-focused home visiting that promotes parents' ability to support the child's cognitive, social, emotional and physical development;
- effective strengths-based parent education, including methods to encourage parents as their child's first teachers;
- early childhood development with respect to children from birth through age three;
- methods to help parents promote emergent literacy in their children from birth through age three, including use of research-based strategies to support the development of literacy and language skills for children who are limited English proficient;
- ascertaining what health and developmental services the family receives;
- working with providers of health and developmental services to eliminate gaps in service by offering annual health, vision, hearing, and developmental screening for children from birth to entry into kindergarten, when needed;
- strategies for helping families coping with crisis; and
- relationship of health and well-being of pregnant women to prenatal and early child development.

Head Start Standards do not specifically outline the number of professional development or training hours required to achieve the standard. The Idaho MIECHV program will partner with subcontractors to identify goals and opportunities for pre-service and ongoing training and professional development for home visiting staff.

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

- Year 1: 20 clock hours of professional development

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

There are various topics for training that may be available to the subcontractors in the state of Idaho. Over time, results of continuous quality improvement activities will likely indicate potential training topics as well. Some topics of training potentially offered through coordination of the Idaho MIECHV program include:

- Screening and referral for domestic violence
- Mandatory reporting: identifying and reporting child abuse and neglect
- Home safety, injury and poison prevention
- Plan, Do, Check, Act Continuous Quality Improvement evaluation

Capacity Development: Staff Recruitment and Retention

As outlined in the Home Visiting Policies and Standards subsection of the Implementation Plan, the home visiting workforce is comprised of professionals and paraprofessionals with knowledge and skills related to early childhood health and development. Relationships between home visitors and families, as well as relationships between home visitors and program supervisors, are critical in improving participant outcome. In response to the MIECHV program funding opportunity, applicants will be required to describe a plan to meet the standards, including a plan to recruit and retain staff. The plans should indicate interviewing techniques employed to identify home visitors, such as role play or case presentation, in order to hire home visiting staff most qualified and able to build trusting relationships with program participants. The plans should outline objectives for staff retention, such as professional advancement and ongoing training. Also the plan should outline a strategy for filling vacancies within 90 days of vacancy.

Early Head Start outlines the expectations for hiring home visitors based on the following qualifications: "Home visitors must have knowledge and experience in child development and early childhood education; the principles of child health, safety, and nutrition; adult learning principles; and family dynamics. They must be skilled in communicating with and motivating people. In addition, they must have knowledge of community resources and the skills to link families with appropriate agencies and services" (Head Start Program Performance Standards 1304.52). The Head Start Program Performance Standards also provide requirements for providing staff training and development as a means to promote staff retention.

Parents as Teachers indicate in the 2011 Quality Assurance Guidelines for Parents as Teachers Affiliates that parent educators have at least a high school diploma or GED and a minimum of two years previous supervised work experience with young children and/or parents. However, it is recommended by Idaho that parent educators have at least a bachelor's or four-year degree in early childhood or a related field. The 2011 Quality Assurance Guidelines describe a hiring priority for parent educators who demonstrate effective communication and interpersonal skills, with a commitment to professional growth.

Plan for Subcontracting

The Idaho MIECHV program intends to award subcontracts to carry out the evidence-based home visiting model. The process of identifying a subrecipient must be in accordance with the Idaho Department of Health and Welfare's contracting policies and procedures as well as the U.S. Department of Health and Human Services Grant expectations for the MIECHV program. The following timeline outlines the major dates anticipated for MIECHV program planning and implementation. Please see also Attachment 12: Draft Timeline for Implementation of the MIECHV program for year 1.

1. June 2011: News release
2. June 2011: Community meetings in target communities
3. July 2011: Capacity assessment in partnership with model developers
4. July – August 2011: Funding opportunity open
5. August 2011: Team review of applications
6. August 2011 – September 2012: Contract with evaluation partner to conduct participatory evaluation and provide technical assistance to subcontractors on data collection, management and analysis
7. September 2011: Award subcontracts to successful applicants
8. September 2011 – September 2012: Implementation of evidence-based home visiting
9. September 2011 – September 2012: Ongoing training, technical assistance, and monitoring

In June and July, 2011 the MIECHV program anticipates partnering with Parents as Teachers National Office and the Idaho Head Start Collaboration Office to further assess community and program readiness to implement the MIECHV program prior to issuing a funding opportunity announcement for local organizations. Model developers will be facilitating a readiness self-assessment for organizations implementing evidence-based home visiting programs in target communities to assess model fidelity, community connectedness, current data collection, continuous quality improvement processes and technological capacity for potential implementation partners. In the target communities, there are currently two Early Head Start home-based programs and two Parents as Teachers programs. Additionally, there are Early Head Start home-based and Parents as Teachers programs in adjacent communities that may be interested in the funding opportunity to expand service areas into the target communities.

In early June, communities were notified of upcoming community meetings to inform stakeholders of the MIECHV funding opportunity through a news release (see Attachment 11). The release announces community meetings to occur within the target communities to introduce the program and inform community members and stakeholders of the MIECHV program. The meetings will take place on:

- June 20th in Kootenai/Shoshone Counties: 10:00am - 12:30pm & 4:00 – 6:30pm, location TBA
- June 27th in Twin Falls/Jerome Counties: 10:00am - 12:30pm & 4:00 – 6:30pm, location TBA

The news release provides a public notice for community members to attend the MIECHV program community meetings. Additionally, public notices will be sent to respondents on the community resource survey in the target communities and surrounding areas. Two community meetings will be held in the two county areas, in the morning and afternoon, in an accessible location for stakeholders in Kootenai and Shoshone counties and Twin Falls and Jerome counties. The Idaho MIECHV program will present information related to the MIECHV program and invite discussion from community members.

In July and August, 2011 a formal request for proposals (RFP) to implement evidence-based home visiting services will be produced and released. The MIECHV program anticipates releasing the funding opportunity via the RFP mid-July. The RFP will be open through mid-August, 2011. Following, the Idaho Department of Health and Welfare's applicants will have the opportunity to submit questions for formal, uniform response throughout the application process. The MIECHV anticipates awarding two sub-contracts in the amount of $175,000 each for year one funding cycle, with a four year project period. The RFP will allow organizations with the capacity to implement Early Head Start home-based or Parents as Teachers evidence-based home visiting models in the target communities to apply.

Applicants will describe a plan to meet the model and MIECHV program expectations in at least the following areas: standards, policies, data collection according to the benchmarks plans, model fidelity and continuous quality improvement. Additionally, the RFP will require applicants to outline staffing and recruitment plans to reach capacity within six months of the contract. RFPs will be reviewed and scored based on weighted criteria on ability to address these areas, according to the Idaho Department of Health and Welfare's scoring protocol. Applicants will describe the intention and capacity to provide evidence-based home visiting services within two communities or partner with organizations to assure both communities have access to evidence-based home visiting programs. The MIECHV program intends to identify and organize a team of interdisciplinary subject matter experts to review and score the RFP applications with training and feedback sessions. The MIECHV program intends to establish a subcontract by mid-September 2011, for a one year period with opportunities for renewal, pending ongoing funding and compliance with contract requirements.

During the first year of program implementation, the MIECHV program intends to identify an evaluation partner to work with the state local contractors to provide guidance for data collection, data analysis and facilitate broad discussions on continuous quality improvement. The evaluation partner will also review the assessment tools, scoring methods, and propose other metrics for measuring progress and success.

Program Supervision

As described previously in the policies and standards subsection of the Implementation Plan, supervisors will be expected to conduct bi-weekly reflective supervision with home visitors. Reflective supervision is considered a best practice for professionals and paraprofessionals working with infants and young children. Reflective supervision provides an opportunity for home visitors to self-reflect and assess, with supervisor support, interactions with families and children, behaviors and feelings to build capacity of

self-awareness. Effective reflective supervision can help home visitors build and maintain strong relationships with families and children to support healthy growth and development.

In Idaho, there is one formal training opportunity for reflective supervision that includes the Endorsement for Infant and Early Childhood Mental Health, support through Idaho Association for Infant, Early Childhood and Mental Health, known as "AIM Early Idaho." It is likely that implementing agencies may not have had formal training in reflective supervision practices prior to implementing the MIECHV program. The MIECHV program intends to assess partnerships and coordinate training opportunities for supervisors to obtain training in reflective supervision. There may be opportunities for training and professional development for supervisors to participate in the AIM Early Idaho Endorsement of Infant and Early Childhood Mental Health.

Estimated Families

Given the Idaho MIECHV program's plan to establish two subcontracts for the first year of MIECHV program implementation, the estimated number of families to be served will vary depending on the successful applicants. It is anticipated that the subcontracts will be in the amount of $175,000 each; however, there are several potential iterations of estimated children served in year 1. For each program, the cost per child varies according to the developmental stage of the program and ancillary services available through the program. Below are estimates of the number of children served by each evidence-based home visiting model during year 1:

Early Head Start
The number of potential program participants is determined by the community need. Programs develop an appropriate budget according to the community need and estimated number of participants. Estimates of the cost per participant in Early Head Start programs range from $8,900 to $12,500. The 2009-2010 Program Information Report indicates that the average salary of home visitors was $27,257.29/year or $13.85/hour. Home visitors may not have a caseload greater than 12 families at a given time. Given the award of $175,000, variability in cost, services, and salaries, it is likely that an Early Head Start subcontractor may serve between 12 – 18 families.

Parents as Teachers
According to the sample first year budget for Parents as Teachers affiliates constructed by the National Office, the cost is $2,915.83 per child, when the average travel in miles per visit is 30. Because of fewer start-up costs, the cost per child decreases in subsequent years to an estimated $2,588.90. Given the contracts will be $175,000, variability in salaries and transportation costs, the sub-award would likely serve approximately 60 participants.

Through their proposed budget, applicants will demonstrate the estimated number of participants that will be enrolled and served within the project period in response to the funding opportunity.

Outreach and Participant Recruitment

Both Parents as Teachers and Early Head Start have the opportunity to define specific participant eligibility, though Head Start Program Performance Standards designate priority to children living in poverty and with developmental disability. In response to the funding opportunity, applicants will outline current and proposed outreach activities to recruit target populations aligned with the model and Idaho MIECHV program target populations. The MIECHV program has identified the following priority populations for enrollment:

- Pregnant women under 21 years old
- Families with prior interaction with child welfare services
- Families with a history of substance abuse
- Family members of the armed services

Early Head Start
Head Start Program Performance Standards outline recruitment expectations (CFR 1305.5) which may include advertisements, news releases, or other forms of outreach to recruit the target population for services. This recruitment process should occur before the beginning of the enrollment year.

Parents as Teachers
In the Parents as Teachers Affiliate Plan, affiliates identify current or proposed recruitment materials, such as print, personal contact, informal meetings, signage, web postings or other. Affiliates should have a clear, written plan for offering and promoting Parents as Teachers services.

Participant Retention Plan

A number of factors contribute to participant retention in home visiting programs. Research indicates that the intensity and duration of programs influence the attrition rates of both staff and participants. As the level of frequency and duration increase, participant engagement and benefits also increase (Center on the Developing Child, 2007 and Daro, D., 2006). In response to the funding opportunity, applicants will describe current and proposed plans for participant retention and plans to monitor participant retention through continuous quality improvement. The MIECHV program intends to work with subcontractors to monitor participant retention, assess retention issues across programs, encourage collaboration between home visiting programs to share challenges and solutions and document successes.

Early Head Start
Participants in Early Head Start develop family partnership agreements that include goals for each family member and are encouraged to participate in roles of leadership in the program. Head Start Program Performance Standards provide for preference for participants as staff vacancies occur.

Parents as Teachers

In the Parents as Teachers Affiliate Plan, affiliates identify strategies to encourage continued participation in services. Some suggested retention and engagement strategies include text or e-mail reminders of upcoming visits, phone or text messages between visits, incentives for completed visits and toys or books appropriate for the topic of the visit. Affiliates should have a clear, written plan for reducing attrition of participants in Parents as Teachers services.

Timeline to Reach Capacity

The MIECHV program estimates that subcontracts will be established by mid-September 2011. Applicants will describe a staffing and recruitment plan in response to the funding opportunity in order to achieve participant and staffing capacity within six months of the contract date. There is recognition that depending on the current organizational capacity there may be challenges in achieving capacity within six months. Idaho MIECHV program Needs Assessment – SIR #1, completed in 2010, indicated that both Early Head Start and Parents as Teachers programs across Idaho maintain waiting lists with hundreds of eligible or interested participants. Potential subcontractors for MIECHV program funding may have existing waiting lists with eligible participants to receive evidence-based home visiting through the MIECHV program, thus time to reach capacity may be shorter.

Early Head Start
Head Start Program Performance Measures indicate that programs must enroll participants on an ongoing basis and maintain a waiting list so that vacancies are filled within an appropriate timeframe.

Parents as Teachers
The Parents as Teachers 2011 Quality Assurance Guidelines outline expectations that programs should collect data related to enrollment and waiting lists. The waiting list should include length of time on waiting list and enrollment date.

Community Resource Coordination

The MIECHV program intends to facilitate community resource partnerships through networking at community meetings, ongoing support and consultation. Community buy-in, strong referral networks and perceived organizational credibility are critical in initial and long-term success of a community-based home visiting program. At the state level, the Idaho MIECHV program has been in the process of cultivating relationships with state administered programs or initiatives, as evidenced in letters of support (Please see Attachments 13-18). There are a number of state level stakeholders that provide critical resources in planning, including relationships with community organizations, training resources and evaluation. The Idaho MIECHV program intends to continue cultivating state level resource networking throughout implementation. The community resource survey conducted by the MIECHV program in March and April of 2011 resulted in an initial snapshot of resources available in communities across the state. Additionally, the 2-1-1 Idaho Careline maintains a repository of local and statewide resources for families and communities. The MIECHV program has extracted a list of resources within each target community.

In response to the funding opportunity for the MIECHV program, applicants will describe existing relationships with community organizations and a plan to cultivate relationships with other community resources. Parents as Teachers and Early Head Start emphasize coordination of services within service areas. Applicants should describe plans for partnering with other home visiting and family support programs within the community. The plans should indicate the process for intake, referral and assurance of non-duplicating services. To the extent possible, applicants should submit letters of support from the following community resources: health care (including primary care providers and/or hospitals), mental health providers, early childhood providers (home visiting, child care, preschools or early interventionist), child welfare, substance abuse prevention providers and education services.

The Idaho MIECHV program intends to make available a number of tools to assist in community network building, including available programs in the 2-1-1 Idaho Careline database, MIECHV program Needs Assessment, and the ZERO TO THREE Home Visiting Community Planning Tool (Schreiber, L, Gebhard, B., Colvard, J., 2011).

Early Head Start

Head Start Program Performance Standards outline expectations of Head Start programs to assist participants in accessing services as well as coordinating services for young children within the state and community. The standards outline the expectation for programs to identify resources within the community for referrals to an array of services including: health, nutrition counseling, substance abuse prevention, mental health, behavioral health, and others. According to Head Start Program Performance Standards, Early Head Start Programs should have outlined channels of communication between the Head Start program and other early childhood programs within a community, in addition to assurance of linkages to appropriate early invention services, as well as implementation of systematic procedures for transitioning children between Early Head Start and other available programs [45 CFR 1304.40(c) (1) and Head Start Act of 2007 – Sec. 645A (b)(5-9;11)], such as other home visiting programs in the community.

Parents as Teachers

Parents as Teachers outlines Community Resource Networks as an Essential Element of the home visiting model. The Essential Elements indicate that "it is essential that at each personal visit, parent educators connect families to resources as needed and then help them overcome barriers to access." Affiliates should outline community resources in the Affiliate Plan, identifying the top five community resources in the Affiliate Plan. The 2011 Quality Assurance Guidelines encourages affiliates to establish working agreements between community agencies to explicitly address connecting participants to specific resources.

Information Systems and Monitoring

Continuous Quality Improvement requires careful monitoring of specific indicators of program and management performance. The Idaho MIECHV program has begun investigation of practice and

performance management software options and intends to continue exploration of available products. The Idaho MIECHV program is partnering with the Bureau of Application Development and Support within the Division of Information Technology to conduct the application analysis. To date, the Idaho MIECHV program has participated in demonstrations for the following products or systems:

- Social Solutions – Efforts to Outcomes
- GoBeyond – Well Family Systems
- Datatude, Inc. – Wise Family
- Redcap

The MIECHV program will continue partnering with the Bureau of Application Development and Support and the Division of Administration to determine the processes, goals and timelines for software product procurement or development.

Prior to releasing the funding opportunity, the Idaho MIECHV program intends to partner with model developers to conduct organizational capacity assessment to investigate a number of factors related to successful model implementation, including data management processes and systems. Idaho MIECHV program subcontractors may be expected to adopt a state identified system if the current management information system does not have the capacity to assess program performance. The MIECHV program recognizes that input and buy-in from subcontractors regarding the management information system is critical for adoption and sustainability of the software product to manage performance and practice.

Early Head Start

Head Start Program Performance Standards require Early Head Start programs to perform a program self-assessment at least annually to ensure compliance with Head Start Program Performance Standards. Early Head Start programs must track service delivery and follow-up data in the Program Information Report, submitted annually to the Office of Head Start. Head Start programs utilize various management information systems with no standard software product.

Parents as Teachers

Parents as Teachers recommends use of Visit Tracker software to track service delivery data, though it is not mandatory. Parents as Teachers Quality Assurance Guidelines outline activities to indicate quality implementation, which can be monitored through a number of different methods.

Monitoring Model Fidelity and Quality Assurance

Idaho MIECHV program understands that there are multiple areas of assessment of model fidelity, including areas both at the state and local level. The Plan for Continuous Quality Improvement outlines the State's approach to monitoring performance and model fidelity. Each program must adhere to model specific standards, as well as MIECHV program standards. The MIECHV program anticipates partnering with the model developer to assure that state monitoring activities can be conducted in conjunction with monitoring conducted by the model developer. Both Parents as Teachers and Early

Head Start conduct quality assurance or monitoring through on-site monitoring visits to grantees/affiliates. As the MIECHV program provides ongoing monitoring and coordinates technical assistance and training, it will be critical to partner with the model developer to align monitoring activities to avoid duplication and to present information in a continuous and integrated manner for subcontractors.

Early Head Start

The Office of Head Start published an updated Monitoring Protocol for FY11, which outlines the monitoring requirements for on-site visits. The Monitoring Protocol provides a framework for review of quality, program management and compliance to the Head Start Program Performance Standards and regulations. The Monitoring Protocol is a tool to measure program compliance outlined in a framework with critical indicators which are meant to assess achievement of objectives for 11 components:

1. Health Services
2. Nutrition Services
3. Safe Environments
4. Transportation Services
5. Disabilities Services
6. Mental Health Services
7. Family and Community Partnerships
8. Education and Early Childhood Development (ECD)
9. Fiscal Management
10. Program Design and Management
11. Eligibility, Recruitment, Selection, Enrollment, and Attendance (ERSEA)

The Office of Head Start expects that Early Head Start programs participate in major on-site monitoring every three years to measure program performance, quality and management against the Head Start Program Performance Standards, and as necessary, in the interim. The Office of Head Start contracts with monitoring teams to conduct on-site monitoring visits.

Parents as Teachers

According to the Covenantal Agreement with Parents as Teachers affiliates, Parents as Teachers National Office intends to conduct quality assurance visits through a Regional Technical Assistance structure to assess compliance with the essential requirements and adherence to the 2011 Quality Assurance Guidelines for Parents as Teachers Affiliates. The quality assurance visits will likely occur on an annual basis or according to program need. Also, according to "Parents as Teachers Fit within State Home Visiting Plans" available on the Parents as Teachers Web site, the National Office provides technical assistance to state level agencies around monitoring, assessing and supporting implementation with fidelity to model and quality assurance maintenance.

Anticipated Challenges and Response to Fidelity and Quality

Idaho's MIECHV program anticipates there to be a number of challenges in achieving model fidelity and quality for its subcontractors. The MIECHV program provides the opportunity to initiate dialogue and strategies around systematic efforts to address home visiting service quality and fidelity. Because of the rural, frontier and independent nature of Idaho's target communities, there will likely be challenges in community and political buy-in, participant recruitment and retention. Additionally, there may be challenges related to reflective supervision, adequate community resources, frequency and duration of home visits, coordinated referrals and data collection.

Home visiting in a frontier community, such as Shoshone county, will require careful monitoring to assure that families receive appropriate frequency and duration of services. The MIECHV program anticipates monitoring challenges through continuous quality improvement, subcontractor reporting requirements and ongoing consultation with subcontractors to overcome barriers. As stated, the MIECHV program will conduct quarterly contract monitoring and submission of required reports every six months. It will be critical to engage an evaluation partner to facilitate assessment of implementation in order to understand processes, barriers and efficiencies across subcontractors.

It is the intention of the MIECHV program to assist subcontractors in building relationships with community partners and resources to establish a common language related to home visiting. There are some resources available at the state level which may be made available to local subcontractors. As an example, the Idaho Association of Infant and Early Childhood Mental Health has adopted a process for professionals in Idaho to obtain an Infant Mental Health Endorsement (I – MHE ®) from the University of Michigan's Association of Infant Mental Health. It will be critical to partner with statewide organizations, such as the Idaho Association of Infant and Early Childhood Mental Health, to cultivate professionals with training to practice reflective supervision. The MIECHV program intends to partner with national model developers to coordinate monitoring visits, technical assistance and training to address issues when changes occur or programs are not meeting Head Start Program Performance Standards or Quality Assurance Guidelines.

Early Head Start

The MIECHV program anticipates that subcontractors implementing the Early Head Start Home-Based home visiting model will be existing Early Head Start program grantees through the Office of Head Start. The Office of Head Start provides training and technical assistance through the Early Childhood Knowledge and Learning Center, regional Head Start Resource Centers and technical assistance staff. The MIECHV program intends to partner with the model developer to access existing monitoring processes, technical assistance, and training opportunities. The MIECHV program intends on partnering with the National Office of Head Start to investigate the feasibility of establishing an agreement to share monitoring reports to efficiently address fidelity and quality issues. Head Start and Early Head Start program grantees participate in significant monitoring every three years with on-site visits from Federal Monitoring teams. In between major monitoring, programs submit risk assessment reporting and participate in technical assistance visits.

Parents as Teachers

Parents as Teachers require affiliates to complete an Affiliate Plan, which outlines the affiliate's intention to adhere to and implement the Essential Elements of Parents as Teachers. Parent as Teachers encourages affiliates and potential affiliates to complete a "Readiness Reflection", a tool developed by the National Office to assess capacity to implement Parents as Teachers model with fidelity prior to implementation. The Idaho MIECHV program intends to partner with the National Model Developer to facilitate completion of these tools prior to funding opportunity announcement to outline potential areas of initial training and technical assistance. As required to maintain ongoing affiliation with Parents as Teachers, programs must complete an annual program self-assessment. Parents as Teachers encourage affiliates to utilize tools for self-assessment to review compliance with the Quality Assurance Guidelines. The Idaho MIECHV program anticipates partnering with the model developer to participate in monitoring activities to assure adherence to Quality Assurance Guidelines and MIECHV program standards.

Collaborative Partners

The Idaho MIECHV program has been working with partners required by Supplemental Information Request #2 to directly express consensus through a memorandum. Since November 2010, the MIECHV program has been meeting with the required consensus partners and presenting information at conferences and meetings as requested. Please find Memorandums of Concurrence within the Appendix I - Memorandums of Concurrence and Letters of Support in Attachment 13-18 from many of the following partners:

- Idaho Children's Trust Fund: Title II - Child Abuse Prevention and Treatment Act (CAPTA)
- Child Welfare – Department of Health and Welfare: Title IV – E and IV – B
- Bureau of Substance Use Disorders, Division of Behavioral Health – Department of Health and Welfare
- Idaho Child Care Program, Division of Welfare Child Care and Development Fund – Department of Health and Welfare
- Idaho Head Start Collaboration Office , Division of Family and Community Services – Department of Health and Welfare
- Early Childhood Coordinating Council, The State Advisory Council on Early Childhood Education and Care
- Infant Toddler Program – IDEA Part C: Department of Health and Welfare
- Developmental Preschool - IDEA Part B: State Department of Education
- Medicaid, Division of Medicaid – Department of Health and Welfare
- Idaho Coalition Against Sexual and Domestic Violence
- Injury Prevention and Surveillance Program – Department of Health and Welfare
- Idaho Department of Corrections
- Idaho Food Stamps Program – Department of Health and Welfare

Participant Outcomes

By implementing evidence-based home visiting programs, the Idaho MIECHV program intends to align program activities with legislatively designated outcomes. Supporting implementation of multiple evidence-based home visiting programs, each with strengths in specific outcome areas, will increase the potential to achieve positive outcomes in multiple benchmark areas. The Plans for meeting Continuous Quality Improvement and Legislatively Required Benchmarks outline the state's intention to monitor implementation processes and participant outcomes. The logic model, goals and objectives outline the intention of the MIECHV program to advance child and family outcomes through high-quality home visiting services. Assessment and response of progress towards improved outcomes will be a primary role of the MIECHV program leadership and evaluation partner.

The Idaho MIECHV program is exploring options for data collection and management with the recognition that programs have model-specific data collection requirements.

Early Head Start
Early Head Start Program grantees are required to submit the annual program data to the Office of Head Start in the form of a Program Information Report. The Early Head Start Programs are required to adhere to Head Start Program Performance Standards annually. Training, data collection and technical assistance provided by the Office of Head Start provide the foundation for achieving participant outcomes.

Parents as Teachers
New and some existing Parents as Teachers affiliates will be required to adhere to the training requirements of the national office, which include attendance at Model Implementation Training and Foundational Training. To assist with annual reporting for model specific requirements, electronic data collection is the preferred data collection method for affiliates. Training, data collection and technical assistance provided by the model developer build the foundation for achieving participant outcomes.

Individual and Family Assessments

The Idaho MIECHV program recognizes the importance of family-centered services, such that services and assessments that are responsive to the family needs are contributing factors to participant outcomes. The proposed MIECHV program policies and standards subsection of the Implementation Plan outlines the expectation that programs provide services according to family needs and assessment results. In response to the funding opportunity, applicants will describe their capacity to provide family-centered services with an emphasis on assessment and data-driven decision making.

Early Head Start
Head Start Program Performance Standards require staff to make observations and deliver ongoing assessments for each child enrolled in Early Head Start. During the initial stages of program participation, families are required to complete a Family Partnership Agreement which includes family goals, responsibilities, timelines and strategies for achieving these goals. If children with identified

developmental delays are enrolled in Early Head Start, the Early Head Start program is required to support the Individual Family Service Plan (IFSP).

Parents as Teachers
In the 2011 Parents as Teachers Quality Assurance Guidelines, core competencies for parent educators are outlined in five major competency areas:

1. Parent educators should practice strength-based family support.
2. Parenting education approach that supports the growth of parents' capacities through research-based methods and principles.
3. Parent educators should demonstrate a respect for diverse needs and characteristics of families
4. Parent educators should understand the influence of varied family systems, culture, school readiness and socioeconomic status in child rearing practices.
5. Parent educators should have the capacity to assess family strengths, needs, culture through observation and assessment to provide family-centered services.

Voluntary Services

The MIECHV program will assure that families receiving home visiting services are participating voluntarily. In response to the funding opportunity, applicants will be required to assure voluntary family participation. Additionally, through ongoing contract monitoring with subcontractors the MIEHCV will assess that home visiting services are provided only to those families volunteering to receive them. Participants may cease participation at any point in program service delivery.

Early Head Start
Participation in Head Start and Early Head Start is voluntary for all children and families.

Parents as Teachers
Participation in Parents as Teachers program is voluntary for all participants.

Maintenance of Effort

As of March 23, 2010 Idaho did not invest State General Funds in early childhood home visitation programs. No funds will be supplanted in the pursuance of the MIECHV program.

Priority Populations

The Idaho MIECHV program intends to assure enrollment of model-specific and MIECHV program priority, target populations through the funding opportunity, CQI efforts and monitoring. Evidence-based home visiting models have been evaluated with very specific target populations. In response to a funding opportunity, applicants will be required to describe current target populations, recruitment and intake methods in accordance with model specific requirements for target populations. Recruitment

methods and intake strategies should be driven by the priority populations to receive services. It is likely that subcontractors will have the opportunity to build referral networks and intake systems to assure enrollment of priority populations. Below are the priority populations for participation in the Idaho MIECHV program, in no specific order:

- Low Income **
- **<u>Pregnant Women</u> ** under 21**
- **History with Child Welfare Services or Child Abuse and Neglect**
- **History of Substance Abuse**
- Tobacco Users
- Parent or Child with Low Academic Achievement
- Children with Developmental Delay**

- **Families of the Armed Services**

Note:
Bold = MIECHV priority populations
** = Early Head Start priority populations
Underlined = Parents as Teachers priority populations

Early Head Start
Head Start Program Performance Standards require that programs recruit and select pregnant women, infants and toddlers to receive Early Head Start Standards. Individual Early Head Start program grantees have the ability to determine specific eligibility requirements for services, with a preference for low-income women, infants and toddlers.

Parents as Teachers
The Parents as Teachers model is designed to serve families throughout pregnancy until their child(ren) enters kindergarten. Affiliates have the opportunity to identify further target populations or eligibility criteria. Affiliates might choose to serve families based on income, parental age, parental education attainment or other. Identification of the population eligible for services should drive recruitment and retention strategies for program affiliates.

Section 5: Plan for Meeting Legislatively – Mandated Benchmarks

Idaho's MIECHV program intends to meet the following performance objectives as outlined below. Between years one and three, the MIECHV program seeks to demonstrate measurable improvement in at least half of the constructs for each of the required benchmark areas. Idaho faces a number of challenges associated with standardized data collection, utilization of administrative data, realizing efficiencies and linking data across-agency. Additionally, some of the construct measures may not be relevant or appropriate measures for the population for which a specific home visiting program is targeted. Because the Idaho MIECHV program will be conducting an RFP process, success of

improvement depends on the relationship and capacity of the state and local contractor to measure and demonstrate improvements. The MIECHV program anticipates facilitating training, technical assistance and support to local contractors in order that adequate resources are available for local contractors. The following outline describes the performance objectives of Idaho's MIECHV program. It should be noted that the ability to collect data and show demonstrable improvement by year 3 on all constructs depends on the models implemented. Each model has a specific target population, such that some constructs may not be relevant or appropriate measures for model target populations. For example, the Parents as Teachers model may be targeting low-risk families with children age 1-5 in a specific community. In this case, maternal and newborn health indicators are not appropriate measures for this population. The measures outlined in the performance objectives and Table 10 – Benchmarks Plan are proposed measures, which may change after grantees are identified. The MIECHV program anticipates collecting data for <u>all</u> constructs for <u>each</u> for the six benchmark areas.

The MIECHV program has begun the process to establish data sharing agreements with state programs for constructs within state administered programs. By meeting with individual program staff to identify data elements, systems and periodicity of reporting, the MIECHV program has been able to incorporate data elements from other state administered programs in the MIECHV program state plan. However, the MIECHV program continues to explore the opportunities for data sharing formally. The MIECHV program anticipates establishing Memoranda of Understanding with other state administered programs such as Child Welfare Title – IV throughout the first year of the program implementation.

Plan for Sampling

The Idaho MIECHV program does not anticipate utilizing a sampling method for the first year of implementation. The Idaho MIECHV program intends to collect data, at a minimum, for all enrolled families for each of the required constructs. The estimated of women, children and families served during the first year is less than 100, which does not merit a sampling method. It would be difficult to establish a sample that might be representative of the entire population served.

Data Collection Schedule

The Idaho MIECHV program created a tool to outline the proposed schedule of data collection for local contractors. Timing of data collection is critical to establishing reliable measurements. Data for each family should be collected at enrollment and at one year of enrollment in program. Each local contractor will be expected to collect construct data on an appropriate timeline given the target population, required screening tools and duration of services. In addition, training will be provided on an annual basis to all home visitors, data support staff and supervisors on data collection integrity, maintenance, and security. Data entry should be completed within four working days of the home visit to assure reliability of data. The MIECHV program recognizes the important balance of data collection burden for home visitors, feasibility of screening tools and collection of adequate detail to assess progress. Local contractors may identify an Information Technology manager (via an additional subcontract) or data support staff to facilitate data entry.

It is critical that the MIECHV program identify an application that is relevant, efficient and allows the appropriate support for users. The MIECHV program is exploring the possibility of an application that allows field data collection and entry via a laptop or tablet. The laptop or tablet would be preloaded with data elements and screening tools for the home visitor with capability for wireless upload into a secure server system. An application would have to allow for offline data collection, local storage and syncing capabilities. It is most likely that the application would be a hosted solution and must be compliant with HIPAA and FERPA requirements. Please see also Section 4 Implementation Plan.

During the first year of program implementation, the MIECHV program intends to identify an evaluation partner to work with the state local contractors to provide guidance for data collection, data analysis and facilitate broad discussions on continuous quality improvement. The evaluation partner will also review the assessment tools, scoring methods and propose other metrics for measuring progress and success.

Data Collection and Analysis Quality

Data collection will occur across programs, as data elements will come from participant, home visitor, to program levels. There are various levels of training that will need to occur in order to assure quality and effective data collection and analysis.

- Front Line Staff: Home visitors or assessment workers will have to be trained on how to effectively gather information through field interview and assessment/screening tools. Each of the standardized screening tools requires some basic training ranging from review of a user's manual to a two day training. Trainings for each respective screening tool must be completed before screening tools are implemented. It is expected that home visitors will spend 10-20 hours a month entering or reviewing data collected in the field. Home visitors will range from paraprofessional to professionals. Each of the screening/assessment tools identified can be administered by both paraprofessional to professionals

- Data Entry: Local contractors may identify staff responsible for data entry and generating some basic reports to support home visitors and supervisors. The data entry staff should attend relevant training for the screening and assessment tools in addition to extensive training in management information system. It is expected that staff dedicated to data entry would spend between 20-50 hours a month entering data, dependent on program size.

- Local Contractor Administration: Supervisors and program administrators should be trained on how to utilize a management information system to effectively conduct continuous quality improvement and outcome analysis for performance management. Additionally, the supervisors should participate in trainings on administration of screening tools in order to guide home visitors through reflective supervision. The supervisors and program administrators should be able to assess data quality for data collected by home visitors and assess trends between home visitors. It is expected the administrators and supervisors spend between 10-25 hours a month on activities related to data collection and management.

- State MIECHV Program Administration: The state MIECHV program is staffed by personnel well versed in data management and analysis. It is expected that the state MIECHV program manager will spend 10-25 hours a month on activities related to data collection, management and analysis. The state MIECHV staff will participate in training for any management information system, data quality, and for screening tools, as necessary. Please see Attachments 22 & 23 key staff resumes and descriptions for staff qualifications.

- Evaluation Partner: The MIECHV program intends to contract with an evaluation partner, possibly a University-affiliated researcher or an independent consultant to partner to work with the state local contractors to provide guidance for data collection, data analysis and facilitate broad discussions on continuous quality improvement. The evaluation partner will be required to commit between 25-35 hours per month to support the MIECHV program. It will be expected that the evaluation partner has extensive background in health, program implementation or evaluation or social science research.

It will be important for the MIECHV program to have access to both aggregate and disaggregate data for data analysis for continuous quality improvement and outcome analysis. In investigating management information systems, the MIECHV program will assure that the identified application has tiered levels of security, each user and role has a specific level of security within the data system. It is critical that an application has the capability to identify data entry and changes by user and role. The application will likely be centrally administered by the state MIECHV program and tiered level or security organized into groups by local contractors. An application should have the ability for the program to aggregate or disaggregate data by community and home visitor.

Demographic and Services Data Collection

The MIECHV program will be required to require local contractors to collect a minimum level of data, where possible, when a referral is received and then at intake. Demographic data such as parent and child age, occupation, race and primary language spoken in the home will be required at intake for families enrolling in the program. Home visitors will be required to document and track referrals made and completed (see Table 10 – Benchmark Area 6). To assess access to services other than the home visiting program to better understand family outcomes.

The following are identified screening tools to be used to measure the constructs defined in Table 10 – Benchmarks Plan. Screening Tools Used: Life Skills Progression Scales, Edinburgh Postnatal Depression Scale, Keys to Interactive Parenting Scale, Protective Factors Survey, Ages and Stages Questionnaire -3, Ages and Stages Questionnaire – Social Emotional

Life Skills Progression Instrument: The LSP was designed to use measures that are helpful in the delivery of program services as well as program evaluation. It is a utilization-focused outcome evaluation tool for families with young children that is as useful clinically to the home visitor as it is for collecting outcome data. The LSP was originally developed in 1998 and has undergone extensive field testing, inter-rater reliability testing, content reliability testing and validity testing. Inter-rater reliability testing demonstrated a 90% reliability of the instrument. In 2002, a content validity study was conducted with

46 multiethnic expert reviewers representing nine disciplines. Alpha scores range between 0.64 and 0.9852, which indicated acceptable to excellent. The LSP training is an 8-hour course designed to establish high inter-rater reliability for cohort data and the home visitor's ability to use the LSP reflectively and to craft reflective questions for a parent that support change in areas of high need. Up to 40 participants can be trained in one session. The cost of training is $2,500 plus LSP monitors 35 parental life skills in these areas:

- Relationships
- Education & Employment
- Parent & Child Health
- Mental Health & Substance Use
- Basic Essentials

Edinburgh Postnatal Depression Scale: The EPDS was designed in 1987 as a simple means of screening for postnatal depression in health care settings. It can also be used by researchers seeking information on factors that influence the emotional well-being of new mothers and their families. The EPDS has undergone numerous reliability and validation studies and refinement to the 10 question scale in use today. The EPDS is in use in numerous countries and has been successfully translated to many other languages. In a community setting, the EPDS is useful in the secondary prevention of postnatal depression by identifying the early onset of depressive symptoms.

Ages and Stages Questionnaires – 3rd Edition and the Ages and Stages Questionnaires – Social-Emotional: The ASQ system was originally developed in the 1970s with the belief that parents are equal partners in assessing child development. The ASQ has been tested for inter-rater reliability and validity numerous times over the corresponding years. Reliability scores are traditionally at 90 percent or higher when comparing parent's scores with health care professional's scores. Additional testing has proven that parents from extremely high risk populations are able to accurately complete the questionnaires on their infants and young children. The ASQ's sensitivity ranges from 70 to 90 percent, and its specificity ranges from 76 to 91 percent. The ASQ-SE was developed in the early 2000s as the emergence for early detection of social and emotional well-being in young children was recognized. The Idaho Infant Toddler Program (IDEA – Part C) utilized the screening tool in the Developmental Milestones to assess children for developmental delay or as at-risk for developmental delay, monitoring and follow-up.

Protective Factors Survey: The Protective Factors Survey began as a project to better assess changes in family protective factors as the focus of community-based child abuse prevention initiatives. The tool was designed to measure multiple protective factors, where prior instruments measured individual protective factors. The survey is designed as a pre- and post-intervention evaluation tool of family change. The PFS is not intended for individual assessment, placement or diagnostic purposes. The Protective Factors Survey is designed to measure multiple protective factors including: Family Functioning/Resiliency, Social Emotional Support, Concrete Support, Child Development/Knowledge of Parenting, and Nurturing and Attachment. The survey has undergone three major field tests. There are 20 items on the Protective Factors Survey, 5 of which assess parents' perception of their own knowledge of parenting and child development. The Protective Factors Survey is a pencil and paper survey. The

survey takes approximately 10-15 minutes to complete. The instrument is divided into two sections, the first section to be completed by a program staff member and the second section to be completed by the program participant. Inter-item reliability measured with Cronbach's alpha estimates range from 0.819 to 0.878. The Idaho Children's Trust Fund (CAPTA – Title II), a key partner of the MIECHV program, is conducting a major Strengthening Families campaign to assess and promote protective factors in families. There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships.

Keys to Interactive Parenting: The Keys to Interactive Parenting Scale© (KIPS) is a 12-item non-standardized observational measure completed by home visitors to assess parenting behaviors. Field tests have demonstrated an inter-rater reliability of 92% among family services providers and an internal consistency of 0.95. Both professionals and paraprofessionals have demonstrated reliability using the KIPS. This scale is broadly used by home visiting programs, including Parents as Teachers and Healthy Families America. Before administering the scale, home visitors or assessment workers must undergo a two-day on site-training with an annual course for recertification. The KIPS takes approximately 20 minutes of observation and 10 minutes to score and has been tested for children ages 2-71 months old. The MIECHV program will assure training is available for local contractors, which includes a two-day, 15 hour training required to utilize the KIPS, with annual recertification for reliability. The approximate costs per training and scale are: $135/learner and $1/screen. The KIPS assesses parenting behaviors on the following scales:

1. Sensitivity of Responses
2. Supports Emotions
3. Physical Interaction
4. Involvement in Child's Activities
5. Open to Child's Agenda
6. Engagement in Language Experiences
7. Reasonable Expectations
8. Adapts Strategies to Child
9. Limits & Consequences
10. Supportive Directions
11. Encouragement
12. Promotes Exploration & Curiosity

Benchmarks and Continuous Quality Improvement

A number of the benchmarks will be utilized for continuous quality improvement, both process and outcome data. Please see Section 7 Plan for Continuous Quality Improvement. After the programs have established a baseline of data for each of the constructs, the MIECHV program intends to partner with local contractors to determine potential benchmarks and goals for each year of the program. Using the Plan, Do, Check Act Method, constructs can be prioritized based on a number of factors with an action plan for achieving improvement on priority constructs. The following is an example of a timeline in conducting a continuous quality improvement at both the local contractor and state level. Conducting a successful continuous quality improvement plan will require partnership from local contractor, state and evaluation partners.

- 0-6 months: Establish a baseline for constructs
- 6-12 months: Assess initial trends for constructs

- 12-18 months: Determine constructs that are priority for improvement, research variables influencing priority construct(s)
- 18-24 months: Introduce training, resources, activities or other strategies to improve construct (s)
- 24-36 months: Assess trends, variables, and performance improvement and set new goals
- 36-38 months: Continue cycle of establishing and assessing constructs for improvement

Data Privacy and Protection

The MIECHV program will assure training is provided on an annual basis to all home visitors, data support staff, and supervisors on data collection integrity, maintenance and security. Parents as Teachers and Early Head Start may require additional training regarding client privacy, rights and ethical conduct. Additionally, the MIECHV program will assure that data and server systems are secure and compliant with state and national privacy requirements, including HIPAA and FERPA. Please see also Section 4 Implementation Plan.

Anticipated Challenges and Barriers to Data Collection

There are many anticipated barriers and changes to data collection for the Idaho MIECHV program and local contractors. Local contractors may not be equipped with sufficient information technology infrastructure to collect all required outcomes for the MIECHV program. Geographic barriers may exist in very rural and frontier areas for in field data collection. Additionally, implementing multiple evidence-based models may introduce barriers in data collection as well. Idaho has few statewide initiatives that broadly utilized one specific screening and assessment tools, therefore there is little existing infrastructure to partner and advance screening and follow-up initiatives. The MIECHV program anticipates requesting technical assistance to assist the state and local contractors to build capacity to collect, maintain and analyze benchmarks and performance data.

Please note that several terms including case files and families may be used interchangeability with other terms. Case files also mean home visiting records or logs or personal visit record. Families, parents and caregivers are often used interchangeably referencing the primary caregiver or the nuclear family unit.

Table 10: Benchmarks, Constructs, Measures and Definitions for all Constructs required for the MIECHV Program

Measure	Definition of improvement	Data Source & Population	When	Justification
BENCHMARK AREA 1: Maternal and Newborn Health				
Construct 1.1: Prenatal Care				
Source: Program, Type: Outcome				
Numerator: number pregnant women enrolled in the program who receive prenatal care by 3rd trimester *Denominator*: number pregnant women enrolled in the program by 3rd trimester	Increase in % enrolled women (pregnant) who receive prenatal by the 3rd trimester	Method: Field Interview Population: Mother Case Files	Women will be asked of status of prenatal care through field interviews within the first month of enrollment or before 27weeks of gestation, whichever is first, until start of third trimester as appropriate	This self-reported measure is not validated, but collected in field interviews with pregnant women as it is relevant, cost-effective and supports other program priorities. Validity and reliability are not known for this measure.
Construct 1.2: Preconception Care				
Source: Program, Type: Outcome				
Numerator: number women (not-pregnant) of childbearing age (ages 15-45 years old) enrolled in the program who regularly take multivitamin (4 or more times per week) *Denominator*: number women (not-pregnant) of childbearing age (ages 15-45 years old) enrolled in home visiting program	Increase in % enrolled women (non-pregnant) regularly taking multivitamin	Method: Field Interview Population: Mother (Women of childbearing age (ages 15-45 years old) Case Files	Women will be asked within for 2 months of enrollment if not pregnant, then every 1 year after. If pregnant, 2 months post-partum and then 1 year after	This self-reported measure assesses women's health and preconception care behaviors. It is relevant, cost-effective to support Title V priorities as there are few standard tools relevant for this measure. Validity and reliability are not known for this measure.
Construct 1.3: Parental Use of Tobacco				
Source: Program, Type: Process				
Numerator: number pregnant women enrolled in the program who smoke referred for smoking cessation any counseling or treatment *Denominator*: number of pregnant women who	Increase in % of referrals for pregnant smokers to cessation or	Method: Review of case files Population: Mother	At intake or anytime pregnancy occurs in service delivery and then throughout pregnancy	This process measure will assess the referrals made by home visitors for smoking cessation counseling or treatment. This may be used as a CQI measure, need to assess available counseling and treatment. Vital Statistics indicates that

Measure	Definition of improvement	Data Source & Population	When	Justification
smoke enrolled in program	treatment	Case Files		smoking throughout entire pregnancies is highest in PHD 1. Validity and reliability are not known for this measure.
Construct 1.4: Inter-birth Intervals				
Source: Program, Type: Process				
Numerator: number mothers and/or fathers of children ages 0 – 2 years old enrolled in the program who receive any education related to optimum birth spacing *Denominator*: total mothers and/or fathers of children ages 0 – 2 years old enrolled in the program (Optimum birth spacing defined as: 2+ years between births)	Increase in % of mothers and/or fathers receiving any education on optimal birth spacing	Method: Review of case files Population: Mother and/or father (caregiver) Case Files	At intake or within 6 months of enrollment, if child is 0-2 years old and then 1 year thereafter	This measure will indicate education related to family planning provided by home visitor when family has a child between 0-2 years old. No standardized tool relevant to inter-birth intervals, specifically. PAT measures family planning using the LSP. Validity and reliability are not known for this measure.
Construct 1.5 Post-Partum Depression (PPD) Screening				
Source: Program, Type: Process				
Numerator: number women screened for post-partum depression using the Edinburgh Postnatal Depression Scale (EPDS) within 6-8 weeks of delivery *Denominator*: number enrolled women within 8 weeks of delivery	Increase in % of women screened for PPD within 8 weeks of delivery using the EPDS	Method: Mother self-report using printed EPDS Population: Mother EPDS results Case Files, positive indication of depression for referral for scores of 12 - 13	At intake, if child is less than one year, or when a women is 6 to 8 weeks post-partum, can be also screened later in post-partum period if needed until infant's first birthday – though will not be included in this measure	The EPDS is widely used to screen for post-partum depression. When indicated with a score of 12 - 13 on the 10-item non-standardized self-report scale, home visitors should refer to further counseling or treatment. The scale can be reproduced at no cost with appropriate citation during publication, is therefore cost effective tool. This process measure will likely be used as a CQI measure for local contractors. Multiple studies have demonstrated validity and reliability of EPDS during pregnancy and prenatally.
Construct 1.6: Breastfeeding				
Source: Program, Type: Outcome				
Numerator: number of women enrolled in the program at or prior to birth through 6 months who predominately breastfeed (where not medically	Increase in % of women predominant	Method: Field interview with mother	This measure would be taken at intake (within first 4 visits) for women	According to the 2009 Idaho PRATS survey, 55.4% of Idaho mothers were breastfeeding at 6 months, with only 32.4% of non-married women compared

Measure	Definition of improvement	Data Source & Population	When	Justification
contraindicated) until infant is 6 months *Denominator*: number of women enrolled in the program at or prior to birth through 6 months Definition of predominately breastfeeding: exclusive breastfeeding for 3-4 months followed by mixed breastfeeding (introduction of complementary liquid or solid foods with continued breastfeeding) to 6 months	breastfeeding for 6 months	Population: Mother Case Files: Interview recorded in case files, there is a possibly of utilizing a food/feeding recall survey	enrolled with children less than 6 months and is breastfeeding at enrollment, or at birth for women enrolled periodically until child reaches six months of age	to 62.5%o of married women and 28.8% of 18-19 year olds. 90.6% of women ever breastfed according to the same survey. PAT utilizes the LSP tool to measure length of breastfeeding; a score of 4 is synonymous to this indicator. EHS measures breastfeeding education. Few standardized tools available for this indicator. Validity and reliability are not known for this measure, however if a breastfeeding practice recall survey is to used, reliability and validity will be considered.
Construct 1.7: Well-child Visits				
Source: Program, Type: Outcome				
Numerator: number of enrolled children who are up to date on the well-child visits according to the Bright Futures – American Academy of Pediatrics (AAP) periodicity of preventive health visits *Denominator*: number children enrolled in the program Definition of well-child visits according to Bright Futures Visits: • 1st week • By 1 month • 2 months • 4 months • 6 months • 9 months • 1 year • 15 months • 18 months • 2 year • 2 ½ year	Increase of % of children attending well-child visits on schedule during enrollment in program according to the Bright Futures – AAP Preventive Visits Guidelines	Method: Field interview with mother Population: Child, mother reporting Case Files: Records of mothers response to interview questions recorded in case files	This self-report measure will be taken at intake (within first 4 visits) and throughout services delivery according to child's age and relevant visits	Idaho Medicaid utilized the Bright Futures – AAP guidelines as the guidance to providers for EPSDT and well-child visit schedule. The First 3 visits and ongoing thereafter, according to the age of child. There are few validated surveys relevant to this measure. PAT utilizes the LSP Health and Medical Care Scale #2 – this would be a score of 5. EHS collects data of up-to-date visits according to EPDST states EPDST schedule. Additionally, this is a Title V priority. Validity and reliability are not known for this measure.

Measure	Definition of improvement	Data Source & Population	When	Justification
• 3 year • 4 year • 5 year Up to date is defined as: completed well child visit within 2 weeks of child's age (before or after) for first two years and then six weeks of age from age two – five years				
Construct 1.8: Maternal Insurance Status				
Source: Program, Type: Process				
Numerator: Number of enrolled uninsured women referred for insurance coverage (DHW – Medicaid, other provider) for application *Denominator*: number of women not insured with credible health insurance	Increase in % of women referred for insurance who do not already have health insurance	Method: Field interview Population: Mother	The self-report of insurance status collected at intake (within first 4 visits) and referral and follow-up made during three months of service	There are few tools to assess insurance status Maternal and Child Health – this is a cost effective and relevant way to measure this indicator. Insurance status is collected by both PAT & EHS using either the LSP or self-report. The MIECHV program is exploring opportunities for utilization of administrative data to assess enrollment in Medicaid over time. Validity and reliability are not known for this measure.
Construct 1.9: Child Insurance Status				
Source: Program, Type: Outcome				
Numerator: number of children enrolled in program with any credible health insurance *Denominator*: number of children enrolled in program Note: *(Idaho definition of creditable health insurance: Coverage that provides benefits for inpatient & outpatient hospital services and physician's medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. IDAPA 16.03.01)*	Increase in % of children with credible health care coverage	Method: Field Interview Population: Child, as reported by caregiver Case Files, record of responses in case file – potential query in Medicaid MIS for Admin. Data	The self-report of insurance status collected at intake (within first 4 visits) and approximately every 3-4 months during service delivery – integrated into assessment of well-child visits	There are few tools to assess insurance status Maternal and Child Health – this is a cost effective and relevant way to measure this indicator. Insurance status is collected by both EHS & PAT during service delivery via self-report of the Life Skills Progression. The MIECHV program is exploring opportunities for utilization of administrative data to assess enrollment in Medicaid over time. Validity and reliability are not known for this measure.

Measure	Definition of improvement	Data Source & Population	When	Justification
BENCHMARK AREA 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits				
Construct 2.1: Child Visits to Emergency Department (ED) all causes				
Source: Program, Type: Process				
Numerator: number enrolled families who receive education about signs of illness, injury or appropriate use of the ED provided within on an appropriate timeline during first year of service delivery *Denominator*: Total number of families receiving service for one year Appropriate timeline defined as: Education should be provided within first 8 months of enrollment for families with children 1-5 years and the first 4 months for children 0-1 year old and should be integrated into assessment of well-child visits	Increase in % of participants to receive education on signs of illness or appropriate use of the ED within first year of service delivery	Method: Case Files, home visit log of activities Population: Caregiver Case Files, as recorded by home visitor	Education regarding illness, injury, and use of ED can occur throughout service delivery, depending on child's age and family needs. This should be assessed every six months	Emergency Department utilization data is especially difficult to assess in Idaho. Idaho does not collect hospital discharge or emergency department data for all hospitals or within in any state data repository. Research indicates that home visiting improves health literary as well as appropriate use of ED, this process measure will assess education provided by home visitors throughout service delivery. This process measure may be used for CQI. The MIECHV program intends to investigate the opportunities for interagency data sharing agreements with local hospitals to obtain ED data. Validity and reliability are not known for this measure.
Construct 2.2: Maternal visits to Emergency Department (ED) all causes				
Source: Program, Type: Outcome				
Numerator: number mothers enrolled in the program with ED visits for any cause during enrollment in the program per calendar year *Denominator*: total number of mothers enrolled in the program during the same period	Decrease in % of mothers who visit the ED for any cause per year	Method: Field Interview Population: Mother Case Files: Self-report by mother tracked in home visit log	This self-reported data collected in field interview with mothers will ask during home visit if they have been to the ED in past six months. Data collected approximately every 5-6 months during service delivery. This should be integrated into assessment of well-child visits	Emergency Department utilization data is especially difficult to assess in Idaho. Idaho does not collect hospital discharge or emergency department data for all hospitals or within in any state data repository. Women will self-report this data as there are few standardized tools to measure this indicator. Additionally, this will be cost effective and relevant to the population served. Validity and reliability are not known for this measure.
Construct 2.3: Injury prevention education				

Measure	Definition of improvement	Data Source & Population	When	Justification
Source: Program, Type: Process – Output				
Numerator: number enrolled caregivers who receive education appropriate to the age of child related to injury prevention during a given time period such as calendar year *Denominator*: the number of enrolled caregivers enrolled during that same time period Injury Prevention defined as education on any the following topics during the appropriate timelines: a. Safe Sleep (0-1 yr) b. Injury Prevention (0-5 yrs) c. Poison Prevention (0-5 yrs) d. Fire Safety (0-5 yrs) e. Car Seat Safety (0-5 yrs), OR f. Home Safety (0-5 yrs)	Increase the % of families who receive education related to injury prevention and child safety in a given time period	Method: Case Files of home visitor activity Population: Caregivers Case Files: Reported by home visitors in home visit log	Education regarding illness, injury, and use of ED can occur throughout service delivery, depending on child's age and family needs. Program administrators should assess this measure every six months	Home safety and injury prevention is a critical component of parent education. Research indicates that home visitors educating families on home safely is associated with decreased incidence of injury and increased health literacy. There are few standardized tools to measure injury prevention education Validity and reliability are not known for this measure.
Construct 2.4: Child Injuries requiring medical treatment				
Source: Program, Type: Process – Input				
Numerator: number of home visitors trained to assess home safety (including injury prevention, environmental hazards, poison prevention, etc.) in a given time period *Denominator*: number of home visitors employed by MIECHV fund for local contractors during same time period	Increase % of trained home visitors on the topic of injury and poison prevention, home safety or child safety in a given time period	Method: Field Interview Population: Mother Case Files: Self-report by mother tracked in home visit log	Local contractor administrative record of staff qualifications and trainings conducted submitted to State annually in reports for contract performance metrics	This input measure will track the capacity of home visitors to present information to families related to injury and poison prevention over time. It is critical that programs have staff equipped to address safety with participants. Without having access to ED discharge data, injuries must be self-reported may not be reliable. Validity and reliability are not known for this measure.
Construct 2.5: Reported suspected maltreatment for children in program				
Source: Administrative, Type: Outcome				
Numerator: number of children enrolled with reported suspected maltreatment for children in the program (allegations that were screened, but not necessarily substantiated), by age	Decrease the % of enrolled children with a suspected child	Method: State Administrative data request	The state MIECHV program will request a data export from the state Child Welfare	The Division of Public Health (MIECHV program) is exploring establishing a data sharing agreement with the Division of Welfare (Child Welfare program). A data sharing agreement would

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: Total number of children enrolled in the program in same given time period	maltreatment report filed over time	Population: Children State data request with FOCUS system	program for children enrolled in the MIECHV program annually to conduct data linkage and analysis	outline allow the MIECHV program to request data exports from the state NCANDS systems (FOCUS), which would include any suspected, substantiated, or first time visits of child abuse and neglect for MIECHV program participants. This is likely the most reliable data source available to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure. If a data sharing agreement is not feasible, the data will be collected via self-report when assessing for well-child visits.
Construct 2.6: Reported substantiated maltreatment for children in program				
Source: Administrative, Type: Outcome				
Numerator: number of children enrolled with reported substantiated maltreatment (substantiated, indicated, or alternative response victim), by age and maltreatment type for children in given time period *Denominator*: Total number of children enrolled in the program in same given time period Data will be collected for these age categories: • 0-12 months • 13-36 months • 37-84 months Data will be collected by type of maltreatment: • Neglect • Physical Abuse • Sexual Abuse • Emotional Maltreatment • Other	Decrease the % of enrolled children with a substantiated child maltreatment over time	Method: State Administrative data request Population: Children State data request with FOCUS system	The state MIECHV program will request a data export from the state Child Welfare program for children enrolled in the MIECHV program annually to conduct data linkage and analysis	The Division of Public Health (MIECHV program) is exploring establishing a data sharing agreement with the Division of Welfare (Child Welfare program). A data sharing agreement would outline allow the MIECHV program to request data exports from the state NCANDS systems (FOCUS), which would include any suspected, substantiated, or first time visits of child abuse and neglect for MIECHV program participants. This is likely the most reliable data source available to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure. If a data sharing agreement is not feasible, the data will be collected via self-report when assessing for well-child visits.
Construct 2.7: First time victims of maltreatment for children in program				

Measure	Definition of improvement	Data Source & Population	When	Justification
Source: Administrative, Type: Outcome				
Numerator: number enrolled children who have substantiated maltreatment, who had no prior maltreatment, during a given time period *Denominator*: number of enrolled children with no prior maltreatment during same time period First time victim defined as: "Had a maltreatment disposition and never had a prior disposition victim" *Note*: Due to a small number of families served, this indicator face small number analysis issues. A more appropriate definition of improvement might be: "lower % of first time victims among home visiting participants compared to health district average of first time victims for children the same age for the same period of time."	Decrease the % of enrolled children with first-time substantiated maltreatment report filed each year, from year 1 to year 3.	Method: State Administrative data request Population: Children State data request with FOCUS system	The state MIECHV program will request a data export from the state Child Welfare program for children enrolled in the MIECHV program annually to conduct data linkage and analysis	The Division of Public Health (MIECHV program) is exploring establishing a data sharing agreement with the Division of Welfare (Child Welfare program). A data sharing agreement would outline allow the MIECHV program to request data exports from the state NCANDS systems (FOCUS), which would include any suspected, substantiated, or first time visits of child abuse and neglect for MIECHV program participants. This is likely the most reliable data source available to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known for this measure. If a data sharing agreement is not feasible, the data will be collected via self-report when assessing for well-child visits.
BENCHMARK AREA 3: Improvements in School Readiness and Achievement				
Construct 3.1: Parent support for children's learning and development				
Source: Program, Type: Outcome				
Numerator: number of parents that demonstrate support for child's learning and development with an average score between 3 – 5 on the Keys to Interactive Parenting Scale (KIPS) or score of 4 or 5 on LSP - scale # 7 in a given time period *Denominator*: number of parents that were observed by home visiting using the KIPS or LSP scale # 7 in a same time period	Increase % of parents scoring 3-5 on the KIPS or scoring a 4 or 5 on LSP - scale # 7 after 12 months of program enrollment	Method: Home visitor observation of parent and child interaction Population: Parent/Caregiver Case files: Assessments will be scored and stored in case files	Home Visitors should begin to observe families interaction over the course of service delivery. Measures should be taken at enrollment (within 4 home visits) or when the child reaches 2 months (if enrolled during pregnancy), and then every six months of program participation thereafter.	This longitudinal indicator aims to assess participant change over time, using a standardized assessment tool. There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships. Early Head Start does not utilize a specific assessment tool for this domain. Parents as Teachers affiliates utilize the Life Skills Progression Instrument as well as the Protective Factors Survey, and the Keys to Interactive Parenting Scale as instruments to assess parenting. The Keys to Interactive Parenting Scale (KIPS) is a 12-item non-standardized observational measure

Measure	Definition of improvement	Data Source & Population	When	Justification
				completed by home visitors to assess parenting behaviors. This scale is broadly used by home visiting programs, including Parents as Teachers and Healthy Families America. The KIPS assesses parenting behaviors on the following scales: 1. Sensitivity of Responses 2. Supports Emotions 3. Physical Interaction 4. Involvement in Child's Activities 5. Open to Child's Agenda 6. Engagement in Language Experiences 7. Reasonable Expectations 8. Adapts Strategies to Child 9. Limits & Consequences 10. Supportive Directions 11. Encouragement 12. Promotes Exploration & Curiosity
Construct 3.2: Parental knowledge of child development				
Source: Program, Type: Outcome				
Numerator: Number of families that score a total of 25 or greater for items 12-16 on the Protective Factors Survey (PFS) *Denominator*: Total number of families who have completed a Protective Factors Survey Number of Protective Factors Survey items 12-16 *Note*: Before subscales can be calculated, all items need to be scored in the same direction such that a higher score reflects a higher level of protective factors. The following items require reverse-scoring: 12, 14, 16.	Increase % of parents improving score on items 12-16 on the PFS after 12 months of program enrollment	Method: Parent report on pages 3-4 paper Protective Factors Survey, home visitor complete pages 1-2 Population: Parent/Caregiver Case files: Assessments will be scored and	Parents should complete the PFS at enrollment and then after one year of program enrollment and every year thereafter until end of service delivery.	This longitudinal indicator aims to assess participant change over time, using a standardized assessment tool. There are many assessment tools that are available to assess knowledge of parenting. The Idaho Children's Trust Fund (CAPTA – Title II) a key partner of the MIECHV program is conducting a major Strengthening Families campaign to assess and promote protective factors in families. There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships. Early Head Start does not utilize a specific assessment tool for this domain. Parents as Teachers affiliates utilize the Life Skills

Measure	Definition of improvement	Data Source & Population	When	Justification
		stored in case files		Progression Instrument as well as the Protective Factors Survey, and the Keys to Interactive Parenting Scale as instruments to assess parenting. This tool is a single instrument that assesses *multiple protective factors* against child abuse and neglect. Additionally, Parents as Teachers affiliates utilize the Protective Factors Survey in a pre-post evaluation method to assess participant change over time. There are 20 items on the Protective Factors Survey, 5 of which assess parents' perception of their own knowledge of parenting and child development. The Protective Factors Survey is a pencil and paper survey. The survey takes approximately 10-15 minutes to complete. The instrument is divided into two sections, the first section to be completed by a program staff member and the second section to be completed by the program participant. Reliability inter-item consistency with Cronbach's alpha estimates ranging from 0.819 to 0.878.
Construct 3.3: Parenting behaviors				
Source: Program, Type: Outcome				
Numerator: Number of parents scoring a 4+ or higher on scale #6 – Discipline on the Life Skills Progression (LSP) Instrument in a given period of time *Denominator*: Total number of parents assessed with scale # 6 of the Life Skills Progression	Increase % of parents scoring 4+ on scale # 6 - Discipline of the – LSP Instrument after 12 months of program enrollment	Method: Home visitor observation of parent discipline techniques Population: Parent/Caregiver Case files: Assessments will	Home Visitor observation with the LSP (with all required scales) should be completed at program enrollment (within 4 visits) and then every six months of program participation thereafter, until the end of service deliver.	This longitudinal indicator aims to assess participant change over time, using a standardized assessment tool. The Life Skills Progression Instrument Scale # 6 – assesses parent discipline, as observed by the home visitor. The Life Skills Progression takes 5-10 minutes to complete and an additional 5 minutes to score.

Measure	Definition of improvement	Data Source & Population	When	Justification
		be scored and stored in case files		There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships. Early Head Start does not utilize a specific assessment tool for this domain. Parents as Teachers affiliates utilize the Life Skills Progression Instrument as well as the Protective Factors Survey, and the Keys to Interactive Parenting Scale as instruments to assess parenting. The LSP is an instrument designed for use by programs serving low income parents of children aged 0-3 years, but it can extend to age 60 months.
Construct 3.4: Parent-Child Relationship				
Source: Program, Type: Outcome				
Numerator: Number of parents scoring a 3.5+ or higher on scale #5 – Nurturing on the Life Skills Progression (LSP) Instrument in a given period of time *Denominator*: Total number of parents assessed with scale # 5 - Nurturing of the Life Skills Progression	Increase % of parents scoring 3.5+ on scale # 5 – Nurturing of the – LSP Instrument after 12 months of program enrollment	Method: Home visitor observation of parent discipline techniques Population: Parent/Caregiver Case files: Assessments will be scored and stored in case files	Home Visitor observation with the LSP (with all required scales) should be completed at program enrollment (within 4 visits) and then every six months of program participation thereafter, until the end of service deliver.	This longitudinal indicator aims to assess participant change over time, using a standardized assessment tool. The Life Skills Progression Instrument Scale # 6 – assesses parent discipline, as observed by the home visitor. The Life Skills Progression takes 5-10 minutes to complete and an additional 5 minutes to score. There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships. Early Head Start does not utilize a specific assessment tool for this domain. Parents as Teachers affiliated utilize the Life Skills Progression Instrument as well as the Protective Factors Survey, and the Keys to Interactive Parenting Scale as instruments to assess parenting. Rigorous testing by independent investigators demonstrates the LSP has high reliability. With training, the inter-rater

Measure	Definition of improvement	Data Source & Population	When	Justification
				reliability runs 78% to 90%
Construct 3.5: Parental Stress or Parental emotional well-being				
Source: Program, Type: Outcome				
Numerator: Number of families that score a total of 30 or greater for items 6-11 on the Protective Factors Survey (PFS) *Denominator*: Total number of families who have completed a Protective Factors Survey Number of Protective Factors Survey items 6-11 *Note*: Before subscales can be calculated, all items need to be scored in the same direction such that a higher score reflects a higher level of protective factors. The following items require reverse-scoring: *8, 9, 11*.	Increase % of parents improving score on items 6-11 on the PFS after 12 months of program enrollment	Method: Parent report on pages 3-4 paper Protective Factors Survey, home visitor complete pages 1-2 Population: Parent/Caregiver Case files: Assessments will be scored and stored in case files	Parents should complete the PFS at enrollment and then after one year of program enrollment and every year thereafter until end of service delivery.	This longitudinal indicator aims to assess participant change over time, using a standardized assessment tool. There are many assessment tools that are available to assess knowledge of parenting. The Idaho Children's Trust Fund (CAPTA – Title II) a key partner of the MIECHV program is conducting a major Strengthening Families campaign to assess and promote protective factors in families. There is currently no state of Idaho standard or tool used to assess parent behavior, skills or parent child-relationships. Early Head Start does not utilize a specific assessment tool for this domain. Parents as Teachers affiliated utilize the Life Skills Progression Instrument as well as the Protective Factors Survey, and the Keys to Interactive Parenting Scale as instruments to assess parenting. This tool is a single instrument that assesses *multiple protective factors* against child abuse and neglect. There are 20 items on the Protective Factors Survey, 6 of which assess parents' perception of their own social and concrete supports, informal supports and tangible services to help cope with stress.
Construct 3.6: Child communication, language, and emergent literacy				
Source: Program, Type: Outcome				
Numerator: Number of enrolled children that score above cutoff on the communication domain of the Ages and Stage Questionnaire – 3 (ASQ – 3)	Decrease the % of children who have scored below cut off	Method: Parent led completion with assistance from home visitor,	Home visitor is to complete the ASQ – 3rd edition ™ with the family at enrollment, if child is	There are numerous standardized assessment tools that can be used for screening children. The Idaho Infant Toddler Program – IDEA Part C implements the ASQ in the developmental

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: Number of enrolled children with completed the communication domain of the Ages and Stage Questionnaire – 3 (ASQ – 3) Note: The ASQ – 3 starter kit in English is approximately $250 and comes with an User's Manual and 21 photocopiable questionnaires	over a given period of time	as needed, to complete the ASQ – 3 Population: Child Case files: Assessments will be scored and stored in case files	greater than 2 months or when a child turns 2 months with appropriate screen and then every four to six months until end of service delivery. If a child is not achieving cutoff, the screens should occur more frequently.	milestones program. Parents can logon to the Department of Health and Welfare website to complete screeners. It is important to align activities with key partners for referral and follow-up in the case of a screen indicating developmental delay. Home visitors will advise parents whenever children according to the ASQ guidelines fall within the close to- or below-cutoff level. The home visitor, with parent consent, will share the ASQ with the child's primary physician. The home visitor will also make a referral to the Infant Toddler Program for any child that indicates further evaluation is necessary. The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. The questionnaires can be completed online, sent home in advance of a visit, or taken on home visits. Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people. The ASQ-3 has been extensively tested for reliability and validity. The sensitivity is 85% and specificity is 85%.
Construct 3.7: Child cognitive skills				
Source: Program, Type: Process - Output				
Numerator: number of enrolled children who have a complete ASQ – 3 screener at least every six months during program participation in a given time period	Increase the % enrolled children with ASQ-3 at	Method: Administrative review of ASQ – 3	Home visitor is to complete the ASQ – 3rd edition ™ with the family	There are numerous standardized screening tools that can be used for screening children. The Idaho Infant Toddler Program – IDEA Part C implements

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: total number of children enrolled in the program in the same time period	least every six months of program participation	assessments in case files Parent led completion with assistance from home visitor, as needed, to complete the ASQ – 3 Population: Parent and child Case files: Review of Home visitor	at enrollment, if child is greater than 2 months or when a child turns 2 months with appropriate screen and then every four to six months until end of service delivery. If a child is below cutoff, the screens should occur more frequently.	the ASQ in the developmental milestones program. It is important to align activities with key partners for referral and follow-up in the case of a screen indicating developmental delay. Home visitors will advise parents whenever children according to the ASQ guidelines fall within the close to- or below-cutoff level. The home visitor, with parent consent, will share the ASQ with the child's primary physician. The home visitor will also make a referral to the Infant Toddler Program for any child that indicates further evaluation is necessary. The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction.
Construct 3.8: Child's positive approaches to learning				
Source: Program, Type: Process - Output				
Numerator: Number of families with children scoring close to- or below-cutoff on the problem solving domain the ASQ – 3 who received information on appropriate learning activities within one month of screen *Denominator*: Number of families with children close to- or below-cutoff on the problem solving domain for the ASQ – 3	Increase in the % of families receiving information on appropriate learning activities within one month of screen	Method: Administrative review of ASQ – 3 assessments in case files Parent led completion with assistance from home visitor, as needed, to complete the ASQ	This process indicator will be reviewed every six months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.	There are numerous standardized assessment tools that can be used for screening children. The Idaho Infant Toddler Program – IDEA Part C implements the ASQ in the developmental milestones program. It is important to align activities with key partners for referral and follow-up in the case of a screen indicating developmental delay. When a child has screen with close to- or below-

Measure	Definition of improvement	Data Source & Population	When	Justification
		– 3 Population: Parent and child Case files: Review of Home visitor case files		cutoff score in the problem solving domain, home visitors should respond provide suggested developmentally appropriate activities to cultivate problem solving skills in subsequent home visits. According to the Home Visiting Evidence of Effectiveness study, both Parents as Teachers and Early Head Start had favorable outcomes related to child development, school readiness and positive parenting practices. This suggests home visitors when adhering to curricula and activities that support child development and school readiness are more likely to have favorable outcomes. This construct could be considered an indicator of model fidelity.
Construct 3.9: Child social behavior, emotional regulation, and emotional well-being				
Source: Program, Type: Outcome				
Numerator: Number of children with a score above cutoff on the Ages and Stage Questionnaire – SE (ASQ – SE) in a given time period *Denominator*: Number of enrolled children with completed the communication domain of the Ages and Stage Questionnaire – 3 (ASQ – 3) in same given time period Note: The ASQ – SE starter kit in English is approximately $195 and comes with an User's Manual and 8 photocopiable questionnaires	Decrease the % of children who have scored below cut off over a given period of time	Method: Parent led completion with assistance from home visitor, as needed, to complete the ASQ – SE Population: Child Case files: Assessments will be scored and stored in case files	Home visitor is to complete the ASQ – SE edition ™ with the family at enrollment, if child is greater than 6 months or when a child turns 6 months with appropriate screen and then every six months until child turns three, then every year thereafter or end of service delivery, whichever occurs first.	There are numerous standardized screening tools that can be used for screening children. The Idaho Infant Toddler Program – IDEA Part C implements the ASQ in the developmental milestones program. It is important to align activities with key partners for referral and follow-up in the case of a screen indicating developmental delay. Home visitors will advise parents whenever children according to the ASQ guidelines fall within the close to- or below-cutoff level. The home visitor, with parent consent, will share the ASQ with the child's primary physician. The home visitor will also make a referral to the Infant Toddler Program for any child that indicates further evaluation is necessary. The Ages and Stages Questionnaire – Social Emotional (ASQ – SE) to an assessment tool to measure children between 3-60 months in the

Measure	Definition of improvement	Data Source & Population	When	Justification
				following seven crucial behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The screen allows the home visitors to quickly recognize young children with behaviors that may need further assessment. Cutoff scores have been arrived through empirical study and can be determined easily. There are screens for 6, 12, 18, 24, 30, 36, 48, and 60 months. Parents/caregivers complete the survey and it's scored by home visitor. Each questionnaire takes 10–15 minutes to complete and just 1-3 minutes to score. Concurrent validity, as reported in percentage agreement between ASQ – SE and concurrent measures, ranged from 81% to 95%, with an overall agreement of 93%. Sensitivity, or the ability of the screening tool to identify those children with social-emotional disabilities, ranged from 71% to 85%, with 78% overall sensitivity.
Construct 3.10: Child's physical health and development				
Source: Program, Type: Outcome				
Numerator: Number of enrolled children that score above cutoff on the gross and fine motor domains of the Ages and Stage Questionnaire – 3 (ASQ – 3) *Denominator*: Number of enrolled children with completed gross and fine motor domains of the Ages and Stage Questionnaire – 3 (ASQ – 3)	Decrease the % of children who have scored below cut off over a given period of time	Method: Parent led completion with assistance from home visitor, as needed, to complete the ASQ – 3 Population: Child Case files: Assessments will	Home visitor is to complete the ASQ – 3rd edition ™ with the family at enrollment, if child is greater than 2 months or when a child turns 2 months with appropriate screen and then every four to six months until child turns three, then every year thereafter or end of service delivery,	There are numerous standardized screening tools that can be used for screening children. The Idaho Infant Toddler Program – IDEA Part C implements the ASQ in the developmental milestones program. It is important to align activities with key partners for referral and follow-up in the case of a screen indicating developmental delay. Home visitors will advise parents whenever children according to the ASQ guidelines fall within the close to- or below-cutoff. The home visitor, with parent consent, will share the ASQ with the child's primary physician. The home visitor will also

Measure	Definition of improvement	Data Source & Population	When	Justification
		be scored and stored in case files	whichever occurs first until end of service delivery. If a child is not achieving cutoff, the screens should occur more frequently.	make a referral to the Infant Toddler Program for any child that indicates further evaluation is necessary. The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. Screens are available at each of the following ages: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 months to assess the following domains: communication, gross motor, fine motor, problem solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction.
BENCHMARK AREA 4: Domestic Violence				
Construct 4.1: Domestic Violence Screening				
Source: Program, Type: Process - Output				
Numerator: number of enrolled families screened for domestic violence using the a standard domestic violence screen (such as: Abusive Behaviors Inventory, Domestic Violence Enhanced Visitation Intervention or Conflict Tactics Scale – Revised) during a given time period *Denominator*: number of enrolled families during same time period	Increase in % of families screened for domestic violence over time	Method: Field interview, self-report Population: Mother – ABI target is females with current or former intimate partners. Case File: Completed ABI will be maintained in home visiting log for scoring, review and follow-up	This self-report inventory will be completed prenatally, or at birth, or on intake if child is older than a newborn (within first 4 visits), whichever occurs first and then every six months later into service delivery until child is 2 years old.	Domestic Violence is a very sensitive subject, which may be difficult for home visitors and participants to address and respond appropriately. There are a number of reliable and valid scales to assess domestic violence. Idaho has not adopted a specific screened to be used in a health care or home setting. One screen the MIECHV programs is exploring is the Abusive Behavior Inventory (ABI) was identified as it is a self-report scale for women or men to complete 30-item scale with 2 subscales that measure the frequency of physical and psychological abusive behaviors. The physical abuse subscale includes 13 items (2 of which assess sexual abuse). The Abusive Behavior Inventory has been assessment for internal consistency: Physical abuse = .70 to .88. Evidence of convergent, discriminant, criterion, and factorial validity.

Measure	Definition of improvement	Data Source & Population	When	Justification
				Parents as Teachers has recently added the Domestic Violence Enhanced Visitation Intervention (DOVE) screening, which includes three prenatal and three postpartum visits. Parents as Teachers is still determining the appropriate training or preparation for parent educators for this promising intervention. Early Head Start does not have a required screening tool. The Idaho Coalition Against Sexual and Domestic Violence (IDVSA) has partnered with the criminal justice system to create the Idaho Domestic Violence Supplement a screening and assessment tool for safety officers. The Idaho MIECHV program is assessing the opportunities to partner with model developers and the IDVSA to identify the most appropriate assessment tool for the programs across the state.
Construct 4.2: Referrals made for families identified with Domestic Violence				
Source: Program, Type: Process - Output				
Numerator: number of enrolled families who received a referral to domestic violence services of those identified as at-risk for domestic violence according to the ABI (following a score of 2.25+ on the ABI) *Denominator*: number of enrolled families who were identified as being at-risk for domestic violence (according to ABI score)	Increase % of families receiving referrals of those "at-risk" for domestic violence services over time	Method: Review of Case Files Population: Families at risk for domestic violence Case File: Documentation of referrals (given & completed) to be maintained in case files	Local contractor and state administrators should review this measure at least every six months. It will also likely be included in an annual report measure submitted by local contractor to state MIECHV program annually to report for contract performance metrics	This process measure will be an important measure in the CQI efforts to assess community networks, partnerships and available resources as well as program performance. The need for accurate and timely documentation is critical in measuring our CQI efforts for this measure. It is hoped that the identified program MIS will produce ticklers when a referral is given and completed. Geographic differences may occur in the data since the resources vary greatly across the state particularly comparing frontier and urban areas. Disparities that exist because of a lack of resources will be addressed at the state and local

Measure	Definition of improvement	Data Source & Population	When	Justification
				level. The state MIECHV program will strategize with local partners methods for establishing needed resources in frontier areas of the state. Validity and reliability are not known for this process measure.
Construct 4.3: Completion of safety plan for families identified with Domestic Violence				
Source: Program, Type: Process - Output				
Numerator: number of enrolled families who complete a safety plan of those identified as at-risk for domestic violence according to the ABI (following a score of 2.25+ on the ABI) *Denominator*: Number of enrolled families who were identified as at-risk for domestic violence (according to ABI score)	Increase in % of families with completed safety plans in place over time	Method: Review of Case Files Population: Families at risk for domestic violence Case File: Documentation of referrals (given & completed) to be maintained in case files	Local contractor and state administrators should review this measure at least every six months. It will also likely be included in an annual report measure submitted by local contractor to state MIECHV program annually to report for contract performance metrics	This process measure will be an important measure in the CQI efforts to assess community networks, partnerships and available resources as well as program performance. The need for accurate and timely documentation is critical in measuring our CQI efforts for this measure. It is hoped that the identified program MIS will produce ticklers when a referral is given and completed. Geographic differences may occur in the data since the resources vary greatly across the state particularly comparing frontier and urban areas. Disparities that exist because of a lack of resources will be addressed at the state and local level. The state MIECHV program will strategize with local partners methods for establishing needed resources in frontier areas of the state. Validity and reliability are not known for this process measure.
BENCHMARK AREA 5: Family Economic Self-Sufficiency				
Construct 5.1: Household Income				
Source: Program, Type: Outcome				
Numerator: number of families with an increased score on the LSP scale #34 – Income after 18 months of enrollment	Increase in % of families showing increased scored	Method: Review of Case Files – LSP Scale #34 over	Home Visitor observation with the LSP (with all required scales) should	This longitudinal outcome indicator will assess a program participant over time, comparing a change in income over time from score of LSP

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: total number of families with a complete LSP Scale #34 in same period of time	on the LSP scale #34 – Income in a given time period	time Population: Families Case File: Completed LSP scored and maintained in case file (electronically or paper)	be completed at program enrollment (within 4 visits) and then every six months of program participation thereafter, until the end of service deliver.	scale #34 – Income at program entry and after 18 months of service. This measure may or may not be influenced by a cohort effect or lost to follow-up. Each of the LSP scales has been independently studied for reliability and validity, thus individual scales can be used without impacting the reliability or validity of the instrument or other scales.
Construct 5.2: Household Benefits				
Source: Program, Type: Process - Output				
Numerator: number of families with an identified need (according to low scores LSP scales #30-35 or other screening tools) referred to benefits program within four months of program participation *Denominator*: number of families with identified need during first four months of program participation Benefits program defined as public benefits programs in this construct a. WIC b. Idaho Food Stamp Program c. Medicaid/SCHIP d. TANF Cash Assistance e. SSI	Increase % of families with identified need referred to benefits programs	Method: Review of Case Files – referrals Population: Families Case File: Home visit logs should be reviewed for referrals made for identified need and time period of referral	Home Visitor observation with the LSP (with all required scales) should be completed at program enrollment (within 4 visits). Local contractors should assess this every six months and may be a CQI measure.	This process indicator is intended to assess the referrals to resources for family identified needs. There may be some challenges to this indicator due to the cultural or political disposition of the population served. It will be critical to understand the barriers to accessing or referring these resources in different areas of the state. The state MIECHV program is exploring the opportunities to sharing de-identified data with other State administered programs to assess utilization of public benefits overtime for MIECHV program participants. Validity and reliability are not known for this process measure.
Construct 5.3: Employment of Adults in Household				
Source: Program, Type: Outcome				
Numerator: number of families with an increased score on the LSP scale #15 – Employment or # 16 – Immigration (only for relevant families) after 18 months of enrollment	Increase in % of families showing increased scored on the LSP scale	Method: Review of Case Files – LSP Scale #15- 16 over time		This longitudinal outcome indicator will assess a program participant over time, comparing a change in income over time from score of #15 – Employment or # 16 – Immigration (only for

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: total number of families with a complete LSP scale #15 – Employment or # 16 – Immigration (only for relevant families) in same period of time	#15 – Employment or # 16 – Immigration (only for relevant families) in a given time period	Population: Families Case File: Completed LSP scored and maintained in case file		relevant families) at program entry and after 18 months of service. This measure may or may not be influenced by a cohort effect or lost to follow-up. Each of the LSP scales has been independently studied for reliability and validity, thus individual scales can be used without impacting the reliability or validity of the instrument or other scales.
Construct 5.4: Education of Adults in Household				
Source: Program, Type:				
Numerator: number of families with an increased score on the LSP scale #12, #13 or #14 (if scale is relevant to population served) Language, <12th Grade Education, and Education after 18 months of enrollment *Denominator*: total number of families with a complete LSP scale #12, #13 or #14 (if scale is relevant to population served) Language, <12th Grade Education, and Education after 18 months of enrollment	Increase in % of families showing increased scored on the LSP scale #12, #13, or #14, Language, <12th Grade Education, and Education (if the scale is relevant to population served) in a given time period	Method: Review of Case Files – LSP Scale #12-14 over time Population: Families Case File: Completed LSP scored and maintained in case file	Home Visitor observation with the LSP (with all required scales) should be completed at program enrollment (within 4 visits) and then every six months of program participation thereafter, until the end of service deliver.	This longitudinal outcome indicator will assess educational attainment for program participant over time, comparing a mean score of LSP scale #12, #13, #14, Language, <12th Grade Education, and Education (if the scale is relevant to population served) at program entry and after 18 months of service. This measure may or may not be influenced by a cohort effect or lost to follow-up. The MIECHV program will work with evaluation partner to identify index or composite scores during year one. Each of the LSP scales has been independently studied for reliability and validity, thus individual scales can be used without impacting the reliability or validity of the instrument or other scales.
Construct 5.4: Health Insurance Status *- see also Construct 1.9 & Construct 1.8*				
Construct 1.9: Health Insurance Status				
Source: Program, Type: Outcome				
Numerator: number of children enrolled in program with any credible health insurance	Increase in % of children with credible health	Method: Field Interview	The self-report of insurance status collected at intake (within first 4	There are few tools to assess insurance status Maternal and Child Health – this is a cost effective and relevant way to measure this indicator.

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: number of children enrolled in program Note: *(Idaho definition of creditable health insurance: Coverage that provides benefits for inpatient & outpatient hospital services and physician's medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. IDAPA 16.03.01)*	care coverage	Population: Child, as reported by caregiver Case Files, record of responses in case file – potential query in Medicaid MIS for Admin. Data	visits) and approximately every 3-4 months during service delivery – integrated into assessment of well-child visits	Insurance status is collected by both EHS & PAT during service delivery via self-report of the Life Skills Progression. The MIECHV program is exploring opportunities for utilization of administrative data to assess enrollment in Medicaid over time. Validity and reliability are not known for this measure.
BENCHMARK AREA 6: Coordination and Referrals for Other Community Resources and Supports				
Construct 6.1: Number families identified for necessary services				
Source: Program, Type: Process				
Numerator: number of enrolled families who have been screened and positively identified for additional services that may be necessary for the family (defined below) during 1st year of service delivery *Denominator*: number of enrolled families in program during same measurement period Necessary services is being defined as any of the following services: • Health care (participants, adults or children, with no regular source of care, which cannot be the ED or urgent care) • Substance Abuse Tx or Counseling (Smoking during pregnancy or score of <3.5 on LSP scale #25 – Tobacco Use) • Mental Health Services (positive Post-Partum Depression screen, EPDS) • SNAP, Heating or Housing Assistance (Have identified needing these services through interview or low scores on Concrete Supports	Increase in % of families screened for ALL necessary services	Method: Administrative Review of Case Files Population: Families Case Files, record of referrals made according to need identified in interviews of screening tools in case file	The home visitor will conduct interviews and screens throughout the first year. This measure should be assessed every six months and may be included in an annual report measure submitted by local contractor to state MIECHV program as a contract performance metric or be used in a CQI process.	A number of sensitive issues are addressed in home visiting programs, it will be critical that the home visitor is trained to effectively administer tools which screen for sensitive topics. Through reflective supervision and performance review supervisors should be assessing home visitors needing additional training or consultation. It will be critical that a management information system have the capacity to track referrals, follow-ups and produce reminders for home visitors in order to assess needs identified through screening and interviews, referrals made and completed. Additionally, it will be important for the MIECHV program to assess local resources in target communities as there may be a hesitance for home visitors to refer families with need if no resource is available. Validity and reliability are not known for this measure.

Measure	Definition of improvement	Data Source & Population	When	Justification
of Protective Factors Survey) • Domestic Violence Services (screened positive on Abusive Behavior Inventory or DOVE Home Visit Program) • Developmental Services (Children identified with potential developmental delay for the following developmental services on ASQ -3 or ASQ – SE Infant Toddler Program(Part C) or Developmental Preschool (Part B))				*Note*: DOVE is a brochure based intervention delivery by public health nurses which aims to prevent and reduce intimate partner violence against pregnant and postpartum women and their infants. The purpose of the study is to test the effect of home visits on reducing domestic violence and improving the lives of pregnant women and their children
Construct 6.2: Number of families receiving referral to necessary referral				
Source: Program, Type: Process				
Numerator: Number of enrolled families who have been identified as needing any necessary services (defined in Construct 6.1) during 1st year of service who receive referral to appropriate service/ *Denominator*: number of families enrolled who have been identified as needing any necessary services during 1st year of service delivery *Note*: The MIECHV considered the following as an indicator: Number of established partnerships to referral sources available in the community for any of the services defined as necessary services. This input, process indicator is particularly important in communities with few available resources of few existing referrals in their resource network. This is not a measure that has validity and reliability measures already associated. Over time, data quality checks will have to occur to informally assess reliability and validity.	Increase in % of families receiving referral following identification of any need	Method: Administrative Review of Case Files Population: Families Case Files, record of referrals made according to need identified in interviews of screening tools in case file	The home visitor will conduct interviews and screens throughout the first year. This measure should be assessed every six months and may be included in an annual report measure submitted by local contractor to state MIECHV program as a contract performance metric or be used in a CQI process.	A number of sensitive issues are addressed in home visiting programs, it will be critical that the home visitor is trained to effectively administer tools which screen for sensitive topics. Through reflective supervision and performance review supervisors should be assessing home visitors needing additional training or consultation. It will be critical that a management information system have the capacity to track referrals, follow-ups and produce reminders for home visitors in order to assess needs identified through screening and interviews, referrals made and completed. Additionally, it will be important for the MIECHV program to assess local resources in target communities as there may be a hesitance for home visitors to refer families with need if no resource is available. Validity and reliability are not known for this measure.
Construct 6.3: Number MOUs within community Service Agencies				
Source: Program, Type: Process				
Numerator: Number of Memorandums of	Increase number	Method: Local	This process indicator will	Both Parents as Teachers and Early Head Start

Measure	Definition of improvement	Data Source & Population	When	Justification
Understanding (MOUs) or other formal agreements with social service, health, or community services organization within the service delivery area (coverage area) at year 3 (or time 2) *Numerator*: Number of Memorandums of Understanding (MOUs) or other formal agreements with social service, health, or community services organization within the service delivery area (coverage area) at year 1 (or time 1)	of MOUs or other formal agreements with social services, health, or community services organization within service delivery area (Ratio >1 indicates improvement)	contractor Administrative Records Population: Local contractor Program Administrative Records (likely a maintain in electronic and paper form)	be reviewed every six months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.	programs have expectations for implementers to cultivate community referral networks. This will be an important measure for CQI for the state MIECHV program to assess the disparities in community resources in different areas of the state. Since the program will be implemented in both rural and frontier areas, there will be interesting opportunities to assess access to resources and participant outcomes. The MIECHV intends to provide significant TA to local contractors as needed to facilitate establishing MOUs with community partners. Validity and reliability are not known for this process measure.
Construct 6.4: Point of contact in agency responsible for connecting with other community-based organizations				
Source: Program, Type: Process - Input				
Numerator: Number of unduplicated community-based organizations with a clear point of contact (defined as: organization name, organization address, contact name and contact phone or e-mail – this could be clinic manager, case worker, intake worker, school counselor, etc.) at year 3 (or time 2) *Denominator*: Number of unduplicated community-based organizations with a clear point of contact (defined as: organization name, organization address, contact name and contact phone or e-mail – this could be clinic manager, case worker, intake worker, school counselor, etc.) at year 1 (or time 1)	Increase number of unduplicated community-based organizations with a clear point of contact over time (Ratio >1 indicates improvement)	Method: Local contractor Administrative Records Population: Local contractor Program Administrative Records (likely a maintain in electronic and paper form)	This process indicator will be reviewed every six months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.	Both Parents as Teachers and Early Head Start programs have expectations for implementers to cultivate community referral networks. This will be an important measure for CQI for the state MIECHV program to assess the disparities in community resources in different areas of the state. Since the program will be implemented in both rural and frontier areas, there will be interesting opportunities to assess access to resources and participant outcomes. The MIECHV intends to provide significant TA to local contractors as needed to facilitate establishing points of contact with community partners. Validity and reliability are not known for this process measure.
Construct 6.5: Number of completed referrals				
Source: Program, Type: Process - Output				

Measure	Definition of improvement	Data Source & Population	When	Justification
Numerator: number of enrolled families who have been referred to any necessary services, (defined in construct 6.1) during 1st year of service who receive appropriate services *Denominator*: number of families enrolled who have been referred to any additional necessary services during 1st year of service delivery	Increase % of completed referrals (families identified with a need, referred and service received) during a given time period	Method: Administrative Review of Case Files Population: Families Case Files, record of responses in case file – potential query for State Admin. Data	This process indicator will be reviewed every six months and submitted to State annually likely to meet contract for performance metrics. This may be a part of the CQI process for more frequent review.	It is important that home visitors follow-up with program participants to assess client's follow-through with a referral. In some cases a participant may or may not want to follow-up on a service. This measure may be used for CQI purposes and to assess the availability of resources in the community. It will be important for the MIECHV program to assess home visitors with the highest success rate of completed referrals for attributes or resources available within a certain community. Validity and reliability are not known for this process measure.

Section 6: Plan for Administration of State Home Visiting Program

Lead Agency

The Idaho Department of Health and Welfare has been designated as the lead agency for the MIECHV program. More specifically, the program will be managed within the Children's Special Health Program (CSHP), Bureau of Clinical and Preventive Services (BOCAPS), Division of Public Health. The Chief of the Bureau of Clinical and Preventive Services serves as the Title V, MCH Director for the state of Idaho. This places the MIECHV program directly within the state's MCH structure. *Please see Attachment 20 for Department Organizational Charts.*

Collaborative Partners

Because Idaho does not have an existing state home visiting program and few existing home visiting programs, the partnership list continues to expand as the program develops. The Idaho MIECHV program concurrency partners have been actively involved throughout the grant development and planning process. As Idaho's state home visiting program is implemented and the system infrastructure develops and matures, we expect our partnerships to expand and become more robust. A listing of public and private partners as of June 2011 can be found in *Attachment 19*. *Please see also Implementation Plan and Draft MIECHV program planning framework in Attachment 1 & 2.*

Overall Management

Jacquie Daniel is the program manager of the Children's Special Health Program and will manage the MIECHV program within the context of other MCH services for children and families. Ms. Daniel will support partnerships, provide budget oversight and manage professional and support staff. Ms. Daniel will assure and support program grant writing and reporting. Ms. Daniel reports directly to the Title V, MCH Director, Dieuwke A. Dizney-Spencer, RN, MHS, who is also the Chief of the Bureau of Clinical and Preventive Services. Ms. Dizney-Spencer will provide support and assure administration of the MIECHV program within the context of the Division of Public Health and Department of Health and Welfare.

The MIECHV program will be directly managed at the state level by Laura DeBoer, MPH, Health Program Manager. Ms. DeBoer will work directly with program implementers, program developers, the concurrency group and other private and public partners as we develop a home visiting infrastructure within the state. Ms. DeBoer will be responsible for assuring program implementation, model fidelity and evaluation. She will also have first level oversight of the program budget. Ms. DeBoer is supported by 0.5 FTE of an administrative assistant. Ms. DeBoer also has access to the MCH Analyst, Mr. Ward Ballard, located in the Bureau of Vital Records and Health Statistics. Job descriptions and resumes for Ms. DeBoer, Ms. Daniel, Ms. Dizney-Spencer and Mr. Ballard can be found in Attachments 22 and 23. Organizational charts for the Department, Division, Bureau and Program can be found in Attachment 20.

Management of the local subcontractors will be identified through a funding opportunity. Ms. DeBoer will work with the subcontractors to assure model fidelity and availability of training and technical assistance resources.

Coordination of Referrals, Assessment and Intake Processes Across Models

At this point, there is not a detailed plan for centralized intake. As the state program develops, coordination of referrals, assessment and intake will be integrated into the system. In the event that two subcontractors are awarded funding opportunities within a single target community, it is the intent of the MIECHV program to facilitate partnerships for referrals and intake processes among subcontractors or partnering organizations.

State and Local Evaluation Efforts

The MIECHV program manager will develop evaluation strategies for the state delivered program(s), as well as assist with the development of an evaluation plan for the systems development work. At the writing of the plan, it has not been confirmed if any Idaho home visiting programs meet the evidence-based criteria. The program manager will work with model developers and program personnel to assure funded programs are adhering to model fidelity. This will be done through contract performance metrics and developer oversight. An independent evaluator will be hired to assess progress towards required benchmarks and the incorporation of federal benchmarks into systems development.

Plans for meeting specific legislative requirements are described below:

- **Well-trained, Competent Staff**: For implemented programs, Early Head Start and Parents as Teachers, the state will work with model developers to secure model specific training for Idaho providers. Training and performance standards will be incorporated into contract performance metrics. The state program will assure provided trainings meet the requirements for evidence-based implementation of the curricula.
- **High Quality Supervision:** The state program will incorporate performance metrics into contracts that monitor supervisor training requirements and standards. The state will work closely with model developers to assure Idaho's evidence-based program supervisors meet national program standards.
- **Organizational Standards:** The state program will incorporate performance metrics into contracts that require subcontractors to meet or exceed organizational standards set forth by the evidence-based model developers. The state will work closely with model developers to assure Idaho's local evidence-based home visiting programs meet national program standards.
- **Referral and Service Networks:** The state program will be working with the home visiting subcontractors in the target communities as well as other stakeholders to establish or strengthen community referral systems. In a broader capacity, the state program will work with the Early Childhood Coordinating Council (EC3) to develop a coordinated and effective statewide referral system for families.

- **Monitoring of Program Fidelity**: The state program will work with program developers to assure grant requirements support complete implementation of evidence-based home visiting models. The state program will provide technical assistance for subcontractors that align with model fidelity. Onsite monitoring visits will also be used to assure fidelity to the model being implemented.

Coordination with other Early Childhood Plans

Throughout the planning process, Idaho's Early Childhood Coordinating Council (EC3) and the State Early Childhood Comprehensive System have been involved. Idaho's Home Visiting State Plan has been aligned with Idaho's Comprehensive Early Childhood Plan 2009 – 2012, to the extent possible. Please see Background and Introduction for further details.

Compliance with Model-Specific Prerequisites

Because Idaho has few home visiting programs and none that are state supported, the state MIECHV program and targeted communities will work closely with model developers to assure fidelity. The greatest implementation challenge may be the development of an adequate data collection system. The Idaho MIECHV program has partnered with model developers throughout the planning process to gather model specific research, tools and resources to support decision making processes. Throughout implementation, there will be ongoing partnership with the model developers to assure that MIECHV program goals, objectives and activities align with model specific requirements. Additionally, the MIECHV program intends to partner with model developers during monitoring processes to assure compliance with model and program requirements.

State Administrative Structure, System Integration and Collaboration

To support the strategies for development and implementation that were set forth in the State Plan submitted in response to the Funding Opportunity Announcement for the MIECHV and expanded here, the state has made several administrative changes. A full time equivalent health program manager position was created to provide direct oversight of the home visiting program. The Children's Special Health (CSHP) program manager is currently committing a minimum of 25% of time to the MIECHV program. The CSHP administrative assistant is supporting the home visiting program at 0.5 of an FTE while the administrative assistant to the bureau is providing 0.25 of an FTE. While the percentage of time committed to home visiting may diminish for some of the support staff as the program develops, the health program manager will remain committed as a 1.0 FTE. While not impacting the home visiting budget, the MCH analyst and the Title V MCH Director are both contributing significant support to the state MIECHV program.

The greatest support to the state home visiting program has been through collaboration with Idaho's EC3, Idaho's Early Childhood Coordinating System. The support to the state program development has been in the form of collaboration and the provision of staff time of VISTA volunteers serving a vista-ship with EC3. The collaboration with the EC3 has been instrumental in integrating home visiting as a viable

component of the early childhood system in Idaho. In March of 2011, the executive council of the EC3 established an ad hoc committee to the council that is charged with integrating home visiting as a strategy that is integrated fully into Idaho's early childhood system (See Attachment 19.) The ad hoc committee will provide a forum for expanding the number of vested entities to participate in development of home visiting programs as one service delivery strategy of Idaho's integrated early childhood system. This structure will provide a mechanism to formalize collaborations that have begun with current and potential partners.

Section 7: Plan for Continuous Quality Improvement

The Idaho MIECHV program recognizes the importance of establishing an ongoing mechanism for evaluating program processes and outcomes to assess performance improvement opportunities, which will enable efficient and effective service delivery to families and monitoring model fidelity. The CQI plan will allow benchmarking of processes and outcomes, data-driven decision-making, adopting location specific policies and practices while adhering to model fidelity, monitoring of implementing organizations' progress towards meeting contractual objectives and scope of work, assessing program implementation and delivery, identifying potential training opportunities and revising organizational processes to meet needs and improve performance.

Implementation of the CQI plan will take place both at the state level and local level. Subcontractors will have contractual obligations to plan and fulfill CQI activities. Each program must adhere to model specific standards, as well as MIECHV program standards. The MIECHV program anticipates partnering with the model developer to assure that state monitoring activities can be conducted in conjunction with monitoring conducted by the model developer. Both Parents as Teachers and Early Head Start conduct quality assurance or monitoring through onsite monitoring visits to grantees/affiliates. Because the MIECHV program will provide ongoing performance monitoring and will coordinate technical assistance and training to the subcontractor, it is critical to partner with model developers in aligning monitoring activities to present information in a continuous and integrated manner and to avoid duplication.

In addition to collaborating with model developers, the MIECHV program plans to assemble a CQI team that will guide assessment and decision-making. The team will consist of key players from all levels of the home visiting program including, but not limited to, a home visitor, a family participant, a home visitor supervisor, an evaluator, program managers, program directors, and model developers. The Idaho MIECHV program understands that having buy-in and participation from all levels of the home visiting program will be instrumental in creating and guiding a culture of quality. Being that CQI will be a new process for the MIECHV program, the program plans on contracting with an evaluator for the duration of the implementation of the program that will assist with CQI activities.

1. Identification of Performance Indicators

A performance indicator is a measure used as a tool that quantitatively describes the degree to which a process or outcome is meeting desired expectations. For the MIECHV program, most of the performance indicators for CQI will align with the data elements for the required benchmark areas. Please see Section 5: Plan for Meeting Legislatively-Mandated Benchmarks for further information about benchmarks.

Some of the indicators that may be assessed during the CQI process include:

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

2. Assessment

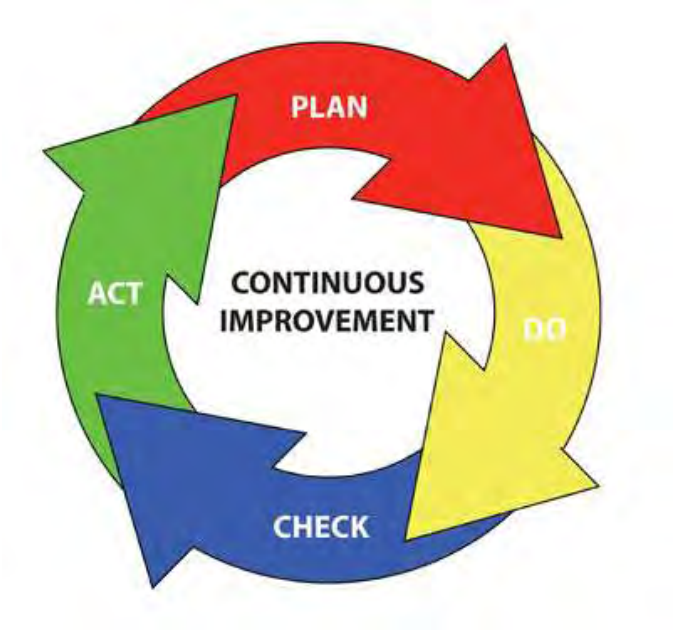
Benchmark data will be collected utilizing a variety of methods including data from enrolled families during home visits, administrative data on participating families from state agency data systems, and operational processes at the state and local levels. Data will be aggregated and analyzed, and assessed for differences between current performance and desired performance based on indicator targets. Data analysis will most likely be built into the data and case management information system utilized by subcontractors, and data will be summarized using programmed report templates. Those processes or outcomes that are not meeting target expectations will be flagged and prioritized for follow-up with Plan-Do-Check-Act process with state/local administrators, model developers and the CQI team.

3. Initiative

Those performance indicators identified as falling short of desired expectations will be considered as opportunities for performance improvement. The MIECHV CQI team will address performance improvement opportunities using the "Plan-Do-Check-Act" framework, which provides a continuous and methodical approach to identify performance problems and possible causes, then outline and prioritize corrective actions. The MIECHV program will provide technical assistance to implementing agencies related to utilizing the PDCA approach for CQI, as well as provide tools to assist in identifying problems and viable solutions. The subcontractor will be required to report on performance indicators, which will be incorporated into contract performance metrics bi-annually to facilitate continuous quality

improvement and assurance of contract compliance. Similar reports will be generated at the state level to monitor programmatic operations. The CQI team will determine which types of reports should be generated and provided to key players to facilitate a culture of quality. Performance interventions will be documented and monitored by the CQI team for improvement in specified processes and outcomes, as well as adherence to model standards.

Plan-Do-Check-Act



4. Evaluation

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

Section 8: Technical Assistance Needs

Currently the home visiting landscape in Idaho is colored by three programs. Idaho has primarily conducted home visiting through early intervention in the Infant Toddler Program (IDEA Part C – ITP), Early Head Start Home-Based and Parents as Teachers. Historically, there have been few centralized efforts to coordinate training and technical assistance opportunities across these models or programs. The Infant Toddler Program early intervention is the only state administered statewide program that offers services through home visiting. Early Head Start Home-Based and Parents as Teachers programs across the state reside in schools, community-based organizations or social service agencies with no

central administering agency in Idaho. Largely, implementing evidence-based home visiting through a state agency as a strategy to address a health, education and social outcomes has not been widely adopted in Idaho.

The MIECHV program anticipates many lessons learned throughout implementation and administration of an evidence-based home visiting program. Idaho's MIECHV program is developing an updated State Plan with the understanding that both the state MIECHV program and subcontractors will need and utilize technical assistance. It is expected that Idaho's MIECHV program will be requesting technical assistance from model developers for model specific training and technical assistance.

State MIECHV Program Anticipated Technical Assistance Needs:

1. Fiscal Leveraging and Cost Analysis of Evidence-based Home Visiting
2. Cross-Model Data Collection, Assessment and Evaluation
3. Stakeholder Development, Communication and Marketing

Local MIECHV Grantee Anticipated Technical Assistance Needs:

1. Continuous Quality Improvement
2. Implementing with Model Fidelity
3. Referral Networks: Building and Tracking Referrals

Given that the newly established Early Childhood Home Visiting Ad Hoc Committee within EC3 is in the infancy of development, the MIECHV program anticipates technical assistance needs related to effective integration of evidence-based home visiting programs into early childhood systems efforts. The newly established Ad Hoc Committee has yet to outline members, goals, objectives and guiding principles. The MIECHV program anticipates participating in this effort, which will assemble stakeholders across home visiting programs, to drive Early Childhood Home Visiting systems development.

Section 9: Reporting Requirements

The Idaho MIECHV program agrees to comply with the legislative requirement for submission of an annual progress report of programmatic activities to the Secretary of Health and Human Services. The annual report will address any revision to, and provide updates on, the following areas:

- Program Goals and Objectives
- Contributions to the ECCS
- Logic Model Changes
- Evaluation to Date
- Implementation in Targeted At-Risk Communities
- Barriers and Challenges in At-Risk Communities
- Work with Model Developer
- Progress Toward Meeting Legislatively Mandated Benchmarks

- Home Visiting Program's CQI Efforts
- Administration of State Home Visiting Program
- Technical Assistance Needs

Citations:

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APPENDIX A: Memoranda of Concurrence

State's Title V Agency

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIEUWKE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-332-7367

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Dieuwke Dizney-Spencer, Chief
Bureau of Clinical and Preventive Services

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 3, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

Dieuwke A. Dizney-Spencer — 3 June 2011

Dieuwke Dizney-Spencer, Chief — Date
Bureau of Clinical and Preventive Services
(Title V Maternal and Child Health Director)

State's Title II – Child Abuse Prevention and Treatment Act Agency

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIEUWKE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Roger Sherman,
Executive Director, Idaho Children's Trust Fund

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 3, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

June 7, 2011

Roger Sherman, Executive Director — Date
Idaho Children's Trust Fund
Title II of the Child Abuse Prevention and Treatment Act

State's Child Welfare Agency

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIERDRE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: 208-334-5530
FAX: 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Shirley Alexander, Program Manager
Children and Family Services Child Welfare

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 2, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

6-7-11

Robert B. Luce, Division Administrator — Date
Child and Family Services
Child Welfare (Title IV-E and IV-B)

State's Single Agency for Substance Abuse Services

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIELWAKE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Kathleen Allyn, Administrator
Division of Behavioral Health

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 2, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

For KPA 6/3/2011

Kathleen Allyn, Administrator
Division of Behavioral Health
(State Agency for Substance Abuse Services)

Date

State's Child Care and Development Fund Administrator

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIEUWKE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Genie Sue Weppner, Program Manager
TANF/Child Care/Community Action Partnership Programs

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 2, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

6/7/11

Genie Sue Weppner, Program Manager — Date
TANF/Child Care/Community Action Partnership Programs
(Child Care and Development Fund Administrator)

State's Head Start Collaboration Office Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG – Director

DIEUWKE SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: 208-334-5930
FAX: 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Carolyn Kiefer, Director
Head Start State Collaboration Office

FROM: Laura DeBoer, MPH
Manager, Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 3, 2011

Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

Carolyn Kiefer, Director
Head Start State Collaboration Office

6/3/11
Date

State's Advisory Council on Early Childhood Education & Care authorized by 642B(b)(1)(A)(i) of the Head Start Act

Received Fax : Jun 08 2011 9:19AM Fax Station : IDHW p. 1

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

DIEUWKE SPENCER - Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State St., 4th Floor
PO Box 83720
Boise, ID 83720-0036
PHONE 208-334-5930
FAX 208-332-7362

Memorandum of Concurrence
Idaho Maternal, Infant, Early Childhood Home Visiting Program

TO: Joan Krosch, Co-Chair
Amber Seipert, Co-Chair
State Advisory Council on Early Childhood Education and Care

FROM: Laura DeBoer, MPH, Health Program Manager
Maternal, Infant, Early Childhood Home Visiting Program

SUBJECT: Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program

DATE: June 7, 2011

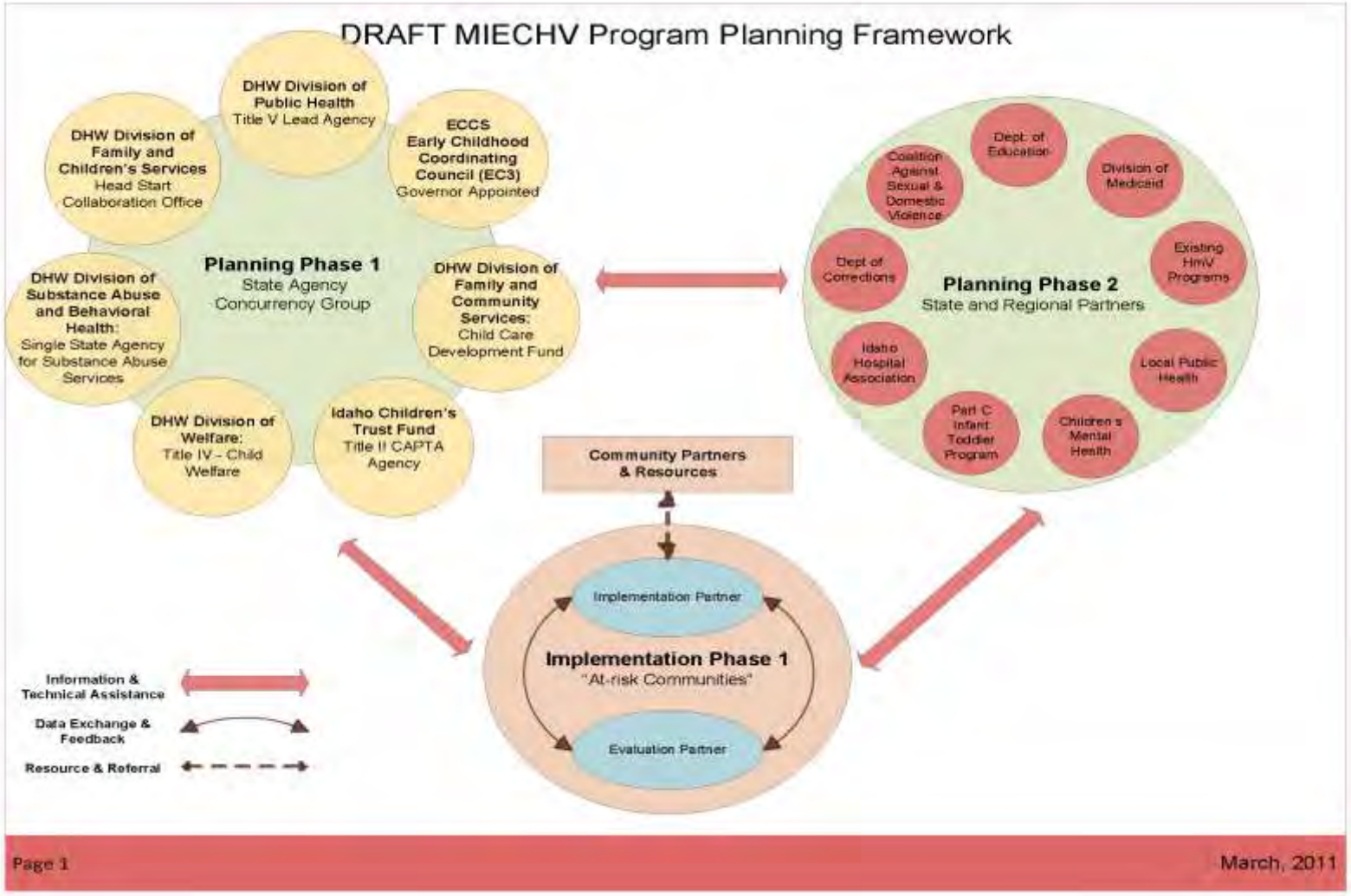
Thank you for your support and participation in the planning process for Idaho's evidence based home visiting program within the Idaho Department of Health and Welfare. Your signature below indicates:

- Commitment to continued collaboration,
- Agreement with implementation of the program, and
- Support of home visiting as part of a continuum of early childhood services.

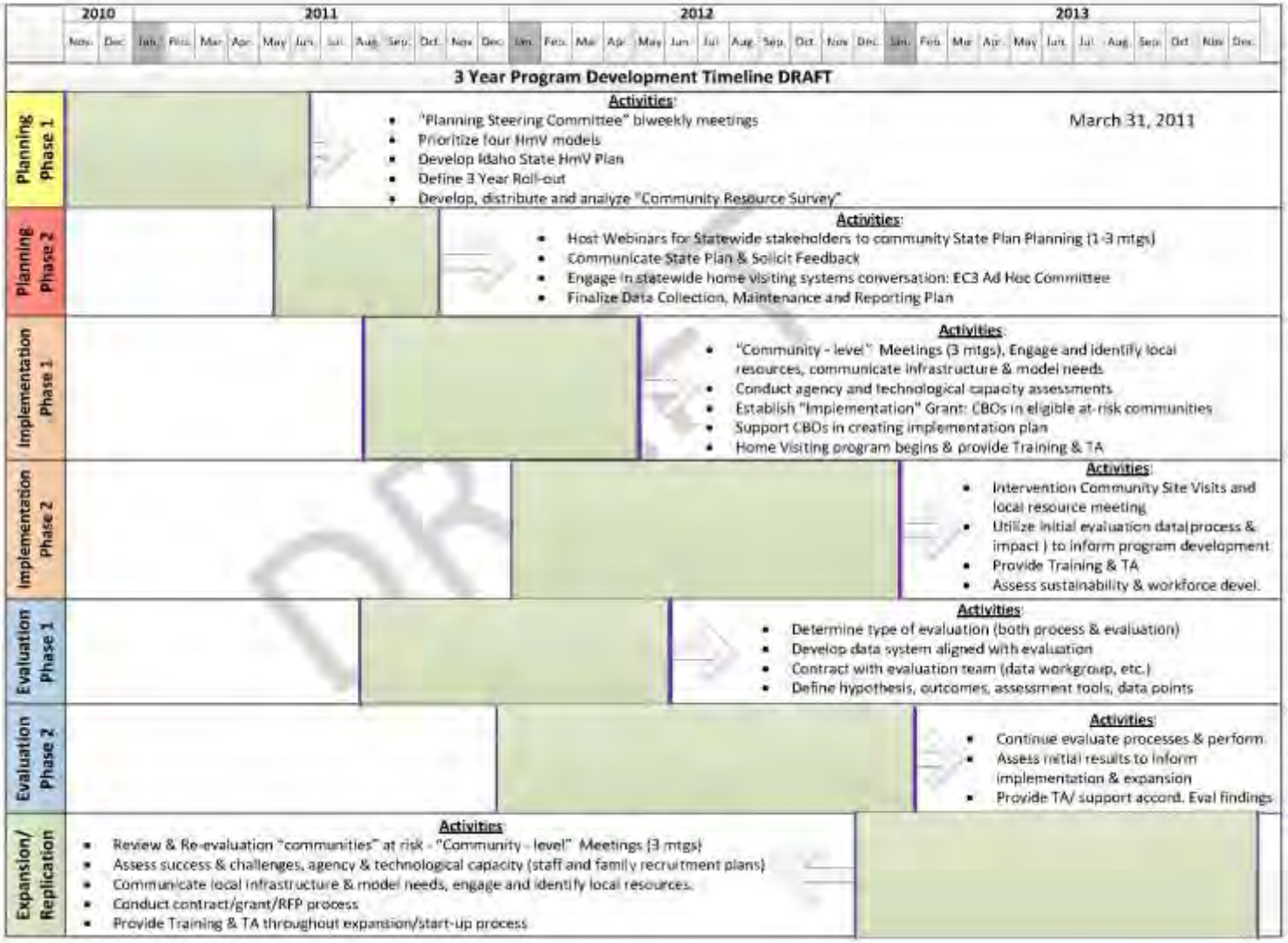
Joan Krosch 6/7/2011
Joan Krosch Date
Department of Insurance, Co-Chair
State Advisory Council on Early Childhood Education and Care
(642B(b)(1)(A)(i) of the Head Start Act)

Amber L Seipert 6/7/2011
Amber Seipert Date
Parent Representative, Co-Chair
State Advisory Council on Early Childhood Education and Care
(642B(b)(1)(A)(i) of the Head Start Act)

ATTACHMENT 1: Idaho's MIECHV Program Planning Framework



ATTACHMENT 2: MIECHV Program Planning Timeline



ATTACHMENT 3: Model Ranking Activity

	NFP	PAT	HIPPY	Triple P	HFA	PCHP	HS/EHS	Safe Care	Incredible Years	Healthy Start	Even Start
Planning • Outcomes • Target Population • Replicability											
Operations • Implementation agencies • Logistics & Capacity											
Workforce Development • Staffing Required • Competency Needed											
Funding • Grant award • Sustainability • Cost per Child											
Collaboration • State & Local Partners • Community Resources • Participant Recruitment											
Communication • State & Local Meetings • Centralized Intake											
Community & Political Support • Culturally Appropriate • Political Relevancy • Sustainability											
Evaluation • Data Systems • Results Utilization • Type of Evaluation											
Notes											
Final Score											

ATTACHMENT 4: Community Resource Survey

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DIEUWKE DIZNEY-SPENCER – Bureau Chief
BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-332-7362

April 7, 2011
Re: Community Resource Survey

Dear Partner Organization,

Idaho's Maternal and Child Health Home Visiting program is conducting a survey to:

1. Collect information on services supporting women, children and families
2. Capture a picture of local resources, community assets, and referral networks
3. Better understand how to support organizations that serve women, children and families

Please take 15 – 20 minutes to complete this survey for your organization, or pass the survey along to the appropriate respondent within your organization. If you believe there are other organizations that could also provide essential information to the survey, please forward this email and attachment those organizations. The survey will be open until April 22, 2011, 5:00 MDT. Your organization's participation is very important to understanding community assets and all responses are appreciated. If you have questions/comments/concerns about the survey or believe you have received this e-mail in error, please contact: Laura DeBoer, Health Program Manager – MCH Home Visiting Program, (deboerl@dhw.idaho.gov) or 208-334-5962. Your time and careful responses are invaluable to the MCH Home Visiting Program and will be shared via the MCH Home Visiting Web page, see additional information at the end of the survey.

When you have completed the survey, please submit the survey to: mchhvsurvey@dhw.idaho.gov.

Many thanks,

Laura DeBoer, MPH
MCH Home Visiting Program
E-mail: DeBoerL@dhw.idaho.gov
Phone: 208.334.0658
Fax: 208.334.4946
Visit us on the Web here

Community Resource Survey
April 2011

When you have completed the survey, please submit the survey to: mchhvsurvey@dhw.idaho.gov.

Organizational Information

Name of Organization:
Name of Respondent:
Job Title of Respondent:
Street Address:
City/Town: State: Zip:
Phone Number:
E-mail Address:
Web Address:

Services

Please indicate which of the following services your organization provides. Service types are listed within topics, but answers are not required for all topics. Please check all that apply (answers may be repeated):

1. Child Development and School Readiness

- ☐ Developmental Disabilities Intervention
- ☐ Developmental Screening
- ☐ Developmentally Appropriate Activities
- ☐ Literacy Activities
- ☐ Social-Emotional Development Support
- ☐ Other: _____

2. Child Health

- ☐ Well Child Visits
- ☐ Immunizations
- ☐ Height/Weight
- ☐ Hearing/Vision/Dental Screening
- ☐ Nutrition Education
- ☐ Developmental Screening
- ☐ Breastfeeding Support
- ☐ Infant & Child Mental Health
- ☐ Other: _____

3. Resources and Coordination of Community Supports

- ☐ Cross-Organizational Partnerships
- ☐ Case Management
- ☐ Referral Tracking and Follow-Up
- ☐ Other: _____

4. Family Economic Self-Sufficiency

- ☐ Adult Literacy Skills
- ☐ Financial Management
- ☐ General Education
- ☐ Job Skills Training
- ☐ Other: _____

5. Maternal Health

- ☐ Alcohol/Tobacco/Substance
- ☐ Breastfeeding Education
- ☐ Mental Health Services
- ☐ Nutrition Education
- ☐ Postpartum Care
- ☐ Postpartum Depression Screening or Treatment
- ☐ Preconception Care
- ☐ Prenatal Care
- ☐ Women's Health Services
- ☐ Other: _____

6. Parenting Skills

- ☐ Parenting Education/Support
- ☐ Nutrition Education
- ☐ Child Development
- ☐ Family Supports/Family Support for Children with Special Health Care Needs
- ☐ Other: _____

7. Child Injuries and Maltreatment

- ☐ Alcohol/Substance Use Counseling or Treatment
- ☐ Behavior Supports/Modification
- ☐ Car Seat Safety
- ☐ Child Protection
- ☐ Child Sexual Abuse Education
- ☐ Emergency or Crisis Day Care
- ☐ Home Visiting
- ☐ Injury Prevention Education

☐ Parenting Support or Education
☐ Risk Assessment or Home Safety
☐ Other: _____

8. Crime or Domestic Violence

☐ Anger Management
☐ Substance Abuse
☐ Supportive Services
☐ Legal Services
☐ Counseling or Mental Health Services
☐ Shelter or Emergency/Crisis Care
☐ Other: _____

Population Served

9. **In 2010**, how many **families** did your organization serve (Unduplicated count, if possible)?
Number ☐ Don't know (don't track families) ☐ We don't serve families

10. **In 2010**, how many **children** *(0-5 years old)* did your organization serve (Unduplicated count, if possible)?
Number ☐ Don't know (don't track children 0-5) ☐ We don't serve children (0-5 years)

11. Which of the following categories best describes your organization's current service area?

☐ Statewide
☐ Multiple counties
☐ One entire county
☐ Part of one county
☐ One community
☐ Other, please specify:

List Areas Served (towns, counties, etc.)	# People (*all clients*) Served in Areas Listed

12. Using the numbers 1 to 3, **rank your organization's top 3** target populations, one being highest priority target:

Population	Rank
Caregivers / parents	
Children birth – 5 years	
Children in foster care	
Children of incarcerated parents	
Children with special needs	
Low income families	
Migrant families	
Pregnant women	
Refugees	
Unemployed	
Other, please specify:	

13. What are the **main** eligibility requirement(s) to receive services from your organization? (Please select no more than two)

☐ Age of child
☐ At-risk as determined by assessment
☐ Court mandated
☐ Developmental delay
☐ Education level
☐ Employment status
☐ English language learners
☐ Income
☐ Medically necessary
☐ Prenatal
☐ Single parent

☐ Teen parent ☐ No eligibility requirements ☐ Other, please specify:

Organizational Capacity

14. **On average**, how long do client families or individuals) receive services from your organization? (Please choose only one)
    - ☐ 1 time
    - ☐ < 6 months
    - ☐ 6 – 12 months
    - ☐ 1 – 2 years
    - ☐ 2 + years
    - ☐ Don't know
15. In your entire organization, what is the total number of full time equivalent (FTE) staff employed (best estimate)?
16. Of those full time equivalents (FTE), how many are direct service staff (best estimate)?
17. How does your organization maintain client and administrative information? (Select one response per column)

Client	Administrative
☐ Electronic Files	☐ Electronic Files
☐ Paper Files	☐ Paper Files
☐ None	☐ None
☐ Not Applicable	☐ Not Applicable
☐ Other, please specify:	☐ Other, please specify:

Community Connections

18. Does your organization currently provide home-based services for children & families? ☐ Yes ☐ No ☐ Not Sure
19. Within the past ten years, has your organization provided home-based services for pregnant women and children? ☐ Yes ☐ No ☐ Not Sure

Evidence-based: An independent researcher has demonstrated the program has positive results for families and children by conducting a randomized control trial, including research that has been published in a peer reviewed journal. To meet this definition, the program must include stringent standards for program replication including standards for implementation and monitoring to ensure that the program is being operated with fidelity to the original model.

20. Does your organization currently implement or utilize any evidence-based programs or curriculum? *(Please see the general definition of evidence-based)* ☐ Yes ☐ No ☐ Not Sure

20a. If YES for 20, please indicate if your organization utilizes any of the following evidence-based home visiting programs:

☐ Early Head Start
☐ Family Check-Up
☐ HFA
☐ Healthy Steps
☐ Home Instruction for Parents of Preschool Youngsters (HIPPY)
☐ Nurse Family Partnership
☐ Parents As Teachers
☐ None of the Above
☐ Other (please specify): _____

20b. **If YES for 20 and NONE for 20a**: Please list the evidence-based programs, practices or curriculums utilized:

21. When thinking about referrals, please indicate the top three sources, from which your organization receives referrals from and sends referrals to, 1 indicating the most referrals:

Referrals From	Referrals To	Client Referral for Your Organization
		Child Care
		Child Protective Services
		Court Ordered/Mandated
		Community Action Agency
		Department of Health and Welfare Regional Office
		Doctor's Office
		Faith Based Organization
		Head Start Program
		Local Public Health District
		Hospital
		Infant Toddler Program
		Mental Health or Counseling Services
		Other Program Participant/Service Recipient
		School Districts
		Self-Referred (i.e. Walk-In)
		WIC

Referrals From	Referrals To	Client Referral for Your Organization
		2-1-1 Careline
		None
		Other (please specify)

22. Considering the communities your organization serves, which of the following would you consider as insufficient or gaps AND duplications in available service. (Select no more than 4 of each)

GAPS	DUPLICATIONS	Service Area
☐	☐	Affordable Housing
☐	☐	Child Care
☐	☐	Family Support/Education
☐	☐	Internet Access
☐	☐	Mental Health
☐	☐	Prenatal Care
☐	☐	Preschool/Early Education
☐	☐	Primary Health Care
☐	☐	Public Transportation
☐	☐	Specialty Health Care
☐	☐	Substance Abuse/Recovery Services
☐	☐	None
☐	☐	Other (please specify)

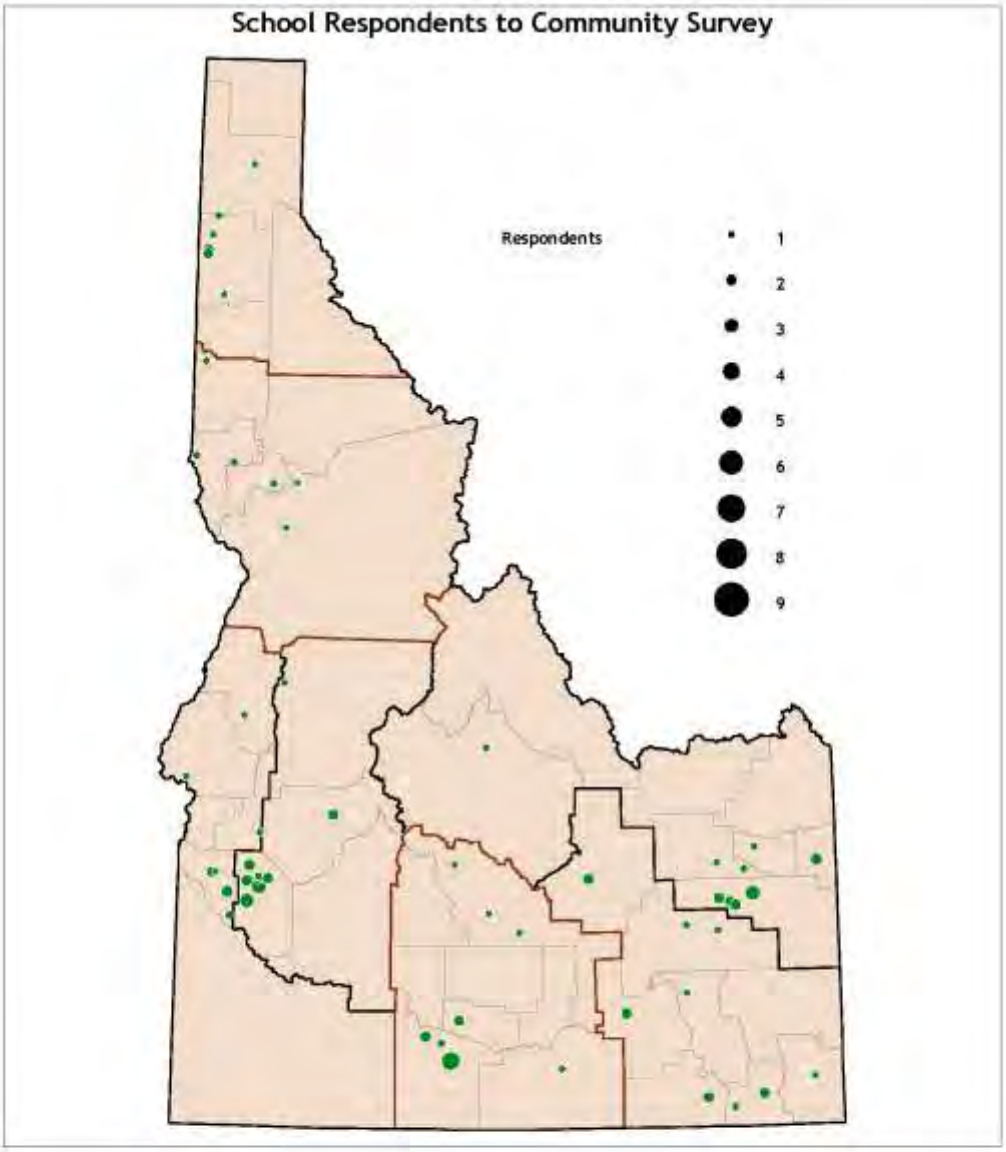
23. Considering your organization, please identify two strengths and two limitations. Select no more than 2 of each.

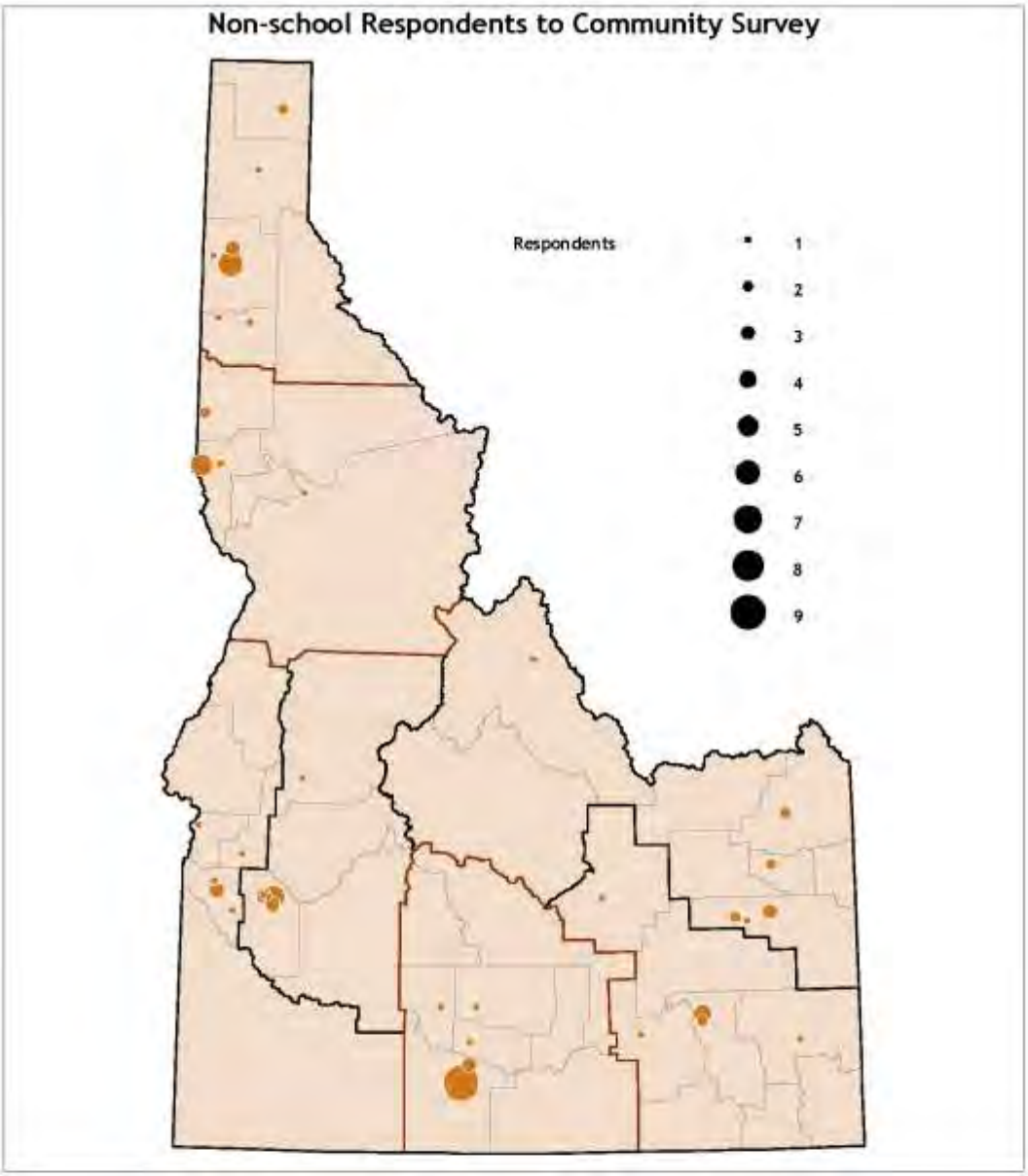
STRENGTHS	LIMITATIONS	Your Organization/Agency
☐	☐	Adequate funding
☐	☐	Affordability of Services
☐	☐	Client Base
☐	☐	Credibility in Community
☐	☐	Geographical Coverage/Reach
☐	☐	Program/ Service Standards
☐	☐	Quality of Services
☐	☐	Service Capacity
☐	☐	Staff Capacity
☐	☐	Visibility
☐	☐	None
☐	☐	Other (please specify)

Please submit the survey to: mchhvsurvey@dhw.idaho.gov

Thank you for completing the survey – we look forward to compiling and sharing the results after the survey is completed. Please visit the Maternal and Child Health Home Visiting Web page to access program and survey updates, by using the following link: http://www.healthandwelfare.idaho.gov/Children/ChildrensSpecialHealthProgram/HomeVisitingProgram/tabid/1521/Default.aspx. Your time and thought are greatly appreciated!

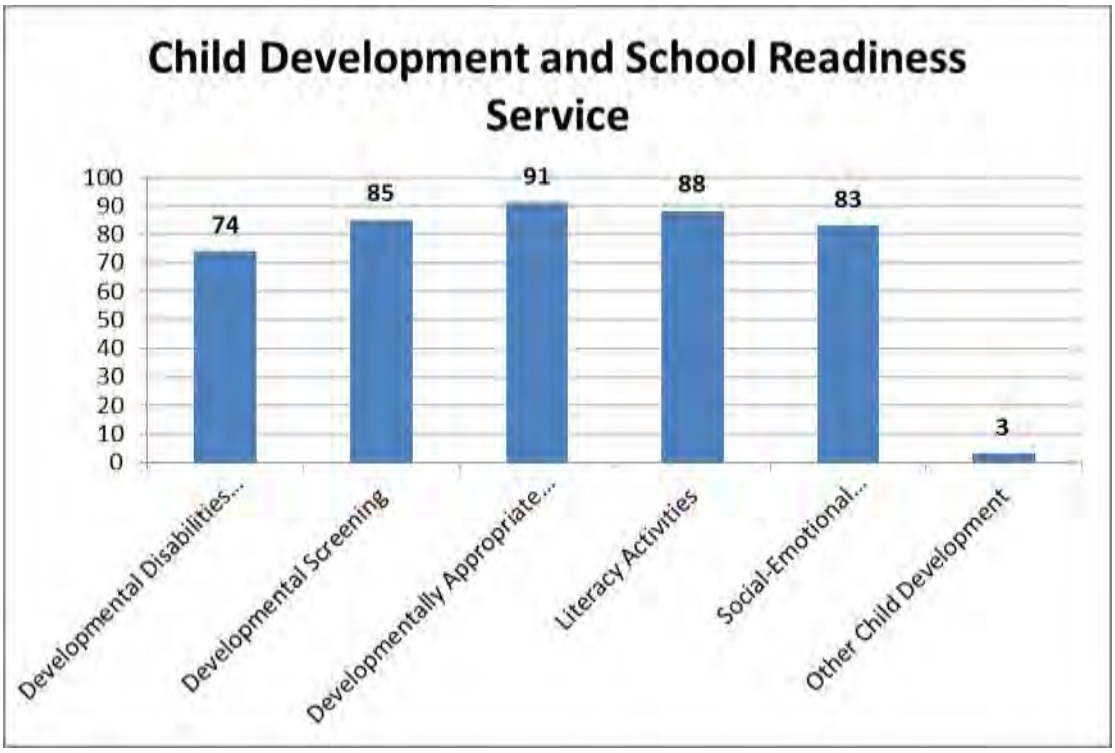
ATTACHMENT 5: Maps of Community Resource Survey Respondents

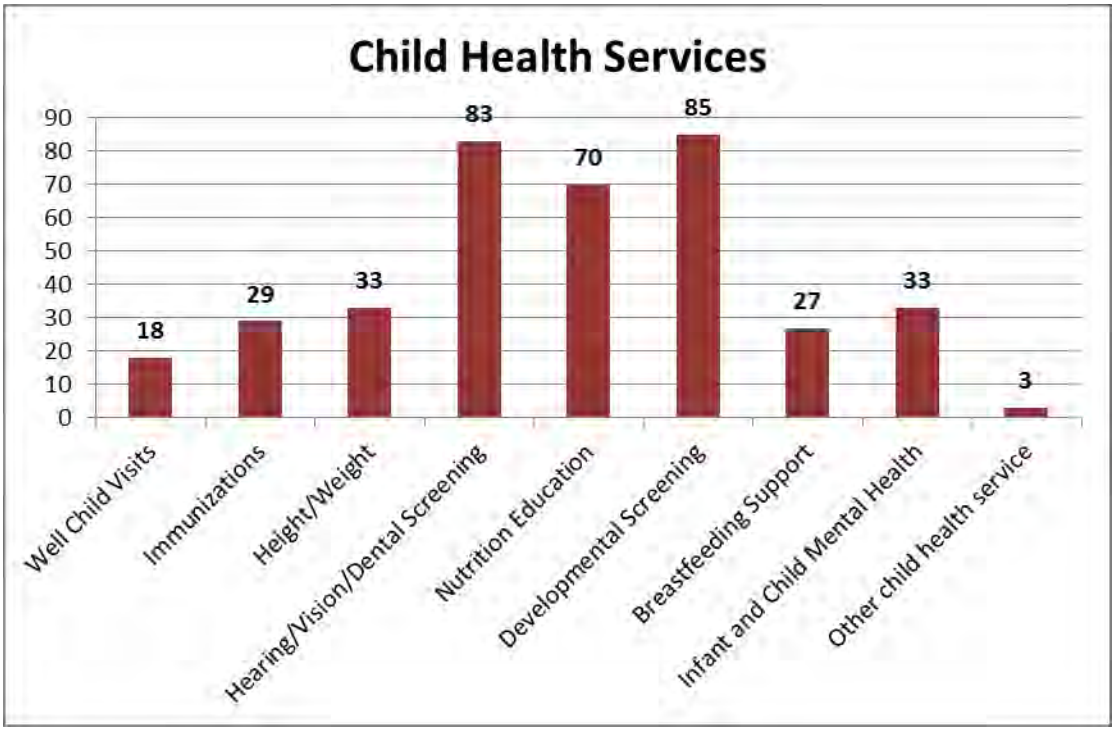


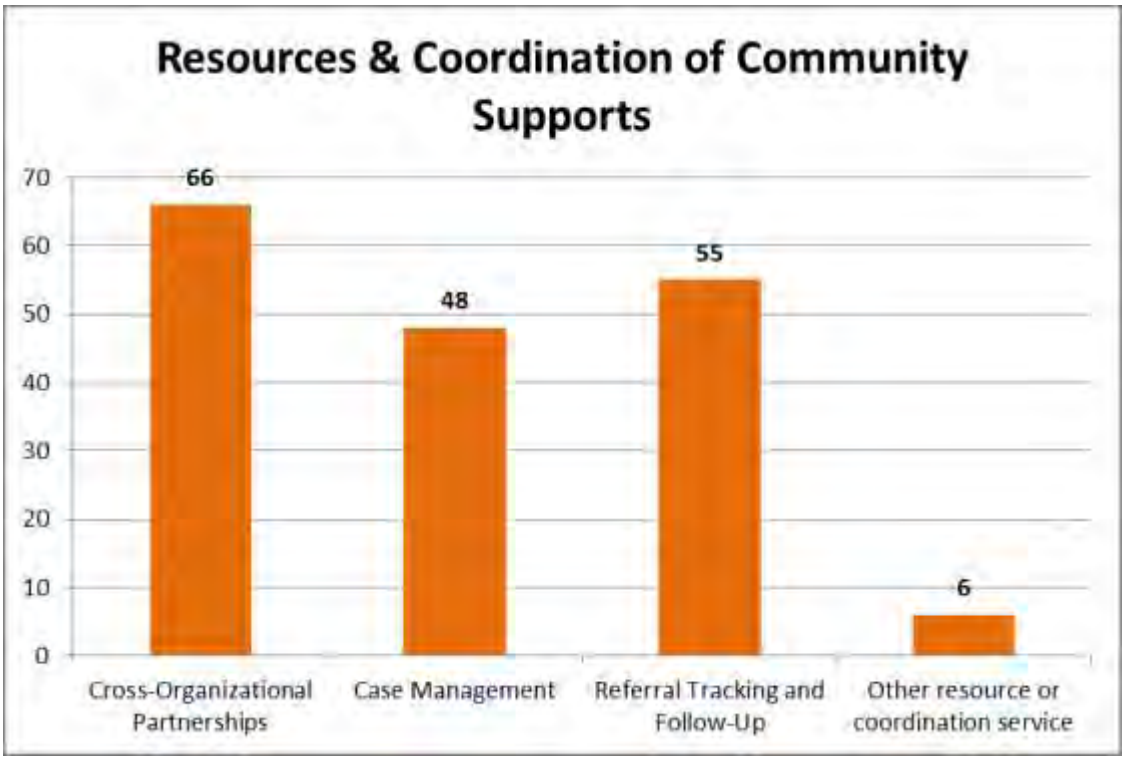

Non-school Respondents to Community Survey
Respondents
1
2
3
4
5
6
7
8
9

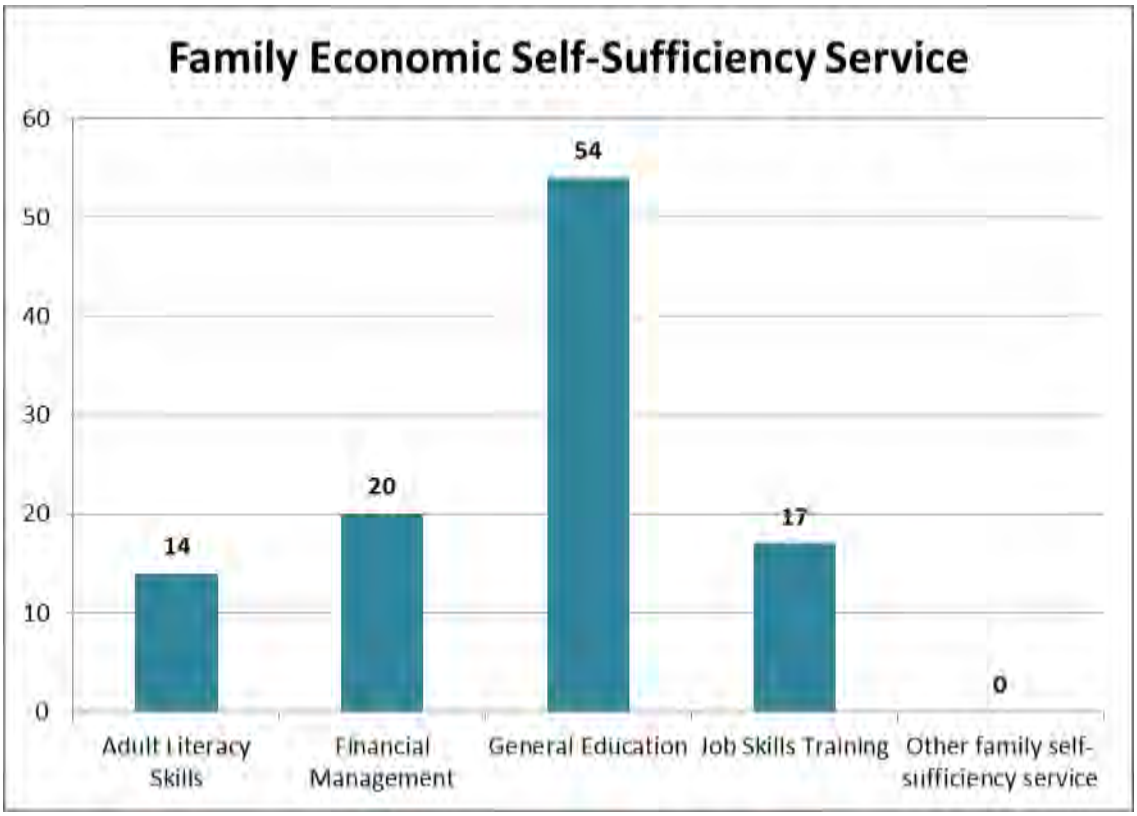
ATTACHMENT 6: Community Resource Survey - Basic Counts of Respondents

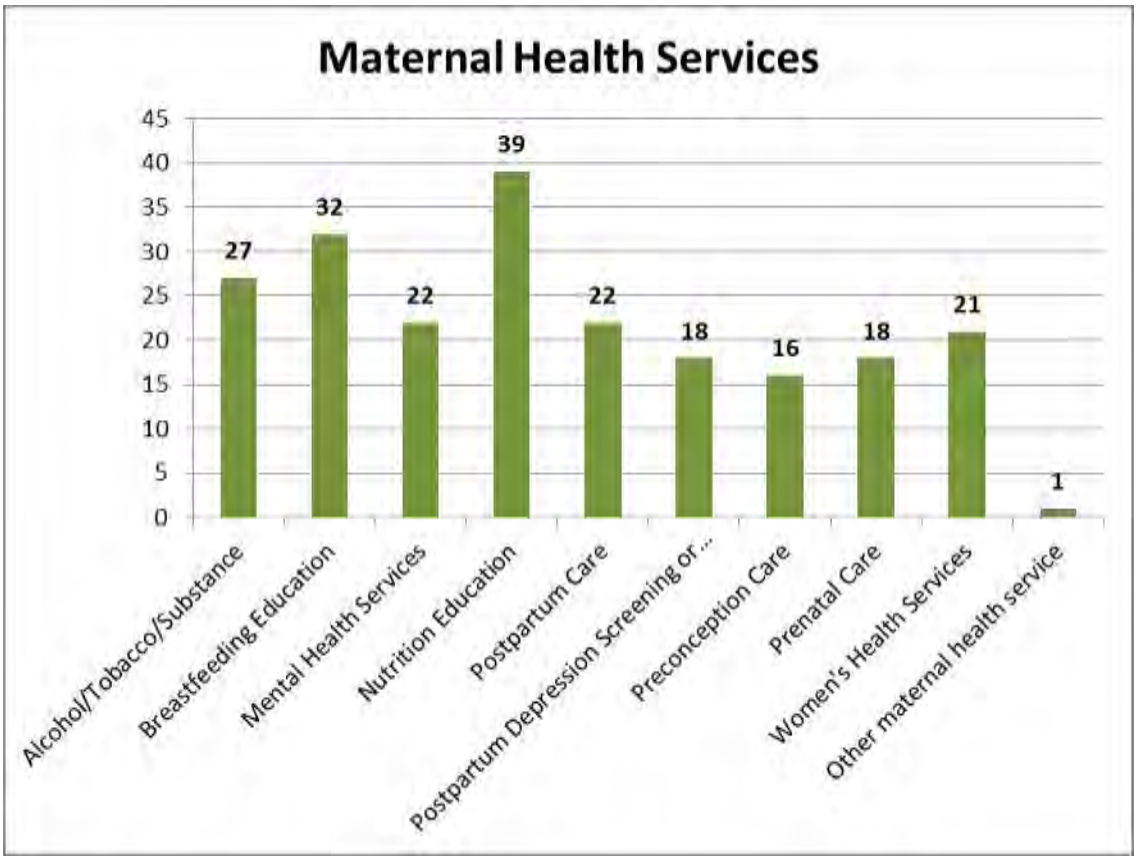
Responses to: "Please identify the type of services which your organizations provides, within categories"

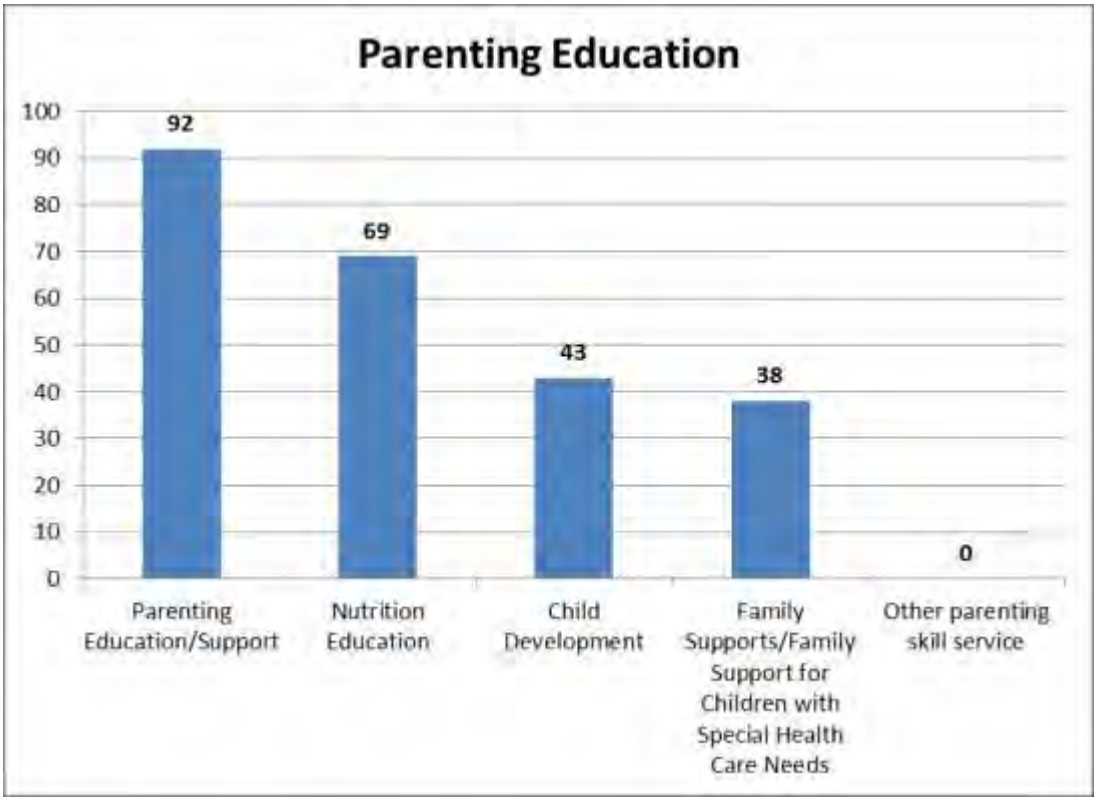


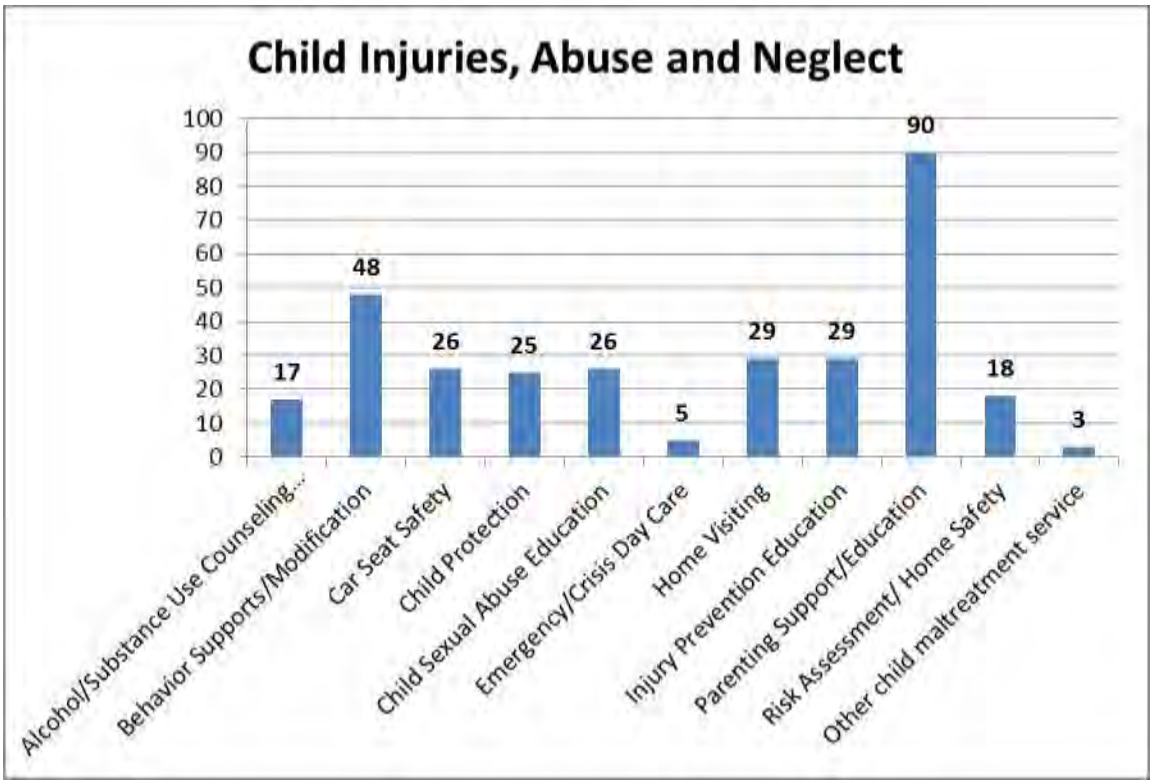


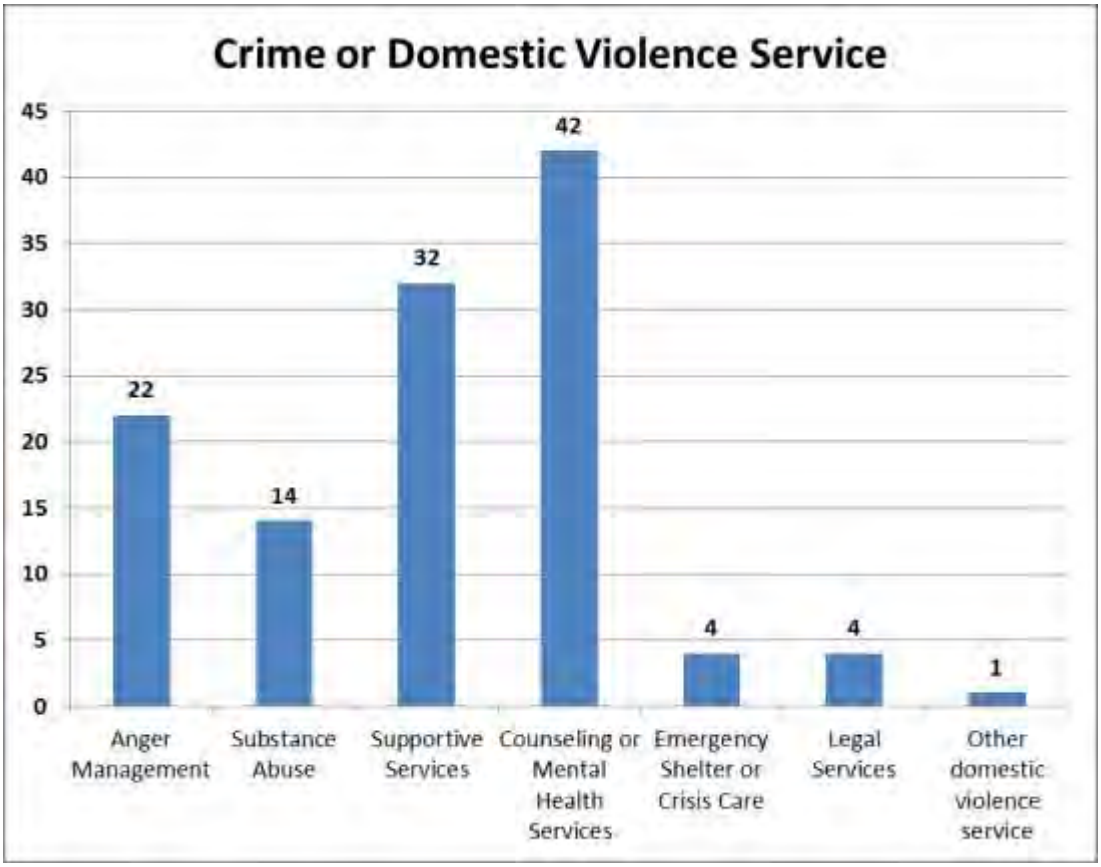

Resources & Coordination of Community Supports
70
60
50
40
30
20
10
0
66
48
55
6
Cross-Organizational Partnerships
Case Management
Referral Tracking and Follow-Up
Other resource or coordination service


Family Economic Self-Sufficiency Service
60
50
40
30
20
10
0
14
20
54
17
0
Adult Literacy Skills
Financial Management
General Education
Job Skills Training
Other family self-sufficiency service

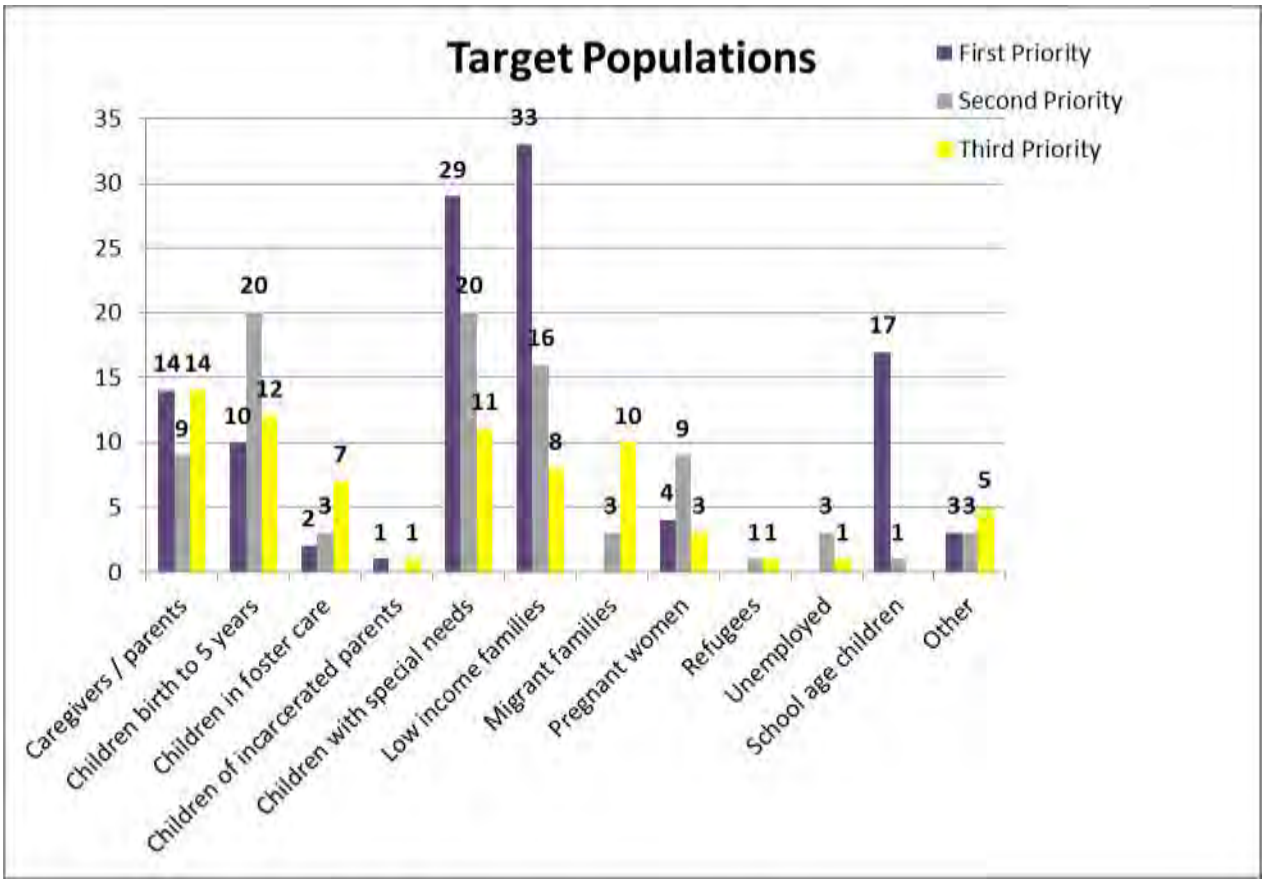

Maternal Health Services
45
40
35
30
25
20
15
10
5
0
27
32
22
39
22
18
16
18
21
1
Alcohol/Tobacco/Substance
Breastfeeding Education
Mental Health Services
Nutrition Education
Postpartum Care
Postpartum Depression Screening or ...
Preconception Care
Prenatal Care
Women's Health Services
Other maternal health service


Parenting Education
100
90
80
70
60
50
40
30
20
10
0
92
69
43
38
0
Parenting Education/Support
Nutrition Education
Child Development
Family Supports/Family Support for Children with Special Health Care Needs
Other parenting skill service

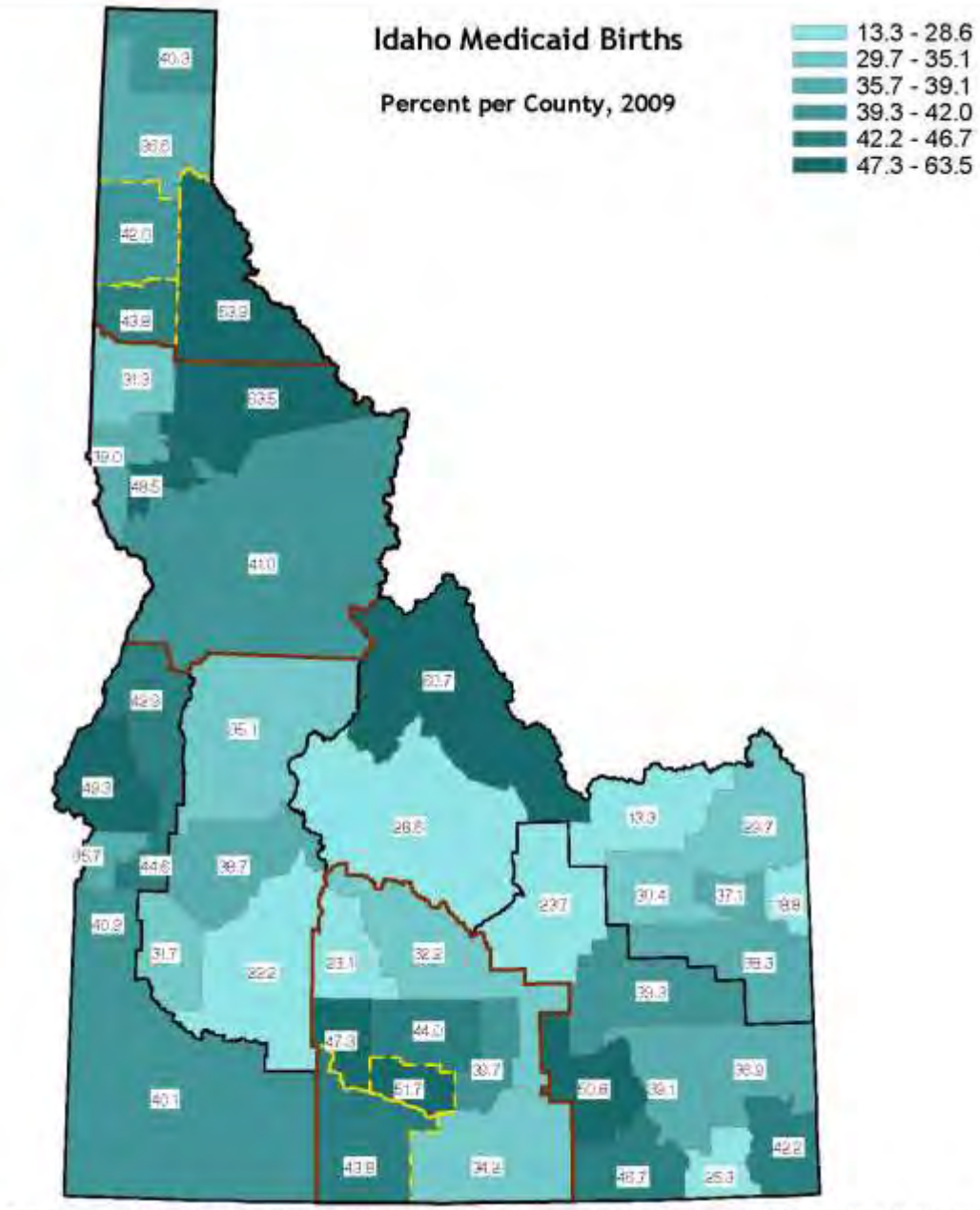

Child Injuries, Abuse and Neglect
100
90
80
70
60
50
40
30
20
10
0
17
48
26
25
26
5
29
29
90
18
3
Alcohol/Substance Use Counseling...
Behavior Supports/Modification
Car Seat Safety
Child Protection
Child Sexual Abuse Education
Emergency/Crisis Day Care
Home Visiting
Injury Prevention Education
Parenting Support/Education
Risk Assessment/ Home Safety
Other child maltreatment service


Crime or Domestic Violence Service
45
40
35
30
25
20
15
10
5
0
22
14
32
42
4
4
1
Anger Management
Substance Abuse
Supportive Services
Counseling or Mental Health Services
Emergency Shelter or Crisis Care
Legal Services
Other domestic violence service

Responses to: "Please identify your organizations top three priority populations, using 1-3"



ATTACHMENT 7: Map of Medicaid Births in Idaho in 2009



Percent of births to Idaho mothers delivered in Idaho where birth certificates indicate that Medicaid paid most of delivery costs. Out of state birth certificates do not always include this data.

ATTACHMENT 8: Evidence Based Home Visiting Model Outcomes Crosswalk with Target Communities

County	Population	Adverse Indicator	Year 1		Year 2+	
			PAT	EHS	HFA	NFP
District 1						
Shoshone	12,660	Low Birth Weight		X	X	X
		Preterm Birth		X	X	X
		Infant Mortality		X	X	X
		DV in Pregnancy		X	?	?
		Adult Binge Drinking	X	X	X	X
		Adult Illicit Drug Use	?	X	X	X
		Poverty	X	X	X	X
		Unemployment	X	X	X	X
		High School Drop Out			?	X
		Substantiated Maltreatment		?	?	X
Kootenai	139,390	Crime			?	?
		Juvenile Crime			?	?
		Adult Binge Drinking	X	X	X	X
		Unemployment	X	X	X	X
		High School Drop Out			?	X
		Substantiated Maltreatment		?	?	X
Bonner	41,403	Juvenile Crime			?	?
		Adult Binge Drinking	X	X	X	X
		Adult Illicit Drug Use	?	X	X	X
		Poverty	X	X	X	X
		High School Drop Out			?	X
		Unemployment	X	X	X	X
Benewah	9,258	Preterm Birth		X	X	X
		DV in Pregnancy		X	?	?
		Adult Binge Drinking	X	X	X	X
		Poverty	X	X	X	X
		Unemployment	X	X	X	X
		High School Drop Out			?	X
		Substantiated Maltreatment		?	?	X
District 2						
Clearwater	8,043	Preterm Birth		X	X	X
		Crime			?	?
		Juvenile Crime			?	?
		Intimate Partner Violence		X	?	?
		DV in Pregnancy			?	?
		Poverty	X	X	X	X

County	Population	Adverse Indicator	Year 1		Year 2+	
			PAT	EHS	HFA	NFP
		Unemployment	X	X	X	X
		Substantiated Maltreatment			?	X
Lewis	3,735	Infant Mortality Rate		X	X	X
		DV in Pregnancy		X	?	?
		Adult Binge Drinking	X	X	X	X
		Poverty	X	X	X	X
District 5						
Twin Falls	75,296	Preterm Births		X	X	X
		Low Birth Weight		X	X	X
		Infant Mortality		X	X	X
		Crime			?	?
		Intimate Partner Violence		X	?	?
		DV in Pregnancy		X	?	?
		Adult Binge Drinking	X	X	X	X
		Adult Illicit Drug Use		X	X	X
		Poverty	X	X	X	X
		Substantiated Maltreatment		?	?	X
		High School Drop Out			?	X
Jerome	21,1262	Preterm Birth		X	X	X
		Low Birth Weight		X	X	X
		Infant Mortality	?	X	X	X
		Juvenile Crime			?	?
		Adult Binge Drinking	X	X	X	X
		Poverty	X	X	X	X
		Substantiated Maltreatment		?	?	X
		High School Drop Out			?	X
Lincoln	4,645	Preterm Birth		X	X	X
		DV in Pregnancy		X	?	?
		Adult Binge Drinking	X	X	X	X
		Adult Illicit Drug Use	?	X	X	X
		Unemployment	X	X	X	X
		High School Drop Out			?	X
Minidoka	19,226	Preterm Birth		X	X	X
		Low Birth Weight		X	X	X
		DV in Pregnancy		X	?	?
		Poverty	X	X	X	X
		High School Drop Out			?	X

ATTACHMENT 9: Parents as Teachers Letter of Initial Approval for Implementation Plan

Parents as Teachers

April 22, 2011

Ms. Laura DeBoer
Children's Special Health Program
450 West State Street, 4th Floor
P.O. Box 83720
Boise, ID 83720-0036

Dear Ms. DeBoer:

Thank you for submitting your State's intent to implement the Parents as Teachers model under the Maternal, Infant, and Early Childhood Home Visiting Program. We thank you for considering Parents as Teachers as one of your evidence-based models.

It is understood from your letter that Idaho is considering a potential expansion of Parents as Teachers in addition to several of the other evidence-based models currently operating. It is also understood that Idaho will follow a grant process, with regards to needs, readiness and capacity in the identified four counties. We understand that you expect to award one or two grants for years one and two.

With this knowledge of your plan and process, we approve the implementation of the Parents as Teachers contingent upon the receipt of the final plan noting the communities for implementation, their needs and capacity. Also, in so doing, you agree that those communities/organizations implementing/expanding this model will review the Readiness Reflection and meet the Essential Requirements for implementation and will do so with fidelity to the model.

Again thank you for the consideration. We look forward to a long relationship with Idaho as we work together to improve the maternal, infant and early childhood outcomes in your state.

Sincerely,

Susan Stepleton, Ph.D.
President/CEO

Cheryle Dyle-Palmer, M.A.
Chief Operating Officer

Board of Directors
2010–2011
Officers
Members
President & CEO
Ex-Officio Members
Founding Director

ATTACHMENT 10: Early Head Start Letters of Initial & Final Approval for Implementation Plan

Letter of Initial Approval

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Laura DeBoer, MPH
Idaho Department of Health and Welfare
MCH Home Visiting Program
Pete T. Cenarrusa Building
450 West State Street, 4th Floor
Boise, ID 83720

Dear Ms. DeBoer,

Thank you for your interest in implementing the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program project in your state, using the Early Head Start (EHS) Home-Based Model.

As Director of the Office of Head Start I am pleased to give you initial approval for implementing the EHS Home Visiting Model. This approval is contingent upon full review of the proposed home visiting implementation plan. The information below is key to implementing the Early Head Start Home-Based Program option in full compliance with all Head Start Program Performance Standards, as they apply to Early Head Start.

Quality services have been the keystone for Early Head Start across its history. In 1994, the Advisory Committee for Services to Infants and Toddlers provided the Federal government with a set of principles to guide the creation of the Early Head Start program. These principles continue to be both a guide and inspiration for quality EHS services. They are designed to nurture healthy attachments between parent and child (and child and caregiver), emphasize a strengths-based, relationship-centered approach to services, and encompass the full range of family needs from pregnancy through a child's third birthday. In short, these principles articulate what a quality EHS program truly delivers to families. They include:

- ***An Emphasis on High Quality*** which recognizes the critical opportunity of EHS programs to positively impact children and families in the early years and beyond.
- ***Prevention and Promotion Activities*** that both promote healthy development and recognize and address atypical development at the earliest stage possible.
- ***Positive Relationships and Continuity*** which honor the critical importance of early attachments on healthy development in early childhood and beyond. The parents are viewed as a child's first, and most important, relationship.
- ***Parent Involvement*** activities that offer parents a meaningful and strategic role in the program's vision, services, and governance.
- ***Inclusion*** strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities.

- ***Cultural competence*** which acknowledges the profound role that culture plays in early development. Programs also recognize the influence of cultural values and beliefs on both staff and families' approaches to child development. Programs work within the context of home languages for all children and families.
- ***Comprehensiveness, Flexibility and Responsiveness*** of services which allow children and families to move across various program options over time, as their life situation demands.
- ***Transition planning*** respects families' need for thought and attention paid to movements across program options and into—and out of—Early Head Start programs.
- ***Collaboration*** is, simply put, central to an Early Head Start program's ability to meet the comprehensive needs of families. Strong partnerships allow programs to expand their services to families with infants and toddlers beyond the door of the program and into the larger community.

The EHS Home Visiting model provides high quality, culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important relationship. The home-based option is designed for families in which the home is the child's primary learning environment. Participants in the EHS home-based model receive a combination of weekly home visits and regularly scheduled group socializations.

Home visits are conducted with parents or the child's primary caregiver for 90 minutes, generally on a year-round basis. The purpose of the home visit is to support parents in their roles as primary caregivers of their child and to facilitate the child's optimal development within their home environments.

Group socializations are offered twice a month and are designed to support child development by strengthening the parent-child relationship. In the context of a group of families, socialization experiences address child growth and development, parenting, and the parent-child relationship.

For EHS programs enrolling pregnant women, home visits are conducted to ensure pregnant women have access to comprehensive prenatal and postpartum care. A home visit is also used to provide prenatal education on topics such as fetal development, labor and delivery, postpartum recovery (including maternal depression), and the benefits of breastfeeding.

In order to meet the needs of the children and families, a Family Partnership Agreement is created that defines the individualized focus for each enrolled child and family. Through this process, parents are integrally involved in determining the goals and experiences that comprise their child's curriculum, and in identifying goals for themselves that best support their healthy development and self-sufficiency.

The scope of services in the home-based program option is comprehensive, including the following services:

Developmental screening, ongoing observation and assessment, and curriculum planning
Medical, dental, and mental health
Child development and education

- Family partnerships and goal setting
- Community collaborations to meet additional family needs

The relationship of the home visitor with parents or expectant parents is central to effective delivery of this program model. Through ongoing interactions in home visits and socializations, this continuity of the relationship becomes the vehicle through which home visitors support and strengthen parents' or expectant parents' abilities to nurture the healthy development of their children.

For additional information, please contact Angie Godfrey at angie.godfrey@acf.hhs.gov.

Sincerely,

Yvette Sanchez Fuentes
Director

Letter of Final Approval

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Laura DeBoer, MPH
Idaho Department of Health and Welfare
MCH Home Visiting Program
Pete T. Cenarrusa Building
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- ***Parent Involvement*** activities that offer parents a meaningful and strategic role in the program's vision, services, and governance.

- ***Inclusion*** strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities.
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- Child development and education
- Family partnerships and goal setting
- Community collaborations to meet additional family needs

The relationship of the home visitor with parents or expectant parents is central to effective delivery of this program model. Through ongoing interactions in home visits and socializations, this continuity of the relationship becomes the vehicle through which home visitors support and strengthen parents' or expectant parents' abilities to nurture the healthy development of their children.

The Office of Head Start looks forward to continuing to work with your state.

For additional information, please contact Angie Godfrey at angie.godfrey@acf.hhs.gov.

Sincerely,

Yvette Sanchez Fuentes
Director

Attachment 11: News Release

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Some of Idaho's most expensive social problems are rooted in early childhood. Issues such as child abuse and neglect, school failure, unemployment and crime can often be correlated to challenging home environments during the critical years of a child's development.

Increasingly, states are focusing on proven prevention strategies to help families who may be struggling. One of the most effective programs is an early childhood home visiting program in which trained professionals visit homes and provide coaching, education and information to support families.

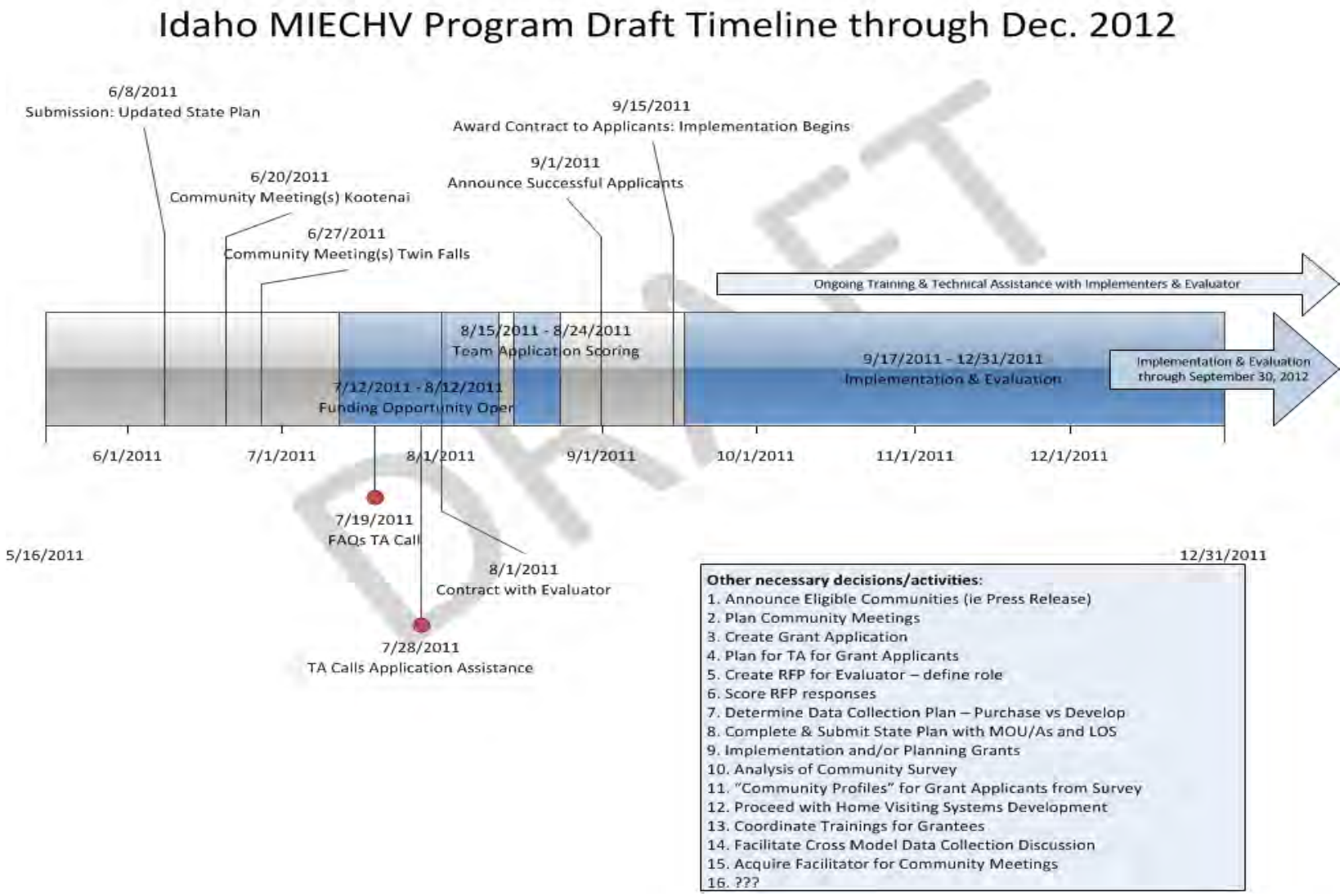
The Idaho Department of Health and Welfare is implementing an evidence-based home visiting program that matches parents with trained professionals during pregnancy and throughout their child's first years. By empowering parents to support their children and encourage self-sufficiency, families and society reap the benefits: children are healthier, safer, better prepared to learn and more likely to become successful adults.

The Idaho home visiting program is being planned for Kootenai, Shoshone, Jerome and Twin Falls Counties. These counties were chosen based on a risk assessment that evaluated premature birth, low-birth weight infants and infant mortality; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; and child maltreatment.

Agencies with the capacity to implement evidence-based home visiting programs in these communities will be eligible to apply for funding this summer. Community forums to discuss the program and participation are scheduled to take place for Kootenai/Shoshone Counties in Coeur d'Alene on June 20th and for Twin Falls/Jerome Counties in Twin Falls on June 27th. The exact locations are being finalized, with the forum hours at both locations scheduled for 10 a.m.-12:30 p.m. and 4 p.m. to 6:30 p.m. The public and interested agencies are encouraged to attend these free forums.

Please visit www.homevisiting.dhw.idaho.gov for updates on the meeting locations or send an inquiry to the DHW home visiting program manager Laura DeBoer.

ATTACHMENT 12: Draft Timeline for Implementation of MIECHV program



ATTACHMENT 13: Letter of Support – IDEA Part B Infant Toddler Program

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

ROBERT B. LUCE – Administrator
DIVISION OF FAMILY AND COMMUNITY SERVICES
450 West State Street, 5th Floor
P.O. Box 83720, Boise, ID 83720-0036
PHONE 208-334-0641
FAX 208-332-7330

May 1, 2011

Audrey Yowell, Ph.D., MSSS
Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dr. Yowell:

Please accept this letter of support on behalf of Idaho's Infant Toddler Program (ITP) for Idaho's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. As the State's Individuals with Disabilities Education Act (IDEA, Part C) lead agency, ITP coordinates the early intervention system, which identifies and assures services for eligible children birth to three years old who have a developmental delay or condition that may result in a delay. The ITP coordinates interdisciplinary service providers to address physical, mental, and/or social emotional development of young children and their families.

ITP is the statewide program for early intervention has programs and service providers available throughout the state. It will be important for the MIECHV programs within the identified "at-risk" communities to coordinate service delivery and referral with the ITP service providers. As participants in the MIECHV program are screened for developmental milestones, children suspected for delay should be connected with the local ITP service coordinators for follow-up. Infant Toddler Program stands ready to receive referrals, to complete multidisciplinary evaluations and provide any needed early intervention

services for the infants and toddlers and their families. As follow-up is conducted, the programs must coordinate efforts to support the optimal development for the child. For children that ITP evaluates who are *not* found eligible for ITP services, there is often a dearth of options available where we can refer to support families that would benefit greatly from parent education or promotion of quality parenting skills and family supports. We welcome the day when MIECHV is implemented as another community resource to which we can refer these families who are not eligible for our services. We expect to be intensely involved in interagency coordination efforts as home visiting programs launch throughout the state.

Since the ITP currently provides the most extensive home visiting services in the State of Idaho, it is critical that as the MIECHV program develops that we assess success of referrals and service coordination. ITP will, in partnership with the MIECHV program, assess data related to referrals and coordination to evaluate the effectiveness of referrals as a means of continuous quality improvement. It will also be important to assess future opportunities for ITP and MIECHV to implement joint training, as available.

I would like to reiterate my strong support for the MIECHV, emphasizing the importance to coordinate efforts both at the State and local level. I eagerly look forward to this future collaboration.

Sincerely,

Mary J. Jones, Program Manager
Idaho Infant Toddler Program

ATTACHMENT 14: Letter of Support – IDEA Part B Idaho State Department of Education

STATE DEPARTMENT OF EDUCATION

P.O. BOX 83720
BOISE, IDAHO 83720-0027

TOM LUNA
STATE SUPERINTENDENT
PUBLIC INSTRUCTION

May 23, 2011

Audrey Yowell, PhD, MSSS
Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dr. Yowell:

Please accept this Letter of Support on behalf of the Idaho State Department of Education (SDE), Individuals with Disabilities Education Act (IDEA) Part B program, for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. IDEA Part B serves children beginning at age three in developmental preschools located in school districts throughout the state of Idaho. It is the goal of Part B to facilitate a smooth, effective transition for children and families receiving early intervention services through IDEA Part C into Part B. The Part C program recognizes the importance of engaging the family of a young child in developing the Individual Family Service Plan (IFSP) and the Individual Education Plan (IEP).

The Idaho SDE Part B program is aware of the unique opportunity to support and educate parents on appropriate child development, in all domains including: physical, cognitive and social emotional through home visiting. As the home visiting program develops it will be critical to identify appropriate assessment tools to measure child development. As children with developmental delays or potential developmental delays are identified, connecting families with the appropriate resources, including Part B or C in a timely fashion is critical in optimizing outcomes of the intervention.

Please consider this letter an expression of the Idaho SDE Part B program's support for implementing evidence-based home visiting through the MIECHV program by connecting the MIECHV program with needed information and stakeholders at the State and local level. Part B anticipates continuing to strengthen the relationship with the MIECHV in order to improve educational outcomes for children in Idaho. There are many opportunities for partnerships and synergies that could be explored at both the State and local levels.

Sincerely,

Shannon Dunstan
Early Childhood & Part B Coordinator

Office Location	Telephone	Speech/Hearing Impaired	Fax
650 West State Street	208-332-6800	1-800-377-3529	208-334-2228

ATTACHMENT 15: Letter of Support – Division of Medicaid

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT – Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 26, 2011

Audrey Yowell, Ph.D., MSSS
Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dear Dr. Yowell:

On behalf of Idaho Medicaid and Children's Health Insurance Program (CHIP), I am happy to provide this letter of support for Idaho's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. Medicaid/CHIP provides health care coverage for approximately one-third of Idaho's children. Medicaid seeks to improve health outcomes for children by providing comprehensive services and encouraging medical homes through the Healthy Connections primary care case management program.

The Department of Health and Welfare (DHW), Division of Welfare, uses an automated system that not only streamlines the eligibility determination process but also allows for cross-benefits eligibility determination. Additionally, DHW has employees known as "navigators" to help families enroll in appropriate programs, such as Medicaid. It will be important to coordinate referral and enrollment of children and families in the MIECHV program and, to the extent possible, augment these existing systems.

We expect that the MIECHV program will reduce the need for health care services for preventable conditions while improving health outcomes for the program's participants. We are very interested in the MIECHV program assessing costs of service provision over time to better understand the long-term impact of the MIECHV program and related health care costs. We look forward to the successful implementation of the program.

Sincerely,

LESLIE M. CLEMENT
Administrator

LMC/rs

ATTACHMENT 16: Letter of Support – Idaho Coalition Against Sexual and Domestic Violence

June 8, 2011

Audrey Yowell, PhD, MSSS
Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dr. Yowell:

Please accept this Letter of Support on behalf of the Idaho Coalition Against Sexual and Domestic Violence (Idaho Coalition) for Idaho's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. The mission of the Idaho Coalition is to engage voices to create change in the prevention, intervention, and response to domestic violence, dating violence, stalking and sexual assault. The Idaho Coalition is a statewide non-profit dual coalition with a membership network of over 80 shelter programs, counseling programs, law enforcement, victim witness units, prosecutors, and allied professionals.

The Idaho Coalition recognizes that one of the goals of the MIECHV program is to address domestic violence through effective screening, referral, and supports. The Idaho Coalition will support the MIECHV program during planning and implementation by providing education, community connections, and assistance to program administrators. The Through the Idaho Coordinated Response to Domestic and Sexual Violence, a project of the Idaho Coalition and funded by a grant to the Idaho Supreme Court, we developed an Idaho Risk Assessment of Dangerousness in Domestic Violence Initiative with risk assessment tools that have been implemented in criminal justice systems. We are currently adapting the tools for use in for screenings in health care settings, along with tools developed by Futures Without Violence, formerly the Family Violence Prevention Fund. Identifying appropriate screening tools and community resources are critical in effectively addressing domestic violence through home visiting efforts.

The Idaho Coalition has recently collaborated with and provided training to the Idaho Perinatal Project, the American Academy of Pediatrics- Idaho Chapter, local hospitals, and Idaho's Health District Directors, and will look forward to working with and supporting the MIECHV program during planning and implementation. In October 2010, on

Domestic Violence and Health Day, the Idaho Coalition along with the Idaho Perinatal Project, St. Luke's, and the American Academy of Pediatrics- Idaho Chapter, launched a public awareness campaign, "Four Out of Five Babies Go to Safe and Loving Homes," with Idaho's 36 birthing hospitals. Posters were displayed in all the hospitals, hospital staff wore "house" pins, and onesies were given to newborns that month. Over a 100 health care and domestic violence providers gathered at the Idaho Statehouse to launch the campaign.

And in October 2010, the Idaho Coalition hosted the Idaho Summit on Domestic Violence and Health, attended by more than 850 professionals, featuring national speakers Jacquelyn Campbell, Ph.D., Linda Chamberlain, Ph.D., and others.

Building this relationship between the Idaho Coalition and MIECHV is important in advancing the objectives of Idaho Coalition and the MIECHV program. The Idaho Coalition encourages continued dialogue during the coming years in order to better partner in order to: increase visibility of sexual and domestic violence issues, reduce the incidence of sexual and domestic violence and equip communities to respond to sexual and domestic violence.

Sincerely,

Kelly Miller
Executive Director
Idaho Coalition Against Sexual and Domestic Violence

ATTACHMENT 17: Letter of Support – Idaho's Injury Prevention and Surveillance Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

JANE S. SMITH – Administrator
DIVISION OF PUBLIC HEALTH
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5947
FAX 208-334-6581
EMAIL smithj2@dhw.idaho.gov

May 9, 2011

Audrey Yowell, PhD, MSSS
Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dr. Yowell:

Please accept this Letter of Support on behalf of Idaho's Injury Prevention and Surveillance Program (IPSP) within the Department of Health and Welfare for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. The goals of the IPSP include the following:

- Reduce the death, disability, and unnecessary healthcare costs to Idaho residents as a result of unintentional and violent injury.
- Enhance the development of a sustainable injury prevention and control program to become a proactive and influential focus for reducing injury in Idaho.
- Develop an injury surveillance system that will store information on planning, implementing, and evaluating statewide injury prevention efforts.
- Develop an injury prevention plan with statewide partners, stakeholders and decision makers that will help reduce injuries.

According to the Rocky Mountain Poison and Drug Center (RMPDC), Idaho's regional poison control center, over 16,000 calls were received during 2009 from Idaho residents and healthcare providers seeking advice and consultation in poison exposure in people of all ages. The majority of these calls (63.7%) were received from parents of children aged 5 years and younger who were unintentionally exposed to poisons in the home. Safe home environments are critical for preventing injury and poison for children age 0-5 years old, the target population for the MIECHV program. IPSP recognizes that one of the goals of the MIECHV program is to reduce injuries, including visits to the emergency department.

Dr. Audrey Yowell
May 9, 2011
Page 2

IPSP intends to support the MIECHV program in the planning and implementation phase by providing training to home visitors on home safety, injury and poison prevention as necessary. It will be important that home visitors be equipped with the proper training, resources, and supervision to promote safety and prevent injury and poising with program participants. Building strong relationships at the state level and connecting local resources will be important in sustained success of the MIECHV program and maximizing potential positive impacts related to injury and poison prevention.

Sincerely,

Stephen M. Manning

Stephen M. Manning, CSP and Manager
Injury Prevention & Surveillance Program
Bureau of Community and Environmental Health

ATTACHMENT 18: Letter of Support – Early Childhood Coordinating Council

COUNCIL MEMBERS

Parents
Tribal Tribe
Tribal Leader

State Legislator
Tim Lanier
Phyllis Kelly

Infant Toddler Program Part C
Mary Jones

Regional Early Childhood Committees
Cathy Shaver

Early Childhood Providers
Terri Nell

Maternal Child Health
Dorothy Dawes

Personnel Preparation: Higher Education
David Allen

State Department of Insurance
Jim Kerr

State Health Care Collaboration
Cynthia Kelly

Business
Mary Jensen

Medicaid
Robin Pratney

Idaho Head Start Association
Slim Burke

State Child Care Administrator
Tom Van Wagoner

EC3
Early Childhood Coordinating Council

May 25, 2011

Audrey Yowell, Ph.D., MSSS
Department of Health and Human Services
Health Resources and Services Administration, Maternal and Child Health Bureau
5600 Fishers Lane 16B – 26
Rockville, MD 20857

Dr. Yowell:

Please accept this letter of support on behalf of Idaho's Early Childhood Comprehensive Systems (ECCS) Grant for Idaho's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. The ECCS grant and plan focuses on continuous, comprehensive, quality, and integrated early childhood programs and policies. The Early Childhood Comprehensive Systems grant works hand-in-hand with the Early Childhood Coordinating Council (EC3) to develop, sustain and advance the Early Childhood Comprehensive Systems Plan. The Early Childhood Comprehensive Systems Plan is built on scientific evidence, best practices and expertise from across the State of Idaho.

The State Early Childhood Comprehensive Systems (ECCS) Plan has been in effect since 2005, with a major update in 2009. The 2009-2012 Plan outlines the goals and activities to systematically approach the following outcome areas: Health, Early Education and Care, Social and Emotional Development, Family Support, Parent Education and System Development. Through partnerships and support of ECCS, the State of Idaho has seen numerous advances in early childhood such as the development of Early Learning Guidelines; Quality Rating System for Child Care; increased enrollment in SCHIP, WIC & Food Stamps; adoption of the University of Michigan endorsement of Infant Mental Health; and many others. The Mission of the ECCS Plan is to: "provide leadership and education and coordinate resources for Idaho's young children and their families."

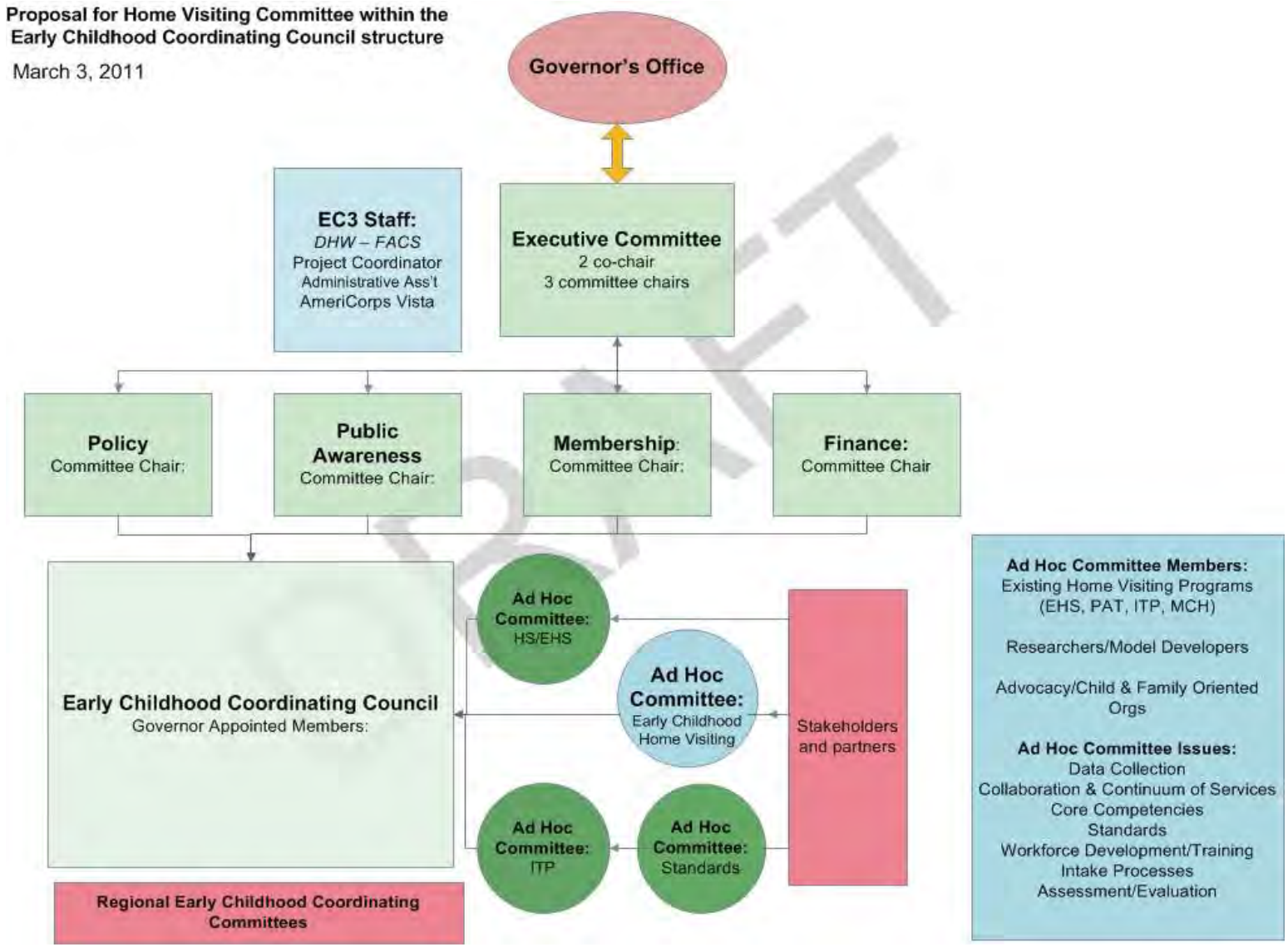
Given the emphasis for MIECHV program grantees to assure that this program is one of several service strategies embedded within the State's early childhood comprehensive systems to promote maternal, infant and early childhood health and well-being, the Idaho State Early Childhood Comprehensive Systems supports and anticipates continued partnerships with the Idaho MIECHV program. To date, MIECHV program leadership has presented information on the background, progress, and plans for the MIECHV program to the EC3 on multiple occasions. Additionally, the EC3 recently established an Early Childhood Home Visiting Ad Hoc Committee to support statewide dialogue, strategies and activities to advance early childhood home visiting in Idaho.

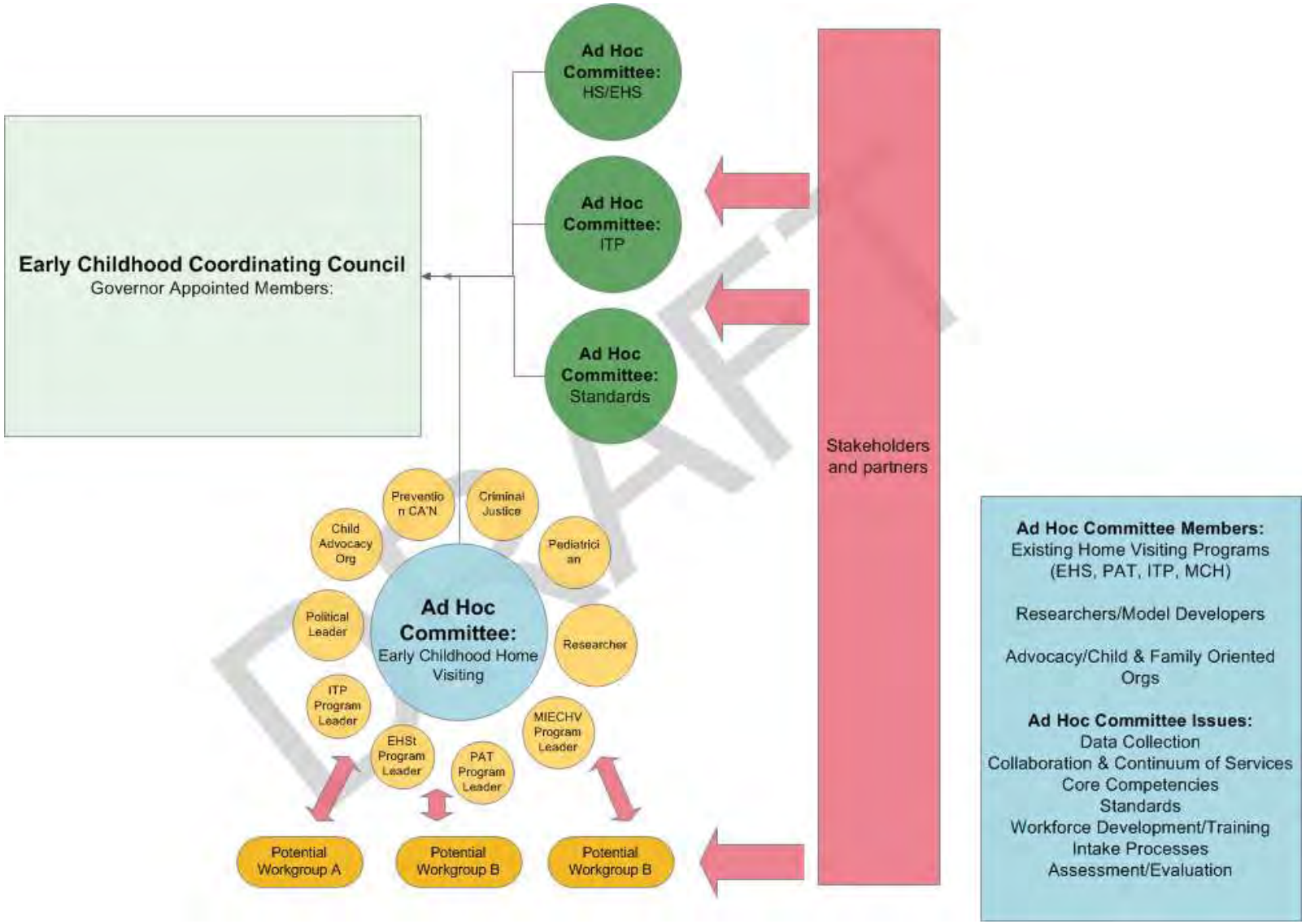
Continued partnership between the Early Childhood Comprehensive Systems work and the MIECHV program is critical in promoting system coordination, integration and dissemination of evidence-based practices, research and policies. It will be important to continue to assess opportunities to partner as the program develops. Please consider this letter an expression of strong support for the MIECHV program in Idaho, emphasizing the importance to coordinate efforts at the State and local levels.

Sincerely,

Larraine Clayton, M.Ed
Early Childhood Comprehensive Systems, Director

ATTACHMENT 19: Early Childhood Coordinating Council Proposed Organizational Structure




Early Childhood Coordinating Council
Governor Appointed Members:
Ad Hoc Committee: HS/EHS
Ad Hoc Committee: ITP
Ad Hoc Committee: Standards
Stakeholders and partners
Ad Hoc Committee: Early Childhood Home Visiting
Preventio n CA'N
Criminal Justice
Child Advocacy Org
Pediatrici an
Political Leader
Researcher
ITP Program Leader
MIECHV Program Leader
EHSt Program Leader
PAT Program Leader
Potential Workgroup A
Potential Workgroup B
Potential Workgroup B
Ad Hoc Committee Members:
Existing Home Visiting Programs (EHS, PAT, ITP, MCH)
Researchers/Model Developers
Advocacy/Child & Family Oriented Orgs
Ad Hoc Committee Issues:
Data Collection
Collaboration & Continuum of Services
Core Competencies
Standards
Workforce Development/Training
Intake Processes
Assessment/Evaluation

ATTACHMENT 20: Current and Anticipated Public and Private Collaborative Partners

Public Partners

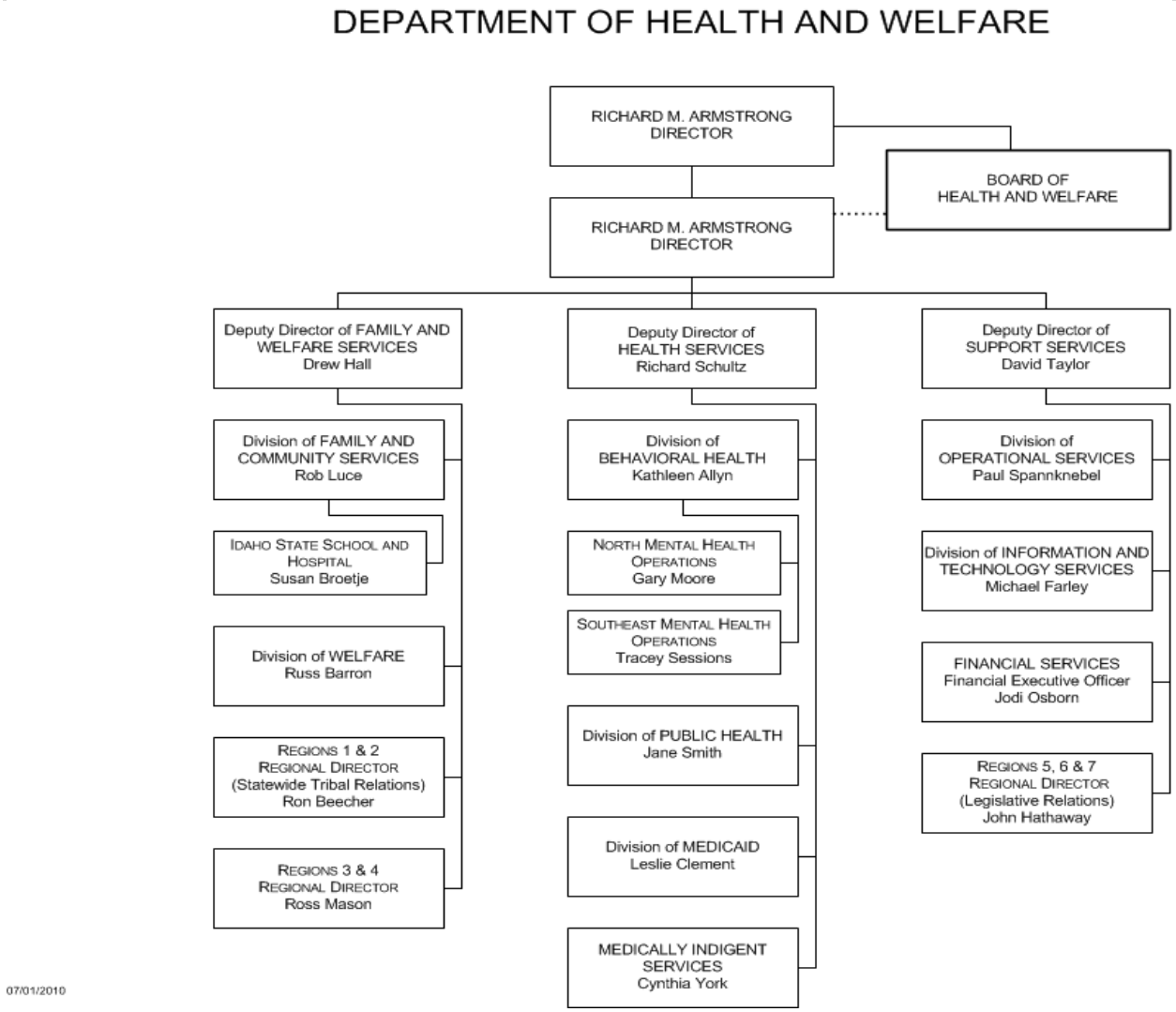
- Title V, MCH
- Idaho Children's Trust Fund (Title II - CAPTA)
- Idaho's Children's Welfare (Title IV-B and IV-E)
- Idaho's Agency for Substance Abuse
- Idaho's Child Care and Development Fund
- Idaho's Head Start Collaboration Office
- Idaho's Advisory Council on Early Childhood Education and Care
- Idaho's Infant Toddler Program (IDEA Part C)
- Idaho's IDA Part B Section 619
- Idaho Medicaid / Children's Health Insurance Program
- Idaho's Domestic Violence Coalition
- Idaho's Mental Health Agency
- Idaho Division of Public Health
- Idaho Department of Corrections
- Idaho's Representative for Temporary Assistance to Needy Families (TANF)
- Idaho's Supplemental Nutrition Assistance Program (SNAP)
- Idaho's Injury Prevention and Surveillance Program
- Local Public Health Districts
- Idaho Head Start Association
- Early Head Start / Migrant Head Start
- Idaho Department of Insurance
- Universities

Private Partners

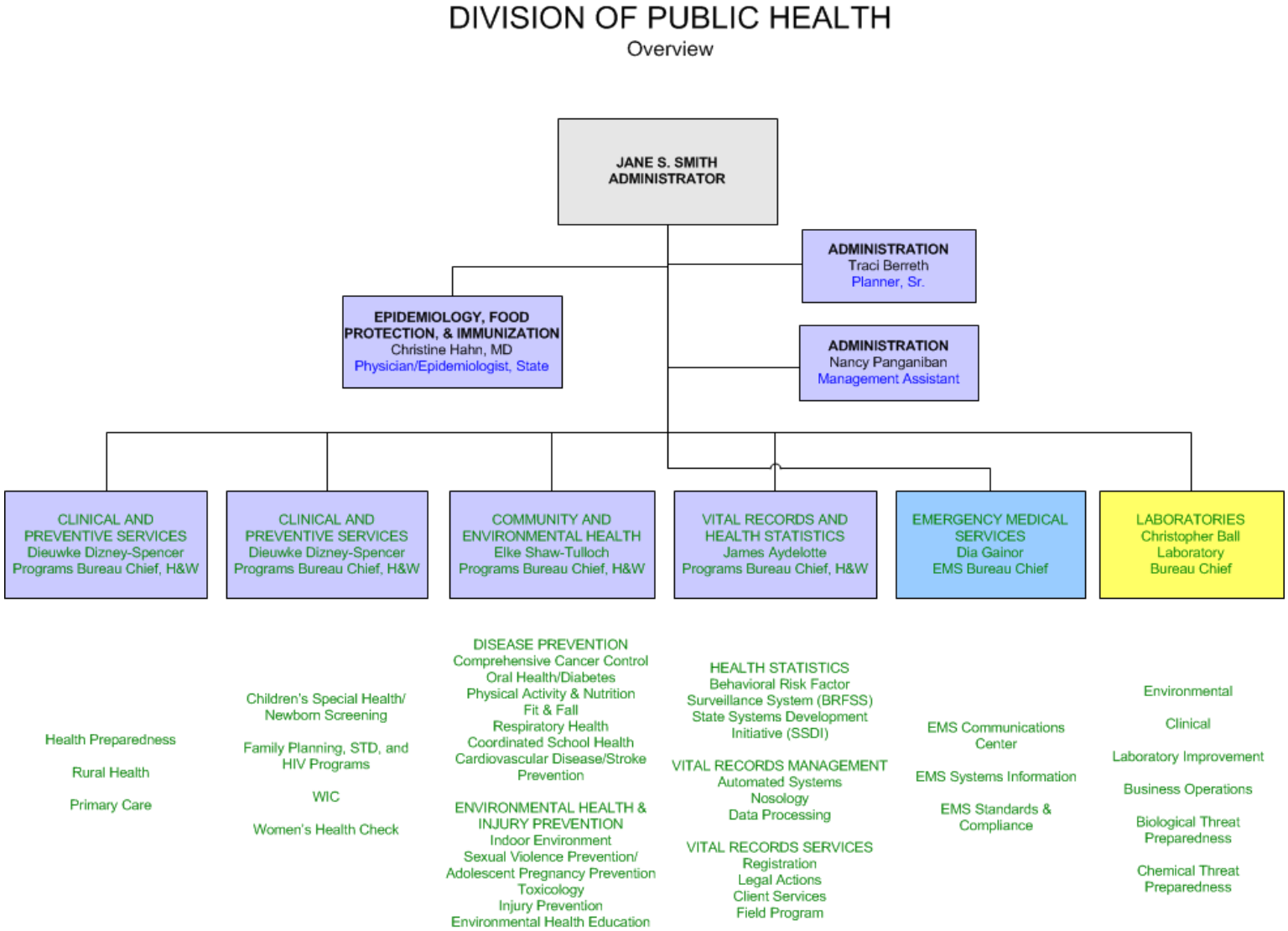
- Idaho Family Advocates
- Idaho Voices for Children
- Idaho Association for the Education of Young Children
- Idaho Perinatal Project
- Idaho Chapter, American Academy of Pediatrics
- Idaho Parents Unlimited
- St. Luke's Children's Specialty Center
- American Academy of Pediatrics, Idaho Chapter
- American Academy of Family Physicians, Idaho Chapter
- Idaho Primary Care Association
- Idaho Consortium for the Preparation of Early Childhood Professionals
- AIM Early Idaho
- March of Dimes, Idaho Chapter

ATTACHMENT 21: Organizational Charts

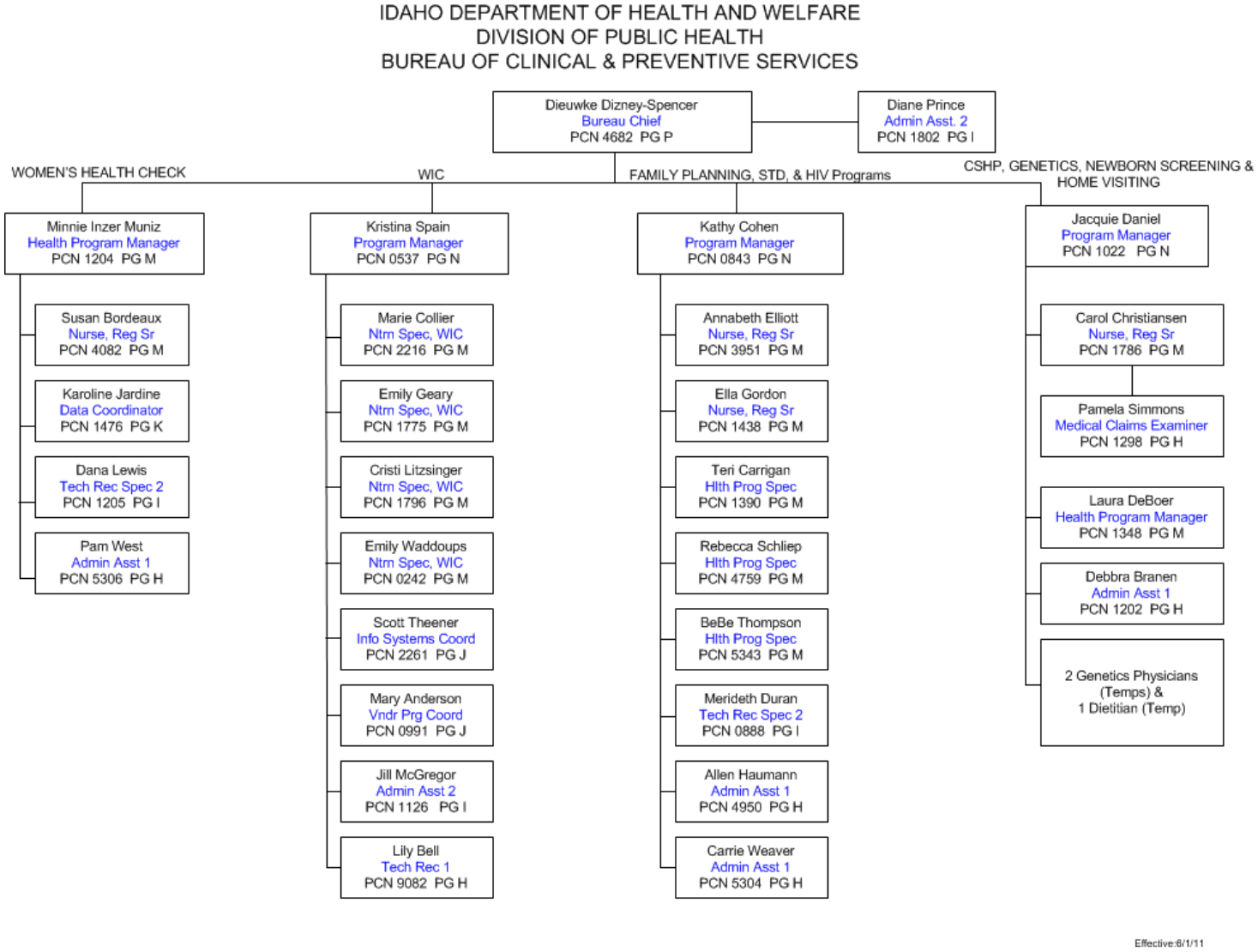
Department of Health and Welfare



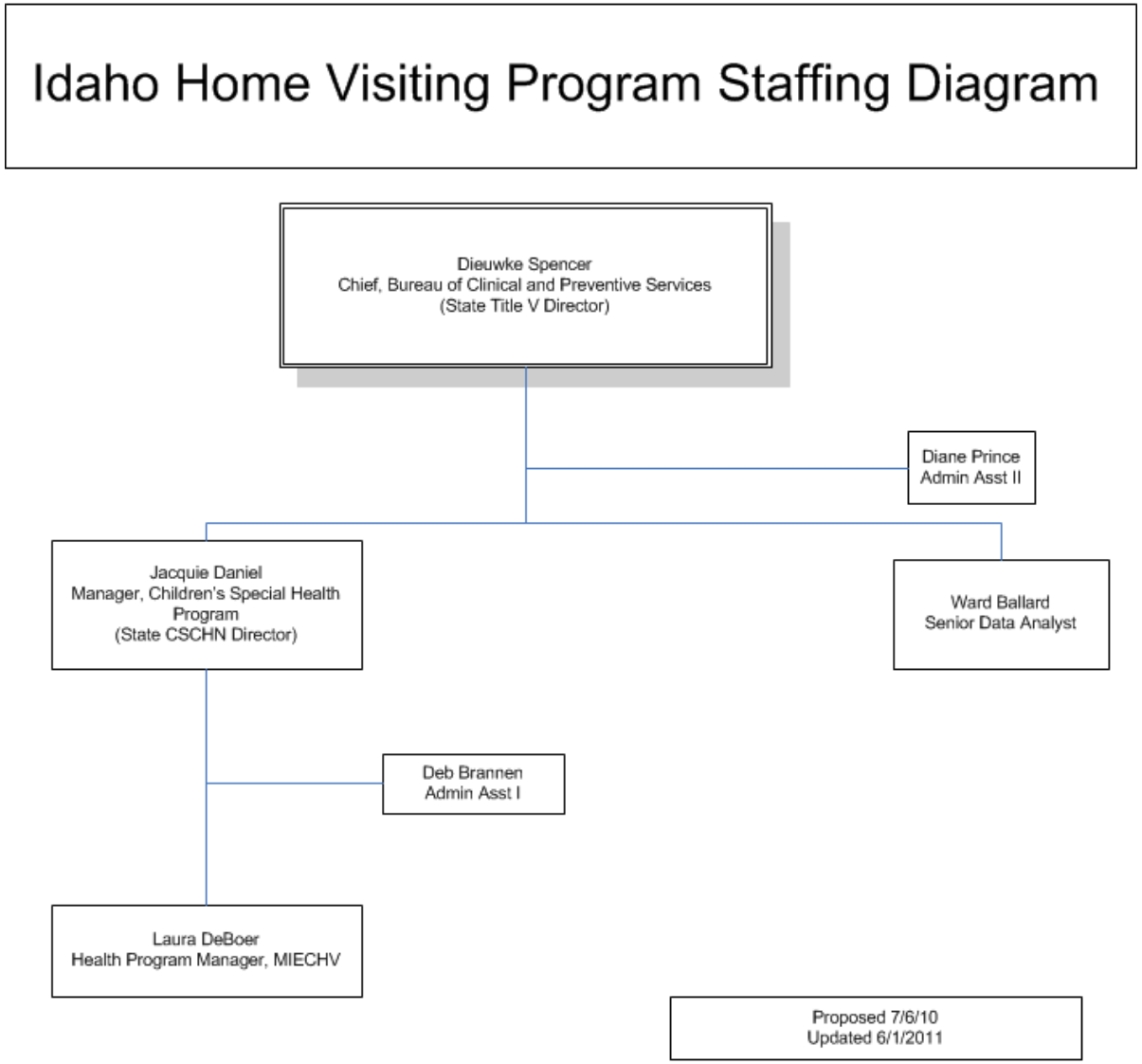
Division of Public Health



Bureau of Clinical and Preventive Services



Maternal, Infant and Early Childhood Home Visiting Program



ATTACHMENT 24: Acronym Guide

AAMC	**Association of American Medical Colleges**
AAP	**American Academy of Pediatrics**
ABI	**Abusive Behavior Inventory**
ASQ – SE	**Ages and Stage Questionnaire – Social Emotional**
BRFSS	**Behavioral Risk Factor Surveillance System**
CBO	**Community Based Organizations**
CQI	**Continuous Quality Improvement**
CYSCHN	**Children and Youth with Special Health Care Needs**
DOVE	**Domestic Violence Enhanced Visitation Intervention**
EB	**Evidence-Based**
EC3	**Early Childhood Coordination Council**
ECCS	**Early Childhood Comprehensive Systems**
ED	**Emergency Department**
EHS	**Early Head Start**
EPDS	**Edinburgh Postnatal Depression Scale**
EPSDT	**Early, Periodic, Screening, Diagnosis and Treatment**
HPSA	**Health Professional Shortage Area**
HV/HmV	**Home Visiting**
IDEA – ITP	**Individuals with Disabilities Education Act – Infant Toddler Program**
IDVSA	**Idaho Coalition Against Sexual and Domestic Violence**
KIPS	**Keys to Interactive Parenting Scale**
LSP	**Life Skills Progression Screening Tool**
MCH	**Maternal and Child Health**
MIECHV	**Maternal, Infant and Early Childhood Home Visiting Program**
MIS	**Management Information System**
MOU/A	**Memorandum of Understanding/Agreement**
MUA	**Medically Underserved Area**
MUP	**Medically Underserved Population**
NCANDS	**National Child Abuse and Neglect Data System**
PAT	**Parents as Teachers**
PDCA	**Plan, Do, Check, Act**
PFS	**Protective Factors Survey**
PHD	**Public Health District**
PPD	**Post-Partum Depression**
PRATS	**Pregnancy Risk Assessment Tracking System**
PSC	**Planning Steering Committee**
SCHIP	**State Children's Health Insurance Program**

STD	**Sexually Transmitted Disease**
WIC	**Women, Infants and Children**