



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Announcement Number: HRSA-15-101
Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program
Formula Grants FY15

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by the

Idaho Department of Health and Welfare
Division of Public Health
Bureau of Clinical and Preventive Services
Maternal and Child Health
MIECHV Program



Project Narrative

Accomplishments and Barriers

Since August 1, 2014, the Idaho Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program made gains in program development, implementation, training, and evaluation. Some of the most significant accomplishments include: provision of support to four local implementing agencies to deliver three evidence-based home visiting models in four targeted counties, beginning a fourth year of service delivery, analysis of data collected for benchmarks, the completion of a statewide survey of home visiting programs in Idaho, a continuous quality improvement (CQI) initiative to address Recruitment and Retention, obtaining a trainer for local implementing agencies (LIAs) on data and CQI efforts, and an inaugural Statewide Home Visiting Summit.

Some of the challenges that the MIECHV program has encountered so far during the fifth program year include: data reporting, recruitment of several of the legislatively identified priority

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Formula Grant FY 2015 populations, local organizational capacity especially in very rural and frontier communities, and limited state MIECHV program staff to fulfill the multi-dimensional and complex nature of the MIECHV program requirements.

The MIECHV program staff endeavored in a number of strategies to address and overcome challenges throughout the year. To address data reporting challenges, the State lead, data specialist and BSU Evaluation Team have worked with database developers, Social Solutions, to clarify reporting needs. Additionally, MIECHV obtained a contract with Michigan Public Health Institute (MPHI) as a trainer to deliver the Data 101 training developed as a joint project between MIECHV and the Design Options for Home Visiting Evaluation (DOHVE) Technical Assistance team. MPHI is scheduled to present the Data 101 training modules from November 2014 through January 2015. This will help LIAs see meaning in data collection and reporting. The program continues to strategize regarding organization and community capacity to implement evidence-based home visiting programs in very rural and frontier communities.

Between February 2014 and April 2014, the MIECHV program successfully renewed contracts with five agencies to continue the implementation of four Evidence Based Home Visiting (EBHV) programs in four target communities, including a cross-state collaboration to implement NFP. Table 1 presents the home visiting models, expected enrollment, actual enrollment, number of completed home visits to date, and the cost per family by the target counties.

Table 1: 2014 Idaho's Local MIECHV Program Enrollment (August 31, 2014)

Target Communities (Counties)	FY11 to FY13 MIECHV programs	Expected Enrollment (Capacity)	Actual Enrollment (August 2014)	# of Home Visits Completed (August 1, 2014 to August 31, 2014)	FY14 Cost per Family
Kootenai & Shoshone	ICARE: PAT	38	36	40	\$3,250
	Panhandle Health District: NFP (with Spokane Regional Health District)	50	36	39	\$8,368
	Mountain States Group: EHS Home-Based	11	8*	16	\$16,250
Twin Falls & Jerome	Community Council of Idaho: EHS Home-Based	18	13*	25	\$10,833
Total		117	93*	120	\$9,675*

**EHS programs count program openings by child rather than by family. Consistent with model fidelity, an EHS program may have more than one child from the same family enrolled. As of August 2014 Mountain States Group EHS has 11 children and is, therefore, fully enrolled. Their cost per child is \$11,818. Community Council of Idaho EHS has 17 children and is nearly fully enrolled. Their cost per child is \$7,647. With this consideration, actual total enrollment is 104 with an average cost per slot of \$7,771.*

Cost per family was calculated by determining the total contract costs for each local implementing agency for their current 12-month contracted period of service delivery (Feb 2013-Jan 2014). The total contract costs include agency personnel, operating, supplies, travel, and indirect costs. The total contract cost was divided by the number of enrolled families as of August 31, 2014 to determine the average annual cost per family. Caution should be used in this use of cost per family since the measure used reflects the total contact divided by the number of families enrolled, rather than actual contract spending. This is due to the fact that the MIECHV program, at the time of this writing, only received the one month's worth of invoices for FY14 reporting year. Cost per family will continue to lower as each LIA is now fully staffed and continues to build toward full program capacity. Cost per family does not include state program personnel or administrative costs. The MIECHV program will continue to support building strong agency organization and management capacity for implementation at the local level.

State Home Visiting Program Goals and Objectives

Progress and Revisions to Goals and Objectives

The MIECHV program established four goals to achieve through the FY12-FY14 formula grants. Goals and objectives are outlined below with accomplishments and updates of progress to date.

Goal 1: By September 2015, continue support to community-based organizations to implement evidence-based home visiting programs in communities at-risk.

- Objective 1.A: By September 2015, collect and assess annual reports from local implementing agencies to provide feedback and address successes and challenges.
 - *Progress:* The MIECHV program put year two Annual reports on hold in order to address reporting issues discovered in the program's database, Efforts To Outcomes (ETO). The state lead and data specialist have worked with ETO and LIAs to address reporting and data collection issues. LIA's continue to submit monthly reports, quarterly summaries, and bi-annual continuous quality improvement reports. Feedback is provided by the State Team.
- Objective 1.B: By January 2015, provide training to local implementing agencies and assess progress on utilizing centralized intake process in target communities.
 - *Progress:* Testing of the Centralized Intake system algorithm continued from June 2013 to November 2013. However, Centralized Intake system roll-out has been delayed to correct missing data entry points needed to accurately sort participant data. The state lead and data specialist continue to work toward a solution with the database provider.
- Objective 1.C: By November 2014, respond to 100% of training and technical assistance requests submitted to the MIECHV program by local implementing agencies for the previous year.
 - *Progress:* Since August 2014, local implementing agencies have made approximately 6 training and technical assistance requests to MIECHV. Over half of the requests are for technical assistance with the program's database, all but one of which are now closed. MIECHV has been able to fully respond to 50% of training and technical assistance requests, which were all related to ETO. The remaining training and technical assistance requests are ongoing, including

addressing complex needs of families served in frontier regions, database issues, and recruitment and retention.

- Objective 1.D: By September 2015, increase formal referral sources or service agreements for local MIECHV contracts and health related organizations within target communities by 50%.
- Updated Objective 1.D: By September 2015, increase formal referral sources or service agreements for local MIECHV contracts and health related organizations within target communities by 20%.
 - Progress: While LIAs have increased the number of informal referral sources by 32%, formal agreements have only increased by 8%. However, the MIECHV program will support LIAs in pursuing formal agreements with their existing informal partners.

Goal 2: By September 2016, support local implementing agencies in collecting quality data and implementing CQI practices in their everyday work.

- Objective 2.A: By December 2014, deliver data use and CQI training to local implementing agencies' staff and collect and measure pre- and post-training indicators of knowledge, skill, and ability.
- Updated Objective 2.A: By March 2015, deliver data use and CQI training to local implementing agencies' staff and collect and measure pre- and post-training indicators of knowledge, skill, and ability.
 - Progress: A contract for a CQI Trainer and Coach was finalized with MPHI, summer 2014. The state team and evaluation team are currently meeting with MPHI to discuss the Data 101 modules to be presented between November 2014 and January 2015 and the CQI Toolkit to be presented March 2015.
- Objective 2.B: By September 2016, provide ongoing data use and CQI consultation and mentorship to trainees and local implementation agencies.
 - Progress: With the finalization of a contract with MPHI and scheduled Data 101 and CQI Toolkit trainings, the MIECHV program is on track to provide ongoing data use and CQI consultation to LIAs from March 2015 to September 2016.
- Objective 2.C: By September 2016, MIECHV and LIAs will use data to guide three identified CQI topics through the Plan-Do-Check-Act cycle.
 - Progress: With the finalization of a contract with MPHI and scheduled Data 101 and CQI Toolkit trainings, the MIECHV program is on track to provide support LIAs in identifying CQI topics through the PDCA cycle. Additionally, the MIECHV program has identified the state-level goals of recruitment and retention, capacity to complete domestic violence screening, and referral and safety planning with female caregivers and pregnant women.

Goal 3: By September 2016, assure continued MIECHV program participation in early childhood systems building efforts through the EC3 Early Childhood Home Visiting Ad Hoc Committee.

- Objective 3.A: By September 2015, 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.

- *Progress:* During summer 2014, the Committee launched an online survey version of the Home Visiting Assessment for States. The survey was sent to all known early childhood home visiting programs in Idaho and was used to identify home visiting system strengths and areas of need. The committee will address system strengths and needs by engaged home visiting programs and stakeholders in an inaugural statewide home visiting summit October 2014. Survey results and feedback from the summit will be used to develop and present a series of community of practice style web conferences.
- Objective 3.B: By June 2015, disseminate organizational capacity assessment to all organizations conducting home visiting to establish a baseline of data regarding home visiting in Idaho.
- Updated Objective 3.B: By July 2014, disseminate Home Visiting Assessment to all organizations conducting home visiting to establish a baseline of data regarding home visiting in Idaho.
 - *Progress:* The Home Visiting Assessment was disseminated July 2014 and results analyzed through August 2014, establishing a baseline of data regarding home visiting in Idaho. The MIECHV program intends to instead use relevant questions from the organizational capacity assessment to further analyze the needs of home visiting programs in Idaho.
- Objective 3.C: By September 2014, support planning and implementation of statewide inaugural home visiting summit, which will provide an opportunity for training and statewide planning.
- Updated Objective 3.B: By October 2014, support planning and implementation of statewide inaugural home visiting summit, which will provide an opportunity for training and statewide planning.
 - *Progress:* The MIECHV program has co-sponsored a training day focused on the results of the Statewide Assessment and Collective Impact on October 28, 2014.
- Objective 4.D: By September 2015, assess all available training in the state that supports home visiting competencies to produce a systems analysis report of gaps and duplications.
 - *Progress:* Work on this goal will be addressed in the coming months when feedback from the home visiting summit is analyzed and compiled.

Goal 4: By September 2016, support LIAs in collecting timely, quality data.

- Objective 4.A: By September 2015, revise the state-level data collection plan.
 - A first draft of the data collection matrix has been completed for Form 1 and Form 2 data collection for the MIECHV Demographic and Service Utilization Report (DGIS).
- Objective 4.B: By September 2016, provide ongoing training and support to local implementing agencies on collecting and reporting high-quality data.
 - The MIECHV program has identified reports measuring demographic data quality in ETO and has begun work with database developers to identify means to measure timeliness of data reporting. Data collection forms are undergoing updates, and LIAs are now required to review forms at least quarterly.

Program Contribution to Early Childhood System

The Idaho Early Childhood Coordinating Council (EC3) is responsible for making recommendations to the governor on issues and topics related to early childhood in Idaho. The EC3's Home Visiting and Parenting Education Ad Hoc committee began working on a statewide assessment of home visiting capacity and coverage during the spring of 2013. However, activities related to the committee were suspended over the summer of 2013 due to member vacations and the resignation of the MIECHV lead position. With the hiring of a new MIECHV lead, activities resumed as of September 2013. The committee and MIECHV co-sponsored a statewide home visiting summit in October 2014. Additionally, MIECHV is partnering with the EC3 and the American Academy of Pediatrics—Idaho Chapter, to present training developed for home visitors to better communicate the importance of early brain development to families. MIECHV began a partnership with the EC3 Data and Resource Committee in March 2014 to use Adverse Childhood Experience data to inform and improve systems of referral for children who have experienced abuse and neglect. There are no expected changes to the originally submitted logic model.

Collaborative Partners

In November 2010, the MIECHV program convened partners to form a planning steering committee. For the first year, the planning steering committee met monthly to provide guidance to the development plans for the MIECHV program. Starting in January 2012, the planning steering committee began meeting every other month to inform program roll-out and implementation. (See also Attachment 10 – Letters of Support.) The planning steering committee includes the following required partners:

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

Steering committee partners are a part of the Department of Health and Welfare or other state agencies. The state of Idaho seeks to develop a culturally diverse, informed and aware workforce through trainings and professional development opportunities. Each of the MIECHV program's partners serves culturally and linguistically diverse populations across Idaho.

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

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

Program Timeline

Below is a description of the proposed goals and objectives for the MIECHV program from March 1, 2015 to September 30, 2017. Please see Attachment 1: Project Timeline for a description of activities to be carried out during this timeframe.

Goal 1: By September 2017, continue support to community-based organizations to implement evidence-based home visiting programs in communities at-risk.

- Objective 1.A: By September 2016, collect, assess and compare annual reports from local implementing agencies (LIAs) to provide feedback and address successes and challenges.
- Objective 1.B: By January 2017, assess progress on utilizing centralized intake process in target communities.
- Objective 1.C: By September 2017, respond to 100% of training and technical assistance requests submitted to the MIECHV program by LIAs for the previous year.
- Objective 1.D: By September 2017, increase formal referral sources or service agreements for local MIECHV contracts and health related organizations within target communities by 20%.

Goal 2: By September 2017, support LIAs in data use and implementing continuous quality improvement (CQI) practices in their everyday work.

- Objective 2.A: By September 2017, provide ongoing data use and CQI consultation and mentorship to trainees and LIAs.
- Objective 2.B: By September 2017, MIECHV and LIAs will use data to guide three identified CQI topics through the PDCA cycle.

Goal 3: By September 2017, assure continued MIECHV program participation in early childhood systems building efforts through the EC3 Early Childhood Home Visiting Ad Hoc Committee.

- Objective 3.A: By September 2016, 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.
- Objective 3.B: By September 2016, support planning and implementation of a second statewide home visiting summit, which will provide an opportunity for training and statewide planning.
- Objective 3.D: By September 2017, assess all available training in the state that supports home visiting competencies to produce a systems analysis report of gaps and duplications.

Goal 4: By September 2017, support LIAs in collecting timely, quality data.

- Objective 4.A: By September 2015, revise the state-level data collection plan.
- Objective 4.B: By September 2017, provide ongoing training and support to local implementing agencies on collecting and reporting high-quality data.

Implementation of State Home Visiting Program in Targeted At-Risk Communities

Engaging Target Communities

Throughout the past four years, the MIECHV program has been working with and through LIAs to engage community partners and promote high quality home visiting. Prior to identifying and contracting with LIAs, the MIECHV program staff hosted community meetings to inform the public of the MIECHV program requirements, conducted organizational capacity assessments with potential LIAs, and presented MIECHV program information at a number of venues and forums. Since the identification of LIAs, these agencies are contractually obligated to host a community advisory board at least every six months with community partners across sectors and participate in Regional Early Childhood Coordinating Councils (RECCs). Additionally, the MIECHV program has developed an annual community partnerships report in which LIAs identify formal and informal community partners. The MIECHV program has communicated expectations for developing formal and informal community partnerships as referral sources, partners, and resources for the LIAs. The MIECHV program will continue to support LIAs to engage community partners by facilitating connections with key partners, sharing information and data on the MIECHV program, and providing training and technical assistance as needed.

Work with Model Developers

The MIECHV program has been communicating with national model developers to develop relationships with these organizations and understand what resources, supports, and expectations national model developers have for the state MIECHV program and LIAs. Idaho has no direct connection to national model developers through an EHS lead, PAT state lead, or NFP state nurse consultant. In the past, communication and coordination with national model developers has been challenging due to lack of clarity of whom to communicate with regarding specific topics, unclear expectations of model developer's role, and staff capacity in both MIECHV program and national model developer offices. However, MIECHV has been able to connect to regional and national model developer offices through networking efforts while attending regional and national conferences and follow up for technical assistance through phone conferences and email.

- **Office of Head Start – Early Head Start:** In March 2012, the MIECHV program submitted a technical assistance (TA) request for support working with the Office of Head Start to identify and outline the state's role, information available, and communication regarding monitoring model fidelity for Early Head Start Home-Based. Since that time, the MIECHV program has had a number of phone conferences with the Office of Head Start in Washington, DC and with the Region X and Region XII Head Start program specialists to identify information related to model fidelity and program support that may be shared with state MIECHV programs and how that information may be shared with state MIECHV programs. This TA is ongoing as the MIECHV program and the Office of Head Start are working together to identify what information will be shared with states or when and how information will be communicated to states related to model fidelity.
- **National Service Office – Nurse-Family Partnership:** The MIECHV program has worked closely with an NFP program developer and nurse-consultant to support the planning, development, and implementation of the first cross-state collaboration to

implement NFP by Spokane Regional Health District and Panhandle Health District.

NFP has been responsive and supportive when challenges have surfaced with this unique implementation of NFP. The MIECHV program worked for several months with NFP National Service Office's legal team to execute a contract between the MIECHV program and NFP for program support, training, and data in January 2013. During FY14, MIECHV has continued its relationship with NFP in order to provide TA on model fidelity. NFP has also assigned a Regional Nurse Consultant to Panhandle Health District who has provided direct support and TA.

- **National Office – Parents as Teachers:** The MIECHV program has had improved communication with the PAT National Office. Initial communication primarily revolved around developing and approving the MIECHV program benchmarks plan. During the past year, the MIECHV program has worked with PAT National Office for TA on model fidelity for intake and data collection on income. MIECHV intends to continue to work with the PAT National Office to clarify state role, information available, and communication regarding model fidelity for PAT.

Curriculum and Materials for Home Visiting Program

Local implementing agencies were identified through a competitive request for proposal process to identify organizations with capacity to deliver evidence-based home visiting services in target communities for priority populations. Contracts with LIAs allowed for 120 days of pre-implementation planning, scale-up, or start-up. The first year contracts with LIAs included additional funds to account for start-up costs, such as curriculum and materials procurement and training. The MIECHV program allowed agencies to obtain curriculum and materials within 120 days of contract execution. All LIAs began service delivery between June and August 2012.

EHS 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 LIAs adopting the EHS Home-Based model is consistent with Head Start Program Performance Standards (HSPPS) and based in child development research and principles. The Community Council of Idaho EHS uses the Partners for a Healthy Baby curriculum. Mountain States Group EHS uses the Circle of Security curriculum. PAT affiliates use the Born to Learn curriculum, which requires staff to be trained in the current Foundational Training. NFP requires a core education curriculum for all nurses that provide services for this program. The core curriculum includes theory, visit structure, and training to support family empowerment.

Training and Professional Development Activities

The MIECHV program recognizes the importance of training to assure competent service delivery, satisfy model and agency expectations, and support the development of a competent home visiting workforce. Training includes pre-service training, ongoing training and professional development. Each home visiting model developer has outlined standards related to personnel training. LIAs are contractually required to obtain and adhere to model specific training and professional development requirements on an ongoing basis beginning at the initiation of service delivery. The MIECHV program has not coordinated specific training with national models. The MIECHV program has coordinated or facilitated the following trainings:

- MIECHV Program Orientation for Contracted LIAs (April 2012)
- Home Visitor Safety (Web-based – June 2012)
- Mandatory Reporting for Child Abuse and Neglect (July 2012)
- Social Solutions Efforts to Outcomes – Data System Training (September 2012)
- Assessing and Addressing Domestic Violence through Home Visiting – Futures Without Violence (October 2012)
- Developmental Parenting and Home Visit Rating Scale (November 2012)
- Mental Health First Aid Training (March 2013)
- Onsite Data System training with LIAs (April 2013, January 2014)
- Literacy and Brain Development (pilot July 2014, all staff October 2014)
- Data 101 Training Modules (scheduled November 2014 – March 2014)
- Continuous Quality Improvement Toolkit Workshop (scheduled March 2014)

Since service delivery began in June 2012, LIAs have taken advantage of local trainings relevant to their program and home visiting staff. LIAs submit monthly and quarterly reports to document staff trainings. For example, LIAs have participated in trainings related to SIDS prevention from the Northwest SIDS Foundation, working with difficult participants, domestic violence, and Positive Parenting with special needs children.

The MIECHV program will continue to assess and respond to training and professional development needs of LIAs. In the coming year, the MIECHV program anticipates providing training in data use, data-driven decision-making, CQI, recruitment and retention, domestic violence, and developmental assessments.

Staff Recruitment, Hiring, and Retention

The MIECHV program recognizes that 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 to participant outcomes. The MIECHV program included 120 days of pre-implementation planning in the contract to allow LIAs to start-up or scale-up, including identifying staff to meet their organizational and model specific requirements for staffing. At the end of the pre-implementation planning phase, MIECHV program staff conducted onsite visits to ensure LIAs were poised to adhere to contract requirements, including developing and maintaining a staffing plan. The plans indicated 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 outlined objectives for staff retention, such as professional advancement and ongoing training. The plan also outlined a strategy for filling vacancies within 90 days of vacancy.

In the contracting process, the MIECHV program included specific minimum staffing requirements aligning to each evidence-based home visiting model in the contract requirements and performance metrics with each local implementation agency. LIAs report changes in staff and challenges with staffing on a monthly report submitted to the MIECHV state lead. Most LIAs have significant internal training resources available to new staff hired through the

MIECHV program. In the rural and frontier target communities, finding and retaining qualified staff residing in the target communities has been particularly difficult.

As of July 2013, two LIAs reported that three home visitors had resigned (one home visitor per agency). Panhandle NFP was able to hire a qualified bachelor's prepared nurse to fill their vacancy August 2013. The new nurse home visitor received training required by NFP National Service Office in October 2013 and began home visits November 2013. Mountain States Group went through several rounds of interviews. Instead of filling both vacancies externally, they selected one candidate new to their agency and two internal hires. All three home visitors carry a mixed caseload of families that are MIECHV funded and Administration for Children and Families funded. During this time, both Panhandle NFP and Mountain States Group EHS have developed CQI plans to retain home visiting staff.

In the contracting process, the MIECHV program incorporated performance metrics into contracts requiring LIAs to adhere to model specific supervisor requirements and standards to maintain model fidelity. Additionally, LIAs must have at least one home visiting supervisor with training in and at least 50 hours of experience with reflective supervision or subcontract with a qualified partner. The Idaho Association for Infant and Early Childhood Mental Health (AIM Early Idaho) has adopted the Michigan Infant Mental Health (IMH) Model and Endorsement. LIAs have varying internal capacity to meet this requirement and some agencies have subcontracted with a qualified Level III – IMH Endorsee in Idaho. There are approximately five endorsed individuals across the state of Idaho in various organizations. One of the challenges to ensuring high quality supervision is the variability in supervision requirements across evidence-based home visiting model. The MIECHV state lead continues to work with national model developers, AIM Early Idaho, and LIAs to ensure high quality supervision.

Referral and Services Network

LIA's are contractually required to develop and maintain community referral partnerships, ensure timely referral to the IDEA Part C, and implement community engagement strategies. Annually, LIAs report on their informal and formal partners in the communities as required by the contracts with the state MIECHV program. The state MIECHV program partners with LIAs to identify referral strengths, gaps, and opportunities to strengthen partnerships. The Idaho Department of Health and Welfare (IDHW) provides the state welfare services, child protective services, foster care, Medicaid, behavioral health, substance use disorders, WIC and more. The MIECHV state lead has been working with the partners within the IDHW to increase awareness of the MIECHV program in target communities and develop referral connections and policies when appropriate.

Three LIAs serving Kootenai and Shoshone counties in northern Idaho participated in several facilitated discussions to develop a coordinated referral and central intake across the three evidence-based models (Nurse-Family Partnership, Early Head Start, and Parents as Teachers). MIECHV staff continues to work with system developers to refine the centralized intake and referral process. The report is expected to be available for use by LIAs in September 2015.

Participant Recruitment and Retention

LIAs are contracted to identify strategies for recruiting and retaining participants that meet both model specific requirements and MIECHV program priority populations. Organizations

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 developed recruitment and retention plans in response to the request for proposal. Of the MIECHV program priority populations, the MIECHV program has selected the following populations for the highest priority for enrollment:

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

LIAs have continued outreach to community partners, including alternative high schools, child welfare services, military family readiness programs and veteran’s coordinators. LIAs continue to refine their referral processes, utilizing recruitment materials, and recruiting participants into the MIECHV program.

Participant recruitment has continued to be challenging in Shoshone and Jerome counties, as these are frontier and rural counties and have communities with no or very limited home visiting services prior to the MIECHV program. Community isolation, lack of trust in and between service providers, and the independent nature of Idahoans have all contributed to slow participant recruitment. Local MIECHV programs have been working diligently to develop trust with community partners and clients to support ongoing recruitment and retention. The most significant referral source of families to the home visiting programs in Shoshone county has been the local Health and Welfare office. Additionally, eligible families are leaving Shoshone county in order to find better employment in Kootenai county and Spokane, WA.

Of note, Mountain States Group EHS had exclusively served Shoshone county. In order to address the issue of families moving from Shoshone county to Kootenai county, the LIA has shifted five of eleven slots to Kootenai county to attempt to maintain continuity of care. LIAs are contractually required that no less than 15% of enrolled participants reside in the less-populated service area.

In an effort to address ongoing referral, recruitment, and retention issues the MIECHV program has reviewed and presented its existing data related to the issue to LIAs during an August 2014 directors’ phone conference. The data was presented with the Recruitment/Referral Continuum developed by the Zero To Three Technical Assistance and Coordinating Center. The MIECHV program intends to use the Recruitment/Referral Continuum toolkit with programs as part of a state-level CQI effort to address the issue.

Table 2: MIECHV Program Attrition Rate (September 1, 2014-August 31, 2014)

Service Area	Program	Total Enrolled	Total Exited	Attrition Rate
Twin Falls & Jerome	Community Council of Idaho: Early Head Start	13*	0	0%
Kootenai & Shoshone	Panhandle Health District: Nurse-Family Partnership	38	3	8%
	Mountain States Group: Early Head Start	8*	0	0%
	ICARE: Parents as Teachers	36	7	18%

**Early Head Start programs count capacity by children. Mountain States is fully enrolled with 11 children. Community Council is nearly fully enrolled with 17 children and a capacity of 18.*

Home Visiting Caseload

As of August 2014, LIAs are between 79 and 85 percent of enrollment capacity of families across the target communities. Agencies are responsible for adhering to model specific enrollment rate requirements to add new clients to a home visitor’s caseload:

- *Early Head Start*: Home visitors may not have a caseload greater than 12 families at a given time. EHS counts slots by children and pregnant women rather than families.
- *Nurse-Family Partnership*: Nurse home visitors are expected to maintain a caseload of 25 families. Nurse home visitors may only add a maximum of 3 families per week to their caseload.
- *Parents as Teachers*: Parent educators are expected to complete 48-60 home visits per month.

Table 7: Local MIECHV Program Capacity and Caseload as of August 2014

	Community Council of Idaho: Early Head Start**		Panhandle Health District: Nurse-Family Partnership		Mountain States Group: Early Head Start**		ICARE: Parents as Teachers	
	Twin Falls	Jerome	Kootenai	Shoshone	Kootenai	Shoshone	Kootenai	Shoshone
Expected Enrollment (Capacity)	13	5	42	8	6	5	30	8
Current Enrollment (August 2014)	10	3	31	5	4	4	31	5
Total Served (Inception through August, 31, 2014)	17	5	71	10	6	16	98	13
Continuing Families (Year 1)*	9	3	29	3	6	5	29	5
Continuing Families (Year 2)*	3	0	8	1	1	1	20	4
New Families (Year 1)*	4	2	13	5	0	0	1	3
New Families (Year 2)*	10	5	34	7	5	4	10	4

*Figures for continuing and new families are projections based on current enrollment, expected enrollment, and attrition. Year 1 timeframe is March 1, 2015 – September 30, 2016 and Year 2 timeframe is October 1, 2016 – September 30, 2017.

**Mountain State Group EHS is currently serving four children and pregnant women (three families) in Kootenai County, seven children and pregnant women (four families) in Shoshone county, meeting model standards for full enrollment. Community Council of Idaho EHS is serving 14 children and pregnant women in Twin Falls County (10 families) and three children and pregnant women (three families) in Jerome County.

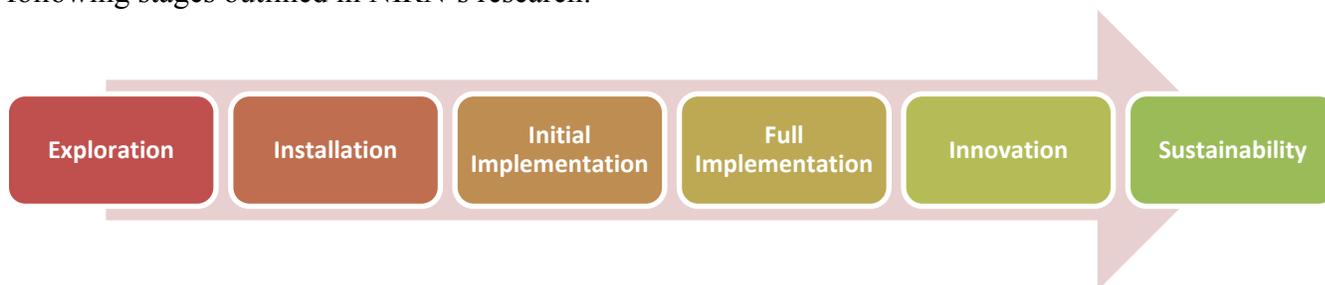
Community Resource Coordination

LIAs submit an annual community partnership report indicating formal and informal partnerships in the target communities. Reports were submitted June 2013 and June 2014. Agencies identified an average of 11 informal community partners and an average of 7 formal community partners including churches, food banks, WIC, legal aid, educational institutions, and more. Home visitors, home visitor supervisors, and program directors have been working to establish meaningful partnerships with traditional and non-traditional community partners in the target communities. As an example, when families are participating in early intervention services or are involved with child welfare, home visitors work closely with partner service agencies to coordinate home visits and ensure objectives of all service providers are met.

Because the MIECHV program is the first and only state-administered home visiting program, the program is in a unique position to facilitate communication and partnerships between LIAs and state programs such as IDEA Part C, WIC, child welfare, substance use disorders, mental health, child care, TANF, and more. State MIECHV program staff have developed relationships with other state program administrators through participation in the MIECHV program steering committee. These relationships help ensure communication, alignment of services and policies, and availability of training and professional development. As an example, the MIECHV program has been working with the Idaho Infant Toddler Program (ITP – IDEA Part C) to ensure ITP staff is able to participate in relevant trainings coordinated by the MIECHV program. Additionally, the MIECHV program works closely with the director of the Idaho Early Childhood Coordinating Council (EC3) funded through the Early Childhood Comprehensive Systems (ECCS) grant to initiate conversations about integration of home visiting into early childhood systems activities.

Challenges Maintaining Model Fidelity and Quality

The MIECHV program understands that there are a multitude of factors related to implementing an evidence-based home visiting program while maintaining fidelity, high quality services, and continuous quality improvement in varying community and organizational settings. Contractually, LIAs must implement home visiting programs with fidelity to the researched program model. The National Implementation Research Network (NIRN) has outlined successful implementation of evidence-based programs and practices, effective interventions and implementation are critical for outcomes. Effective implementation occurs over time in the following stages outlined in NIRN's research:



LIAs are in different stages of implementation of evidence-based home visiting. Two LIAs have been implementing PAT and EHS for more than ten years, while two other LIAs started up EHS and NFP programs through the MIECHV program. One challenge the MIECHV program has is supporting LIAs considering where each agency is on the spectrum of implementation stages.

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Ongoing communication and dialogue with LIAs allows the MIECHV program to provide supports to agencies as identified.

Because of the frontier and independent nature of Idaho's target communities, there have been challenges in community buy-in, participant recruitment, and retention. This program has provided an opportunity to initiate dialogue about strategies to advance systematic efforts to achieve quality and fidelity in home visiting at the community and state level to increase visibility and buy-in of the MIECHV program. This dialogue continues through the local Community Advisory Boards, Regional Early Childhood Coordinating Council meetings, and outreach and recruitment efforts by local implementing agencies. Additionally, there have been challenges related to reflective supervision and understanding how to adhere to model specific requirements for reflective supervision. LIAs are contractually obligated to provide reflective supervision for at least an hour a month for each home visitor. One agency has subcontracted with an IMH-E Level III affiliated with the Idaho Association for Infant and Early Childhood Mental Health (AIM Early Idaho). Challenges still remain for LIAs in navigating what constitutes reflective supervision and who is qualified to provide it, as well as the differences between model requirements for providing reflective supervision and the AIM Early Idaho requirements for reflective supervision.

Implementing an evidence-based home visiting program in a frontier community, such as Shoshone County, has required careful monitoring to assure that families receive appropriate frequency and duration of services. The MIECHV program anticipates addressing such challenges through CQI, reporting requirements, and ongoing consultation with LIAs to overcome barriers. Agencies submit monthly reports with home visiting data and a description of challenges and successes of implementation. In these reports, agencies indicated building connections with partners and clients in rural and frontier communities were challenging and that home visitors who travel long distances and work in low-populous areas feel isolated and require more supervisory support. The MIECHV program will work with LIAs to determine how to better support home visiting staff in rural and frontier areas.

Finally, the MIECHV program will conduct ongoing training and annual onsite contract monitoring visits with LIAs that will include a review of adherence to model fidelity. However, the MIECHV program has struggled to define its role in monitoring model fidelity in partnership with national model developers and to understand federal expectations for how and to what degree state MIECHV programs are to assure model fidelity. However, as MIECHV has strengthened its relationships with the Office of Head Start, PAT and NFP, roles in monitoring model fidelity continue to clarify.

Progress Toward Meeting Legislatively Mandated Reporting on Benchmark Areas

The MIECHV program has dedicated a significant amount of time and resources to continue the development and implementation of the data collection plan. Idaho's benchmark plan was approved in April 2012 after LIAs were identified and began pre-implementation planning. During the benchmarks plan approval process, the MIECHV program began to develop standard data collection forms for the EHS and PAT programs and worked with NFP for an approved variance for data collection. In July 2013, the MIECHV program submitted a revised benchmarks plan, after the receipt of guidance from TA providers regarding the submission of

the DGIS Forms 1 and 2 and discrepancies in benchmark and comparison periods. LIAs utilize the following MIECHV program forms in addition to the standardized assessment and screening tools:

- Home Visit Encounter Form (Every home visit)
- Child Health Form (Intake and every 6 months)
- Maternal Health Form (Intake and every 6 months)
- Demographics Intake Form and Demographics Update Form (Intake and annually)
- Ages and Stages Questionnaire – 3rd (Intake, if child is 6 months, and every 6 months)
- Ages and Stages Questionnaire – SE (Intake, if child is 6 months, and every 6 months)
- Home Inventory Form (Intake, if child is 6 months, and annually)
- Everyday Stressors Index (Intake and annually)
- Edinburgh Postnatal Depression Scale (45 days postpartum)
- Relationship Assessment Tool (Within 3 months of participation)

With many moving parts and extenuating factors, including rapidly changing information, local implementation agency communication on timelines and expectations for data collection, and lengthy data system updates and testing, all contributed to challenges in the collection of benchmark data for the MIECHV program. The MIECHV program has been compiling benchmarks data from a variety of sources, which is a very complex and intricate process. Sources for the benchmarks data are from a variety of sources including: local implementation agency reports, participant data collection forms, state administrative data systems, and participant screening and assessment tools. The MIECHV program continues to extract, clean, and analyze data for upcoming DGIS reports.

All four LIAs have reported issues utilizing the data system due to lack of familiarity, difficulty in navigation, challenges in running reports in the system, and data system glitches. These challenges have impacted the quality of data entered into the system by LIAs. While a large quantity of previously missing data has been put into ETO, the process of addressing missing data continues. There have been ongoing challenges with the data system since it went live. In December 2013 and January 2014, the MIECHV state lead conducted onsite visits with the LIAs to assess issues with data entry and data system navigation. The MIECHV state lead and data specialist have uncovered a number of updates that were needed in the data system. The MIECHV program continues to work with the database provider to make updates to the data system. The MIECHV program will also continue to provide data system training to LIAs.

Despite challenges, the MIECHV program has had a number of successes implementing the benchmark data and collection plan. Data collection compliance from LIAs has increased with greater communication on timeframes. The quality of data entry has also improved with ongoing TA from the data specialist. Since the submission of Form 2 for the FY14 DGIS, there is now enough data to begin to analyze how LIA's are performing in both process and outcome measures of the benchmarks. The BSU Evaluation Team has begun compiling quarterly benchmark summaries for each LIA for trend analysis to identify strengths and CQI topics. This has been supported by MIECHV efforts to streamline data quarterly checking and cleaning systems to ensure quality data.

The data specialist is currently responding to TA requests by LIAs and increasing capacity to develop reports in the data system through continued training. The MIECHV data specialist runs reports and extracts data from multiple levels: participant, home visitor, agency, target community, or statewide. Additionally, the data system specialist has worked with the database provider to update components of the data system, develop and run reports, and monitor data entry and data quality. The MIECHV program is well positioned to continue high quality data collection at the frequency outlined in the approved benchmarks plan.

State Home Visiting Program CQI Efforts

Updated CQI Progress

Prior to FY14, the MIECHV program had been working with the LIAs to understand where organizations are on the continuum of implementation. The evaluation team interviewed each of the local MIECHV programs prior to program implementation to establish a baseline of qualitative information regarding organizational priorities including CQI, capacity for reflective supervision, and community partnerships. The MIECHV program identified a need for training and skills development in data use and integration of continuous quality improvement into ongoing performance management. Using data effectively is a critical component in assessing model fidelity, client progress, program performance and informing the CQI process.

In response to the need for CQI training, the MIECHV program submitted a TA request to develop a series of interactive, skill building modules and workshops that utilize a variety of communication mediums including: web-based, didactic, and collaborative group learning for local MIECHV program staff. The content of this series of learning modules should gradually build competence in using data for performance management in a CQI process. Some key elements of this CQI training series are: Becoming Knowledgeable Consumers of Data (Data points), Utilizing Data to Manage Change (Business process and data flow), and Improving Outcomes (data in a systemic context). Additionally, the state MIECHV program anticipates presenting tools and workshops to guide development of local CQI teams in the coming year with the aid of MPHI, contracted to provide CQI training and coaching to MIECHV and LIAs. To support development of CQI teams and tools, the state MIECHV program established quarterly supervisor roundtable calls that began in December 2012, in which much focus has been on CQI plans and processes.

With the hiring of a new state lead in August 2013, TA on CQI resumed to support the writing of a job description for a trainer and coach that could deliver the Data 101 training series, CQI workshop, and provide mentoring to state and local staff for CQI processes. TA was also provided to continue CQI support to implementing agencies to prepare them for training and coaching. Quarterly supervisor roundtable calls resumed in October of 2013, to discuss LIA and state MIECHV CQI goals. Additionally, individual agency check-in calls with the state lead have been instituted between the quarterly supervisor roundtable calls, addressing CQI efforts as well as other training and TA needs. The state lead made site visits in December 2013 and January 2014 to local implementing agencies, which included discussing the progress of local level CQI teams and their efforts.

MIECHV also provided TA to the three North Idaho programs to help them better address CQI at the regional level through their shared Community Advisory Board, which is hosted quarterly.

The North Idaho implementing agencies experienced frustration with the recruitment and consistent attendance of other community members. MIECHV sought TA and was able to support a transition to a Community Advisory Board meeting that includes two large community level meetings and two small meetings focused only on CQI.

CQI Plan

The MIECHV program has established ongoing mechanisms for evaluating program processes and outcomes to assess performance improvement opportunities and to enable efficient and effective service delivery, including the development of CQI learning modules for implementation agencies. The CQI plan allows benchmarking of processes and outcomes, data-driven decision-making, site specific improvement plans, monitoring local contractor progress towards contractual objectives, assessing program implementation and delivery, identification of potential training opportunities, and revisions of processes to meet needs and improve performance.

Implementation of the CQI process at the state and local levels is in development and will include a state CQI team and local CQI teams. The local CQI teams currently include: home visitors, supervisors, and community members. The BSU evaluators have been providing quarterly updates for LIA's. MIECHV is working with LIAs to involve parents. The state CQI team currently includes: state lead, data specialist, BSU Evaluation Team, local implementing agency directors and home visiting supervisors. MIECHV intends to recruit model developers (when available) and partners. Buy-in and participation from all levels of the program will be instrumental in creating and guiding a culture of quality.

PAT, NFP and EHS conduct quality assurance or monitoring through onsite visits to grantees/affiliates. Because the MIECHV program provides ongoing performance monitoring and coordinates TA and training with LIAs, the MIECHV program has been cultivating partnerships with national model developers to align monitoring activities and determine methods for developing CQI plans and processes in accordance with expected processes and outcomes.

When the CQI teams are fully established, the teams will be oriented to the PDCA framework and sequence for implementing a CQI process:

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 align with the constructs in required benchmark areas. The indicators being assessed during the initial CQI process are based on the outcomes identified from Form 2 of the FY14 DGIS. These items include:

- Preconception care
- Referrals for maternal and child health insurance and identifying resources for families that do not qualify for either Medicaid or the health insurance subsidies
- Reducing visits for children to the Emergency Department
- Reducing the incidence of children requiring medical treatment for injuries
- Parent knowledge of child development

- Increasing family self-sufficiency
- Referral completion (providing appropriate referrals and referral follow-up)
- Developmental Assessments
- Domestic Violence referrals
- Timely and complete data collection

From these issues, Domestic Violence referrals continues as a state-level goal. LIA's have adopted, local level indicators including education on the risks of smoking, completing forms in a timely manner, and referrals. The state has submitted and received approval for TA on domestic violence as of May 2014.

2. Assessment

Benchmark data is being 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 analysis and reporting for initial implementation has been occurring since June 2012 to assess differences between current performance and desired performance based on targets. At this point, most baseline data has been established. The MIECHV data system (Efforts to Outcomes) is a robust reporting functionality to facilitate the assessment stage. Those processes or outcomes not meeting target have been flagged and prioritized for follow-up with the PDCA process with state/local administrators, model developers, and the CQI team.

3. Initiative

The MIECHV CQI teams have begun to address performance improvement opportunities using the PDCA framework, which provides a continuous and methodical approach to identify performance problems and possible causes, then outline and prioritize strategies for improvement. The MIECHV program has been providing TA to local contractors related to the PDCA approach for CQI and provide tools to assist in identifying problems and solutions.

LIAs are contractually obligated to submit a CQI report every six months (pictured below). The first CQI reports were submitted July 2012 prior to enrolling families in service delivery and have been re-submitted every six months. LIAs identified the following topics for improvement:

- Collecting and entering quality data efficiently and accurately
- Increase home visit completion rates
- Improve play group and parent-child interactions
- Hiring, training, and retaining home visitors in frontier and rural communities
- Community partnership development
- Availability of dental and mental health providers in rural and frontier communities

Performance interventions are documented and monitored by the CQI team for improvement in specified processes and outcomes, as well as adherence to model standards.

The State has selected Benchmark 4: Domestic Violence as its focus for CQI. This includes assessments, referrals, and safety planning. The state team is in the Plan stage of PDCA, gathering data to conduct a root cause analysis of assessment completion. The state has worked

Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program Formula Grant FY 2015 with the BSU evaluation team to collect the data related to incomplete and late assessments or analyzing participant characteristics and program compliance. MIECHV reviewed the data with LIAs during the May 2014 quarterly director's phone call. It was determined that an underlying issue is recruitment and retention of high-risk families. Data on recruitment, retention, and active participants was reviewed during the August 2014 quarterly director's phone call, as well as the Recruitment/Referral Continuum. The MIECHV program plans to use the Recruitment/Referral Toolkit to further analyze and address the issue.

The recruitment and retention of high-risk families increased the importance of domestic violence assessments, referrals and safety plans. Capacity to identify and address domestic violence is crucial to health and safety outcomes of women and children enrolled in MIECHV. Children who live in homes where the mother has experienced domestic violence are more likely to experience learning or behavior problems. Addressing domestic violence through early intervention supports all benchmark outcomes for children, meaning they are more likely to be ready to learn at school age.

4. Evaluation

The MIECHV program requires LIAs to submit an annual performance evaluation. The performance evaluation summarizes 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.

MIECHV Program CQI Report

MIECHV Program Continuous Quality Improvement (CQI) Report			
Report due: Every 6 months by the 15 th July & January			
Contract Number:	Date of Report Submitted:	Dates of Report:	
		From:	To:
Contractor Name:			
Contact Name:			
Contact E-mail:			
Contact Phone:			
Part 1: Continuous Quality Improvement Plan and Staff:			
Instructions: Briefly describe the progress and challenges faced implementing the Continuous Quality Improvement plan. Indicate persons responsible for and engaged in the CQI plan.			
Part 2: Progress on Continuous Quality Improvement Plan			
Instructions: Referring to the PDCA Framework, briefly describe processes and activities implemented in Table 1: Continuous Quality Improvement.			
PDCA Cycle Framework			
<ol style="list-style-type: none"> Plan: Identify the problem or issue that needs to be addressed. This may require process mapping or key informant interviews to get to the root of the problem. Do: Generate solutions to the issues or problems and select the most likely solution(s). Implement a pilot project or policy to test the solution. The "Do" phase is the test phase. Check: Measure the success of the pilot solutions before full implementation. Gather lessons learned and determine what may have made the pilot better. Incorporate improvements for additional pilots or full implementation. Act: Implement the solution broadly and continue assessment of success of the solution. Then seek further areas in need of improvement. 			
5-16-12		5-16-12	

Topic 1:	
Plan: <i>Issue/topic</i>	
Do: <i>Action taken to address issue, include dates and timelines</i>	
Check: <i>Analysis of improvement due to the action taken</i>	
Act: <i>Changes needed to maintain or continue improvement</i>	
Persons Involved:	
Topic 2:	
Plan: <i>Issue/topic</i>	
Do: <i>Action taken to address issue, include dates and timelines</i>	
Check: <i>Analysis of improvement due to the action taken</i>	
Act: <i>Changes needed to maintain or continue improvement</i>	
Persons Involved:	
Topic 3:	
Plan: <i>Issue/topic</i>	
Do: <i>Action taken to address issue, include dates and timelines</i>	
Check: <i>Analysis of improvement due to the action taken</i>	
Act: <i>Changes needed to maintain or continue improvement</i>	
Persons Involved:	

Administration of State Home Visiting Program

The IDHW is the designated lead agency for the MIECHV program. The program is managed within the Maternal and Child Health Program (MCH), Bureau of Clinical and Preventive Services, Division of Public Health. The Chief, Bureau of Clinical and Preventive Services.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Program Support Center
Financial Management Service
Cost Allocation Services

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October 23, 2014

Jodi Osborn, Financial Executive Officer
Idaho Department of Health & Welfare
450 West State Street, 9th Floor
Boise, Idaho 83720-0036

Dear Ms. Osborn:

This letter provides approval of the Idaho Department of Health & Welfare Cost Allocation Plan (Plan) amendment which was transmitted to our office on July 15, 2014. The Plan amendment is effective September 1, 2014.

Acceptance of actual costs in accordance with the approved Plan is subject to the following conditions:

- 1) The information contained in the Plan and provided by the State in connection with our review of the Plan is complete and accurate in all material respects.
- 2) The actual costs claimed by the State are allowable under prevailing cost principles, program regulations and law.
- 3) The claims conform with the administrative and statutory limitations against which they are made.

This approval relates only to the methods of identifying and allocating costs to programs, and nothing contained herein should be construed as approving activities not otherwise authorized by approved program plans or Federal legislation and regulations.

Implementation of the approved Cost Allocation Plan may subsequently be reviewed by authorized Federal staff. The disclosure of inequities during such reviews may require changes to the Plan.

If you have any questions concerning the contents of this letter, please contact Stanley Huynh of my staff at (415) 437-7829.

Sincerely,

Arif Karim, Director
Cost Allocation Services

cc: Carol Peverly, CMS
Joann Simmons, ORR

Patricia Fisher, ACF

Francisco Lebron, FNS

ATTACHMENT 1: Project Timeline

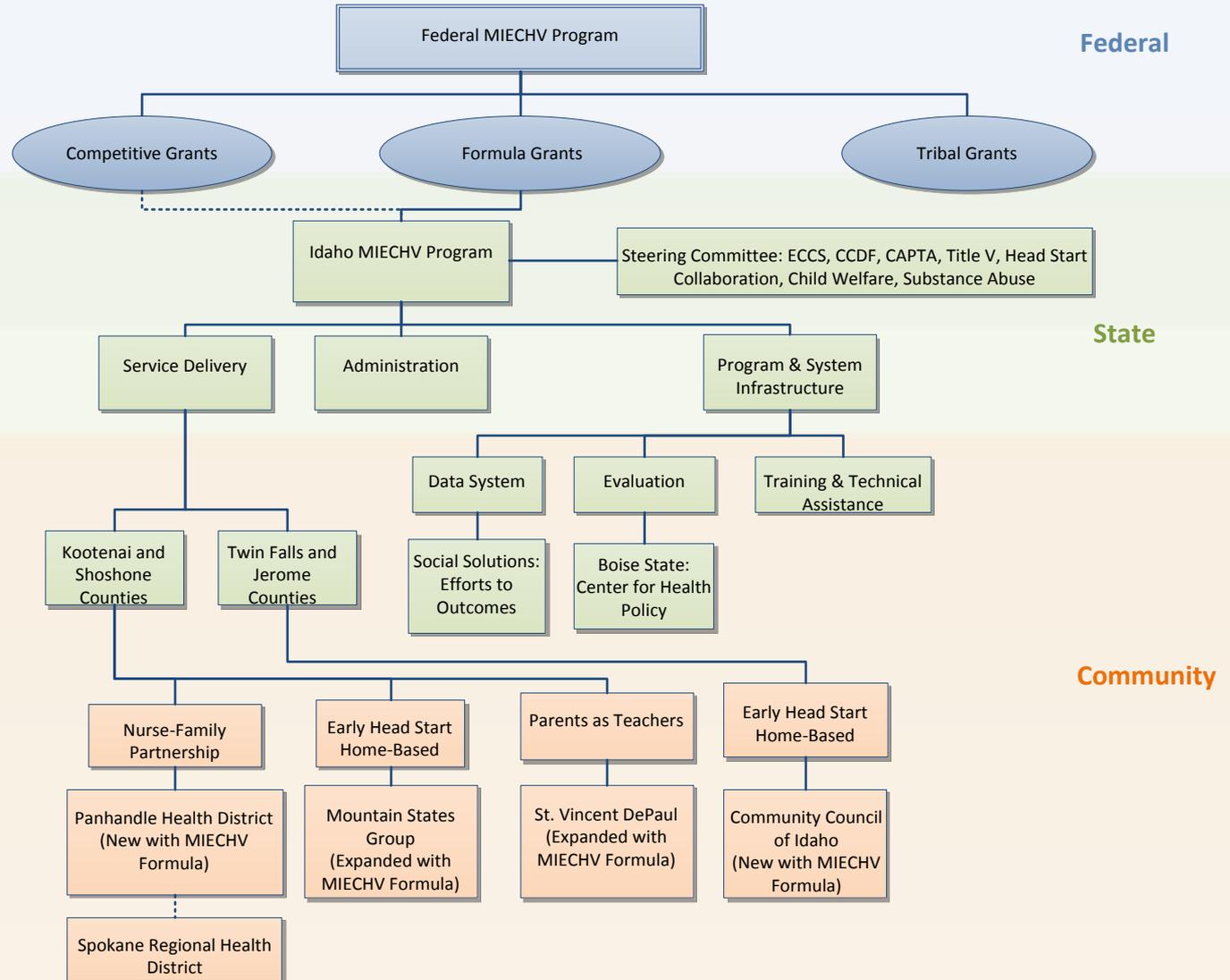
Activity	Timeframe	Person Responsible
Goal 1: By September 2017, continue support to community-based organizations to implement evidence-based home visiting programs in communities at-risk.		
<i>Objective 1.A: By September 2016, collect, assess and compare annual reports from LIAs to provide feedback and address successes and challenges.</i>		
Provide written response to annual reports to address successes, challenges, recruitment, retention, and program sustainability.	August 2015—September 2015	State lead
Compare 2015 Annual Reports to 2014 Annual Reports to identify successes and continued challenges in implementation.	August 2015—September 2015	State lead Data specialist
Hold teleconference with all local implementing agencies (LIAs) to discuss common implementation and service delivery themes across all agencies.	September 2015	State lead
<i>Objective 1.B: By January 2017, assess progress on utilizing centralized intake process in target communities.</i>		
Provide ongoing training and technical assistance regarding centralized intake and referral in Kootenai and Shoshone counties.	March 2014—September 2017	State lead Data specialist
Use data collected from Central Intake systems to provide feedback to identify types of referrals and referral partners.	November 2015, November 2016	State lead Data specialist
Hold teleconference to discuss common recruitment and referral themes in home visiting programs including strengths and areas of quality improvement.	January 2016, January 2017	State lead Data specialist
<i>Objective 1.C: By September 2017, respond to 100% of training and technical assistance requests submitted to the MIECHV program by LIAs for the previous year.</i>		
Document receipt of formal and informal training and technical assistance requests from LIAs.	September 2015	Data specialist
Provide initial response to requests including next steps within 3 business days.	November 2015	Data specialist
Assess requests and determine method for delivery of training and technical assistance, including need assistance from national technical assistance providers or national model developer assistance.	January 2016	State lead Data specialist
Provide training and technical assistance per requests and assess need for on-going assistance	January 2016—September 2017	State lead Data specialist
<i>Objective 1.D: By September 2017, increase formal referral sources or service agreements for local MIECHV contracts and health related organizations within target community by 20%.</i>		
Provide ongoing support to LIAs to identify community resources and referrals for women, children, and families enrolled in home visiting programs.	March 2015—September 2017	State lead
Utilize the Recruitment/Referral Toolkit to identify strengths and needs in building referral relationships with community organizations.	January 2016—July 2016	State lead Data Specialist

Activity	Timeframe	Person Responsible
Goal 2: By September 2017, support LIAs in data use and implementing continuous quality improvement (CQI) practices in their everyday work.		
<i>Objective 2.A: By September 2017, provide on-going data use and CQI consultation and mentorship to trainees and LIAs.</i>		
Develop and provide CQI Toolkit Refresher Workshop based on progress and needs identified from ongoing consultation and mentorship to LIAs.	March 2016	Training contractor
On a monthly basis, provide ongoing data use and CQI consultation and mentorship to trainees and LIAs via webinars, teleconference, or email.	April 2015 – July 2016	Training contractor
Build systems and capacity for ongoing CQI, and CQI mentorship at the local, regional, and state levels.	July 2016-September 2017	State Lead Data Specialist Evaluation Team LIA's
<i>Objective 2.B: By September 2017, Idaho MIECHV and LIAs will use data to guide three identified topics through the Plan-Do-Check-Act cycle.</i>		
Review progress on benchmarks, home visit rates, enrollment and retention to identify strengths and areas of need at the state level and by program	March 2015—January 2016	State lead Evaluation team Data specialist
Conduct root causes analysis of identified topics and develop a plan to address using data, CQI consultation, and mentorship to staff and LIAs via webinars, teleconferences, or email.	April 2015	State lead Data specialist
Review data showing progress on identified CQI topics, analysis for improvement with data use and CQI consultation and mentorship to staff and LIAs via webinars, teleconferences, or email.	August 2015	State lead Data specialist
Implementation of solutions to identified CQI topics with data use and CQI consultation and mentorship to staff and LIAs via webinars, teleconferences, or email.	February 2016—September 2017	State lead Data specialist
Goal 3: By September 2017, assure continued MIECHV program participation in early childhood systems building efforts through the EC3 Early Childhood Home Visiting Ad Hoc Committee.		
<i>Objective 3.A: By September 2016, 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.</i>		
Create work plan describing major activities to address goals, based on the results from the Statewide Home Visiting Assessment, and feedback from the Statewide Home Visiting Summit.	March 2015	State lead Ad hoc committee
Present work plan describing major activities to address goals to the EC3 for feedback and approval.	May 2015	State lead Ad hoc committee
Implement work plan activities including in-person trainings, webinars, and social media.	June 2015—September 2016	State lead Ad hoc committee

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Activity	Timeframe	Person Responsible
<i>Objective 3.B: By September 2016, support planning and implementation of second statewide home visiting summit, which will provide an opportunity for training and statewide planning.</i>		
Use feedback from inaugural summit to plan for a second annual or bi-annual summit.	January 2015	State lead Ad hoc committee
Develop agenda, and identify speakers for summit.	May 2015—July 2015	State lead Ad hoc committee
Hold second annual (or bi-annual) statewide home visiting summit for all home visiting agencies and stakeholders, including stakeholders in the philanthropy and business sectors.	October 2015	State lead Ad hoc committee
Use feedback to inform Ad-hoc committee strategic planning and plan future home visiting summits.	January 2016	State lead Ad hoc committee
<i>Objective 3.D: By September 2017, assess all available training in the state that supports home visiting competencies to produce a systems analysis report of gaps and duplications.</i>		
Identify major home visiting competencies to be addressed during the assessment with input from ad hoc committee and other stakeholders	February 2016	State lead Ad hoc committee Evaluation team
Conduct statewide home visiting competency assessment	August 2016	State lead Evaluation team
Compile and analyze results from home visiting competency assessment	December 2016	Evaluation team
Report results from the home visiting competency assessment to Ad Hoc Committee and determine recommendations for next steps for addressing gaps in training	September 2017	State lead
Goal 4: By September 2017, support LIAs in collecting timely, quality data.		
<i>Objective 2.A: By September 2015, revise the state-level data collection plan.</i>		
Review and refine data dictionary with technical assistance from DHOVE.	June 2015—August 2015	Data specialist
Refine data collection matrix using the Plan-Do-Check-Act cycle and technical assistance from DHOVE.	June 2015—August 2017	State lead Data specialist
<i>Objective 2.B: September 2017, provide ongoing training and support to LIAs on collecting and reporting high-quality data.</i>		
Create clear definitions of ‘data quality’ for contract monitoring with LIAs.	March 2015	Data specialist Evaluation team
Provide annual reports highlighting data captured and data challenges to LIAs.	December 2015	Evaluation team
Provide refresher training to LIAs on utilizing, navigating, and entering data into the ETO data system.	January 2016	Data specialist
Provide ongoing support to LIAs on correct use of forms, assessments, and data reporting.	March 2015—September 2017	Data specialist

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



10/15/2014