IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Maternal, Infant and Early Childhood Home Visiting Formula Grant Program
FY11
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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 entity responsible for carrying out the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program planning, evaluation 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 serves a state where the people are as diverse as the landscape.

As a frontier state, Idaho is subject to challenges not found in highly populated, urbanized states. Idaho's geography 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 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 special 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 9). A careful balance of the needs of these populations and the viability of providing services requires effort and continuous dialogue between both local and state partners. 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 itself through development of local programs and services through grassroots efforts rather than a centralized approach. This philosophy is present within the political leadership, which influences allocations to programs within state government, including on Idaho's health programs.

Demographics

The 2010 estimated population for Idaho was 1,567,582, ranking 39th of the fifty United States in population. However, the population increased 21.1% from 2000 to 2010, more than double the national average of 9.7%. 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 18.9 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 2010, the national average for population density was 87.3 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 1,567,582 persons, approximately 127,000 are children under the age of 5. In 2009, an estimated 53% of young were living in low income households at 200% FPL or below, 21% in poverty (< 100% FPL or below) and 8% living 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 (seasonally adjusted) to 9.4% in May, 2011 (U.S. Bureau of Labor Statistics retrieved on July 1, 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. 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 11.2% of the population is Hispanic. In 2009, as the proportion of births to Hispanic mothers (15%) is greater than the overall population (10.2) by approximately 4%, possible evidence of demographic shifts in Idaho. In parts of the state, approximately 30% of all births in 2009, were to Hispanic mothers. Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is 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. Due to the agricultural nature, more than half of Idaho's Hispanic population resides in two Public Health Districts (PHD), with 32.5% residing in PHD 3 and 20.4% in PHD 5, along the Snake River Plain.

There are six Native American tribes across the state with approximately 18,350 persons, 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. The majority of Native Americans reside on five reservations in northern, eastern and southern Idaho in PHDs 1, 2, 3 and 6. Notably, Idaho resettles the large number of international refugees, the majority reside in PHD 4, the largest population center in the state. Currently, most of the incoming refugees are largely from: Iraq, Myanmar, and the Democratic Republic of Congo. The following figure describes the distribution of population of Idahoan's across the Public Health Districts. The state population is rapidly changing, as evidenced by 21.1% population growth in the past ten years. Both the Hispanic and non-Hispanic population continue to grow in Idaho. Note: target communities are within PHD 1 and 5.

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

	Total Population	% Total Population	5 Year Ave. Births	% Births to Hispanic	% 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, 2009, Idaho Vital Statistics Report 2009, National Center for Children in Poverty State Profile 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

	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
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.
Note: *Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.

Figure 1: Map of Idaho's Public Health Districts

Access to Health Care

In addition to the geographic barriers, availability of primary care, specialty care and health insurance coverage 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. 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. 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 July 1, 2011).

Title V Maternal and Child Health and Early Childhood Systems

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 multiple 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.

1. **Reduce premature births and low birth weight.**
2. *Reduce the incidence of teen pregnancy.*
3. Increase the percent of women incorporating effective preconception/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 MIECHV 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 consolidating 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.

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 statewide needs assessment conducted in 2008 resulted in six outcome areas encompass the service delivery system and the networks of support services for young children.

Table 3: Early Childhood Comprehensive Systems Outcome Areas and Goals

Out-come Area	Health	Infant, Early Childhood Mental Health/SE Dev.	Early Learning/Education and Care	Parent Education	Family Self-Sufficiency
Goal 1	**Accessible and affordable health care**	*Service delivery system for infant and early childhood mental health*	Quality child care	*Parent education - Common language & understanding of child development*	*Family supports for children with disabilities*
Goal 2	**Comprehensive development screening and**	**Pre- and post-partum depression screening and referral**	*Integrated learning opportunities for children from birth to*	**Parent education resources**	**Accessible & affordable health care**

	monitoring		*5 years old*		
Goal 3	*Nutrition for young children*		Common language and understanding of child development	*Education and resources for incarcerated parents*	Quality child care
Goal 4	**Immunization rates**				
Goal 5	**PPD screening and referral**				
Goal 6	Follow-up Newborn Hearing Screening				

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 farther 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.

Section 1: Needs Assessment and Identification of Target At-Risk Communities

Needs Assessment Overview

The Needs Assessment – Supplemental Information Request #1 conducted in September 2011, analyzed risk factors at the Public Health District level, the defined community and unit of analysis. The seven PHDs are arranged around the seven 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 available at the PHD level. Within each of the seven PHDs, there are autonomous health departments, which conduct public health services including, but not limited to: surveillance, health inspections, health preparedness, immunizations, family planning, WIC and STD clinics. 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. Compared Z-score method, for each county to the statewide mean to determine number of standard deviations (SD) from statewide mean (Z-score of 1 = 1 SD greater than mean),
4. For Z-scores greater than 1, counties got "1 point" for each indicator,
5. Summed "points" to create county risk score (Note: counties could have "1 point" for each indicator" for a potential total of "13 points"),
6. Calculated the "Sum Risk Score" for each PHD by adding each county risk score,
7. 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),
8. Ranked risk index for each PHD from highest to lowest,
9. Determined three highest ranked PHD's "at-risk communities."

Table 4: Community Risk Ranking from SIR #1 – Needs Assessment

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

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

The Needs Assessment identified PHDs 2, 1, and 5 as the "at-risk communities." However, given the scope of the intervention, geography, and guidance in the SIR #2 – Updated State Plan Guidance, it was 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 counties 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, , etc.):
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)
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)

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 resource networks in communities across Idaho. With guidance from the planning steering committee (concurrency partners), the MIECHV program developed a survey to collect information related to utilization of evidence-based programs, in-home services, community-based organizations, target populations, service areas and more. The MIECHV program utilized a non-probability, convenience sample of more than 550 potential respondents across disciplines, including social service, health, early learning, faith-based, education and community-based organizations. The original sample included more than 400 elementary principals. The survey elicited 192 responses via Survey Monkey: 70 partial and 122 complete responses. Analysis continues on the 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.

At-Risk, Target Communities

For the purpose of Years 1 and 2 of the MIECHV program in Idaho, four communities (counties) have been identified as target communities based on thorough analysis of multiple variables including: analysis of risk, geography, proximity and infrastructure. These four counties, considered two, two-

county areas will be eligible to apply for MIECHV program funds to implement evidence-based home visiting in accordance with MIECHV program requirements (*see implementation plan*). In no order:

- Kootenai County (PHD 1)
- Shoshone County (PHD1)
- Twin Falls County (PHD 5)
- Jerome County (PHD 5)

Needs and Resources of Target Communities

Each county has unique population, geography, strengths and needs. 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 6 indicates that the communities vary greatly in population characteristics. Twin Falls and Jerome counties have greater prevalence of young children, Hispanics and teen births. Kootenai and Shoshone counties have higher rates of civilian veterans, Medicaid births, unemployed citizens and smoking during pregnancy.

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
2010 Population	138,494	12,765	77,230	22,374	1,567,582
% Population Birth-5 (2010)	6.4%	5.2%	8.3%	10.5%	8.1%
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 Hispanic (2010)	3.8%	3.0%	13.7%	31.0%	11.2%
% 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 due to population density

Given the diverse nature of Idaho, the MIECHV program engaged communities via community meetings to engage leaders and garner information about community characteristics. The Idaho MIECHV program

hosted community meetings in each of the four target communities in late June 2011. The purpose of the community meetings included the following:

1. Generate a shared understanding of the MIECHV program,
2. Identify relationships between potential community partners, and
3. Secure an understanding of the community's strengths and needs respective to this opportunity

In each of the community meetings, participants developed an inventory of community resources related to the six benchmark areas, engaged in a discussion about the program and roll-out, and identified strengths and barriers to implementing the MIECHV program in each community. The activities and discussion provided a wealth of community perspective related to the implementation of the MIECHV program. The following is an abbreviated inventory of the community strengths.

Table 7: Community Strengths as Identified in Community Meetings June 20 & 27, 2011

Kootenai County	Shoshone County	Twin Falls County	Jerome County
▪ Early Head Start and Head Start ▪ ICARE – Parents as Teachers ▪ Strong partnerships across programs ▪ Groups meet to share and collaborate ▪ Mindset of collaboration – leverage resources ▪ Waiting list for services ▪ Cross model training ▪ Interagency luncheon ▪ Potential home visitors already trained/funded ▪ Administrative support from PHD	▪ Prior home visit programs successful ▪ Need/interest – families likely open ▪ Small community ▪ Physicians are strong partners ▪ Partner with other agencies to build stronger objectives ▪ Partnerships generate "lots" of owners ▪ Educators recognize value of early childhood ▪ Credibility of HS/EHS and school district	▪ Collaboration in place to leverage ▪ EBHV in place ▪ Migrant/Seasonal HS ▪ Community programs address outcomes ▪ Early Head Start partnership with PHD ▪ Faith-based organizations ▪ Refugee Center ▪ PHD relationships with licensed centers and child care providers ▪ Mental health staff at Early Head Start ▪ One of 2 State Mental Health and Drug /Child Protection Drug Courts	▪ Trusted bilingual providers (MD, PA, RN) ▪ Committed medical system and providers ▪ Translators & volunteers ▪ Bilingual Smiles for Kids ▪ Bilingual WIC CAs ▪ EHS/PDH partnership ▪ Collaborate on grants ▪ Teen pregnancy project ▪ School district support ▪ ID Community Council ▪ Lessons learned from prior positive youth development program ▪ Jerome Interfaith Ass'n ▪ Clinic PPD screening ▪ Leverage experience

Existing Home Visiting Capacity in Idaho

Given the eight evidence-based home visiting models, two are currently implemented in communities around the state. Early Head Start (EHS) Home-Based and Parents as Teachers (PAT) currently operate in multiple 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.

In July 2011, the MIECHV program conducted an organizational capacity assessment in partnership with model developers (Idaho Head Start Collaboration Office and Parents as Teachers national office) to learn about capacity of organizations to implement evidence-based home visiting in the target communities. The organizational capacity assessment was completed by four organizations in the target communities. Analysis of the organization capacity assessment indicated there is varied capacity of existing evidence-based home visiting programs in the target communities. There is one affiliated Parents as Teachers programs in Kootenai County, with a total of three parent educators. One other program in Kootenai County has applied for Parents as Teachers affiliate status. There is one Early Head

Start Home-based program in Kootenai County, not currently serving Shoshone County. In Twin Falls, the Early Head Start Home-based program serves Twin Falls and Jerome Counties.

Table 8: Estimated capacity of home visiting programs in target communities

	Parents as Teachers	Early Head Start	Total	Est. 20-5 Population	% 0-5 Population Served
Kootenai	39	159	198	8,634	2.3%
Shoshone	0	0	0	613	0%
Kootenai + Shoshone	39	159	224	9,247	2.4%
Twin Falls	0	80	80	5,728	1.4%
Jerome	0	Not Known	0	2,009	0%
Twin Falls + Jerome	0	80	80	7,737	1.0
All Target Communities	39	239	278	16,984	1.6%

Source: Idaho MIECHV program Organizational Capacity Assessment 2011.
Note: Early Head Start is number of funded slots

The 2009-2010 Idaho Head Start Program Information Report (PIR) indicate funded enrollments for 357 children and 45 pregnant women for all Early Head Start Home-Based programs in Idaho, all programs report a significant waiting list. According to the Parents as Teachers 2009-2010 Annual Report of Idaho, eight affiliates served 636 families and 1,020 children in PAT programs across Idaho. According to the Head Start 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 parent educators, 16 are full-time and 22 are part-time. In Idaho during 2009-2010, there were 85 home visitors working in one of thirteen evidence-based home visiting programs. It should be noted that there are home visitors working within the Infant Toddler Program (ITP – IDEA Part C) to provide in-home early intervention services. The Infant Toddler Program 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 physical, mental and emotional development and support the families' needs and is key in the early childhood systems.

Coordination among Existing Services

There are no known coordinated efforts to screen, identify and refer families into the evidence-based home visiting services in the state of Idaho such as a centralized intake, with the exception of early intervention services. Early intervention services provided through the Infant Toddler Program identify families include developmental screenings and participation in a developmental milestones program and other Child Find activities. Infant Toddler Program and Head Start programs collaborate to coordinate transition plans between programs. Infant Toddler Program Offices and Head Start Programs are required to have an MOU to assure seamless referrals for children with suspected or confirmed developmental delays. Additionally, the Department of Health and Welfare employs staff navigators to facilitate connection to appropriate benefit programs offered by the State. In communities, there may be other formal agreements for referral or service exchange. For example, in Twin Falls and Jerome

counties the Early Head Start home-based program has an agreement with the Local Public Health Department to provide nurses for home visits at specific intervals during service delivery.

The state MIECHV program plans to facilitate connection between existing screening and referral processes with local contractor implementing the MIECHV program. In order to build the referral networks, coordinate services, and address gaps in services, the MIECHV program intends to support local contractors to partner with other evidence-based home visiting programs, early intervention and other services within the communities. It is likely that the Idaho MIECHV program will request technical assistance related to establishing centralized intake processes and service integration across agencies. Over time, the MIECHV program will provide tools, resources and technical assistance to coordination among evidence-based home visiting programs and other child serving organizations.

Local and State Capacity for Integration into Early Childhood Systems

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, public and private preschool, and preschool services for developmentally delayed children. Some examples of successful integration include the Infant Toddler Program and Head Start, which 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. Replicating exemplary partnerships in the state in the context of an evidence-based home visiting program is critical for integration to the early childhood systems.

The MIECHV program intends to partner with the Early Childhood Coordinating Council (EC3) through the newly established Early Childhood Home Visiting Ad Hoc Committee within the EC3. The EC3 provides a forum for leaders to strategize and identify opportunities for collaboration and integration. Accordingly, the Early Childhood Home Visiting Ad Hoc Committee will provide an avenue to develop partnerships within the early childhood community and build home visiting infrastructure. The MIECHV program intends to continue convening the planning steering committee and shifting focus to implementation, evaluation and diffusion of information during year 2 of the Idaho MIECHV program.

Communities Not Identified for Year 2

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 years 1 and 2 of the Idaho MIECHV program. According to the SIR #1 - Needs Assessment, 14 counties identified as at-risk and 26 were not identified as at risk and will not be targeted by the MIECHV program in year 1 or 2.

Table 9: All counties according to risk as identified in the Needs Assessment

MIECHV Program Year 1 -2 Target Counties	**Counties identified as at-risk in Needs Assessment**		**Counties not identified as at-risk**		
Jerome	Benewah	Gooding	Ada	Canyon	Lemhi
Kootenai	Blaine	Idaho	Adams	Caribou	Madison
Shoshone	Bonner	Latah	Bannock	Clark	Oneida
Twin Falls	Boundary	Lewis	Bear Lake	Custer	Owyhee
	Camas	Lincoln	Bingham	Elmore	Payette
	Cassia	Minidoka	Boise	Franklin	Power

	Clearwater	Nez Perce	Bonneville	Fremont	Teton
			Butte	Gem	Valley
				Jefferson	Washington

Section 2: Goals and Objectives

The Idaho MIECHV program goals and objectives describe the broad vision for year 1 and year 2 of the MIECHV program. Goals focus on the anticipated state level processes and outcomes, as well as collaboration with the EC3. The goals describe a vision of success in establishing a state administered evidence-based home visiting program. Goals address phases of program development including planning, implementation, evaluation and system's integration. Partnering with the EC3 and other early childhood 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 support for quality and fidelity to achieve positive outcomes for children and families. Idaho's goals and objectives are set within a timeframe that acknowledges the likely challenges and for a new program in a state with modest home visiting. Finally, the goals articulated below are aligned, to the extent possible, with the goals and priorities outlined in Idaho's Title V Maternal and Child Health Block Grant Needs Assessment for 2010 and the Comprehensive Early Childhood Plan for 2009-2012. Given the overlapping project periods, the goals are identical for years 1 and 2 with expanded objectives. Please see Attachment 1 and 2 for Project Logic Model and Project Timeline.

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

- *Objective 1.A*: By October 1, 2011 award implementation contracts to three organizations to implement evidence-based home visiting programs in priority "at-risk communities."
- *Objective 1.B*: By December 1, 2011 establish a cross-state partnership to implement a partial team of Nurse-Family Partnership in two of the four target communities.
- *Objective 1.C:* By June 1, 2012 support implementing organizations in identification of specific performance objectives and indicators for Continuous Quality Improvement.
- *Objective 1.D*: By September 30, 2012 collect and assess annual report from year 1 grantees to provide direction to years 2-5 of the MIECHV program.
- *Objective 1.E*: By September 30, 2012 conduct a feasibility study in target communities to establish a centralized intake process for home visiting programs in target communities.

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.
- *Objective 1.C:* By June 2012, partner with evaluation team to identify performance indicators and reports for the state and each of the local contracts to meet continuous quality improvement requirements.

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.
- *Objective 3.C*: By September 2012, increase formal referral sources or service agreements for local MIECHV contracts and health related organizations within target community by 40%.

Goal 4: By September 2012, increase training opportunities and assessments for domestic violence, 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.
- *Objective 4.C*: By September 2012, assure that 50% of home visitors working with the MIECHV program have received training related to assessment and referral for domestic violence.

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.
- *Objective 6.C*: By June 2012, disseminate organizational capacity assessment to all organizations conducting home visiting to establish a baseline of data regarding home visiting in Idaho
- *Objective 6.D*: By September 2012, support planning and implementation of statewide inaugural home visiting summit, which will provide an opportunity for training and statewide planning .

Section 3: Proposed Home Visiting Models and Explanation of Model Meeting Community Needs

Home Visiting Model Selection

In November 2010, the Idaho MIECHV program began to investigate home visiting models likely to be considered evidence-based models according to the legislative definition. 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. The following home visiting models, in rank order, emerged as 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 previously described, SIR # 1 –Needs Assessment data indicated six counties at moderate to high risk, four of which have been identified as target communities for year 1 and 2, see Identification of Target Communities. Given the target communities risk factors, existing infrastructure and model strengths, the three models were identified for implementation years 1 and 2 of the Idaho MIECHV program:

1. Early Head Start – Home-Based (Years 1 and 2) – All target communities
2. Parents as Teachers (Years 1 and 2) – All target communities
3. Nurse-Family Partnership (Year 2) – Kootenai and Shoshone counties

Table 10 is a crosswalk between the risk factors for the four target communities aligned with the research-based outcomes of Parents as Teachers, Early Head Start – Home-Based, and Nurse-Family Partnership according to outcome areas reported in the Home Visiting Evidence of Effectiveness Study (retrieved from http://homvee.acf.hhs.gov on July 8, 2011).

Table 10: Target Community Risk Factors and Model Outcomes

	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
PAT				**X**	**X**			**X**				**X**	
EHS				**X**	**X**							**X**	
NFP	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**				
Kootenai					•	•	•	•	•			•	
Shoshone	•	•	•	•	•			•	•		•	•	•
Twin Falls	•	•	•	•		•		•	•	•	•	•	•
Jerome	•	•	•	•			•	•	•			•	

Source: Idaho's SIR #1 – Need Assessment

Community Involvement

The Idaho MIECHV program recognizes the importance of community engagement in the program planning and development process. In April 2011, Idaho's MIECHV program conducted a "Community Resource Survey" to gather information about services and networks in communities across Idaho. The community resources survey was developed over the course of several months the MIECHV planning steering committee to collect information related to utilization of evidence-based programs, in-home

services, community-based organizations, target populations, service areas, and more. Analysis continues on the 162 responses sufficient for evaluation.

In 2011, the Idaho MIECHV program engaged communities through the community resource survey, issuance of a news release, community meetings and organizational capacity assessments. Engaging community leaders and partners is critical to provide context to the SIR #1 – Needs Assessment. Community involvement will continue to be critical throughout program implementation and evaluation. Mid-June, the Idaho Department of Health and Welfare issued a targeted news release announcing upcoming community meetings in target communities. On June 20th and 27th 2011, the MIECHV program hosted four professionally facilitated meetings, one in each target community, in Kootenai and Shoshone (18 stakeholder attendees), Twin Falls and Jerome (18 stakeholders attendees).

During the meetings, stakeholders participated in a resource mapping process followed by an information presentation of the MIECHV program and discussion of community strengths and barriers related to program implementation. This meeting informed MIECHV program leadership of community stakeholder perspective related to the MIECHV program. Following the community meetings, the MIECHV program conducted an organizational capacity assessment in partnership with model developers (Idaho Head Start Collaboration Office and Parents as Teachers national office) to learn more about capacity of organizations to implement evidence-based home visiting in the target communities. The organizational capacity assessment was submitted by four organizations in the target communities. The results of the organizational capacity assessment will inform the RFP and technical assistance requests during the initial stages of implementation. The MIECHV has and will continue to a process and activities to support ongoing community engagement during years two through five of the MIECHV grant. 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 home visiting programs, but none administered by the State. Parents as Teachers and Early Head Start Home-Based are the two evidence-based home visiting models that exist in Idaho, implemented in at least 13 programs throughout the State. Community-based organizations funded by varying sources offer these models of home visiting services. For year 1, the Idaho MIECHV program identified Parents as Teachers and Early Head Start Home-Based as models to be implemented in target communities. For year 2, the Idaho MIECHV program will continue to support Parents as Teachers and Early Head Start, but will also support start-up and implementation of a partial Nurse-Family Partnership team. Please see Implementation Plan for anticipated program roll-out for years 1 and 2. In outgoing years of the MIECHV program, Idaho anticipates conducting a feasibility study to add 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 (PAT) programs operate throughout the state of Idaho. One affiliate program operates in the target communities, in Kootenai County. In all of the programs across the state, 38 parent educators served 636 families in 2009-2010. There are three parent educators serving Kootenai County. 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 programs.

Of the approximately 127,000 children birth to 5 years old in Idaho, less than 1% was served by Parents as Teachers in 2009-2010. Each Parents as Teachers affiliate reports waitlists.

Early Head Start:
There are five Early Head Start (EHS) Home-Based programs in the state of Idaho. Two of these programs operate in the "at-risk communities." Current EHS Home-Based grantees include Mountain States Group in Kootenai and College of Southern Idaho in Twin Falls. In 2009-2010, in the HS/EHS 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 target communities, there are a total of 239 funded for children and pregnant women. The 2010 Idaho Head Start Data Book reports that less than 5% of the eligible pregnant women and children receive Early Head Start services.

Nurse-Family Partnership:
Currently, there are no existing Nurse-Family Partnership (NFP) programs in the state of Idaho. There have been prior short-term home visiting programs that employ nurse home visitors for various organizations, but none are sustained. The following chart describes the justification for a two nurse satellite team in Kootenai and Shoshone counties. The proposed two nurse team would be a satellite and cross-state partnership with the established Nurse-Family Partnership program in the Spokane Regional Health District. Please see Implementation Plan for additional detail. Public Health District 1 has the highest rates of smoking prior and during pregnancy and rates of births covered by Medicaid in the state. Given the number births to women under 24 years of age, Medicaid birth rates, first time pregnancies and likely participants, the MIECHV program estimates that there are greater than 80 women who may participate in a Nurse-Family Partnership Program in Kootenai and Shoshone counties.

Table 11: Population Estimation Justification for Nurse-Family Partnership

	Average Births 2007-2009	2009 Births	% Smoke Pre-Pregnancy	% Smoke through Pregnancy	% Medicaid Births	2009 Births to Women Age < 24	Potential Participants
Kootenai	1775	1770	25.4%	13.7%	42%	658	75
Shoshone	125	133	39.1%	23.3%	52%	62	7
PHD 1		2538	26%	14.90%	41%		

Anticipated Adaptations

There are no anticipated adaptations of PAT, NFP or EHS during years 1 or 2 of program implementation. Please see Attachment 8 model developer approval letters approving the year 2 implementation plan. Although there are no anticipated adaptations for year 1 or 2, there may be required model adjustments to address sparsely populated areas and geographic challenges. Please note that the proposed cross-state partnership for Nurse-Family Partnership will be the first cross-state partnership implemented in the country. There may be alterations of administrative structure, however there are no anticipated changes to core components that may alter the Nurse-Family Partnership model.

Plan to Ensure Model Fidelity

The Idaho MIECHV program anticipates supporting local contractors by integrating indicators of fidelity into program processes, such as including building fidelity measures into RFP process, developing and monitoring contract performance measures, coordinating training and technical assistance, partnering with model developer monitoring activities, data systems development or procurement and development of resources and tools. The following outlines 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 (RFP) 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 materials
- Proper settings
- Staff qualifications
- Staff training and supervision
- Number and length of home visits
- 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. RFP applications to implement evidence-based home visiting will be scored on a number of factors, including responses to model fidelity and fidelity indicators, and organizational and community awareness. Applicants will have varying capacity to support model fidelity, thus the MIECHV program intends to provide ongoing support to local contractors to adhere to model requirements.

2. Contract Performance Measures:

The MIECHV program will establish contracts with successful applicants to RFP 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 of 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 (CQI):

Organizations implementing will also be contractually obligated to participate in continuous quality improvement to assess process and performance. 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 and Plan for Continuous Quality Improvement .

Anticipated Challenges and Technical Assistance Needs

There are a number of challenges that may occur during implementation and evaluation of the MIECHV program. There are few existing evidence-based home visiting programs in Idaho. A systematic effort to support and advance multiple evidence-based home visiting programs is 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. Completed organizational capacity assessments suggest there

is a number of training and technical assistance needs of organizations implementing home visiting. MIECHV program may need technical assistance in at least the following areas:

1. Continuous quality improvement
2. Data collection and analysis
3. Domestic violence screening and referral
4. Maternal depression screening, referral and effective treatment (in and out of home)
5. Establishing an effective referral network (community resources network)
6. Centralized intake processes
7. Program evaluation and data-driven decision-making

Section 4: Implementation Plan

The implementation plan for the Idaho MIECHV program is designed to align with the *Lifecourse Perspective* and the *Strengthening Families* frameworks. 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 create 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. Factors such as poverty, low educational attainment, low birth weight and exposure to family violence are associated with negative impacts in children's outcome later in life. The *Strengthening Families* framework suggests that a number of protective factors, if present or cultivated, can mitigate or reduce the impact on adverse events in early childhood. Evidence indicates that supporting protective factors by empowering communities and families provides the foundation for positive child development. The implementation plan intends to build the Idaho's MIECHV program through the lens of the *Lifecourse Perspective* and *Strengthening Families* frameworks.

The Idaho MIECHV program will release a funding opportunity in the form of an RFP to organizations to implement evidence-based home visiting in target communities in the late summer to early fall 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, news releases, community meetings in target communities and organizational capacity assessments for organizations conducting home visiting in target communities. Please see the *Target Community Identification* and *Model Selection* sections that provide a background on the community engagement to date. Community involvement is critical throughout program implementation and evaluation. Mid-June 2011, the Idaho Department of Health and Welfare issued a targeted news release announcing upcoming community meetings in target communities. On June 20th and 27th, the MIECHV program hosted four professionally facilitated meetings, one in each target community, in Kootenai and Shoshone (18 stakeholder attendees), Twin Falls and Jerome (18 stakeholders attendees). The purpose of the community meetings included the following:

1. Generate a shared understanding of the MIECHV program,
2. Identify relationships between potential community partners, and
3. Secure an understanding of the community's strengths and needs respective to this opportunity

Following the community meetings, the MIECHV program conducted an organizational capacity assessment in partnership with model developers (Idaho Head Start Collaboration Office and Parents as Teachers national office) to learn more about capacity of organizations to implement evidence-based home visiting in the target communities. The organizational capacity assessments were submitted by four organizations in the target communities. The results of the organizational capacity assessment will inform the RFP and technical assistance requests during the initial stages of implementation.

The Idaho MIECHV plans to continue to develop relationships at the local level throughout the initial years of planning, implementation and evaluation. Ongoing partnerships and relationship building will be critical to the long-term sustainability and adoption of an evidence-based program. The cycle of ongoing community engagement will likely be replicated during years three through five of the MIECHV grant. In a cyclical process, the Idaho MIECHV program intends to conduct the following activities in partnership with local contractors 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 or teleconferences)
3. Targeted response to identified need (strategic action plan, continued monitoring, and development of tools or training)

Table 12: 2011 MIECHV Community Meeting Attendees by Organization

Community Meetings Attendance List – Organizations Present			
Kootenai and Shoshone Counties		**Twin Falls and Jerome Counties**	
Organization	**City, State**	**Organization**	**City, State**
Panhandle Health District	Hayden, ID	Valley Therapy Services	Jerome, ID
ICare/St. Vincent de Paul	Coeur d'Alene, ID	South Central Public Health District	Twin Falls, ID
Department of Health & Welfare	Coeur d'Alene, ID	College of Southern Idaho Early HS	Twin Falls, ID
DHW-Infant and Toddler Program	Coeur d'Alene, ID	Department of Health and Welfare	Twin Falls, ID
North Idaho College Head Start	Coeur d'Alene, ID	College of Southern Idaho Head Start	Twin Falls, ID
Family Support Services	Post Falls, ID	South Central Public Health	Twin Falls, ID
University of Idaho Coeur d'Alene	Coeur d'Alene, ID	Infant Toddler	Twin Falls, ID
Mountain States Early Head Start	Coeur d'Alene, ID	College of Southern Idaho	Twin Falls, ID
Mountain States Early Head Start	Coeur d'Alene, ID	DHW Infant Toddler	Twin Falls, ID
St. Vincent de Paul	Coeur d'Alene, ID	Infant Toddler	Twin Falls, ID
FSSNI/Learning Garden Developmental Preschool	Post Falls, ID	South Central Public Health District	Jerome, ID
Panhandle Health District	Hayden, ID	College of Southern Idaho Early HS	Twin Falls, ID
Kootenai Medical Center	Coeur d'Alene, ID	St. Benedicts Family Medical Center	Jerome, ID
University of Idaho/NIC HS	Coeur d'Alene, ID	College of Southern Idaho	Twin Falls, ID
PHD/RECC co-chair	Hayden, ID		
KMC	Coeur d'Alene, ID		
North Idaho College HS/RECC	Coeur d'Alene, ID		
NIC Head Start	Post Falls, ID		

Policies and Standards

The Idaho MIECHV program intends to support existing Maternal and Child Health and Early Childhood practices, policies and standards in Idaho. 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 areas for standards within a contract requirements

with a local contractor. Details of each of these standard areas can be found in the Idaho MIECHV Updated State Plan for 2010. These six standards may change and evolve over time.

1. Frequency and duration of visits
2. Appropriate curriculum for lifecourse stage
3. Family recruitment, selection and enrollment
4. Home visiting staff recruitment, selection, training and supervision
5. Data collection and records
6. Program evaluation

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

Model Developer Technical Assistance

The Idaho MIECHV program has engaged model developers during planning via phone and e-mail to broaden understanding of model requirements. Through multiple question and answer calls with the Parents as Teachers national office, Nurse-Family Partnership National Service Office, and the Office of Head Start the Idaho MIECHV program has garnered model specific information regarding, monitoring, training, data collection, and technical assistance. The Idaho MIECHV program intends to schedule ongoing calls with model developers to coordinate monitoring, training and technical assistance with MIECHV program local contractors as needed during implementation. Parents as Teachers national office and the Idaho Head Start Collaboration Director reviewed and provided feedback in development of the organizational capacity assessment. Organizations completing the capacity assessment were able to seek model specific guidance and technical assistance from model develops while completing the organizational capacity assessment. Please see Attachment 8 for model developer approval letters.

Early Head Start

Idaho's MIECHV program anticipates ongoing communication with the Office of Head Start and the Idaho Head Start Collaboration Office regarding Idaho's training and technical assistance needs to assure that local contractors access appropriate training and technical assistance. The MIECHV program anticipates learning more about Office of Head Start's ability to partner for monitoring reports, site visits, 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.

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 programs, arranged around these topics:

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

Parents as Teachers

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 or representative, such as Idaho, a regional technical assistance specialist is designated to carry out the state quality assurance activities, including quality validation visits. Idaho's MIECHV program anticipated ongoing communication 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 and coordinate trainings and technical assistance for local contractors. Likely inquiries include: local contractors progress in achieving the essential elements, coordinating the Foundational and Model Implementation Training, and data collection and management. Idaho MIECHV program intends communication with Parents as Teachers national office or regional Technical Assistance specialist quarterly, or as needed.

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

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

Nurse-Family Partnership

Nurse-Family Partnership has developed a robust set of tools and technical assistance to communities and organizations implementing Nurse-Family Partnership programs. The National Service Office engages the community to garner support of community leaders and organizations as a means to encourage sustainability and community buy-in. During the program start-up and implementation technical assistance includes: Orientation to the program model and implementation requirements, community planning – feasibility testing, selection of implementing agency, selection and education of home visiting staff, program implementation, monitoring and continuous quality improvement, and development of an RFP process. The National Service Office provides assistance to states or communities in selecting a local agency to host the program. During the start-up process, consultation is available to administrators for hiring staff, recruitment, including a multi-step orientation and education process for new home visitors and an additional training and consultation process for supervisors.

Anticipated communication includes inquiries related to hosting a community meeting to identify potential local contractors, progress in achieving the 18 model elements, compilation of an RFP for a local contractor and financing strategies. Idaho MIECHV program intends to communicate with the Nurse-Family Partnership National Service Office or regional office staff quarterly, or as needed.

Timeline for Obtaining Curriculum

The Idaho MIECHV program anticipates contracting with organizations with capacity to delivery evidence-based home visiting services in target communities and populations. Timeline for obtaining curriculum will depend on successful respondents to the RFP. If successful RFP applicants are currently implementing home visiting, timelines for obtaining curricula may be shorter than organizations not currently implementing home visiting. Local contractors should adhere to model requirements for obtaining curricula. Curriculum and required pre-service training should be obtained by local contractors within the first three months of contract establishment. Exceptions will be made in extenuating circumstances, such as trainings unavailable during first three months of contract period.

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 (HSPPS) and based in child development research and principles. Parents as Teachers affiliates implement the Born to Learn curriculum, which requires staff to be trained in the current Foundational Training. Nurse-Family Partnership 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

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

Early Head Start

Head Start Program Performance Standards (HSPPS) for staff qualifications and development outline the content of training that must be provided to home visiting staff. HSPPS do not specifically outline the number of professional development or training hours required to achieve the standard. The Idaho MIECHV program will partner with local contractors to identify goals and opportunities for pre-service, ongoing training and professional development for staff. Training content should be related to:

- structured child-focused home visiting that promotes parent ability to support child development;
- strengths-based parent education, including methods to encourage parents as child's first teacher;
- early childhood development with respect to children from birth through age three;
- methods to help parents promote emergent literacy in their children, including use of research-based strategies to support skill development 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, when needed;
- strategies for helping families coping with crisis; and
- relationship of health and well-being of pregnant women to prenatal and child development.

Parents as Teachers

Parent educators and supervisors are expected to complete “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

Nurse-Family Partnership

NFP Core Education for nurse home visitors and supervisors includes face -to-face and long distance education. Nurse home visitors and supervisors must complete the core education prior to enrolling

clients and conducting home visits. The National Service Office established requirements for home visitors, supervisors and data entry staff to have computers in order to participate in educational offerings. In addition, nurse home visitors must stay current on professional licensure requirements for continuing education. Nurse home visitors are expected to participate in clinical and reflective supervision, case and team meetings as a means of continuing education and professional development.

The MIECHV program is assessing current training and professional development opportunities available through various training initiatives. Organizations throughout the State provide training related to infant mental health, reflective supervision, child development, and other topics. Such trainings may be available for local contractors in Idaho. Over time, continuous quality improvement activities may direct training topics as well. Some potential training topics coordinated by the 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

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. In response to the MIECHV program funding opportunity, applicants will be required to describe a plan to meet the standards described in the Updated State Plan 2010 Implementation Plan, 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 home visitor expectations based on these qualifications: “Home visitors must have knowledge and experience in child development and early childhood education; 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” (HSPPS 1304.52). The HSPPS also provide requirements for staff training and development to promote staff retention.

Parents as Teachers indicate in the 2011 Quality Assurance Guidelines for Parents as Teachers Affiliates that parent educators must have at least a high school diploma or GED and a minimum of two years previous supervised work experience with young children or parents. However, it is recommended 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.

Nurse-Family Partnership expects organizations to recruit and hire bachelor’s prepared nurses unless there is not such a workforce available. Model Element 8 underscores the importance of organizational commitment to hire qualified staff to meet NFP standards. Nurse home visitors should integrate the Standards of Nursing Practice into the NFP intervention and maintain therapeutic relationship, set

boundaries, and achieve program outcomes. Organizations should provide an environment supportive of retention of qualified nurse home visitors by compensation, supervision, and learning opportunities.

Plan for Contracting

The Idaho MIECHV program intends to award contracts to organizations to provide evidence-based home visiting services in the four target communities. The process of identifying local contractors 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 implementation. Please see Attachment 2: Project Timeline for year 2 of the MIECHV program.

1. July 2011: Review Organizational Capacity Assessments to inform Request for Proposal
2. July –August 2011: Establish contract with university-based Evaluation partner
3. August 2011: Issue Request for Proposal for Early Head Start and Parents as Teachers
4. August 2011: Community meeting with NFP in Kootenai and Shoshone counties
5. August – September 2011 : Request for Proposal Open
6. September 2011: Team review of responses to RFP, issue RFP for NFP
7. August 2011 – September 2012: Evaluation partner to conduct participatory evaluation and provide technical assistance to subcontractors on data collection, management and analysis
8. October 2011: Award contracts to three successful applicants in target communities
9. October 2011 – September 2012: Implementation of evidence-based home visiting, award contract to successful applicant for NFP satellite
10. October 2011 – September 2012: Ongoing training, technical assistance, and monitoring

The Department of Health and Welfare issued a targeted news release announcing community meetings in the four target communities scheduled for late June, 2011. The news release was public notice for community members regarding MIECHV program community meetings. The professionally facilitated meetings provided an opportunity for stakeholders to outline community resources, learn about the MIECHV program requirements and dialogue about community strengths and barriers. In July, 2011 the MIECHV program conducted an organization capacity assessment to inform the RFP process. The assessment addressed the following areas: model fidelity, community network, current data collection, continuous quality improvement processes and technological capacity.

In August 2011, the MIECHV program anticipates issuing a formal request for proposals (RFP) to implement evidence-based home visiting services. The RFP will likely be open for four – eight weeks, in which applicants will have the opportunity to submit questions for answer. The MIECHV anticipates conducting separate RFP processes per model. Depending on guidance given by the Department's Division of Operational Services, Years 1 and 2 funds will be rolled into RFPs that are model specific. One RFP will published for each proposed model. The Idaho MIECHV program anticipates awarding three contracts in the amount of $190,000 to Parents as Teachers and Early Head Start programs in the target communities, which will include funds from years 1 and 2. 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.

The third RFP will support the start-up of a two-nurse satellite of the Spokane Regional Health District Nurse-Family Partnership in Kootenai and Shoshone counties. The RFP will identify the organization that will administratively house the two-nurse satellite team. Organizations with the capacity to hire and

retain nurses to establish Nurse-Family Partnership satellite must work within the Spokane Regional Health District Nurse-Family Partnership team. The Idaho MIECHV program continues to explore opportunities to partner. The model developer, Spokane Regional Health District, and local contractor will participate in careful planning do address formal agreements related to supervision, mentoring, financing and policies in order to establish a strong and viable cross-state partnership.

Table 13: Outline of Plans for Contracting Years 1 – 3

Program Year	Contract Amount	No. of Awards & Models	Contract Type
Year 1	$190,000	2 (EHS or PAT)	First Year
Year 2	$360,000	1 (NFP)	First Year
Year 2	$190,000	1 (EHS or PAT)	First Year
Year 3	$140,000	3 (EHS or PAT)	Continuation
Year 3	$300,000	1 (NFP)	Continuation

In response to the RFP 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 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 either of the two, two-community service area or partner with organizations to assure both communities have access to evidence-based home visiting programs. The MIECHV program intends to organize an interdisciplinary team of experts to review and score RFP applications after completing training and feedback sessions. The MIECHV program intends to establish contracts by October 2011, for a one year period with opportunities for renewal up to four years, 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 and local contractors to provide guidance for data collection, data analysis and facilitate broad discussions on continuous quality improvement. The evaluation partner will review assessment tools, scoring methods, and propose metrics for measuring progress and success.

Program Supervision & Reflective Practice

Reflective supervision and practice are critical processes by which home visitors and supervisors articulate the challenges and successes of families and children. Reflective practice allows critical thinking and perspective taking of the family and home visitor experience to broaden insight into work with families. 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. Additionally, reflective practice has been associated with reduced turnover and increase job satisfaction for home visiting staff. As outlined in the 2010 Updated State Implementation Plan, supervisors will be expected to conduct at least bi-weekly reflective supervision with home visitors.

In Idaho, there is one formal training opportunity for reflective supervision that includes the Endorsement for Infant and Early Childhood Mental Health, through Idaho Association for Infant, Early Childhood and Mental Health, known as "AIM Early Idaho." The AIM Early Idaho Endorsement is based

on the competencies identified by the Michigan Association for Infant Mental Health. Idaho's endorsement recognizes four different professional levels from entry level to mastery level. The first cohort of endorsement candidates is completing training in 2011-2012. In the RFP process, organizations will identify resources to assure capacity for reflective supervision. According to the Organizational Capacity Assessment, organizations have varying capacity for reflective supervision. The MIECHV program is working with AIM Early Idaho to assess partnerships and coordinate training for reflective practice. AIM Early Idaho is hosting an Infant Mental Health Summer Institute August 2011.

Parents as Teachers, Nurse-Family Partnership and Early Head Start require or allow for reflective and clinical supervision in model requirements. Parents as Teachers requires a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings. Nurse-Family Partnership in Model Element 13 and 14 requires nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate theory integration, and facilitate professional development. Early Head Start supervisors are expected to share clinical knowledge of child development, family support, and HSPPS and may contract with a mental health expert to provide reflective practice.

Participant Recruitment and Retention

The Idaho MIECHV program will contract with organizations to serve target communities with evidence-based home visiting services. Organizations will describe recruitment and retention plans in response to the RFP. It is expected that recruitment strategies are relevant to the model-specific target populations and the MIECHV priority populations. According to the Organizational Capacity Assessments, organizations use various recruitment and retention strategies for participants. Some organizations do not conduct recruitment activities, others place notices in newspapers, local businesses and health fairs within the community. Most organizations did not identify specific participant retention plans. 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). Participant retention is centered in the relationship between the home visitor and participant and connections with community resources. The MIECHV program intends to support local contractors to monitor participant recruitment and retention, assess trends, and encourage collaboration between programs to share challenges and solutions.

Each evidence-based home visiting model has model specific participant eligibility. 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 child welfare interaction
- 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. Recruitment process should occur before the beginning of the enrollment year. 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.

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 and reducing participant attrition. In the Affiliate Plan, affiliates identify strategies to encourage continued participation, such as text reminders of upcoming visits, phone or text messages between visits, incentives for completed visits and books appropriate for the topic of the visit.

Nurse-Family Partnership

Nurse supervisors and program administrators are expected to establish relationships with community resources to build a resource and referral network. Client recruitment typically occurs through resource and referral networks such as WIC, schools, or community health clinics. Clients are enrolled when first visit occurs and forms are completed, with only one pre-enrollment visit. Participant retention is based on nurse home visitor relationship, support and education provided on such topics as prenatal health behaviors and child's neurodevelopment. Nurse-Family Partnership encourages programs to recruit women early in pregnancy as data indicate earlier entry is related to longer participation.

Program Capacity and Timeline to Reach Capacity

The results of the RFP process will influence the total number of families enrolled in the MIECHV program. In the RFP process, organizations will indicate estimated number of families served by the contract and timeline to reach capacity. The following table provides an estimate of number of families served with MIECHV program funds, based on program cost per child. Program elements such as staff credentials, ancillary services, and frequency and duration of visits influence cost of service delivery.

Table 14: Estimated Families Served through MIEHV program

Model	Contract Amount	Estimated Families Served
EHS	$190,000	12-24 families
PAT	$190,000	24-30 families
NFP	$360,000	50 families

The MIECHV program estimates that contracts will be established by October 2011. Applicants will describe a staffing and recruitment plan in response to the RFP in order to achieve participant and staffing capacity within six to nine months of the contract date. There is recognition that organizational capacity there may limit this expected timeline. Idaho MIECHV program 2010 Needs Assessment – SIR #1, indicated that both Early Head Start and Parents as Teachers programs across Idaho maintain waiting lists of eligible or interested participants. Local contracts of MIECHV program may have existing waiting lists with participants eligible to receive evidence-based home visiting through the MIECHV program, thus time to reach capacity may be shorter. In the RFP applicants will provide a budget to demonstrate the estimated number of participants to be enrolled within the project period.

Early Head Start

The number of potential program participants is determined by the community need. Programs develop an appropriate budget according to the estimated participants per community need. Cost per child estimates for Early Head Start programs range from $8,900 to $12,500 per year. Home visitors may not have a caseload greater than 12 families at a given time. HSPPS indicate programs must enroll on an ongoing basis and maintain a waiting list so that vacancies are filled within an appropriate timeframe.

Parents as Teachers

According to the sample first year budget for constructed by the national office, first year costs per child is approximately $2,915, with average travel 30miles per visit. Second year cost per child is $2,690 due to fewer start-up costs. The 2011 Quality Assurance Guidelines expect programs collect data related to enrollment and waiting lists, including length of time on waiting list and enrollment date.

Nurse-Family Partnership
Nurse home visitors participate in significant pre-service training, mentoring and supervision during the first months of program start-up. Each home visitor is expected to maintain a caseload of 25 families. Nurse-Family Partnership expects programs to reach caseload within nine months of start-up.

Community Resource Coordination

During the community meetings, participants mapped community resources according to benchmark areas to initiate conversation about community networks in target communities. Additionally, participants received the Zero to Three Home Visiting Community Planning Tool to continue community conversations related to home visiting. Community buy-in, referral networks and perceived credibility are critical in initial and long-term success of community-based home visiting programs. At the state level, the Idaho MIECHV program has been cultivating relationships with state administered programs and initiatives. There are numerous stakeholders whom provide resources critical in planning, training resources and evaluation. The Idaho MIECHV program intends to continue cultivating state level resources throughout implementation. Additionally, the community resource survey conducted by the MIECHV program in resulted in a snapshot of resources available in communities across the state.

In response to the RFP for home visiting services, applicants will describe existing relationships with community organizations and a plan to cultivate relationships with other community resources. Parents as Teachers, Nurse-Family Partnership 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 (primary care providers/ hospitals), mental health providers, early childhood providers (home visiting, child care, preschools or early interventionist), child welfare, substance abuse providers and education services. The Idaho MIECHV program intends to provide tools to assist in community building, including SIR #1 - Needs Assessment and 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 and coordinating services for young children within the community. The HSPPS indicate programs should 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. Early Head Start programs should outline channels of communication between the early childhood programs within a community, linkages to appropriate early invention services, and transition procedures for transitioning children between Early Head Start and other programs, such as other home visiting programs [45 CFR 1304.40(c) (1) and Head Start Act of 2007–Sec. 645A (b)(5-9;11)].

Parents as Teachers
Parents as Teachers outlines Community Resource Networks as an Essential Element of the 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 address connecting participants to resources.

Nurse-Family Partnership
Nurse-Family Partnership expects organizations implementing the program to be credible in the community for providing prevention services to low-income families and convene a community advisory board to meet quarterly to promote community support according to model elements 17 and 18.

Information Systems and Monitoring

Continuous Quality Improvement requires monitoring of program performance and management indicators. The Idaho MIECHV program has begun to investigate practice and performance management software solutions through product demonstrations and intends to continue exploration. The Idaho MIECHV program is partnering with the Bureau of Application Development and Support within the Division of Information Technology to explore solutions. The MIECHV program anticipates developing an RFP for a software solution to support data collection, maintenance and analysis of process and outcome data. The Bureau of Application Development and Support and the Division of Administration continue to assist in RFP development, processes, goals and timelines for software solution procurement. Response to the organizational capacity assessment indicated that organizations are of various stages of automated data collection and management. Idaho MIECHV program local contractors will likely 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 local contractors 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 programs to perform a self-assessment at least annually to ensure compliance with HSPPS. 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, such as PROMIS, with no standard.

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. Parents as Teachers programs in Idaho utilize KIDS, a data system produced for Parents as Teachers in Idaho.

Nurse-Family Partnership
Nurse-Family Partnership requires implementing agencies utilize a web-based solution to track process and outcome measures. According to Model Element 15, the home visitors collect a specific set of data in order to assess and guide implementation, supervision, enhance quality and fidelity.

Monitoring Model Fidelity and Quality Assurance

Local contractors must implement models as similarly as possible to the program structure studied in high-quality research. Idaho MIECHV program understands that there are a multitude of factors related

to implementation and assessment of model fidelity. The Plan for Continuous Quality Improvement outlines the State's approach to monitoring performance and model fidelity. Each program must adhere to model standards and MIECHV standards. The MIECHV program anticipates partnering with the model developer to align state monitoring activities with model developer monitoring activities to the extent possible. Parents as Teachers, Nurse-Family Partnership and Early Head Start conduct quality assurance or monitoring through on-site monitoring visits. As the MIECHV program provides monitoring and technical assistance coordination and training, it will be critical to partner with the model developer to align activities to avoid duplication and to present information in a continuous and integrated manner.

Early Head Start
The Office of Head Start published Monitoring Protocol for FY11, outlining the monitoring requirements for on-site visits. The Monitoring Protocol provides a framework for review of quality, program management and compliance to the HSPPS and regulations. The Monitoring Protocol is a tool to measure compliance in a framework of critical indicators meant to assess achievement of 11 required components. The Office of Head Start expects Early Head Start programs to participate in major on-site monitoring every three years to assess performance, quality and management of HSPPS, and in the interim, as necessary. The Office of Head Start contracts with teams to conduct on-site monitoring.

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", the national office provides technical assistance to state level agencies around monitoring, assessing and supporting implementation with fidelity to model and quality assurance.

Nurse-Family Partnership
Nurse-Family Partnership integrates fidelity and quality assurance measures for every model element into its web-based information system. The Nurse-Family Partnership National Service Office monitors implementing agencies' program fidelity, the quality data collection and provides feedback as needed. Nurse-Family Partnership has identified more than 20 indicators for model fidelity and supports states and implementing agencies in collecting and analyzing data for every phase of implementation.

Anticipated Challenges and Response to Fidelity and Quality

Idaho's MIECHV program anticipates a number of challenges in achieving model fidelity and quality. This program provides a window to initiate dialogue about strategies to advance systematic efforts to achieve quality and fidelity in home visiting. Because of the frontier and independent nature of Idaho's target communities, there may 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 such challenges through CQI, reporting requirements and ongoing consultation with local contractors to overcome barriers. The MIECHV program will conduct quarterly contract monitoring and biennial required reporting. It will be critical to engage an evaluation partner to assess

implementation in order to understand implementation drivers and barriers across local contractors. The MIECHV program will assist local contractors in building relationships with community partners and resources to build awareness of home visiting. The MIECHV program will facilitate connections with state level resources for local contractors, such as the AIM Early Idaho Endorsement. The MIECHV program intends to partner with national model developers to coordinate monitoring visits, technical assistance and training to address ongoing or emerging issues related to quality and fidelity.

Early Head Start

The MIECHV program anticipates that local contractors implementing the Early Head Start Home-Based model will likely be existing grantee. 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 monitoring processes, technical assistance, and training opportunities and investigate establishing an agreement to share monitoring reports to address fidelity and quality issues. Head Start and Early Head Start program grantees participate in significant monitoring at least every three years with on-site 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 current and potential affiliates to complete a "Readiness Reflection" to assess capacity to implement the model with fidelity prior to implementation. The Idaho MIECHV program intends to partner with the model developer to facilitate completion of these tools as necessary. Ongoing affiliation with Parents as Teachers requires programs complete an annual self-assessment. The Idaho MIECHV program anticipates partnering with model developer in monitoring activities, where possible.

Nurse-Family Partnership

Nurse-Family Partnership has outlined a phased implementation, starting with the Pre-Implementation phase. During this phase prospective programs are required to complete an Implementation Plan. Nurse-Family Partnership staff review the Implementation Plan to assure organizations have sufficiently vetted the NFP requirements. The MIECHV program anticipates partnering with Nurse-Family Partnership to assure completion of the Implementation Plan. NFP requires an annual plan and a number of reports during the first two years of implementation. Given there are no NFP teams in Idaho and the proposed satellite team is the first cross-state partnership team, there will be barriers to assuring all partners are adequately sharing information, expectations, and reports. The proposed cross-state partnership will require frequent communication between state, local contractor, Spokane Regional Health District and the model develop. The MIECHV program anticipates investigating with the NFP National Service the possibility of shared reporting and monitoring activities.

Collaborative Partners

The Idaho MIECHV program has been working with required concurrency partners in a planning steering committee to guide program planning. Please see Attachment 5 for Memoranda of Concurrence.

Table 15: Idaho MIECHV program current and anticipated partners are listed below

Public Partners		
Title V, MCH	Idaho Child Welfare (Title IV-B/IV-E)	Idaho Agency for Substance Abuse
Universities	Idaho Department of Insurance	Idaho Department of Corrections
Local Public Health Districts	Idaho Injury Prevention & Surveillance	Idaho Division of Public Health

Idaho Early Childhood Coordinating Council	Idaho Temporary Assistance to Needy Families (TANF)	Idaho Children's Trust Fund (Title II - CAPTA)
Migrant/Seasonal Head Start	Idaho Head Start Association	Idaho Domestic Violence Coalition
Idaho Medicaid CHIP	Idaho IDEA Part B Section 619	Infant Toddler Program (IDEA Part C)
Idaho Food Stamp Program	Idaho Head Start Collaboration Office	Idaho Child Care and Development Fund
Idaho Mental Health Agency		
Private Partners		
Idaho Voices for Children	AIM Early Idaho	March of Dimes, Idaho Chapter
Idaho AEYC	St. Luke's Children's Specialty Center	Idaho Consortium for the Preparation of Early Childhood Professionals
Idaho Chapter, AAFP	Idaho Primary Care Association	Idaho Parents Unlimited
Idaho Perinatal Project	Idaho Family Advocates	Idaho Chapter, AAP

Integrating MIECHV program into Early Childhood System

Early childhood services in Idaho include a various programs and services including the Infant Toddler Program, Child Care, WIC, Head Start and Early Head Start, Parents as Teachers, public and private preschool, and preschool services for developmentally delayed children. Some examples of successful integration include the Infant Toddler Program and Head Start advisory councils within the governance structure of the EC3. The Children's Trust Fund and child care leaders partnered to establish training curricula for child care providers within the Quality Rating System to promote protective factors through the Strengthening Families framework. Replicating exemplary partnerships in the state in the context of an evidence-based home visiting program is critical for integration to the early childhood systems.

The MIECHV program intends to partner with the EC3 through the newly established Early Childhood Home Visiting Ad Hoc Committee. 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 provide an avenue to develop partnerships within the early childhood community and build home visiting infrastructure. The MIECHV program intends to continue convening the planning steering committee to guide implementation, evaluation and diffusion of information during year 2.

Participant Outcomes

By implementing evidence-based home visiting programs, the Idaho MIECHV program intends to align program activities with legislatively mandated outcomes. Implementing 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. Idaho MIECHV program has identified multiple evidence-based models to diversify the home visiting capacity, services, and outcomes. The Benchmarks and CQI Plans outline the state's intention to monitor implementation processes and participant outcomes. The logic model, goals and objectives outline the intention to promote 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.

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 2010 Updated State Plan Implementation Plan outlines expectation that programs provide services according to family needs

and assessment results. In the RFP, applicants will describe capacity to provide family-centered services with emphasis on assessment and data-driven decision making according to family strengths and needs.

Early Head Start
HSPPS 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: practice strength-based family support, supports the growth of parents' capacities through research-based methods and principles, demonstrate respect for diverse needs and characteristics of families, understand the influence of varied family systems, culture, school readiness and socioeconomic status in child rearing practices and have capacity to assess family strengths, needs, culture through observation and assessment to provide family-centered services.

Nurse-Family Partnership
The Nurse-Family Partnership requires a number of different assessments at intake and throughout service delivery. Some of the assessments include Maternal Health Assessment, Health Habits Form, Infant Health Care Form and the Ages and Stages Questionnaire. Nurse home visitors utilize results of these assessments to provide services relevant to the participants needs.

Voluntary Services

The MIECHV program will assure that families receiving home visiting services are participating voluntarily. In response to the RFP, applicants will assure voluntary family participation. Additionally, ongoing contract monitoring with local contractors the MIECHV will assess that home visiting services only voluntary and 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 participants.
Parents as Teachers: Participation in Parents as Teachers program is voluntary for all participants.
Nurse-Family Partnership: Client participates voluntarily in the NFP program (Model Element 1).

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. Below are the priority populations for participation in the Idaho MIECHV program, in no specific order:

- *Low Income* **
- ***Pregnant Women*** ***** under 21***
- **History with Child Welfare Services or C'AN**
- **History of Substance Abuse**
- Tobacco Users
- Low Academic Achievement Parent/Child
- Children with Developmental Delay**
- **Families of the Armed Services**

Note Priority Populations indicated by: **Bold** = MIECHV, ** = EHS, Underlined = PAT, *Italicized* = NFP

Early Head Start
HSPPS require that programs recruit and select pregnant women, infants and toddlers to receive Early Head Start services. 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 child enter(s) kindergarten. Affiliates have the opportunity to identify further target populations or eligibility criteria. Affiliates might choose to serve families based on income, parental age, education attainment or other. Identification of eligible population should drive recruitment and retention for program affiliates.

Nurse-Family Partnership
Nurse-Family Partnership outlines the model requirements into 18 elements. Elements 2-4 describe the target population for the program. Enrollees should be a first-time mother, meet low-income criteria at intake, and be enrolled in the program no later than 28 weeks into pregnancy. Identification of the population eligible for services should drive recruitment and retention strategies for NFP program.

Plan for Evaluation

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 to 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. In mid-June, the MIECHV program released a notice soliciting proposals from University-based researchers to provide evaluation activities for the MIECHV program. Proposals were due to the MIECHV program leadership for team review on July 15th and are subject to review. Proposals will guide the evaluation plan for years 1 and 2. The objectives of the evaluation are as follows:

1. Provide technical assistance to local contractors related to:
    a. Data Collection & Analysis
    b. Continuous Quality Improvement Methods
    c. Model Fidelity and Standards
2. Partner with the state MIECHV program to develop and refine a data collection and benchmarks plan:
    a. Review of child and family assessment tools
    b. Facilitate state-level discussion of home visiting data collection
    c. Assess and provide guidance on performance management information systems options
3. Design a participatory evaluation to assess implementation:
    a. Determine methods for data collection to assess program implementation, including cost analysis
    b. Define and collect indicators of model fidelity
    c. Assess community context, including resource and referral networks

Section 5: Plan to Meeting Legislatively Required Benchmarks

Idaho's MIECHV program intends to meet program objectives as outlined in the Goals and Objectives and Table 16. 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, and linking data across-program and agency. 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 and technical assistance to assure adequate resources for local contractors.

Demonstrating measurable improvement on various process and outcome indicators will be the product of a complex set of factors related target population, model, environment, relationships, measurement tools and many others. Evidence-based home visiting models have specific model elements required to achieve the outcomes and maintain fidelity. Some of the legislatively mandated benchmarks and constructs are out of the scope of the researched based outcomes for the home visiting models. Each evidence-based home visiting model has been studied with specific target populations, such that some constructs may not be relevant or appropriate measures for model specified target populations. The measures outlined in Table 16– Benchmarks Plan are proposed measures, which may change based on feasibility of collection or analysis of proposed measures, which may require reconciliation of model specific requirements for data collection. The MIECHV program anticipates collecting data for all constructs for all families participating in MIECHV funded programs for each of 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. The MIECHV staff has met program staff of state administered programs to identify data elements, systems and periodicity of reporting, to incorporate into the MIECHV program state plan. The MIECHV program continues to explore the opportunities for formal data sharing. The MIECHV program anticipates establishing Memoranda of Understanding with state administered programs such as Child Welfare Title–IV in years 1 and 2 of program implementation.

Plan for Sampling

The Idaho MIECHV program does not anticipate utilizing a sampling method for the years 1 and 2 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 number served during the years 1 and 2 does not merit a sampling method, as it would be difficult to establish a representative sample.

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. During the first year of program implementation, the MIECHV program intends to identify an evaluation partner to provide guidance for data collection, data analysis and facilitate broad discussions on CQI, review the assessment tools, scoring methods and propose other metrics for measuring progress and success.

Identification of Data System

The Idaho MIECHV program has begun investigation of practice and performance management software options through multiple product demonstrations and intends to continue explore available products. The Idaho MIECHV program is partnering with the Bureau of Application Development and Support within the Division of Information Technology in the Department of Health and Welfare to explore data system options. The MIECHV program anticipates developing an RFP for a software solution to support data collection, maintenance and analysis of process and outcome data. Due to the cost of data system, the Division of Administration requires an RFP for procurement of a software solution. The Bureau of Application Development and Support will assist in RFP development for software solution. Responses to the organizational capacity assessment indicated that organizations are various stages of automated data collection and management. Idaho MIECHV program local contractors will likely 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 local contractors regarding the management information system is critical for adoption and sustainability of the software product to manage performance and practice. It is critical the MIECHV program identify an application that is relevant, efficient and provides appropriate support to users.

It is important for the MIECHV program to have access to both aggregate and disaggregate data for CQI and outcome analysis. In identification of management information systems, the MIECHV program will assure that application has tiered levels of security, each user and role has a specific level of security within the system. The application should have the capability to identify data entry and changes by user and role. The application will likely be centrally administered by the state MIECHV program with tiered security organized into by local contractor. 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 must allow offline data collection, local storage and syncing capabilities. It is likely it will be a hosted-solution must be compliant with HIPAA and FERPA requirements. The MIECHV program will work with software vendors and local contractors to develop an implementation plan and timeline. There will likely be a period of development when the product is customized for the Idaho MIECHV program and tested by local contractors prior to implementation.

Data Collection and Analysis Quality

All aspects of the MIECHV program will be subject to data collection given the nature of outcome and process measures. Various levels of training will be required given the intensive data requirements.

- **Field Staff**: Home visitors will be trained to effectively gather information via field interview and screening tools. All standardized screening tools require training, which must be completed prior to implementation of the tools. Home visitors should spend 10-20 hours per month entering or reviewing data. All screening tools can be administered by paraprofessional and professionals.

- **Data Entry**: Local contractors may identify staff responsible for data entry and generating reports to support home visitors and supervisors. The data entry staff should attend relevant training for screening and assessment tools and extensive training in management information systems. Data entry should spend between 20-50 hours per month entering data, given program size.
- **Local Contractor Administration**: Supervisors and program administrators should be trained on the management information system to conduct CQI and outcome analysis for performance management. Supervisors should participate in trainings screening tools to guide home visitors in reflective supervision. The supervisors and program administrators should be able to assess data quality and assess trends between home visitors. Administrators and supervisors should spend between 10-25 hours per 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. The MIECHV program manager should spend 10-25 hours per month on activities related to data collection, management and analysis and participate in training for management information system, data quality, and screening tools, as necessary.
- **Evaluation Partner**: The MIECHV program intends to contract with a University-based evaluation partner to work with state and local contractors and provide guidance for data collection, data analysis and facilitate broad discussions on CQI. The evaluation partner should spend 25-35 hours per month to support the MIECHV program. The partner should have extensive background in health, implementation, evaluation or social science research.

Demographic and Services Data Collection

The MIECHV program will 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 document and track referrals made and completed to assess access to services other than the home visiting program and better understand family outcomes. The following are screening tools will be used to measure the constructs:: Life Skills Progression Instrument, 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 helpful in the delivery of program services and program evaluation. It is a utilization-focused outcome evaluation tool for families with young children that many be used to collect clinical and outcome data by home visitors. LSP training is an 8-hour course and the cost of training is $2,500 and monitors 35 parental life skills.
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 its current scale.
Ages and Stages Questionnaires – 3rd Edition and the Ages and Stages Questionnaires – Social-Emotional: The ASQ system was originally developed in the 1970s and has been tested for inter-rater reliability and validity numerous times over the years. 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.
Protective Factors Survey: The tool was designed to measure multiple protective factors, prior tools measured individual protective factors. The survey is designed as a pre- and post-intervention evaluation tool of family change and has undergone three major field tests. The PFS is not intended for individual assessment, diagnostic purposes but is designed to measure multiple protective factors.

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 inter-rater reliability among family services providers. Both professionals and paraprofessionals have demonstrated reliability using the KIPS, upon completion of two-day training.

Benchmarks and Continuous Quality Improvement

Many of the constructs may be utilized for continuous quality improvement (CQI), please see Section 7 Plan for Continuous Quality Improvement. At program inception, local contractors will establish a baseline for each construct. The MIECHV program intends to partner with local contractors to determine potential benchmarks and goals for each year of the program. With baseline data, the MIECHV program and local contractors will prioritize constructs for performance improvement using the Plan, Do, Check Act Method. This method requires an action plan to measure and achieve improvement on priority constructs. Successful CQI process requires commitment of local contractors, state and evaluation partners. The following is an example timeline of a CQI process:

- 0-6 months: Establish a baseline for constructs
- 6-12 months: Assess initial trends for constructs
- 12-18 months: Prioritize constructs for improvement, research variables influencing construct(s)
- 18-24 months: Introduce training, resources, activities or 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, Nurse-Family Partnership and Early Head Start also require 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.

Anticipated Challenges and Barriers to Data Collection

There are many anticipated barriers and challenges 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. Synchronizing the timing of development and implementation of a data system and home visiting services will be important and will likely be a challenge. Geographic barriers may exist in very rural and frontier areas for in field data collection. The independent nature of Idaho's populous may present a challenge in collecting data on all families served by the MIECHV program. Additionally, implementing multiple evidence-based models may introduce barriers in data collection as well. Idaho has few statewide initiatives that broadly utilize 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 16: 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 asked status of prenatal care in field interviews within first month of enrollment or before 27 weeks of gestation, whichever is first, until start of 3rd trimester.	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) 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 smoke enrolled in program	Increase in % of referrals for pregnant smokers to cessation or treatment	Method: Review of case files Population: Mother Case Files	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 smoking throughout entire pregnancies is highest in PHD 1. Validity and reliability are not known.
Construct 1.4: Inter-birth Intervals				
Source: Program, Type: Process				
Numerator: number mothers and/or fathers of children birth – 2 years old enrolled program who receive education related to optimum birth spacing	Increase in % of mothers and/or fathers receiving	Method: Review of case files	At intake or within 6 months of enrollment, if child birth-2 years old and	This measure will indicate education related to family planning provided by home visitor when family has a child between 0-2 years old. No

Measure	Definition of improvement	Data Source & Population	When	Justification
Denominator: total mothers and/or fathers of children birth – 2 years enrolled in the program Optimum birth spacing defined: 2+ years between birth	any education on optimal birth spacing	Population: Mother and/or father (caregiver) Case Files	then 1 year thereafter.	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 Case Files: EPDS positive indication of depression 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 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	Increase in % of women predominant breastfeeding for 6 months	Method: Field interview with mother Population: Mother Case Files: Interview recorded in case files, possibly of using food/feeding recall survey	This measure would be taken at intake (within first 4 visits) for women 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.	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 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. NFP collects breastfeeding on the Infant Birth Form and Infant Health Care Form required at 6, 12, 18, and 24 months post-partum. Few standardized tools available for this indicator. Validity and reliability are not known for this measure, however if breastfeeding practice recall survey used, reliability/validity will be considered.
Construct 1.7: Well-child Visits				
Source: Program, Type: Outcome				

Measure	Definition of improvement	Data Source & Population	When	Justification
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, 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 six weeks from two – five years	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. NFP utilizes its Infant Health Care Form; required at 6, 12, 18, and 24 months post-partum. Additionally, this is a Title V priority. Validity and reliability are not known for this measure.
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 Case Files	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. NFP collects in interview at intake and four subsequent times. The MIECHV program is exploring opportunities for using 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*	Increase in % of children with credible health care coverage	Method: Field Interview Population: Child, as reported by caregiver Case Files: record of	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. NFP collects in interview at intake and four subsequent times. The MIECHV program is exploring opportunities for utilization of

Measure	Definition of improvement	Data Source & Population	When	Justification
and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. IDAPA 16.03.01)		responses in case file – potential query in Medicaid for Admin. Data		administrative data to assess enrollment in Medicaid over time. Validity and reliability are not known for this measure.
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 of 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 during home visit. Ask if they have been to the ED in past six months. Data collected approximately every 5-6 months during service delivery.	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. This will be cost effective and relevant to population served and could be integrated into review of well-child visits. Validity and reliability are not known for this measure.
Construct 2.3: Injury prevention education				
Source: Program, Type: Process – Output				
Numerator: number enrolled caregivers who receive education appropriate to the age of child related to	Increase the % of families who	Method: Case Files of home visitor	Education regarding illness, injury, and use of ED can	Home safety and injury prevention is a critical component of parent education. Research indicates

Measure	Definition of improvement	Data Source & Population	When	Justification
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)	receive education related to injury prevention and child safety in a given time period	activity Population: Caregivers Case Files: Reported by home visitors in home visit log	occur throughout service delivery, depending on child's age and family needs. Program administrators should assess this measure every six months .	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 topic of injury/poison prevention, home safety or child safety in a time period	Method: Field Interview Population: Mother Case Files: Self-report 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 *Denominator*: Total number of children enrolled in the program in same given time period	Decrease the % of enrolled children with a suspected child maltreatment report filed 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 to assess child abuse and neglect in Idaho. However, exact validity and reliability are not known

Measure	Definition of improvement	Data Source & Population	When	Justification
				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 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				
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	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 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

Measure	Definition of improvement	Data Source & Population	When	Justification
time victims for children the same age for the same period of time."				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 The KIPS assesses parenting behaviors on the following scales: Sensitivity of Responses, Supports Emotions, Physical Interaction, Involvement in Child's Activities, Open to Child's Agenda, Engagement in Language Experiences, Reasonable Expectations, Adapts Strategies to Child, Limits & Consequences, Supportive Directions, Encouragement, Promotes Exploration & Curiosity	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. NFP uses observation and self-report noted in client record (collected at entry and 1 year post enrollment). 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 completed by home visitors to assess parenting behaviors. This scale is broadly used by home visiting programs, including Parents as Teachers.
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:	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	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. NFP uses

Measure	Definition of improvement	Data Source & Population	When	Justification
12, 14, 16. 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.		scored and stored in case files		observation and self-report noted in client record (collected at entry and 1 year post enrollment). 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. 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.
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 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. Rigorous testing by independent investigators demonstrates the LSP has high reliability. With training, the inter-rater reliability runs 78% to 90%	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 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. NFP uses observation and self-report noted in client record (collected at entry and 1 year post enrollment). 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.
Construct 3.4: Parent-Child Relationship				
Source: Program, Type: Outcome				
Numerator: Number of parents scoring a 3.5+ or higher	Increase % of	Method: Home	Home Visitor observation	This longitudinal indicator aims to assess participant

Measure	Definition of improvement	Data Source & Population	When	Justification
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	parents scoring 3.5+ on scale # 5 – Nurturing of the – LSP Instrument after 12 months of program enrollment	visitor observation of parent discipline techniques <u>Population</u>: Parent/Caregiver Case files: Assessments will be scored and stored in case files	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.	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. EHS does not utilize a specific assessment tool for this domain. NFP uses observation and self-report noted in client record or dyadic assessment form. PAT affiliates utilize the Life Skills Progression Instrument, Protective Factors Survey, and Keys to Interactive Parenting Scale as instruments to assess parenting.
Construct 3.5: <u>Parental Stress</u> 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*. 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. This tool is a single instrument that assesses *multiple protective factors*	Increase % of parents improving score on items 6-11 on the PFS after 12 months of program enrollment	<u>Method</u>: Parent report on pages 3-4 paper Protective Factors Survey, home visitor complete pages 1-2 <u>Population</u>: 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. EHS does not utilize a specific assessment tool for this domain. NFP utilizes Maternal Health Assessment Form. PAT 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.

Measure	Definition of improvement	Data Source & Population	When	Justification
against child abuse and neglect.				
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) *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 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%.	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 be scored and stored in case files	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 end of service delivery. If a child is not achieving cutoff, the screens should occur more frequently.	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. 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.
Construct 3.7: Child cognitive skills				
Source: Program, Type: Process - Output				

Measure	Definition of improvement	Data Source & Population	When	Justification
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 *Denominator*: total number of children enrolled in the program in the same time period The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. Screens are available 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.	Increase the % enrolled children with ASQ-3 at least every six months of program participation	Method: Administrative review of ASQ – 3 assessments in case files Parent led completion with assistance from home visitor, , to complete ASQ–3 Population: Parent and child Case files: Review of Home visitor	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 end of service delivery. If a child is below cutoff, the screens should occur more frequently.	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.
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 Note: This construct could be considered an indicator of model fidelity.	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 – 3 Population: Parent and child Case files: Review of Home visitor case files	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-cutoff score in the problem solving domain, home visitors should provide suggested developmentally appropriate activities to cultivate problem solving skills in subsequent home visits. According to the HomVEE study, both PAT, NFP and EHS had favorable outcomes related to child development, school readiness and positive parenting practices. This suggests that when home visitors adhere to curricula that support child development and school readiness, are more likely to have positive outcomes.
Construct 3.9: Child social behavior, emotional regulation, and emotional well-being				
Source: Program, Type: Outcome				

Measure	Definition of improvement	Data Source & Population	When	Justification
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. 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.	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) is an assessment tool to measure children between 3-60 months in the 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.
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) The ASQ questionnaires take 10–15 minutes for parents to complete and 2–3 minutes to score. Screens are available to assess the following domains: communication, gross motor, fine motor, problem	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:	Home visitor complete the ASQ – 3rd edition ™ with the family at enrollment, if child is greater than 2 mon. or when a child turns 2 mon. with appropriate screen and then every four to six months until child turns three, then every year thereafter or end of service delivery, whichever	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.

Measure	Definition of improvement	Data Source & Population	When	Justification
solving, and personal-social, plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction.		Assessments will be scored and stored in case files	occurs first until end of service delivery. If a child is not above cutoff, screens should occur more often.	The home visitor will also make a referral to the Infant Toddler Program for any child that indicates further evaluation is necessary.
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 PAT has recently added the Domestic Violence Enhanced Visitation Intervention (DOVE) screening, which includes three prenatal and three postpartum visits. PAT is determining appropriate training or preparation for parent educators for this promising intervention. 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. Idaho MIECHV program is exploring opportunities to partner with model developers and IDVSA to identify the appropriate assessment tools.	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 screen to be used in a health care or home setting. One screen the MIECHV programs is exploring is the Abusive Behavior Inventory (ABI) 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 assessed for internal consistency: Physical abuse = .70 to .88. Evidence of convergent, discriminant, criterion, and factorial validity.
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	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	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	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

Measure	Definition of improvement	Data Source & Population	When	Justification
(according to ABI score)		Case File: Documentation of referrals (given & completed) to be maintained in case files	local contractor to state MIECHV program annually to report for contract performance metrics	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. Validity and reliability are not known for this 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. Validity and reliability are not known for this 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 *Denominator*: total number of families with a complete LSP Scale #34 in same period of time	Increase in % of families showing increased scored on the LSP scale #34 – Income in a given time period	Method: Review of Case Files – LSP Scale #34 over time Population: Families Case File: Completed LSP kept 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 a program participant over time, comparing a change in income over time from score of LSP 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 overall reliability or validity.
Construct 5.2: Household Benefits				

Measure	Definition of improvement	Data Source & Population	When	Justification
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: WIC, Idaho Food Stamp Program, Medicaid/SCHIP, TANF Cash Assistance, 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 need and time 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 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 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 *Denominator*: total number of families with a complete LSP scale #15 – Employment or # 16 – Immigration (only for relevant families) in same period of time	Increase in % of families showing increased scored on the LSP scale #15 – Employment or # 16 – Immigration (for relevant families) in a time period	Method: Review of Case Files – LSP Scale #15- 16 over time Population: Families Case File: LSP kept case file		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 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 instrument reliability or validity.
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	Method: Review of Case Files – LSP Scale #12-14 over time Population: Families Case File: Completed LSP scored and	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

Measure	Definition of improvement	Data Source & Population	When	Justification
	population served) in a time period	maintained in case file		scales has been independently studied for reliability and validity, thus individual scales can be used without impacting instrument reliability or validity.
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 *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, caregiver report Case Files: record in case file – potential query to Medicaid 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.
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	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
identified needing services through interview or low scores on Concrete Supports of PFS) • Domestic Violence Services (screened positive) • 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 indicator: Number of established partnerships to referral sources available in community for any of the services defined as necessary services. This input, process indicator is particularly important in communities with few available resources or existing referrals in their resource network. This is not a measure that has validity and reliability measures, over time data quality checks will occur to 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 is critical that a management information system have capacity to track referrals, follow-ups and produce reminders for home visitors to assess needs identified through screening and interviews, referrals made and completed. Additionally, it is 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 not known for this measure.
Construct 6.3: Number MOUs within community Service Agencies				
Source: Program, Type: Process				
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 3 (or time 2) *Numerator*: Number of Memorandums of Understanding (MOUs) or other formal agreements	Increase MOUs or other formal agreements with social services, health, or community organization within service	Method: Local contractor Administrative Records Population: Local contractor	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	PAT, NFP, and EHS expect implementers to cultivate community referral networks. This is an important measure for CQI for the 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

Measure	Definition of improvement	Data Source & Population	When	Justification
with social service, health, or community services organization within the service delivery area (coverage area) at year 1 (or time 1)	delivery area (Ratio >1 is improvement)	Program Administrative Records	review.	intends to provide TA to local contractors as needed to facilitate MOUs with community partners. Validity and reliability are not known for this 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	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.	PAT, NFP, and EHS 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 rural and frontier areas, there will be 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				
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 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: State Administration of Home Visiting Program

Lead Agency

The Idaho Department of Health and Welfare was designated as lead agency for the MIECHV program. 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 in the state MCH structure. Please see Attachment 3 for Organizational Charts.

Collaborative Partners

Because Idaho does not have an existing state home visiting program and few existing home visiting programs, the partnership list will continue to expand as the program develops. The Idaho MIECHV program concurrency partners have been actively involved throughout the grant development and planning process, in a planning steering committee. As Idaho's state home visiting program is implemented and the system infrastructure develops and matures, partnerships are expected to expand. Public and private partners as of July 2011 can be found in Section 4: Implementation Plan.

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, 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 and other partners as home visiting infrastructure develops 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 works with MCH Analyst, Mr. Ward Ballard, located in the Bureau of Vital Records and Health Statistics. Job descriptions and biosketches can be found in Attachment 4. Management of the local contractors will be identified through the RFP process. Ms. DeBoer will work with local contractors to assure model fidelity and availability of training and technical assistance.

Coordination of Referrals, Assessment and Intake Processes Across Models

To date, there is no detailed plan for centralized intake. As the state program develops, coordination of referrals, assessment at intake will be integrated into program development activities. In the event that two local contractors are awarded funding in a target community, the MIECHV program anticipates facilitating partnerships for referrals and intake processes among local contractors and partners.

State and Local Evaluation Efforts

The MIECHV program manager will develop evaluation strategies for the state delivered program(s), as well as assist in development of an evaluation plan for the home visiting systems development. The program manager will work with model developers and program personnel to assure local contractors are adhering to model fidelity. This will be done through contract performance metrics and developer oversight. An evaluation partner will be contracted 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 local contractors, 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 MIECHV program will incorporate performance metrics into contracts to monitor supervisor requirements and standards. The state will work with model developers to assure local contractor supervisors meet national model standards.
- **Organizational Standards:** The state MIECHV program will incorporate performance metrics into contracts that require local contractors 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 contractor meet national program standards.
- **Referral and Service Networks:** The state MIECHV program will partner with local contractors in the target communities and 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 coordinated and effective statewide referral systems.
- **Monitoring of Program Fidelity**: The state MIECHV program will work with model developers to assure contract requirements support complete implementation of evidence-based home visiting models. The state MIECHV program will provide technical assistance and onsite monitoring visits for local contractors that assure with model fidelity during implementation.

Coordination with other Early Childhood Plans

Throughout the planning process, the MIECHV program has presented to the Idaho's Early Childhood Coordinating Council (EC3), part of the State Early Childhood Comprehensive System. 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 additional information.

Compliance with Model-Specific Prerequisites

Because Idaho has few home visiting programs and none state administered, with the exception of IDEA Part C – Infant Toddler Program, the MIECHV program and target communities will work closely with model developers to assure fidelity. The greatest implementation challenge may be the identification and implementation 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 requirements.

State Administrative Structure, System Integration and Collaboration

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

The greatest support to the MIECHV program has been through collaboration with Idaho's EC3, Idaho's Early Childhood Coordinating Council. The support to the MIECHV 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 charged with integrating home visiting as a strategy into Idaho's early childhood system. The ad hoc committee will provide a forum for expanding the number of stakeholders to participate in development of home visiting programs as a 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, location specific policies and practices while adhering to model fidelity, monitoring local contractor progress towards contractual objectives and scope of work, assessing program implementation and delivery, identifying potential training opportunities and revising processes to meet needs and improve performance.

Implementation of the CQI plan will take place both at the state level and local level. Local contractors will have contractual obligations to plan and fulfill CQI activities. Each contractor must adhere to model specific standards and 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. Parents as Teachers, Nurse-Family Partnership and Early Head Start conduct quality assurance or monitoring through onsite visits to grantees/affiliates. Because the MIECHV program will provide ongoing performance monitoring and will coordinate technical assistance and training with the local contractor, it is critical to partner with model developers in aligning monitoring activities to present information in an integrated manner and 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 partners from across the home visiting program including, but not limited to, a home visitor, a family participant, supervisor, evaluator, program managers, program directors, and model developers. The Idaho MIECHV program understands that buy-in and participation from all levels of the program will be instrumental in creating and guiding a

culture of quality. Being that CQI is new process for the MIECHV program, the program plans on contracting with an evaluator for the duration of program implementation to 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 constructs in required benchmark areas. Please see Section 5: Plan for Meeting Legislatively-Mandated Benchmarks for 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 MOU's within community
- 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 local contractors related to the PDCA approach for CQI, and provide tools to assist in identifying problems and solutions. The local contractor will be required to report on performance indicators, which will be incorporated into contract performance metrics bi-annually to facilitate CQI 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.

4. Evaluation

The MIECHV program will require local contractors 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 consists of three programs. Idaho has primarily conducted home visiting through early intervention in the Infant Toddler Program (IDEA Part C), 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 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 understands that both the state MIECHV program and local contractors will need 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. The MIECHV program anticipates requesting technical assistance to assist the state and local contractors to build capacity to collect benchmarks and performance data. 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 with other vested stakeholders.

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
4. Establishing a centralized intake process

Local MIECHV Grantee Anticipated Technical Assistance Needs:

1. Continuous Quality Improvement
2. Implementing with Model Fidelity
3. Data Collection and Analysis for data-driven decision making
4. Maternal Depression and Domestic Violence screening and referrals
5. Referral Networks: Building and Tracking Referrals

Section 9: Reporting Requirements

The Idaho Maternal, Infant and Early Childhood program intends to comply with the legislative reporting requirements by submitting required progress report within 90 days of completion of each project period. The progress report will include updates and progress achieved in the following areas:

1. Program Goals and Objectives
2. Promising Approach Updates
3. Implementation in Target Communities
4. Progress towards Meeting Benchmarks
5. Continuous Quality Improvement Efforts
6. MIECHV Program Administration Updates
7. Technical Assistance Needs