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Abstract

The Connecticut (CT) Department of Public Health (DPH) is the State Title V Agency, and is the state agency designated by the Governor to apply for and administer the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program grant funds for Connecticut.

Children living in poverty are at greater risk for developmental and behavioral problems, health issues, learning disabilities, and cognitive delays. Children of low-income families are also at increased risk for child abuse or neglect, and of becoming involved with the child protection and juvenile justice systems. Children living in poverty in high-risk communities tend to do poorly in school and struggle throughout their school years. The state Medicaid eligibility data identifies the percentage of Connecticut children living in poverty at 28%, suggesting that more than 60,000 children in the State from 0-5 years of age are at risk for poor outcomes in the state.

Based on the results of the 2010 Connecticut Home Visiting Needs Assessment, the State identified 16 cities and towns as having the greatest need for home visiting services. The towns of Windham and Ansonia/Derby were selected for implementation of high quality, evidence-based home visiting programs in the State Plan. Through this State Plan, DPH will expand and improve the home visiting system for the state's most vulnerable families by implementing the following: 1) A CT Parents As Teachers (CT-PAT) program in New Britain, CT; and 2) A Nurse Family Partnership (NFP) program in New London, CT.

The overarching goals of the State Plan are to: 1) Support improvements in maternal, child and family health; 2) Promote effective implementation and expansion of evidence-based home visiting programs and systems in the state with fidelity to the model selected; 3) Reach high-risk and hard-to-engage populations; and 4) Support a family-centered approach to home visiting.

Connecticut appreciates the opportunity to expand and enhance its current home visiting programs and looks forward to the opportunity to strengthen its early childhood system of care through evidence-based practice.

Section 1: Identification of Connecticut's Targeted at-Risk Communities

Needs Assessment and Selection Process

In 2010, in preparation for the development of the CT updated State Plan for MIECHV Programs (referred to in this document as the State Plan; *http:www.ct.gov/MIECHV_State plan*), the DPH completed the Statewide Needs Assessment for MIECHV Programs (referred to in this document as the Needs Assessment; *http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf*). A set of key indicators were identified and an index of need was established. The indicators included the unemployment rate, excess low birth weight and excess non-private insurance at birth. Percentages of young children living in poverty, low third grade school achievement, high school dropout rates, and excess abuse or neglect were used to establish the need for early childhood services. The Needs Assessment identified the most vulnerable communities and they were ranked by the level of risk. The Needs Assessment revealed that sixteen towns in CT have a very high need for MIECHV services (see Table, *below*).

Need for Maternal, Infant, and Early Childhood Services
Connecticut, 2008

Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
Very High Need for Maternal & Infant AND/OR Early Childhood Services [1]							
Bridgeport**	Bloomfield** Bristol** East Hartford** Hartford** New Britain**	Torrington* Winchester*		Ansonia** Derby* Meriden** New Haven** Waterbury**	New London**		Putnam** Windham**
High Need for Maternal & Infant AND/OR Early Childhood Services [2]							
	East Windsor Enfield* Manchester* Plainville Windsor Locks			East Haven* West Haven**	Griswold* Norwich** Sprague*	Vernon*	Killingly* Plainfield*
Moderate Need for Maternal & Infant AND Early Childhood Services [3]							
Danbury**		Plymouth*			Groton*		Chaplin* Thompson*

[1] - Towns identified as very high need for either Maternal & Infant or Early Childhood services.
[2] - Towns identified as high need for either Maternal & Infant or Early Childhood services.
[3] - Towns identified as moderate need for both Maternal & Infant and Early Childhood services.

Towns identified by the Governor's Early Childhood Research & Policy Council as a priority (**) or competitive (*) town are shown.

In February 2011, the DPH established the *ad hoc* Home Visiting Advisory Committee (HVAC). The HVAC members included the agencies or individuals required to concur on the State Plan (Attachment 5: Memorandum of Concurrence). The HVAC assisted with the development of the State Plan, which included selection of the target communities. The HVAC met weekly or bi-weekly through mid-May during the development of the State Plan, and used the Needs Assessment to identify communities with very high need. Ansonia/Derby and Windham were identified to benefit from the implementation of one or more of the Health Resources and

Services Administration (HRSA) approved evidence-based home visiting models.

Communities Represented in the State Plan

The rural communities of Ansonia/Derby and Windham were represented in the State Plan and were the first two of four communities in which MIECHV programs were implemented. These towns ranked very high in need for maternal and child health services, as identified by the Needs Assessment. The DPH convened community forums in each of the targeted communities. Participants were invited by a key community contact and included state, public, private and non-profit representatives actively working in that community. The community forums were coordinated and conducted in a relatively short time period, which showed the commitment of the participants to improving services for families in their families. Information about each of the seven evidence-based home visiting models to be considered for implementation was provided to the forum representatives. Using data and open discussion, the strengths and needs of each community were highlighted. The DPH provided state and local data relevant to each of the indicators, which drove the discussion on selecting the model that would best fit the needs of the community. The community representatives worked collaboratively to select an evidence-based model that they considered best responded to the needs of their community and determined the appropriate lead agency for implementation of the selected model. The representatives expressed commitment to mobilize a collaborative partnership of local organizations to fully support the MIECHV effort.

The Ansonia/Derby community selected the Early Head Start Home-based (EHS HBO) program for their community and identified Training Education and Manpower, Inc. (TEAM) as the lead implementing agency. TEAM is a private non-profit corporation founded in 1965 with the mission "to connect individuals and families with solutions that lead to well-being, self-sufficiency and full participation in the community." The EHS HBO program is a home visiting model designed to provide high-quality child and family development services to low-income pregnant women and families with infants and toddlers (birth to age 3 years).

The Windham community forum participants selected the Parents As Teachers (PAT) model and identified Generations Family Health Center (Generations) as the lead implementing agency. Generations is a federally qualified health center providing accessible, high quality primary care, oral health care, and behavioral health services in the Windham community. The PAT model will be implemented there and the program will serve pregnant non-first time mothers, including those with child welfare involvement. The PAT philosophy and theoretical framework focuses on human ecology and family systems, developmental parenting, and attribution theory, as well as on empowerment and self-efficacy.

The lead agencies in Ansonia/Derby and Windham are well-established organizations within those communities. The home visiting models selected for implementation in response to the particular needs of their communities are evidence-based. The corresponding model developers will support the implementation of the program. The implementing agencies agree to participate in any required training, contractual agreements, and/or technical support offered by the model developer. In-depth descriptions and implementation plans for the initial two Connecticut communities can be found online in the State Plan.

Assessment of Strengths, Risk Factors, and Needs

New Britain

Despite being in the ranks of *very high need* communities in the Needs Assessment, New Britain has many strengths. Key among these is a strong history of collaboration among service providers to both prevent duplication of services and maximize limited resources. In 2008, the New Britain Early Childhood Collaborative brought together parents, educators, and health and social service providers to develop a *Blueprint for New Britain's Young Children*. The Blueprint report, which identifies areas of need and strategies for the community to address those needs, has been used as a guide for collaborating organizations to open a new Family Wellness Center and develop new oral language development programs. In addition, New Britain recently received federal funding to bring the Child and Family Interagency Resources, Support, and Training (Child FIRST) in-home behavioral health service model to the town.

New Britain has a population of 70,548, and has risks and challenges similar to those found in larger urban communities (see Needs Assessment). These challenges include: an early childhood (ages 0-4 years) percent poverty of 31.6%, compared to the statewide average of 15.6%; an increased high school dropout rate of 5.4 per 100, compared to the statewide rate of 1.9 per; an increased 2008 unemployment rate of 8.5%, compared to a statewide rate of 5.7%;; a teen (ages 15-19 years) pregnancy rate that was the highest in the state (75.6 per 1,000, compared to the statewide rate of 25.0 per 1,000); and a median annual income of $37,000 compared to CT's statewide average of $66,000 (CT Department of Labor, July 2011) .

In calendar year 2008, a total of 1,083 babies were delivered to New Britain mothers, and 67% of those deliveries were paid for by a non-private source. A total of 278 (25.7%) of these babies were born to mothers without a high school diploma (almost twice the state average). According to the 2010 census, 31.6% of children in New Britain under the age of 18 live below the federal poverty level (FPL). Ninety-three percent of children in the New Britain school system qualify for free or reduced price meals.

While programs in the community work collectively to address the needs, services are limited and programming is often at maximum capacity. The City of New Britain has hosted the CT PAT program since 1999, but the program remains at capacity, with an estimated four openings available annually. Currently, the CT-PAT program at the Hospital of Central Connecticut (HOCC) serves 50 pregnant or parenting teens at New Britain High School, with an addditional 30 more enrolled families from within the community. These 80 families are visited weekly. The program attempts to serve families prenatally through age five. The CT-PAT program, the home visiting program attempting to serve families with multiple risk factors, is able to serve less than half of the births to teen parents in poverty, less than 40% of the low birth weight babies born into poverty, and less than one-fourth of the teen births in New Britain.

New London

A population of 25,891 residents living in approximately six square miles lends the City of New London a familiarity to the environment. This provides a strong networking capability to serve at-risk individuals. A large number of small places of worship and academic institutions exist in the community, however, that are often considered burdens on the tax structure of the City. Similarly, while New London is considered the transportation hub of southeastern CT, but is also

seen as an intersection of interstate and regional drug traffic.

A Teen Pregnancy Prevention (TPP) Task Force consisting of local hospitals, faith-based organizations, municipalities and other community organizations was established by the New London health department as a result of a citywide assessment. The TPP Task Force has been concerned with prevention of both teen pregnancy and sexually transmitted infections. The Task Force focuses on education of the community and prevention of overlapping efforts. One of their most notable activities include small group meetings in homes across the community to present the program, "Are you an Askable Parent?" In addition, during Fall, 2010, leaders of faith-based organizations included the topic of healthy sexuality in messages to their communities.

The risk factors highlighted in the Needs Assessment indicate the following for New London: a percent unemployment of 8.75%, above the statewide percent of 5.7%; a teen (15-19 years) birth rate of 29.5 per 1,000, above the statewide rate of 25.0 per 1,000; 13.1% of mothers who entered prenatal care late or not at all, above the state average of 12.4%; and a high school drop-out rate of 4 per 100, compared to the state rate of 1.9 per 100 (see Needs Assessment).

An analysis of the 2010 births at Lawrence & Memorial Hospital shows further risk factors. Of the 243 births that occurred to residents of New London, 166 (68%) were paid by non-private insurance; 94 (38.7%) were of Hispanic ethnicity; and 53 (21.8%) were of Black/African American race. Current statistics for the New London school system designate the city as a universal feeding community, which deems 95% of the families at the federal poverty level.

New London is adjacent to the City of Groton, which houses the U.S. Navy Sub-base. Naval families move between the communities of Groton and New London, where there is military and low-income housing. Young naval families experience separation from family, many for the first time, and the young spouses, primarily women, are often in need of support during pregnancy, as well as infant and child care. Without their own parents nearby, the women seek services in the surrounding communities to help them cope with the challenges of raising a family, often while their spouse is deployed for many months.

Existing Home Visiting Services

New Britain

The New Britain community hosts six small home visiting programs. The programs include three Family Enrichment programs funded by the Department of Children and Families (DCF) and three PAT programs, two of which offer more intensive weekly visits through the Nurturing Families program. The DCF-funded Family Enrichment programs focus on intervention services to high risk families who are mandated to participate in an intensive parenting education program.

The school district's two Family Resource Centers (FRCs) utilize the PAT curriculum in monthly visits to approximately 40 families. These less intensive voluntary services are offered to families whose children will attend the two elementary schools that house the FRCs and participation is not limited to families with multiple risk factors. The two Nurturing Families Programs use the PAT curriculum with a more intensive schedule of weekly visits and participation is limited to families identified with multiple risk factors using a screening tool.

These programs are run by the HOCC serving 80 families and the University of Connecticut Health Center (UCHC). The UCHC located in Farmington, CT has taken on eight families in New Britain in an effort to address some of the unmet need in New Britain. The CT-PAT Programs serve the New Britain community providing weekly home visits to pregnant and parenting parents. Both PAT models are voluntary.

New London

There are six home visiting programs in New London, two of which use evidence-based models: 1)The Visiting Nurses Association of Southeastern CT (VNASC) operates a home visiting program for first time, at-risk, low-income mothers. The program was designed using the Nurse Family Partnership (NFP) evidence-based model; however the VNA has no formal affiliation with the model or model developer. 2) The CT-PAT Program operates out of Lawrence & Memorial Hospital. 3) The Early Head Start program operated by the Thames Valley Council for Community Action also utilizes the PAT model.4) The Healthy Start program located at Lawrence & Memorial Hospital assists uninsured women with enrollment into the state's Healthcare for UninSured Kids and Youth (HUSKY) plan and offers expedited eligibility for pregnant women under 250% of the FPL. 5) The Birth to Three Program is State Individuals with Disabilities Education Act (IDEA, Part C) program and offers services in a home-like environment to families of infants with, or at-risk for developmental delays. 6) The Ledgelight Health District offers home visiting to families and children with asthma through the *Putting on Airs* Program. A sanitarian and a public health nurse visit the home and conduct an environmental assessment for factors that trigger asthma, and provide education on use of inhalers and prevention. The program is successful in preventing repeat hospitalizations in children due to asthma related illness.

Existing Mechanisms for Screening, Identifying, and Referring Families and Children to Home Visiting Programs

New Britain

The CT-PAT site at the HOCC employs an intake worker through Nurturing Connections who is available to screen pregnant and parenting mothers for risk factors that may indicate child abuse or neglect through Nurturing Connections, and who serves as the point of entry for the CT-PAT program. Many of these referrals come late in pregnancy or immediately following the delivery. The intake worker can also receive and solicit intakes throughout the hospital community, including the birthing center, prenatal clinic, and local obstetricians, as well as community settings. The screening involves either a scan of medical records and/or a face-to-face interview with the parent(s) for identifying high or low risk of poor parenting, child maltreatment, or other risk factors. A screening tool assists the screener to determine the level of anticipated need for referrals to the appropriate resources. Parents determined by the screening to be at lower risk of being abusive or neglectful are offered a second function of the Nurturing Connections program. This component involves contacting parents by phone and offering support, educational materials and referral information to other community services. High-risk families are enrolled in the CT-PAT home visiting program, which provides weekly home visiting and case management.

New London

There is no central intake or point of entrance for referring families to home visiting services in New London. Referrals arrive to organizations from a variety of sources. Referrals to the VNASC come directly from the Lawrence and Memorial Hospital, and Obstetrics/Gynecology (OB/GYN) clinics.

Currently Available Referral Resources and Future Needs

New Britain

The HOCC will hire an outreach worker to facilitate referrals throughout the community. The worker will be familiar with and connected to a variety of resources throughout the community. Potential referral sources are: The Spanish Speaking Center for food, education assistance; the Human Resource Agency for job readiness, childcare, and fatherhood; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC for food supplements, nutrition information and education; the New Britain Board of Education for adult education programming and programs to support teen mothers; and the New Britain Public Health Department for testing, immunizations, and protective services.

To enhance communication between the home visiting program and general community, a home visiting coordinating committee will be developed. The committee will provide joint professional development, unified referral systems, and work to prevent duplication of services. The committee will work closely with the existing Child FIRST program, another home visiting program in the community, to ensure that families with behavioral health needs get the clinical mental health support and services that they need. The committee will also refer families to the Birth to Three program, the State IDEA Part C program. Each home visitor will be trained to administer the Ages and Stages questionnaire to assess the child's social, emotional, and developmental milestones. Home visitors and the Birth to Three program will work collaboratively to determine the level of services the family needs and make appropriate recommendations and/or referrals.

The New Britain Oral Health Collaborative received a five-year grant from the CT Health Foundation in 2010 to support and educate prenatal mothers about the importance of oral health. This program works with all community organizations by offering groups and workshops free of charge. Although the State Healthy Start program is located outside the City of New Britain, the director of the CT-PAT program serves with the host organization of the Healthy Start program on the Tunxis Community College Human Services Advisory Board. In addition, CT-PAT regularly refers families for support from HUSKY, Care for Kids and TANF, and encourages utilization of programs and services within the program infrastructure. The WIC program is centrally located in the community, and its location makes access to services convenient for families. The director of WIC serves on the CT-PAT Advisory Board and is currently collaborating with CT-PAT and the New Britain public schools to open a satellite WIC site in the high school.

New London

The VNASC receives referrals from the Lawrence and Memorial Obstetric clinic, the State DCF, and private obstetrician practices.

The New London CT-PAT program established the Parent Education Network (PEN) for community organizations serving families. Membership includes the Nurturing Families Network (NFN) at Lawrence and Memorial Hospital, State Healthy Start, Fatherhood Initiative (Madonna Place), Daddy Boot Camp (Lawrence and Memorial Hospital), Lawrence and Memorial Hospital childbirth educators, VNASC, United States Navy Family Support, CT Family Support Network, lactation nurses (Lawrence and Memorial Hospital), nurse managers, labor and delivery units, and the postpartum units (Lawrence and Memorial Hospital).

The VNASC participates in the PEN meetings and will establish mechanisms for referral through the participating partners. The use of an advisory committee will be a primary way to interact and elicit referrals from several sources. The VNASC has well-established connections to the agencies and organizations that care for pregnant women and their children. Furthermore, the VNASC's affiliation with the local community hospital enables a smooth and timely exchange of referrals. The VNASC provides nursing support to: a young motherhood program at the city adult education center, the homeless shelters in New London, and school nursing services in New London. Outreach visits are made to private practitioner's offices. The VNASC is represented on numerous community groups, where information is shared about programs and services. The programs include: New London County Health Care Collaborative, United Way Council of Executives, PEN, New London Community Care Team, and the Community Health Center Advisory Committee. The VNASC has a staff of 250 individuals.

Coordination Among Programs and Resources

New Britain

The community will develop a home visiting coordinating committee to provide joint professional development, unified referral systems and prevent duplication of services. This coordinating committee will work closely with the Child FIRST program to assure that families with behavioral health needs get the clinical mental health support and services that they need. The CT-PAT Program will continue to refer families of children with potential developmental delays to the Birth to Three program for an evaluation.

New London

The VNASC will meet monthly with the PEN to coordinate home visiting services in the community and to address service gaps. The VNASC will establish a referral network with community resources, including military resources, to refer families when programs reach capacity.

In 2005, the VNASC established the Nurse Family Care Program Advisory Committee and began meeting to educate members about the model of intensive nursing intervention that was proposed to serve first time mothers and their children. Their input was encouraged on the protocols for care of the mothers and infants. The committee consisted of representatives from the obstetric clinic at Lawrence & Memorial Hospital, the chief of obstetric services at Lawrence & Memorial Hospital, a local pediatrician, a professor of early childhood education and development, the public safety officer of the New London Police, two representatives of the social services safety net (Madonna Place, Community Partnerships) and the Nurturing Families Connections (NFC) staff and supervisors. The committee met twice at the beginning of the program, and determined that they would act as consultants, and encouraged staff to call them

when their expertise could be valuable.

The VNASC governing board is representative of the communities that the agency serves from the Rhode Island border to the City of Old Saybrook, CT. The twenty member board is a policy board that meets monthly. The agency is an affiliate of the Lawrence & Memorial Corporation, the parent company of the hospital. The chief executive officer of the Hospital has a seat on the board and is actively involved in its activities. The VNASC also has a professional advisory committee of community professionals in active practice and is a member of the Council of United Way executives and the New London County Health Collaborative.

Local and State Capacity to Integrate the Proposed Home Visiting Services into an Early Childhood System

Rosa M. Biaggi, MPH, MPA, Chief Family Health Section and State Title V Director is the Principal Investigator on the MIECHV grants. The CT Early Childhood Comprehensive System (ECCS) grant is administered in the Family Health Section of the DPH. The ECCS grant is referred to in this application as the Early Childhood Partners (ECP) Project. The goal of the ECP is to create a comprehensive system that ensures children are healthy and ready to learn by age five. The DPH and the Commission on Children co-chaired a steering committee that included eight state agencies, community and statewide organizations, local government, philanthropy, and public and private stakeholders involved with early childhood health and education. A strategic plan was developed to determine how CT could implement strategies to address the five ECP domains: 1) early care and education; 2) mental health and social emotional development;
3) access to medical homes; 4) family support; and 5) parenting education. The ECP Project Director serves as a member of the State Advisory Council (SAC). This is a statewide organization of state and local early childhood advocates. Within the last several years, home visiting has become a focus of the SAC. Some of the members of HVAC are also members of the ECP SAC. (Attachment 3: Project Organizational Chart)

In 1995, the CT Children's Trust Fund (CCTF), now a division of the Department of Social Services (DSS), launched a major initiative to develop a universal home visiting program throughout the state, pursuant to Sec. 17a-56 of the CT state statutes establishing the NFN. The CCTF was charged with developing "the structure for a state-wide system" for the home visiting program. The legislation also required the CCTF to develop a training program, standards, protocols and a data system to document the impact of the program, including the incidence of child abuse or neglect, risk profiles, and demographics of the families participating in the program. In 2003, the CCTF adopted the PAT program model and expanded the CT-PAT Nurturing Families program from two to 42 sites.

Communities at Risk Not Being Selected For Implementation of the State Home Visiting Program

The eleven towns that were identified through the Needs Assessment as "very high" need for maternal and infant services, but were not funded through this project due to insufficient financial resources, include: Bloomfield, Bridgeport, Bristol, East Hartford, Hartford, Meriden, New Haven, Putnam, Torrington, Waterbury and Winchester.

Section 2: Home Visiting Program's Goals and Objectives

Goals and Objectives
The overarching goal of the CT MIECHV program is to develop a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships (Attachment 1: Project Logic Model). To improve the home visiting system for the most vulnerable families in CT, DPH will: 1) Expand the CT-PAT Program in New Britain, and 2) Implement the NFP model in New London. The three primary goals are:
Goal 1: Strengthen and improve the programs and activities carried out under Title V.
Objectives: 1) Establish quantifiable, measurable baseline data; 2) Identify and implement a data collection system; 3) Establish and monitor data collection and reporting guidelines; 4) Conduct ongoing continuous quality improvement activities; 5) Conduct process and outcome evaluation.
Goal 2: Improve coordination of services for at-risk communities.
Objectives: 1) Establish memorandums of understanding (MOUs) or other formal agreements with other health or social service agencies in the community; 2) Establish clear points of contact between the home visitor and collaborating agencies; 3) Establish and maintain a coalition of community service providers; 4) Connect individuals and families with needed services; 5) Follow up on referrals to ensure that services are provided; 6) Connect participants to health insurance resources; 7) Report maltreatment of children; 8) Connect participants to possible economic, employment, and education assistance programs; 9) Refer participants to relevant domestic violence services; 10) Provide referrals to parenting support services, as needed; and 11) Provide referrals to local and state resources as needed.
Goal 3: Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.
Objectives: 1) Increase access to home visiting services for at-risk families; 2) decrease the risk of harm or injury among families receiving home visiting services; 3) improve communication between the home visitor and non-English speaking families, including those who are deaf or hearing impaired.

The timeline for the implementation of this project is included in Attachment 2.

Section 3: Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of the Targeted Community(ies)

The CT MIECHV Needs Assessment included detailed demographic, economic and social outcome data for the state's 169 towns, an overview of maternal, infant and early childhood services, and a town by town assessment of need. Seventeen communities were identified to be at "very high" need for services. Based on the Needs Assessment data, the HVAC initially identified two of the 16 communities, Ansonia/Derby and Windham, as communities that could benefit from the implementation of an evidence-based home visiting model.

As described in the State Plan, the Ansonia/Derby community is fraught with issues that increase the risk for poor maternal, infant, and child health outcomes: increased unemployment and

housing cost rates; homelessness; decreased income levels; increased use of federal and state nutrition programs; and decreased access to health care due to lost insurance and transportation issues. Identified maternal health issues include: prenatal depression, pregnant or postpartum women with cognitive limitations, and parental substance use or abuse. The Ansonia/Derby community identified the Early Head Start program as meeting the needs of the community, a home visiting model designed to provide high-quality child and family development services to low-income pregnant women and families with infants and toddlers (birth to age 3 years).

Windham, the second community identified in the State Plan, is mostly rural. It is anchored by the small City of Willimantic, where nearly 70% of its culturally diverse population lives. Willimantic is in the top ten among towns with the highest rates of poverty in the state, where children from birth to age four living in poverty was 38.6 percent in 2008. Teen pregnancy, inadequate prenatal care, low birth weight, homelessness, and an increased rate of sexual abuse contribute to the risks and needs of the Windham community. Windham has identified Generations as its lead agency for implementation of the selected home visiting program. The organization is a federally-qualified healthcare center providing accessible, high quality primary care, oral health care, and behavioral health services. The CT-PAT home visiting model will be implemented in Windham, and the program will serve families from prenatal to kindergarten entry. The CT-PAT philosophy and theoretical framework focuses on human ecology and family systems, developmental parenting, and attribution theory, as well as on empowerment and self-efficacy.

The lead agencies in Ansonia/Derby and Windham are well-established organizations within their respective communities, and the home visiting models chosen by the communities are evidence-based and have been identified as meeting the particular needs of those communities. Both agencies will be supported by the models' developers, and both agree to participate in any required trainings or technical support offered by the model developers. In-depth descriptions and implementation plans for the initial two communities can be found in the State Plan.

Evidence-Based Home Visiting Model and Needs of the Community

New Britain

Two community meetings were held in New Britain in anticipation of this project. The first was with local representatives from the Wheeler Clinic (Project Launch), Discovery Collaborative, Head Start, State DCF and the HOCC. The DPH convened the second meeting and attended a community forum. The greatest challenge identified by the group at the community forum was that the needs of the community exceeded the capacity of the existing CT-PAT home visiting program, which only served first time mothers, and which recruits women often in the third trimester of pregnancy or after delivery. New Britain selected the CT-PAT model for implementation in their community, will expand existing services to enroll women early in the pregnancy, and will include mothers with a previous child. The CT-PAT program is an approved home visiting model, including four components: 1) personal visits; 2) group connections; 3) health, hearing, vision; and 4) a developmental screening and resource network. These components are closely integrated to create overall impact. The model is a cohesive package of services with four primary goals: 1) Increased parent knowledge of early childhood development and improved parenting practices; 2) Early detection of developmental delays and health issues; 3) Prevention of child abuse or neglect; and 4) Increased childhood school

readiness and success.

For more than a decade the existing Nurturing Families program in New Britain serves families at risk for child abuse or neglect. Research has shown that participants have low rates of substantiated abuse or neglect, 1.3% to 4.4% per year.[1]

Windham

The Windham community described a lack of services for mothers who have existing children, and families with child welfare involvement. The Windham community also selected the CT-PAT model for implementation, which is outlined in detail in the State Plan.

New London

New London will implement the NFP model. In the *Home Visiting Evidence of Effectiveness Review: Executive Summary* (*http://homvee.acf.hhs.gov/*), the NFP was identified as the model demonstrating the most extensive impacts in outcome achievement among the domains evaluated. NFP was determined to have favorable impacts in the following outcome domains: child health, maternal health, child development and school readiness, reductions in child maltreatment, positive parenting practices and family economic self-sufficiency. In total, the number of favorable impacts on primary and secondary outcome measures was 64. NFP was the only model to meet all implementation requirements specified in the MIECHV legislation. The NFP is associated with a national organization or institution of higher education and has the following characteristics: 1) Existence for three years; 2) Specific minimum requirements for visit frequency; 3) Minimum education requirements for home visiting staff; 4) Supervision requirements for home visitors; 5) Specific education/training requirements for home visiting staff; 6) Fidelity standards local implementing agencies must follow; 7) A system for monitoring fidelity; and 8) Specific content and activities for home visits.

In 2004, the VNASC began the planning process to respond to the growing teen pregnancy rate in New London, as identified by the Teen Pregnancy Prevention Task Force After further investigation of the model and communication with the researcher David Olds, it was determined that VNASC funding could not support the program. The decision was made to begin a program that followed the guiding principles of NFP and to follow the model as closely as possible. The available funding allowed for 20 to 30 women to be admitted to the program, which the VNASC named the *Nurse/Family Care Program*. The program has been widely accepted by patients, with the main referral source being Lawrence & Memorial Hospital and the local obstetric community. A local advisory committee was convened to gather support for this method of care. The *Nurse/Family Care Program* admitted its first mothers in 2005 and continues to operate at this time. Although the program has remained small due to the available funding for the intensive nursing visits, the outcomes have been positive.

The VNASC continues to operate a look-alike NFP model in the community without funding, technical support or training, yet is a successful provider of home visiting and prevention

[1] Damboise, M., Hughes, M., and Black, T. (2009). Nurturing Families Network: 2009 Annual Evaluation Report. Prepared for the Children's Trust Fund. Center for Social Research, University of Hartford, West Hartford, CT.

services to low-income families. The NFP model has shown evidence of successful outcomes in maternal health, child health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, family violence and crime, positive parenting practices, and family economic self-sufficiency. Skilled nursing visits include information and coaching in prenatal care, infant care, coaching in activities to promote the emotional, physical, and cognitive development of young children. The nurse works with the mother to set personal and family goals to increase family economic self-sufficiency. The New London community chose the NFP model because of their experience with the look-alike NFP model and the degree of evidence in eight domains supporting the NFP model with positive outcomes.

Ansonia/Derby

As outlined in the State Plan, the communities of Ansonia and Derby, in addition to societal issues associated with poverty, high unemployment, and teen births, lack a public transportation system. This creates additional barriers for families accessing prenatal care or needing to transportation. The model selected for implementation by the community was the Early Head Start Home-Based Option program.

State's Current Capacity to Support the Model and Prior Experience with Implementing the Model (s) Selected

Connecticut has 40,000 births per year and has the capacity to support the implementation of high-quality home visiting services while expanding the scale and scope of the program to improve outcomes for vulnerable children and families. These efforts are intended to improve the health and well-being of vulnerable populations by addressing child development within a life course framework and a socio-ecological approach.

The existing HVAC includes the following representatives: the State's Title V Director; the State Director for Title II of the Child Abuse Prevention and Treatment Act (CAPTA); the State child welfare agency (Title IV-E and IV-B); Director of the State Single State Agency for Substance Abuse Services; the State Child Care and Development Fund Administrator; Director of the State Head Start State Collaboration Office; the State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act; Director of the Individuals with Disabilities Education Act (IDEA) Part C; and the State Title I program.

The State of Connecticut has shown a significant commitment to home visiting by sustaining state funding for the CT-PAT Nurturing Families program, its high-quality evidenced-based home visiting program. The CCTF has presented program findings to build support within the legislature for program expansion. As a result, the CCTF state budget for home visiting grew from $300,000 for two sites in 1996 to approximately $10 million for 42 sites. While it is not feasible to predict the state budget four years from now, it is reasonable to believe that, based on past history of the state's commitment to home visiting, there would be continued support for these needed services in the State.

In 1995, the CCTF launched a major initiative to develop a universal home visiting program for families at risk of child abuse or neglect throughout the state. The state legislature passed Sec. 17a-56 of the CT state statutes establishing the NFN and charged the CCTF with developing "the structure for a state-wide system" for the home visiting program. The legislation also required the

CCTF to develop a training program, standards, protocols and a data system to document the impact of the program, including the incidence of child abuse or neglect, risk profiles, and demographics of the families participating in the program. In 2003, the CCTF adopted the PAT program model and expanded the Nurturing Families program from two to 42 sites. The CT-PAT Nurturing Families program provides services to first time mothers who give birth in any of the 29 birthing hospitals in the State, with expanded programs in two urban areas, Hartford and New Haven. In 2009, CT-PAT NFN program provided home visiting services to 1,997 families, screened 7,200 women, and provided Connections services to 1,700 people. Nearly 100 home visitors provided services, and six hundred families participated in Nurturing Parenting groups.

Plan for Ensuring Implementation with Fidelity to the Model

State's Overall Approach to Home Visiting Quality Assurance

The DPH will collect data reports thrice annually from each of the four communities on all of the benchmark areas and constructs. The data will be reviewed and evaluated on an ongoing basis to monitor outcomes and identify areas needing improvement. The DPH MIECHV staff will provide technical assistance to the four communities on the development of a Continuous Quality Improvement (CQI) plan. Technical assistance will be provided by DPH to each of the four communities, as needed, and the contracted programs will follow the model developers' guidelines for home visiting staff. Additionally, the contracted programs in Windham, Ansonia/Derby, New Britain, and New London will work with the model developers to comply with the required staff trainings, data collection, and reporting and practice policies.

New Britain

The CT-PAT program will collect individualized data. The data collected currently includes all of the legislatively-mandated benchmarks with the exception of two sub-categories. Modifications will be made to the data system to ensure that fields for all required benchmarks and construct areas are included. All new home visitor staff will be trained in the use of measurement tools and data collection system.

The supervisor of the CT-PAT Program will participate in home visits on an ongoing basis to become acquainted with the families being served, and to observe client interactions and the education delivered to the family. The supervisor will meet with each home visitor on a weekly basis and will provide reflective supervision.

New London

The NFP focuses its CQI efforts on program implementation and maternal (pregnancy and life course) and child health, and developmental outcomes. The NFP uses a proprietary web-based information system that monitors key implementation components and outcomes, which are compared to benchmarks achieved in the original randomized controlled trials. Data gathered through the NFP web-based information system are analyzed routinely for quality improvement. A key focus of CQI is the assurance that NFP sites implement the program in accordance with fidelity to the 18 core model elements. Reports made available to sites enumerate the degree to which they meet, exceed or fall short of implementation benchmarks and maternal and child health outcomes. These reports align to a considerable degree with the new federal benchmarks for home visitation programs, and allow comparison to standards achieved in the original

randomized controlled trials and to the Healthy People 2020 goals. With new enhancements in 2011 to the NFP web-based information system, NFP sites are able to download real-time reports that can be segmented by period of program implementation. These enhancements enable sites to monitor performance across time and to measure progress. Additionally, NFP nurse consultants use these reports to develop quality improvement strategies and tactics with implementing agencies to improve program performance.

The DPH will participate in the NFP developer-required training for states.

State's Approach to Program Assessment and Support of Model Fidelity
At the community level, each implementing agency will work with the model developers for professional training, technical assistance, policies and guidelines to ensure fidelity with the model. The model developers have reviewed the plan and submitted letters of approval (Attachment 8 Model Developer Approval Letters). The developers require the implementing agencies to submit periodic reports. The CQI process, professional training, technical assistance, contract language, program policies and practice guidelines, curriculum and other tools will be used to support and monitor the implementation of high-quality home visiting services with fidelity to the model. The CT-PAT program will work with the local PAT office. The New Britain and Windham CT-PAT programs have secured commitment from the PAT model developer for continued technical assistance and guidance. The program coordinator at the New London site has secured a commitment from the NFP model developer for ongoing support and technical assistance (Attachment 8: Model Developer Letters).

The DPH will establish fidelity measures to monitor implementation of the programs thrice annually. In addition, the contracted program managers in New London, New Britain, Windham and Ansonia/Derby will follow model developer policies for home visitors, including timelines for reflective supervision and regular technical assistance, and will use metrics to ensure fidelity to the structural or programmatic implementation. The DPH will conduct frequent site visits during the implementation phase, and site visits thrice annually afterwards, at a minimum.

Anticipated Challenges and Risks to Maintaining Quality and Fidelity
There are no anticipated challenges to maintaining model quality and fidelity. The selected communities and designated lead agencies are very familiar with the respective models and are experienced in monitoring the performance of their program and services.

The four communities acknowledge the challenge of attrition and it may be an area for technical assistance. Culturally competent home visitors have the expertise and knowledge to keep families engaged to maximize parental benefits from the program. Issues related to homelessness and migration out of a program catchment area are among the challenges that influence attrition, but that may exceed the scope of the program. The impact of homelessness, transiency, and lack of transportation are state level systems issues and will be explored by DPH and the.

Anticipated Technical Assistance Needs
The DPH requested technical assistance from HRSA with benchmarks and constructs reporting in the State Plan, and will continue to request or participate in TA opportunities offered by

HRSA or other entities.

Section 4: Implementation Plan for Proposed State Home Visiting Program

State's Approach to Developing Home Visiting Program Policies and Setting Standards
The DPH is the lead agency for the administration of the MIECHV program and is home to the State's Title V MCHBG funding. The DPH collaborated with multiple public and private sector agencies and the HVAC to conduct the Needs Assessment and State Plan. The DPH MIECHV Team convened community forums with the communities that were identified through the Needs Assessment as being of very high need for home visiting services.

Subsequent to completion of the Needs Assessment and State Plan, and identification of the communities and their chosen models, the DPH MIECHV Team worked with model developer contacts and the chosen Windham, Ansonia/Derby, New London and New Britain lead fiduciary agencies to identify model-specific information and data to meet HRSA MIECHV requirements. This included completion of a Benchmark document develop by DPH that aligned with the Nurse Family Partnership, Parents as Teachers, and Early Head Start data reporting requirements. The DPH continues to work with the model developers and lead agencies to obtain and/or modify data systems for Benchmark data collection, analysis, and reporting. These activities will be developed to meet DPH and HRSA continuous quality improvement, reporting, and evaluation standards and requirements.

The DPH will incorporate model policies and standards into DPH MIECHV contracts. Each model has standards for the clients they serve, including: staffing, supervision, program execution, and training. The DPH will develop MIECHV program policies and standards that address commonalities across programs. These policies and standards include services that are provided to at-risk families, and offered: primarily in the home; generally weekly, with increased or decreased frequency in response to family need; and at a time that is convenient for the family. Service policies and standards also include: an initial client/family assessment; referral to additional resources, when needed; and ongoing assessment and data collection. Services will be provided by home visitors or nurses. An important component will be high quality clinical supervision and reflective practice for all home visitors and supervisors. Additional policies and standards include supervision of home visitors and nurses by supervisory and management personnel who meet qualifications identified by the model developers and lead agency. The MIECH program will also include an active outreach, referral and documentation process, as well as collaboration with other agencies and the general community.

Process for Engaging At-Risk Communities
Each of the four funded communities was identified through the Needs Assessment as very high risk communities. The selected programs in the four communities have been designed to target very high-risk families who are most vulnerable.

New Britain
The New Britain CT-PAT program coordinator also serves as the NFN program coordinator. The NFN only accepts first time mothers, so any non-first time mother referred to NFN will be automatically referred to the CT-PAT program. The program is housed in the HOCC, and

referrals from prenatal care providers in the hospital and satellite sites are well-established. The New Britain PAT coordinator will participate on an advisory board that meets quarterly to ensure referral and connections to community-wide resources. This board acts as a liaison to the community by keeping the program informed and connected to city and statewide initiatives. Specific to this initiative, the New Britain community will establish a Home Visiting Coordinating Committee with all local home visiting agencies and programs.

New London

The process of community engagement will be two-fold: 1) Mobilizing the organizations that interact with the target population, such as PEN, Children First Initiative, inner city faith communities, and the NFP Advisory Committee; and 2) Engaging individual women at risk through one-to-one encounters at the OB/GYN clinic, the Community Health Center, Planned Parenthood, low income housing, and the VNASC health care staff.

The VNASC is well-established in the New London community, and their nurses have provided home visiting services to families for many years. They are invested in the community and are effective in making contacts with available resources. Referrals to community agencies are individualized and based on patient needs. Referrals are often initiated by the nurse through telephone calls, on-site visits, electronic mailing, and attendance at community meetings. In some cases, the nurse provides the patient with contact information for these services. They in turn are encouraged to follow through for the initial communication.

Examples of care coordination includes the Birth to Three program for patients whose children have developmental delays or disabilities, WIC for nutritional assistance, State Healthy Start for assistance with obtaining health insurance, and Planned Parenthood for people in need of reproductive health services.

Education of the community and individuals is the primary engagement activity of the NFP. Community involvement will be supported by formation of an advisory task force comprised of local medical and social service providers and parent representatives. The initial task force will involve: medical providers of obstetrical and pediatric services from private physician practices, Lawrence and Memorial Hospital's obstetric clinic, the community health center, and United Community and Family Services; specialized community nursing services including that provided by the Navy-Marine Corp Relief Society, Child and Family Agency, and Planned Parenthood of New London; social and health based services serving the Latino community, including Centro de la Comunidad and Rios de Sanidad; area educational resource centers, including New London Adult Education, Three Rivers Community College, WIC of New London, and the Ledge Light Health District; providers of addiction services including Mother's Retreat and Stonington Institute; early school readiness and nutritional programs, such as that provided by the Thames Valley Council for Community Action; and a representative of the benevolent organization, Community Foundation of Eastern Connecticut. Parental representation will be provided at a minimum by an active program participant, as well as a parent graduate. The task force will meet on a monthly basis at which time progress toward desired outcomes and goals will be reviewed, and development of new or changed goals will be.

State's Approach to the Development of Home Visiting Program Policy and to Setting Standards for the State Home Visiting Program

The goal of the MIECHV program is to create a comprehensive system that ensures children are healthy and ready to learn, by age five. Rosa M. Biaggi, MPH, MPA, Chief of the Family Health Section and State Title V Director is the Principal Investigator on the MIECHV grants. The CT ECCS grant is administered in the Family Health Section of the DPH. The ECCS grant is referred to in this application as the ECP Project. The goal of the ECP Project is to create a comprehensive system that ensures children are healthy and ready to learn by age five. The DPH and the Commission on Children co-chaired a steering committee that included eight state agencies, community and statewide organizations, local government, philanthropy, and public and private stakeholders involved with early childhood health and education. A strategic plan was developed to determine how CT will address the five ECP domains: 1) early care and education; 2) mental health and social emotional development; 3) access to medical homes; 4) family support; and 5) parenting education. The ECP Project Director serves as a member of the SAC, and the SAC subcommittee of Home Visiting and Family Engagement is represented by the MIECVH Team.

The DPH will work with the HVAC to establish the following: 1) A centralized call line for all referrals to home visiting, using United Way 211 Information and Referral Line; 2) Home visiting recruitment policies that include written verification of home visitor personal and employment references, a state and national criminal background check, with disclosure of arrests, charged, and convictions for child abuse or neglect; 3) A method to communicate and provide services to families who do not use English as their primary language, including families who are deaf or hearing impaired; and 4) Minimum educational requirements, other qualifications and certification for home visitors.

The DPH will work with the community leads and model developers throughout this process and will train communities on any new program policies prior to implementation. The DPH agrees to participate in developer-required trainings and will work with contracted providers to facilitate fidelity in the implementation of the home visiting programs. Home visiting programs maintain fidelity to the model. The DPH has submitted the State Plan to the model developers and received letters of approval. (Attachment 8, Developer Approval Letters).

New Britain, Windham and Ansonia/Derby staff will participate in the PAT training in November 2011. All home visiting staff will receive training and will obtain any required certification prior to working with families.

The National Service Office of the NFP will provide services to New London VNASC directly and through the regional NFP program developer. Services include: planning assistance; marketing and communication resources; policy; financing and government relations consultation; nursing education and home visit guideline; a data collection and reporting system; and ongoing consultation to support NFP implementation. Two DPH staff members will participate in the NFP training.

Timeline for Obtaining the Curriculum or Other Materials Needed

New Britain

The HOCC is a CT-PAT site, and the project director is PAT-trained. New Britain will work with the CT-PAT Advisory Committee to develop an implementation plan that meets all of the new PAT requirements and to arrange training of new staff. The existing CT-PAT program is limited to first-time mothers only and is in a town with the highest teen birth rate in the state. The program is at capacity and has a need for expanded services. The MIECHV program in New Britain will not be limited to first time mothers and will reach capacity within a relatively short period. It is expected that the contract between the HOCC and the DPH will be in place by March 2012.

New London

The proposed timeline for New London is based on the required trainings scheduled by NFP. The timeline includes: Submission of the application to NFP by December 1, 2011; Staff recruitment and hiring by January 15, 2012; Registration for NFP Core Education by January 30, 2012; Begin education of referral sources February 15, 2012; Staff orientation to agency and completion of self-study by February 28, 2012; Begin enrollment of clients March 10, 2012; and Enroll 23-25 clients per nurse by December 15, 2012.

The DPH will start the contract process as soon as the FY2011 notice of grant award is received. Funding will be available to initiate activities in New Britain and New London upon execution of the contracts with the DPH. It is expected that the contracts will be executed between January 2012 and March 2012.

Training and professional development activities

New Britain

In collaboration with the CCTF, ongoing professional development training will be offered to all New Britain CT-PAT staff. Training is offered through the HOCC as part of the staff educational enhancement efforts, and educational reimbursement is made available. The HOCC collaborates with Early Head Start, Early Childhood Collaborative, Wheeler Clinic (community based mental health), as well as partners with other collaborative CT-PAT sites to exchange professional development training. The New Britain CT-PAT staff will attend the National Home Visiting Summit.

New London

The VNASC will provide staff with the following ongoing trainings: basic standards of home visiting; bag technique, safety, client respect, Health Insurance Portability and Accountability Act; infection control; Community and referral resources; Corporate compliance and ethics; NFP training as determined by the model developer; and the National Home Visiting Summit.

Recruitment, Hiring, and Retention of Staff

New Britain

The existing PAT Nurturing Families program at THOCC has been successful in retaining staff throughout its contract with the CCTF. For the past eleven years, this site has been successful in retention of home visiting staff, with no turnover in staffing. The recruitment process for this organization will include networking with other CT-PAT Nurturing Families sites as well as

connection with the established board members particularly Tunxis Community College (Human Services & Early Childhood Departments) to recruit paraprofessional staff. Retention for staff members will replicate the success of the current program, in that the importance of team building, personal and professional development, and reflective supervision will be mirrored.

New London
The VNASC is the local nursing employer of choice and has proven success in staff hiring and Retention, and has current employees involved in the NFP "look alike" program that are eager to be part of the NFP program. The organization also has other employees in the school and home health care program that may wish to apply for the positions. Strong community connections over many years have positioned VNASC favorably with the maternal infant community of nurses. Retention of nurses is expected to be high due to the vetting process that is undertaken prior to hiring.

Subcontractor Organizations
New Britain
THOCC will recruit for a per diem Registered Nurse practitioner to provide birthing preparation classes to low income participants. The position will be recruited within the hospital organization and through referrals from other successful birthing preparation programs within urban cities. A competitive salary will increase the probability for high staff retention.

New London
The New London VNASC does not anticipate using any subcontractors.

Clinical Supervision and Reflective Practice
New Britain
The replication model contract with CT-PAT requires participation in weekly reflective supervision with each home visitor. This supervision consists of time for reflections about case interactions and administrative processes, such as data collection, planning and development. The program clinical supervisor will receive supervision from the program director. The program director will further receive supervision from the corresponding director of social work. The clinical supervisor will be experienced in home visiting services and will hold at minimum a graduate degree in social work or human services.

New London
Supervisors at VNASC are provided with the tools and education to be effective nursing supervisors in the programs to which they are assigned. The NFP supervisor will follow the NFP program standards and the research design. The NFP provides substantial assistance during the implementation planning process, including: conference calls and meetings with community stakeholders to build consensus about the program's value and the best way to implement it locally; knowledge sharing from experienced implementing agencies about funding strategies and sources; and support in developing and submitting a plan to implement.

The NFP nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical

supervision, case conferences, team meetings and field supervision.

To ensure that nurse home visitors are clinically competent and supported to implement the NFP Program, nurse supervisors provide clinical supervision with reflection through specific supervisory activities. These activities include:

- One-to-one clinical supervision: Weekly 1:1 one-hour meetings between a nurse and supervisor for the purpose of reflecting on a nurse's work including management of her caseload and quality assurance.
- Case conferences: Meetings with the team dedicated to joint review of cases, data reports and charts using reflection for the purposes of solution finding, problem solving and professional growth. Experts from other disciplines are invited to participate as needed.
- Team meetings: Meetings held for administrative purposes, to discuss program implementation issues, and team building twice a month for at least an hour.
- Field supervision: Joint home visits with supervisor and nurse. Every four months the supervisor makes a visit with each nurse to at least one client. Additional visits are conducted at the nurse's request or at the supervisor's discretion.

Program Participants

New Britain

The home visiting program identifies at-risk parents in the local prenatal clinics, birthing centers, OB/GYN offices, hospital-based advisory groups, and through collaboration with the New Britain Public Schools. The screen identifies risk factors in child abuse or neglect, mental health, poverty and homelessness. This screening tool is used to determine the level of anticipated need, so the screener can make timely referrals to the appropriate resources and/or initiate admission to a program. The HOCC is the center of the community and is well-known for its support of young pregnant and parenting mothers. The CT-PAT Nurturing Families Program has been present in the community for eleven years, and the hospital houses a peer-facilitated support group program for young mothers that has been in place for twenty-five years. The program has a partnership with New Britain High School and in an effort to serve the high numbers of adolescent parents, it has located a staff member on-site. Groups are held at the high school to further the collaboration and visibility of the service providers. The home visitor can see up to 15 mothers a week while having a caseload of 12-18. Cases are assigned weekly, bi-weekly or monthly home visits, based on need. It is estimated that if New Britain receives three new home visitors the site will reach its capacity within the first six months with an estimated total of 60 new families served. Groups will be offered to support families who are awaiting services, and referrals to other appropriate resources will be made.

New London

Recruitment of NFP participants will be through the network of service agencies and personal outreach. The participants will be vetted carefully to ensure that the standards of the NFP are met. It is anticipated that 100 participants will be registered in the first year. Unless otherwise specified by the model developer, priority will be given to participants who: Have low incomes; Are pregnant women who have not attained age 21; Have a history of child abuse or neglect or have had interactions with child welfare services; Have a history of substance abuse or need substance abuse treatment; Are users of tobacco products in the home; Have, or have children with, low student achievement; Have children with developmental delays or disabilities; and Are in families that include individuals who are serving or have formerly served in the armed forces,

including families that have members of the armed forces who have had multiple deployments outside of the United States.

Coordination with Other Programs and Resources

New Britain

As part of the Project LAUNCH grant, a Child Wellness Council has been established in New Britain to provide guidance to program implementation. The Council meets quarterly and engages a cross-section of agencies and organizations at both the state and local level. The Council collaborates with the ECC Children's Health Committee on issues related to young children and their families. Other coordinating bodies include the New Britain School Readiness Council and Head Start's Health Advisory Committee. These multidisciplinary groups work closely together in New Britain to improve outcomes for young children and families.

To enhance the implementation of new home visiting services in the community, a Home Visiting Coordinating Committee will be established. The purpose of this committee will be to develop strategies for managing referrals, develop a common intake form to use across programs serving families with young children, share professional development and networking opportunities, and ensure continuity of care for families with young children.

New London

An advisory Committee will be formed in New London to ensure participation with the community network. Referral receipt and handling will adhere to the standards of the VNASC. Feedback to referring agencies on program successes and challenges will be made periodically, and referral perception of the program will be surveyed annually.

The VNASC works with many organizations in the community. A PEN exists and is comprised of agencies serving pregnant women, infants, children and families in the community. VNASC staff will participate in monthly meetings of this group to increase collaboration, and to discuss referral strategies and capacity issues.

The VNASC will work closely with local OB/GYN practices, the community health center, Lawrence and Memorial Hospital and private practices for referrals. The VNASC works with State Healthy Start to assist pregnant women who need access to health insurance and care, WIC for nutrition education and support, and other social service agencies in the community.

Community involvement will be supported by the formation of an advisory task force comprised of local medical and social service providers and parent representatives. Additional members shall be included as the program develops.

The initial task force will involve medical providers of obstetrical and pediatric services from private physician practices, Lawrence and Memorial Hospital's Obstetric Clinic, the Community Health Center, and United Community and Family Services; specialized community nursing services including that provided by the Navy-Marine Corp Relief Society, Child and Family Agency, and Planned Parenthood of New London; social and health based services serving the Latino community, including Centro de la Comunidad and Rios de Sanidad; area educational resource centers including New London Adult Education, Three Rivers Community College,

OIC of New London, and the Ledge Light Health District; providers of addiction services including Mother's Retreat and Stonington Institute; early school readiness and nutritional programs such as that provided by the Thames Valley Council for Community Action; and a representative of the benevolent organization, Community Foundation of Eastern Connecticut. Parental representation will be provided by an active program participant as well as a parent graduate. The task force will meet on a monthly basis at which time progress towards desired outcomes and goals will be reviewed and development of new or changed goals will be addressed as needed.

Collection of Data and Continuous Quality Improvement (CQI)
Each community program coordinator will collect, monitor and analyze all required individualized client data for the program. The DPH will provide training for the communities on the development of a CQI plan. The programs will submit required reports to the model developer annually or as otherwise specified. The local agencies (contractors) contracting with the DPH for the implementation of the MIECHV programs will submit programmatic and expenditure reports to the DPH three times per budget year.

The contractors will use data collection forms developed by DPH that will align with the federally-required benchmarks and constructs. The DPH will review contractor reports against the terms and conditions of the contract, approved budget, expected deliverables, and other requirements. The DPH will meet at least annually with each contractor to assess the implementation and status of the program. The DPH will conduct thorough examinations of the contractors' reports, site visit reports, and data analysis, and will use the findings to inform the contractors about changes that may be required for improvement.

The DPH will generate reports annually on town-specific population data to evaluate the impact of the MIECHV project on the community.

Generating and Using Data to Inform Performance Improvement

Data System Integration; Monitoring, Assessing, and Supporting Implementation with Fidelity to the Chosen Models and Maintaining Quality Assurance
Connecticut does not have an integrated early childhood data system at this time. Initially, each of the four MIECHV communities will use the database required by the model developer, or a database specifically developed for their agency.

The DPH has contracted with a data planning consultant at the state DCF to create a plan for a data sharing agreement among multiple state agencies. The contractor will develop a four-year plan that will include the expansion to other programs served with state or federal dollars.

Each home visiting program will report thrice annually to the DPH on a form developed by the DPH. DPH will submit the total aggregate data to HRSA as required.

The CQI efforts will focus on improvements in program implementation and achieving maternal (pregnancy and life course) and child health and development outcomes. The NFP uses a proprietary web-based information system that monitors key implementation components and

outcomes, which are compared to benchmarks achieved in the original randomized controlled trials. Data gathered through the NFP web-based information system are analyzed routinely. A key focus of CQI work to date has been on assurance that NFP sites implement the program in accordance with the 18 core model elements, which increase the likelihood that the program will be delivered with fidelity to the model. Reports made available to sites enumerate the degree to which they meet, exceed or fall short of implementation benchmarks and maternal and child health outcomes. These reports align to a considerable degree with the new federal benchmarks for home visitation programs. These reports also allow comparison to standards achieved in the original NFP randomized controlled trials and to Healthy People 2020 goals. With new enhancements in 2011 to the NFP web-based information system, NFP sites are now able to download real-time reports that can be segmented by period of program implementation. Additionally, NFP nurse consultants use these reports to develop quality improvement strategies with implementing agencies to determine ways of improving program performance.

Anticipated Challenges to Maintaining Quality and Fidelity, and Proposed Response

New Britain

The only anticipated challenge in this program is the ability to meet the demand for services. New Britain has high rates of child abuse or neglect, low educational attainment and teen pregnancies. New Britain has the highest rate of repeat pregnancies in the state. With the addition of home visitors and the implementation of additional groups, it is anticipated that a significant impact will be made on the families served. Demands in excess to capacity will be directed to proposed groups to act as a support while families await openings in the programs.

New London

It is anticipated that the NFP staff will admit participants who do not meet the NFP eligibility criteria and that the staff will have challenges in refusing admission. Alternative resources will need to be identified to address the needs of these people, and to ensure that the program is implemented with fidelity to the model. The VNASC has established linkages with local agencies for maternal and child health programs, and will be available to help in seeking alternative programs.

Collaborative Public and Private Partners

New Britain

The following list includes public and private partners for the New Britain CT-PAT Program: CCTF, Early Childhood Collaborative, State Department of Education, New Britain public schools, DPH Immunizations Program, WIC, Junior League of Greater New Britain, First Congregational Church of New Britain, Tunxis Community College, YWCA, Human Resource Agency, New Britain public library, Wheeler Clinic, and the University of Connecticut Health Center.

New London

The VNASC has been in existence in the New London community for over 50 years and has well-established public and private partners that include: Centro de la Communidad, Community Foundation of Eastern CT, Early Head Start, Thames Valley Council for Community Action, Even Start/New London Adult Education, Mother's Retreat/The Connection, Nursing and Allied Health/Three Rivers Community College, Putting on Airs/Ledgelight Health District, Rios de

Sanidad/Encuentros de Esperanza, school-based health clinics, Stonington Institute, United Community and Family Services, WIC Program, Young Parents Program, Child and Family Agency, five local private OB/GYN practices, and four local private pediatric practices.

Integrating the State's MIECHV Program into the Early Childhood System

Donna Maselli is a member of the SAC, Home Visiting and Family Engagement subcommittee. Many of the members of the SAC are also members of the HVAC, so efforts of the state's MIECHV program will complement the State's plan for a coordinated Early Childhood System.

Additionally, model developers offer extensive support to states for the implementation of their models and planning for the design of state, city and local systems focused on achieving program outcomes. The CT HVAC is responsible for assuring that the home visiting models work toward the state's common goal of a comprehensive, evidence-based early childhood system.

Assurance of Result Noted in the Legislation

The DPH assures that it will achieve the results noted in the legislation and will show improvement in at least four benchmarks and half of the constructs, over a three-year period. The DPH MIECHV Team of epidemiologists and program staff developed the measures and tools for the MIECHV benchmarks and constructs. The DPH has also developed a supplemental client worksheet to aid contractors as they develop benchmarks and constructs. The MIECHV contractors will collect data for all of the following benchmark areas: improved maternal and newborn health; prevention of child injuries, child abuse, neglect or maltreatment; reduction emergency room visits; improvement in school readiness and achievement; reduction in crime or domestic violence; and improvements in family economic self-sufficiency.

The DPH MIECHV Team will conduct frequent site visits to monitor and review the collection of the required data and to guide the implementing agencies in how to use these data as part of their CQI process. The DPH has requested technical assistance from HRSA for the benchmarks and data collection and will participate in any technical assistance offered. This is further described in Section 5: Plan for Meeting Legislatively-Mandated Benchmarks.

Assurance of Individualized Assessments and Services

Individualized family data will be collected at the local level at the time of enrollment of the family in the program, and during subsequent weekly home visits. The implementing home visiting program directors and supervisors will monitor data collection at the community level. The PAT, NFP and Early Head Start model developers all require implementing programs to collect individualized data on all clients enrolled. The Windham and New Britain PAT programs will use a combination of paper reporting and a home-developed database to collect individualized data. The New London community home visitors are provided with laptops to enter individualized client data at each visit. Aggregate data can be extracted in the format required by DPH for reporting on benchmarks and constructs. The EHSHBO program will use the National Head Start database to collect individualized client data and will report aggregate data to DPH and the Head Start Office.

Assurance That Services Will Be Provided on a Voluntary Basis

The DPH contractors will assure that all services are voluntary. Each contract will include language stating that participants are informed on enrollment that the services are strictly

voluntary and that they can withdraw from the program at any time. The contractor will be required to obtain written consent for participation from each client that includes the statement indicating it is voluntary.

Assurance That the State Will Comply With the Maintenance of Effort/Non-Supplantation Requirement

Connecticut agrees to comply with the Maintenance of Effort (MOE) requirement. As of March 23, 2010, the State of CT was spending $10,389,446 of State general funds on the NFN home visiting program. The State of CT agrees to maintain proper documentation for the MOE and other fiscal reporting requirements of the grant for auditing purposes, agrees to maintain this baseline level of funding, and agrees to comply with any requests for an audit, as established under Section 506 of Title V, modified for this Program as authorized under P.L. 111-148, Subsection L, Sec. 2951.

Assurances that priority will be given to serve eligible participants who:

The CT MIECHV program will assure that priority will be given to serving participants who: Have low incomes (with priority to those who are at or below the FPL, or unemployed); Are pregnant women under the age of 21; Have a history of child abuse or neglect or have had interactions with child welfare services; Have a history of substance abuse or need substance abuse treatment; Are users of tobacco products in the home; Have, or have children with, low student achievement; Have children with developmental delays or disabilities; and/or are in families that include individuals who are serving or have formerly served in the armed forces, including families that have members of the armed forces who have had multiple deployments outside of the United States.

The contractual agreement between DPH and the contractors specifies the target population and the minimum numbers served annually in each home visiting program.

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

Connecticut's MIECHV Program will support collection of data on legislatively-mandated benchmarks within each of the four selected communities. The benchmark areas include: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvement in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. Each of the benchmark areas has state-specific constructs identified with measurable goals for monitoring progress, improvement and outcomes.

Connecticut will meet the requirements for quantifiable, measurable improvement in benchmark areas through ongoing data collection and reporting for each of the required six benchmarks. All home visiting staff will be trained on the collection and reporting of benchmarks and constructs data, use of screening tools, data collection and reporting systems, reporting requirements, confidentiality, and available community resources. Through training and ongoing technical assistance, the DPH will assure that all home visitors are familiar with best practices in

observation and documentation of contacts with families.

Connecticut will collect data on each participating family rather than use a sampling approach for benchmark areas. The data will be collected for families enrolled in the program and who receive services funded through the MIECHV Program. To demonstrate improvement in at least four benchmark areas over time, Connecticut will show improvement in at least half of the constructs under each benchmark area. Benchmark measures will be utilized for CQI purposes to enhance program operation and decision-making and to individualize services. Proposed measures are both developmentally appropriate for the corresponding constructs and appropriate to use with the populations served by the home visiting program. To the extent possible, data collected across all benchmarks will be coordinated and aligned with other relevant state, local or model requirements for data collection.

Measure selection and justification: To select appropriate measures for each construct, efforts were initiated to match required data with information that is routinely collected by home visitors in the current data systems. Each required benchmark was assessed against the current database system to determine: 1) which benchmarks and constructs are captured as required; 2) which are captured but need modification to meet the requirement; and 3) which need to be added. For data points that are not being measured, data collection tools were reviewed and assessed for validity/reliability, cost, feasibility, and capacity of staff to implement, as well as potential impact on the family and their home visitor relationship. Final selection of the measurement tool was based on a combination of these factors, with the lowest-cost, lowest-risk method selected whenever possible. All selected measures have been reviewed for appropriateness for use with the populations served by the program.

Plan for Ensuring Data Quality: The CT-PAT home visitors are certified parent educators with a minimum of a Bachelor's degree and related experience, meet the training requirements of the State Home Visiting Standards of Practice, and are trained in the administration and use of all required tools. All newly hired CT-PAT home visitors and supervisor(s) will participate in the PAT-required trainings and certifications.

The New London NFP staff and two DPH home visiting staff members will participate in the NFP required trainings. The state administrators and coordinator, as well as program managers, are required to have working knowledge of all aspects of home visiting program operation, working knowledge of public health strategies and surveillance, and proven experience translating data into functional program improvement.

The Ansonia/Derby EHS HBO program will be administered by the Office of Head Start, Administration of Children and Families (ACF), and U.S. Department of Health and Human Services. The TEAM, Inc. must submit a detailed plan to ACF for program implementation and adherence to applicable performance standards. The home visitors will receive training and certification on the PAT Born to Learn curriculum and will meet all requirements of the Office of Head Start. The Office of Head Start requires TEAM, Inc. to have written staff polices that are approved by the Policy Council or Policy Committee. At a minimum, the policies must include: 1) descriptions of each staff position, addressing, as appropriate, roles and responsibilities, relevant qualifications, salary range, and employee benefits; and 2) a description of the

procedures for recruitment, selection and termination.

Data Safety and Monitoring: The home visitors will receive training about regulations to protect the privacy and integrity of families served, assuring full compliance with federal and state regulations guarding participants from harm, including internal review boards and human subject protections, and the Health Insurance Portability and Accountability Act. In addition, all staff are required to follow best practices in observation and documentation of contacts with families, including sensitive and responsive administration of interviews and screening tools. Staff working with families in their homes are also trained in identification and mandated reporting of all forms of child maltreatment and neglect. Training for new staff will be provided as needed and as required by the model developers. Program supervisors are responsible for managing and monitoring on-going data safety.

Demographic and service-utilization data: In addition to the reporting requirements for each benchmark area, each program collects individual-level demographic and service-utilization data on the participants in the program to analyze the progress children and families are making. Individual-level demographic and service-utilization data will include: family's participation rate in the home visiting program (e.g., number of visits completed/number of scheduled visits, frequency of visits); demographic data for the participant child pregnant woman, and primary caregiver(s) receiving home visiting services including child's gender, age of all (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family; participant child's exposure to languages other than English; and family socioeconomic indicators (e.g., family income, employment status).

Data Analysis Plan: The programs will submit data to DPH three times per budget year. Baseline data will be established during year one and finalized at the end of the first project year. During year one and subsequent years, data will be reviewed by the metrics of each measure based on a data system query.

Connecticut's Benchmark Plan table is provided in Attachment 7. Each table contains information for each construct and includes the proposed indicator, measurable objective, tool or data source, validity of the source, population being assessed, any special consideration, how the data will be collected, and plans for data analysis.

Section 6: State Administration of the State Home Visiting Program

Lead Agency for the Program

The CT DPH is the Lead Agency designated by the Governor of Connecticut for the State Plan and program. The HOCC will be the lead agency for implementation of the CT-PAT in New Britain, CT, the VNASC will be the lead agency for implementation of the NFP model in New London, Generations Family Health Center is the implementing agency for CT-PAT in Windham, and TEAM, Inc. is the lead agency for implementing the Early Head Start Home-based option program in Ansonia/Derby, CT.

The DPH is the recipient of the Title V MCHBG funding and is highly-experienced in the

collection, analysis, and reporting of federally required maternal and child health data. The DPH plans to obtain technical assistance from the model developers on community-level data collection process that will support federal reporting requirements.

Rosa M. Biaggi, MPH, MPA, Chief Family Health Section, Title V Director and Principal Investigator on this grant, serves as the Chairperson of the CT HVAC. (Attachment 3: Project Organizational Chart).

Collaborative Partners

The HVAC consists of the following partners: the State's Title V Director; Title II Director of the Child Abuse Prevention and Treatment Act (CAPTA); State child welfare agency (Title IV-E and IV-B); State Department of Mental Health and Addiction Services; Child Care and Development Fund (CCDF) Administrator; Director of the State's Head Start State Collaboration Office; State Advisory Council on Early Childhood Education; Individuals with Disabilities Education Act (IDEA) Part C and the State's Elementary and Secondary Education Act Title I program. These partners are key planning, policy and decision makers for the CT MIECHV program.

Additionally, the DPH will partner with the NFP National Service Office and the National PAT Office.

Management Plan

This project will be managed by the DPH MIECHV Team, and future grant opportunities as well as existing activities, will be managed by the Team. The Team consists of:

- Rosa Biaggi, MPA, MPH, Section Chief of the Family Health Section, and MCH Title V Block Grant Director (PI; 10% in-kind). Ms. Biaggi has provided management and overall oversight of the program since funding began in July, 2010. She oversaw development of the Needs Assessment, State Plan, and contract processes for the MIECHV Program. She will continue to oversee and provide executive decisions about all aspects of the Program.
- Carol Stone, PhD, MPH, MA, MAS, Supervising Epidemiologist, Maternal, Infant, and Child Health Unit (10% in-kind). Dr. Stone took a lead role in development of the Needs Assessment and supervised development of the MIECHV Program Benchmarks and Constructs. She will continue to supervise the staff participating in the MIECHV Team.
- Donna Maselli, RN, MPH, Nurse Consultant, Maternal, Infant, and Child Health Unit (25% in-kind). Ms. Maselli took a lead role in development of the State Plan, developed and provided oversight on execution of the contracts with Ansonia/Derby and Windham, as well as the contract with the State Department of Child and Families (DCF). She will continue to manage the contract with DCF, and will take primary responsibility for communication with the HRSA program officer and grants manager and EHB system.
- Mary Emerling, RN, BSN, Nurse Consultant, Maternal, Infant, and Child Health Unit (50% FTE). Ms. Emerling joined the team in July, 2011, and has taken a lead role in development of contracts with New London and New Britain. She will continue to manage these contracts upon execution.
- Margie Hudson, BSN, MPH, Health Program Associate, Maternal, Infant, and Child Health Unit (100% FTE). Ms. Hudson will join the Team in October, 2011, and will take primary responsibility for the contracts with Ansonia/Derby and Windham.

The CT-PAT Program will be managed by Jennifer Hernández, MS and current Doctorate in Education candidate. Ms. Hernández has served as the Program Director of the CT-PAT Nurturing Families site since 1999.

The Program Director for the NFP model will be Leah F. Hendriks, RN, BSN. Ms. Hendriks is highly experienced in maternal and child health, home visiting and clinical nursing. (Attachment 4: Job Descriptions/Resume Key Personnel).

The home visitors will meet the minimum standards required by each model developer.

Plan For Coordination of Referrals, Assessment, and Intake Processes Across the Different Models

As noted in the State Plan, CT will implement centralized intakes for home visiting through the Child Development Infoline. Additionally, each community will work through their advisory groups to establish community systems for referral and will establish a mechanism to refer families to other community resources or programs when the MIECHV- funded home visiting programs reach capacity.

Identification of Other Related State or Local Evaluation Efforts of Home Visiting Programs That Are Separate From the Evaluations of Promising Approaches

The DPH submitted the Child FIRST model to HomVEE for an expedited review on July 20, 2011. The model was subsequently approved as an evidence-based home visiting model and will be eligible for implementation in future Connecticut communities.

Job Descriptions for Key Positions, Including Resumes

Job descriptions and resumes for key personnel are included in Attachment 4.

Organization Chart

The project organizational chart is included in Attachment 3.

Staff

Every effort will be made to assure that home visitors are competent to work with the families, culture(s) and language in the communities that they will serve. The home visitors will receive training on their respective roles. The CT-PAT home visitors will have a minimum of a bachelor's degree in early childhood, social work education or other related field. The NFP nurse will be registered and licensed to practice in the State of CT and will have a minimum degree of a Bachelor of Science in nursing.

Home visitors will have extensive knowledge and skills, including an understanding of child abuse or neglect, the ability to conduct a developmental screening, parenting and home management skills, and the ability to access community resources. Home visitors will work with each family to ensure a connection to a primary medical care provider and to ensure that families receive proper medical care. They will be required to participate in all state or federally required trainings.

Registered nurses deliver the NFP intervention. This has been demonstrated to bolster the program's effectiveness. Registered nurses have an educational background that supports knowledge delivery of health care information, critical thinking, assessment skills and delivery of the individualized care including planning, referrals and evaluation of interventions that are part of the nursing process and NFP program.

Each NFP home visitor will be a registered nurse licensed by the State of CT and State Board of Nursing and must meet the requirement of the state Nurse Practice Act. The NFP National Service Office provides competency based core education that is required for all nurses in the program. The education model is based on: the theories that support the model; visit structure; tools for building self- efficacy; promoting behavior change and goal setting and attainment; and methods to encourage parents to become emotionally available and responsive parents.

Continued skill development of home visitors in the NFP model is through supervision, consultation and ongoing professional development. Registered nurse supervisors receive competency-based education from the NFP National Service Office focused on supervision within the NFP model and receive regular and ongoing support from their NFP regional nurse consultant. Each must meet the nursing supervisor competencies. The NFP regional nurse consultants provide service and support the nurse supervisor through technical assistance in program operations and quality improvement.

Supervision

As described in this application, the NFP supervisor will provide supervision through the use of reflective practice with each home visitor, joint home visits, team meetings, and case conferences. The NFP supervisor assists the home visitor to develop a fuller understanding of their work with families. Together they consider approaches for engaging and working with individual families, solving problems and handling crises as they occur. Individual supervision is provided to home visitors on a weekly basis. The supervision is designed to promote skill development and provide deeper knowledge of the NFP Program. The supervisor provides a supportive and safe framework for practice reflection, building community relationships, discussing complex cases. The supervisor also provides resources for professional development and quality improvement. Supervisors will use reflective supervision techniques to address issues related to family functioning and dynamics, as well as the experience of the home visitor working with the family. Supervisors also provide direct supervision through joint visits with the home visitors and hold group supervision sessions.

The CT-PAT clinical supervisors conduct the Kempe Family Stress Checklist (The Kempe). Often the home visitor joins the supervisor for the assessment. The Kempe is a 10–item scale that measures risk for difficulties. The Kempe is a psycho- social risk assessment tool used during an interview. It covers a variety of domains, including psychiatric, criminal and substance abuse history, childhood history of care, emotional functioning, attitudes towards and perception of child, discipline of child, and level of stress in the parent's life. Scores on the Kempe range from 0 to 100. Scores less than 25 are considered low risk, while scores in the 25-25 range are considered moderate risk, 40-60 high risk, and 65- 100 severe risk.

Organizational Capacity to Implement Activities Involved
The HOCC and the VNASC have the capacity and experience to implement the activities with the models. The HOCC has housed the CT-PAT Nurturing Families Program for the past twelve years, and have not experienced turn-over in staff.

The VNASC has been serving the maternal, infant and child population in the New London Community for more than fifty years and has the staff with the clinical experience to implement the NFP model.

Referral and Service Networks
Each of the communities will work with their collaborating partners to establish a local referral and service network. The DPH will conduct site visits to each location and will monitor community referrals through the collection of data. Connecticut will implement a statewide centralized referral line through the United Way information and Referral Line 211, where families and providers can refer women to home visiting programs in their community.

Monitoring of Fidelity of Program Implementation
As the lead agency responsible for the maternal, infant and early childhood home visiting program in CT, the DPH has overall responsibility for assuring that the programs are implemented with fidelity to the selected models. The DPH will conduct periodic site visits through the implementation phase and will collect programmatic and financial expenditure reports to monitor activities. The DPH will establish contractual agreements with the lead agencies. The DPH plans to provide technical assistance to each community in the development of their CQI plan, which will assist in monitoring fidelity.

The communities will assign a supervisor or manager with direct responsibility for monitoring fidelity of the selected model, as described or required by the model developer. The implementing/lead agencies have knowledge of and experience in implementing the home visiting programs they have selected. This experience will help ensure adherence to fidelity of the models.

How the State or Communities Will Comply With Any Model-Specific Prerequisites for Implementation
The implementing agencies and the DPH have been in contact with the model developers throughout this process. The partnership will continue through the implementation of the programs. The implementing agencies will be supported by the model developers and agree to participate in any required trainings or technical support offered by the model developer. The DPH received letters of approval from the model developers for the implementation of the selected models in each community (Attachment 8: Developer Approval Letters).

Strategies for Making Modifications
No modifications to the models will be made. The Windham community will be provided supplemental funding to provide childbirth classes to expectant families. This service will encourage families to enroll in home visiting earlier in pregnancy and will take advantage of this window of opportunity to promote healthy behaviors, refer for services and provide parent/newborn education.

The Ansonia/Derby community will be provided supplemental funding to promote fatherhood initiatives in the Early Head Start Home Visiting program.

The DPH will not contract with an independent evaluator, since it is only required for evaluation of a promising program.

Collaborations Established With Other State Early Childhood Initiatives
The DPH works closely with the SAC and is the recipient of the ECCS grant. The composition of the HVAC promotes interagency collaboration and planning toward achieving the goals of the State Plan. The MIECHV is funding an interagency collaborative data effort to enable state agencies to collect program and outcome data on families served. (Attachment 5: Memorandum of Concurrence).

Section 7: State Plan for Continuous Quality Improvement

The DPH recognizes that a well-designed CQI program will strengthen services within the home visiting program and result in more effective program implementation and improved participant outcomes. The DPH will participate in any technical assistance opportunities provided by HRSA on CQI strategies. The DPH will provide technical assistance to the communities of New Britain and New London on the development of community-specific and statewide CQI plans. The DPH MIECHV Team is highly-experienced in early childhood health and services, early intervention, maternal and infant health, research, education, program development, data collection and analysis.

The DPH will work with the model developers and program manager from each community to develop an ongoing CQI program specific to their model and community. A benefit of the individualized CQI program will be to allow for adaptation of the evidence-based home visiting model selected to the unique community settings, in which they are implemented, taking advantage of local strengths, and addressing specific local needs and challenges.

The CQI program will be data-driven and will provide a means for the community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups. Analysis of the data at regular intervals will identify key components of effective interventions and referrals, provide rapid information about changes needed, assist in identifying potential training and technical assistance needs, and support the most effective use of resources.

This well-designed CQI program will also assist the state with monitoring for fidelity of the implemented models. Reports to assess the contractors' performance on a variety of indicators associated with their processes and outcomes will be developed by DPH. The DPH will provide training to the communities on effective use of CQI reports to measure improvement and/or plan for modifications as needed.

The benchmarks and constructs table is included in Attachment 7.

Section 8: State Technical Assistance Needs

The DPH has participated in training and technical assistance webinars offered by the Department of Health and Human Services. The DPH has participated on the Region One calls with the Project Officer and other New England MIECHV representatives. The technical support offered to date has been a valuable asset during the planning phase.

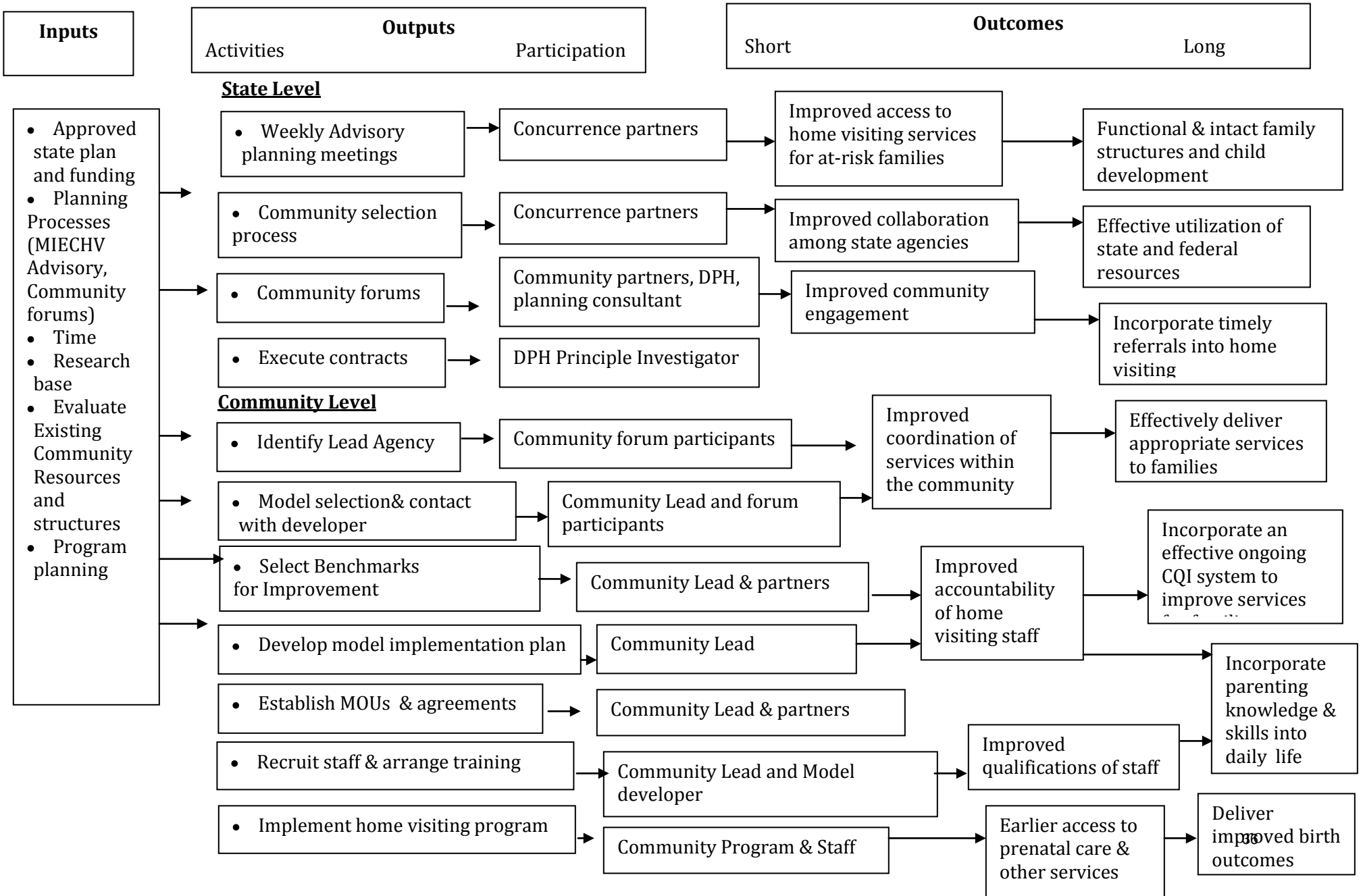
The DPH anticipates the need for additional technical assistance in fiscal leveraging, data and information systems, continuous quality improvement/quality assurance, sustainability, development of a statewide early childhood system, and program evaluation.

The DPH would benefit from technical assistance related to the benchmark and data collection across multiple home visiting models within a state and the subsequent federal reporting.

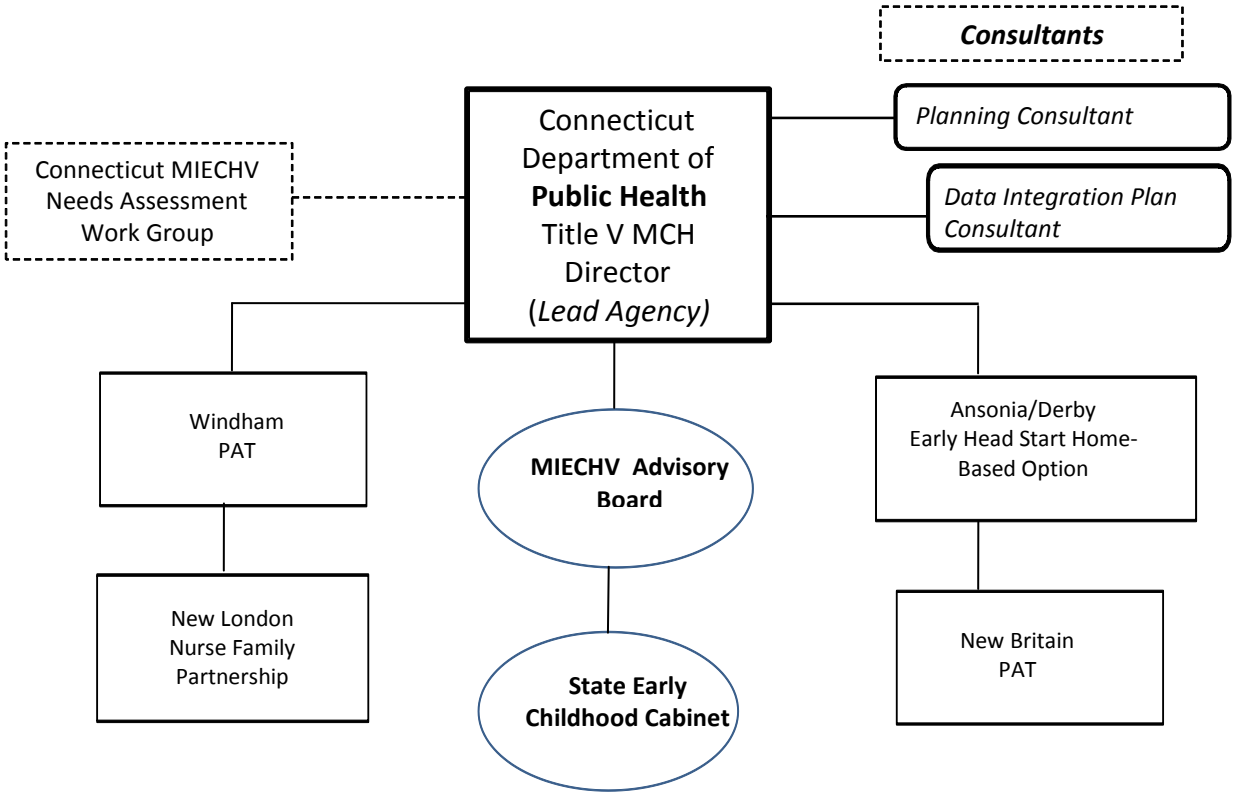
Section 9: Status of Meeting Reporting Requirements (Assurances)

Connecticut agrees to comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. The report will address all of the required elements, and will be submitted in the format requested and by the specified due date. This report shall address updates and progress on the following: State Home Visiting Program Goals and Objectives; State Home Visiting Promising Approach Update; Implementation of Home Visiting Program in Targeted At-risk Communities; Progress toward Meeting Legislatively Mandated Benchmarks; Home Visiting Program's CQI Efforts; and Administration of State Home Visiting Program.

Program: CT Maternal, Infant, Early Childhood Home Visiting (MIECHV) program
Overarching Goal: Develop a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships.
Problem Statement: Communities identified through the Statewide MIECHV Needs Assessment have a very high need for services.



Connecticut MIECHV Timeline 10/1/11-9/30/12		
When	**Steps/Activity**	**Responsible**
	New Britain (NB) New London (NL)	
October 1, 2011	DPH starts contract process with NB and NL Community Lead agencies	DPH
October 15, 2011	Communities begin developer application process	NL and NB
November 2011	PAT Training Offered	PAT
November 14, 2011	Recruitment will begin for new staffing	NL and NB
January 1, 2012	Contracts with NB and NL executed	DPH
January 2-5, 2012	NB New Staff orientation at Hospital of Central CT (THOCC)	THOCC-Human Res.
January 2, 2012	NL Recruitment of NFP Supervisor and 4 staff nurse visitors	VNASC
January 6, 2012	NB PAT Program workgroup for staff orientation	THOCC- PAT Director
January 9,2012	NB PAT in house training-partnering home visits begins	THOCC-Clinical Supervisor
January 13, 2012	NB Advisory Board meeting	THOCC-PAT Director
January 16, 2012	NB PAT in house training-documentation begins [ongoing]	THOCC-PAT Director
January 16, 2012	NL Execute Contract	DPH/VNASC
January 16, 2012	NL Hire Staff	VNASC
January 30, 2012	NL Register for NFP Core Education	VNASC
*February, 2012	NB PAT staff attend National Home Visiting Conference	THOCC - PAT Director
February 13, 2012	NLNFP Agency Orientation. Begin basic program set up	VNASC
February 20, 2012	NL VNASC NFP Staff self-study unit	VNASC NFP Staff
February 27, 2012	NL Face-to-Face Core Education	VNASC NFP Staff
*March, 2012	NB PAT Staff to attend Parents as Teachers training	THOCC-PAT Director
March 2012	***NB PAT home visits will begin***	THOCC-Home visitor
March 1, 2012	NB Outreach and marketing will begin	THOCC- Director PAT
March 2, 2012	NB PAT referrals will be taken	THOCC-Intake Worker
March 3, 2012	NB PAT client assessments will be scheduled	THOCC –Clinical Supervisor
March 3-31, 2012	NB PAT Client assessments will be completed	HOCC –Supervisor
March 5, 2012	NL NFP Begin enrolling clients	VNASC NFP Staff
March 16, 2012	NB PAT Birthing Class to be held	THOCC-Nurse
April 13, 2012	NB PAT Advisory Board Meeting	THOCC-PAT Director
April 20, 2012	NB PAT Family Group to be held	THOCC-home visitors
May 9, 2012	NB Community Wide Baby Shower Outreach	THOCC-Intake Worker
May 18, 2012	NB PAT Family Group to be held	THOCC-home visitors
June 15, 2012	NB PAT Family Group to be held	THOCC-home visitors
July 13, 2012	NB PAT Advisory Board Meeting	THOCC-PAT Director
July 15, 2012	NB PAT Family Group to be held	THOCC-home visitors
August 15, 2012	Program Annual Field Trip for New Britain families	THOCC
August 24, 2012	NB PAT Family Group to be held	THOCC-home visitors
September 1, 2012	NB PAT Program meets capacity	THOCC-Supervisor
September 7, 2012	NB PAT program annual recognition event for families	THOCC
September 12, 2012	NB PAT Family Group to be held	THOCC-home visitors
September 30, 2012	NL NFP Reach caseload of 20 -25 active families	VNASC NFP Staff
*Indicates that PAT training dates have not been finalized		


Consultants
Connecticut Department of **Public Health** Title V MCH Director (*Lead Agency*)
Planning Consultant
Data Integration Plan Consultant
Connecticut MIECHV Needs Assessment Work Group
Windham PAT
New London Nurse Family Partnership
MIECHV Advisory Board
State Early Childhood Cabinet
Ansonia/Derby Early Head Start Home-Based Option
New Britain PAT

Attachment 4

Job Descriptions/Resumes for Key Personnel

Title V Director: Assumes overall responsibility for all phases of this project, including the submission of a realistic plan to conduct a needs assessment, integration of the Title V Needs Assessment into the statewide Home Visiting Program assessment, coordination with other required parties identified in the funding announcement, managerial responsibility for completion of the full needs assessment, implementation of plan, meeting deadlines for all grant submissions and progress reporting, staff assignments; delegation of duties, appointment of DPH representatives to committees and boards, provide status reports to the Commissioner of the DPH.

Nurse Consultants and Health Program Associate: To coordinate the development and implementation of Connecticut's Home Visiting Program; work collaboratively with the Strategic Planning Consultant; apply professional knowledge in the implementation of home visitation program; implement, coordinate, and evaluate activities of assigned programs or health care services; maintain active liaison with other partners; assist in the development of standards of care to assure safety and quality of services provided; identify members for the CT Home Visiting Program Advisory Board; coordinate and facilitate meetings and trainings; ensure the fidelity is maintained; coordinate/standardize the development of statewide home visitation definitions, including definition of risk levels, standards, and training and educational requirements of home visitors; coordinate state and federal reporting as required; work with evaluator to develop a quality assurance plan; review program reporting form templates to assess for ability to measure *process, impact and outcome* objectives.

ROSA M. BIAGGI, M.P.H., M.P.A.

Professional Experience:

May 2009 Present **Health Services Section Chief, Family Health Section**
State MCH Title V Director
State of Connecticut Department of Public Health, Hartford, CT
Major responsibilities:

- Responsible for the Division's strategic planning; contract development and budgeting; program development, implementation, and evaluation; internal and external reporting; staff supervision; and coordination and collaboration with other units within the Department, other governmental agencies, and non-governmental organizations.

June 2005 May 2009 **Director of Health Services Division (Chief, AIDS and Chronic Diseases Section)**
State of Connecticut Department of Public Health, Hartford, CT

October 2001 June 2005 **Public Health Services Manager (Director, AIDS and Chronic Diseases Division)**
State of Connecticut Department of Public Health, Hartford, CT

June 1997 October 2001 **Program Coordinator**
Hispanos Unidos, Inc., New Haven, CT

June 1993 May 1997 **Health Educator**
Hispanos Unidos Contra el SIDA/AIDS, Inc., New Haven, CT

Education: **Master of Public Administration, 2001**
Major: Health Care Management, GPA: 3.68
University of New Haven, West Haven, CT 06516
Master of Public Health, 1997
Major: Health Education and Promotion, GPA: 3.50
Southern Connecticut State University, New Haven, CT 06519
Bachelor of Arts in Secondary Education, 1986
University of Puerto Rico, Rio Piedras, P.R. 00936

Memberships: Presidential Advisory Council on HIV/AIDS 2003-2007
National Alliance of State and Territorial AIDS Directors 2001-2008
Southern Connecticut State University, Alumni Association/Public Health Alumni Chapter
World AIDS Day Planning Committee of New Haven 1996-2001
Volunteer Co-Founder of Camp Meechimuk summer can for HIV/AIDS affected children in Connecticut (Prog. Dir. 1996;Arts & Crafts Dir. 1997-1999; Counselors in Training Dir. 2000; Asst. Dir. 2001; Planning Committee Member 1996-2001)

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME	POSITION TITLE
Stone, Carol	Epidemiologist 4
eRA COMMONS USER NAME STONE1957	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Ohio Wesleyan University	BA	1976-1980	Mathematics, Bacteriol
Ohio State University	M Appl Stats	1980-1982	Applied Statistics
Indiana State University	MA	1982-1984	Microbiology
Indiana University	PhD	1984-1989	Biochemistry
Univ of Calif, Riverside, & Ind Univ Med Cent	Post-Doc	1989-1991	Physical Biochemistry
Johns Hopkins School of Public Health	MPH	2003-2007	Epidemiology

A. Positions and Honors.

Positions

Assistant Scientist/Assistant Professor **1991-1995**
Dept Biochem & Molecular Biology, Indiana Univ School of Medicine, Indianapolis, IN

Associate Scientist/Associate Professor **1995-1996**
Dept Biochemistry & Molecular Biology, Indiana University School of Medicine, Indianapolis, promoted with *unanimous* recommendations, with an excellence in research

Associate Professor of Chemical Biology **1996-2000**
Dept Chemistry & Chemical Biology, Stevens Institute of Technology, Hoboken, NJ

Associate Director, Dept Chemistry & Chemical Biology **1998-2000**
Stevens Institute of Technology, Hoboken, NJ

Margaret and Herman Sokol Endowed Chair in Chemistry & **2000-2002**
Associate Professor, Dept Biology & Molecular Biology
Montclair State University, Upper Montclair, NJ

Epidemiologist 1 **2002-2003**
Health Care Quality, Statistics, Analysis & Reporting; Health Information Systems & Reporting, Connecticut Department of Public Health, Hartford, CT

Epidemiologist 2 **2003-2005**
Health Care Quality, Statistics, Analysis & Reporting; Health Information Systems & Reporting, Connecticut Department of Public Health, Hartford, CT

Epidemiologist 3 **2005-2009**
Epidemiology Unit; Family Health Section, Public Health Initiatives Branch, Connecticut Department of Public Health, Hartford, CT

Epidemiologist 4 **2009-pres**
Supervisor, Maternal, Infant, and Child Health Unit; Family Health Section, Public Health Initiatives Branch, Connecticut Department of Public Health, Hartford, CT

Other Experience and Professional Membership

1992 – Present Member, American Association for the Advancement of Science
2002 – Present Member, American Public Health Association; reviewer, MCH Section abstracts
2002 – Present Member, Connecticut Public Health Association
2007 – Present Founding Team, Genomics Forum, American Public Health Association
2008 – Present Reviewer, Maternal and Child Health Journal

Mary Emerling, B.S.N., R.N.

Experience Jul 2011 - present CT Dept. of Public Health/Public Health Initiatives

Nurse Consultant/ Maternal, Infant and Early Childhood Home Visiting (Formula Grant Program)/Hartford Healthy Start Program

- Contract development,
- Training/meeting coordination,

2006 – July 2011 CT Dept. of Public Health/ Operations Branch

Nurse Consultant/Mobile Field Hospital (MFH) Project Coordinator

2004-2006 CT Dept. of Public Health/Community-Based Regulations

Day Care/Youth Camp Nurse Consultant

2003-Jan 2004 CT Dept. of Public Health/Infectious Diseases
Epidemiologist II

2002- 2003 CT Dept. of Public Health/Infectious Diseases
Epidemiologist I

1999 - 2002 Memorial Elementary School East Hampton
School Nurse

Education 1995-1997 Austin Peay State U. Clarksville, TN
B.S.N. Bachelors in the Science of Nursing

1992-1995 Hopkinsville Community College
A.A, Associated in Arts

Military Service 1981-1985 United States Army
Medical Specialist Honorable Discharge

Donna C. Maselli, RN, MPH
90 Summer Lane
Rocky Hill, Connecticut 06067
T: (860) 563-7770
Email: donna.maselli@ct.gov

Curriculum Vitae

EDUCATION:
University of Connecticut, Farmington, CT, Master of Public Health, 2005
Charter Oak State College, New Britain, Connecticut, BS Psychology, 2000
Greater Hartford Community College, Hartford, CT, Registered Nurse, 1980

PROFESSIONAL EXPERIENCE:
May 2008 – Present
Nurse Consultant
Primary Care & Prevention Unit
Connecticut Department of Public Health
Hartford, Connecticut

- Program management- Healthy Start, Case Management for Pregnant Women, Centering Pregnancy and Planned Parenthood;
- Developed evaluation plan for Case Management for Pregnant Women program and Centering Pregnancy;
- Developed activities and interventions for the contractors to address primary prevention activities related to health risks in pregnant women such as smoking cessation, substance abuse, sexually transmitted disease, healthcare, domestic violence, and support systems;
- Contract management;
- Program evaluation;
- Grant writing and management- Personal Responsibility Education Program, Maternal, Infant and Early Childhood Home Visiting grant; and
- DPH representative on Advisory Boards

September 1999 – May 2008
Nurse Consultant
Newborn Screening Program, Children with Special Health Care Needs Unit
Connecticut Department of Public Health
Hartford, Connecticut

March 1995 - May 1997
Nurse Consultant, Inspector/Complaint Investigator
Connecticut Department of Public Health
Bureau of Health Systems Regulation

- Monitored hospitals, community health centers and long term care facilities for state and federal regulatory compliance
- Interpreted state and federal regulations and wrote state violations and federal deficiencies
- Utilized considerable knowledge of standards of care in licensed health care facilities
- Prepared written detailed reports of investigations and findings

MARGIE HUDSON, R.N., B.S.N., M.P.H

PROFESSIONAL EXPERIENCE:

Connecticut Department of Public Health- Hartford, CT **1995-Present**

Injury Prevention Program

Program Coordinator

- Incorporate public health approach into work with state and local collaborators including data dissemination, assessment, behavioral strategies and evaluation.
- Convened and facilitated the Interagency Suicide Prevention Network, complete State Plan.
- Participated in state, local, regional interdisciplinary & interagency collaborations.
- Completed CDC CORE Injury Grant included State Injury Plan, State 5 yr. Injury Data Book and convened and facilitated the Injury Community Planning Group.
- Conduct program planning, development, management and consultation of and about intentional injury and related issues.
- Develop request for proposals, manage & document review processes.
- Develop reporting processes, monitor budgets and contracts.

VNA Group Inc. - Hartford, CT **1993-1995**
Extended Service Unit Nurse

CIGNA Corporation- Bloomfield, CT **1987-1993**
Nursing Supervisor

- Supervised full-time and part-time registered nurses including hiring, progressive discipline, performance reviews, training & scheduling.
- Administered emergency and & episodic care to employees.
- Developed clinical guidelines, protocols, evaluation instruments; compiled & analyzed data, provided reports.
- Planned, organized, coordinated & evaluated health promotion & safety programs.

Visiting Nurse and Home Care Inc. - Hartford, CT **1978-1987**
Staff Nurse/Area Health Education Center Liaison (1981-1987)

St. Francis Hospital and Medical Center **1971-1978**
Staff Nurse – Intensive Care and Coronary Care Units

EDUCATION AND LICENSURE:

University of Connecticut Graduate School, Farmington **May 1994**
Master of Public Health
University of Connecticut - Storrs **June 1971**
Bachelor of Science in Nursing

Registered Nurse License - Connecticut

RODERICK L. BREMBY
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

TELEPHONE
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July 20, 2011

Jewel Mullen, MD, MPH, MPA
Commissioner
CT Department of Public Health
410 Capitol Avenue, MS 13COM
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Mullen:

On behalf of the Connecticut Department of Social Services, the state agency administrator of Title II of the Child Abuse Prevention and Treatment Act (CAPTA) Director and Child Care and Development Fund (CDDF), I submit this letter of concurrence to demonstrate our commitment to collaboration with the Connecticut Maternal, Infant and Early Childhood Home Visiting State Plan to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The implementation of the Nurse Family Partnership model in New London, Connecticut and the expansion of the CT Parents As Teachers/Nurturing Families Program in New Britain, Connecticut will support home visiting as part of a continuum of early childhood services within the State of Connecticut. We look forward to continued collaboration with your agency in this important work.

Sincerely,

Roderick L. Bremby
Commissioner

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

July 19, 2011

Jewel Mullen, MD, MPH, MPA
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue, MS 13COM
P.O. Box 340308
Hartford, CT 06134-0308

Dear ~~Commissioner Mullen~~ Jewel:

On behalf of the Connecticut Department of Children and Families, the State's Child Welfare Title IV-E and IV-B agency, I submit this letter of concurrence to demonstrate our commitment to collaboration with the Connecticut Maternal, Infant and Early Childhood Home Visiting State Plan to improve health and developmental outcomes for at-risk children through evidence-based home visiting programs.

The implementation of the Nurse Family Partnership model in New London, Connecticut and the expansion of the CT Parents As Teachers/Nurturing Families Program in New Britain, Connecticut will support home visiting as part of a continuum of early childhood services within the State of Connecticut.

Sincerely,

Joette Katz
Commissioner

STATE OF CONNECTICUT
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STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

July 19, 2011

Jewel Mullen, MD, MPH, MPA
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue, MS 13COM
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Mullen:

On behalf of the Department of Mental Health and Addiction Services (DMHAS), the single state agency for substance abuse services, I submit this letter of concurrence to demonstrate our commitment to collaboration with the Connecticut Maternal, Infant and Early Childhood Home Visiting State Plan to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The implementation of the Nurse Family Partnership model in New London, Connecticut and the expansion of the CT Parents as Teachers/Nurturing Families Program in New Britain, Connecticut will support home visiting as part of a continuum of early childhood services within the State of Connecticut.

Sincerely,

Paul J. DiLeo, MS, FACHE
Acting Commissioner

cc: Patricia Rehmer, MSN, Commissioner

(AC 860) 418-7000
410 CAPITOL AVENUE, P.O. BOX 341431 • HARTFORD, CT 06134
www.dmhas.state.ct.us
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CT Head Start State Collaboration Office

July 21, 2011

Jewel Mullen, MD, MPH, MPA
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue, MS 13COM
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Mullen:

I am writing as requested to provide this letter to accompany the next phase application to HRSA for Connecticut's Maternal, Infant and Early Childhood Home Visiting Program to improve health and development outcomes for at-risk children through evidence-based home visiting programs. I understand that a letter from the State Head Start State Collaboration must accompany the state's application.

The implementation of the Nurse Family Partnership model in New London, Connecticut and the expansion of the CT Parents As Teachers/Nurturing Families Program in New Britain, Connecticut will indeed support home visiting as part of a continuum of early childhood services within the State of Connecticut.

AS you know, Early Head Start is among the originally designated evidence based models from which states and communities could chose for implementation. Should the State of Connecticut wish to consider supporting the implementation of the Early Head Start evidence based model I would be happy to work with you on the state implementation plan for home visiting and assist in any way I can.

Sincerely,

Grace Whitney

Grace Whitney, PhD, MPH, IMH-E® (IV)
Director

CT State Department of Education, 165 Capitol Avenue, Hartford, CT 06106
Temporary Phone: 860-713-6831, Email: grace.whitney@ct.gov

July 18, 2011

Jewel Mullen, MD, MPH, MPA
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue, MS 13COM
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Mullen:

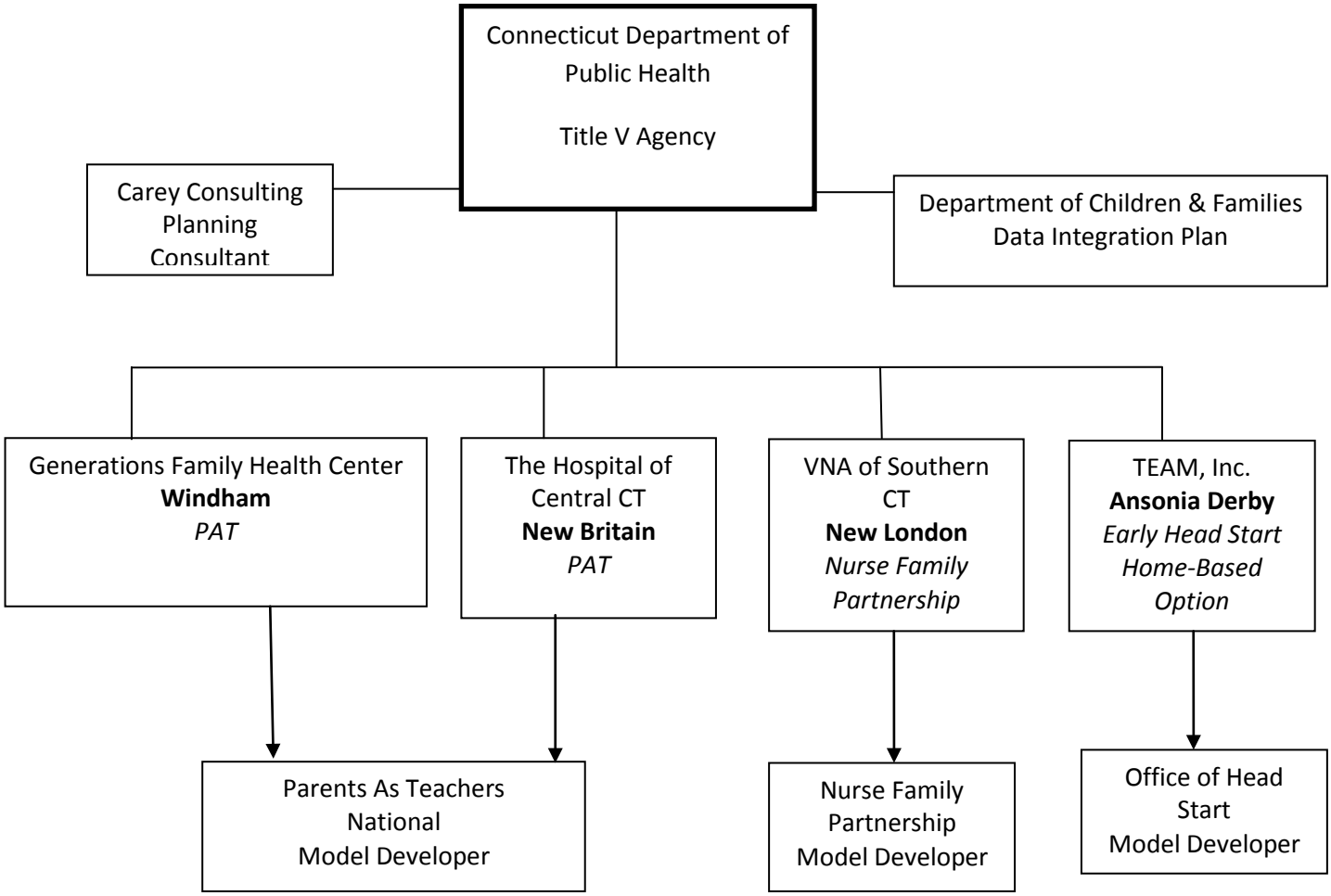
On behalf of the State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act, I submit this letter regarding collaboration with the Connecticut Maternal, Infant and Early Childhood Home Visiting State Plan to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The implementation of the Nurse Family Partnership model in New London, Connecticut and the expansion of the CT Parents As Teachers/Nurturing Families Program in New Britain, Connecticut will indeed support home visiting as part of a continuum of early childhood services within the State of Connecticut.

We are also aware, per Appendix J of this Funding Opportunity - HRSA-11-187, that the department is able to submit models for HRSA review as evidence based models. We request that DPH submit Child FIRST to HRSA for review by HomVEE as an evidence-based model in this application due July 21, 2011. With this stipulation fully considered, we concur and demonstrate our commitment for this grant application.

Sincerely,

Elaine Zimmerman
Co-Chair, Home Visitation and Family Engagement
Connecticut Early Childhood Education Cabine


Connecticut Department of Public Health
Title V Agency
Carey Consulting Planning Consultant
Department of Children & Families Data Integration Plan
Generations Family Health Center
Windham
PAT
The Hospital of Central CT
New Britain
PAT
VNA of Southern CT
New London
Nurse Family Partnership
TEAM, Inc.
Ansonia Derby
Early Head Start Home-Based Option
Parents As Teachers National Model Developer
Nurse Family Partnership Model Developer
Office of Head Start Model Developer

Appendix D

Connecticut Annual Benchmarks and Constructs, December, 2011
Connecticut Department of Public Health (DPH)

Definitions for Commonly-Used Terms

Completed Referral: A referral in which the home visitor receives confirmation from the family that action occurred as a result of a referral.

Enrolled children: Includes children in an enrolled family who are 0 through 5 years of age. Some home visiting models may only collect information on a single index child.

Evidence-based instrument: A screening or assessment tool with documented evidence of effectiveness in the focus population for the topic being screened. An evidence-based instrument has reliability of at least 0.65, validity of at least 0.5, and is normed. The same instrument must be used during all program periods.

Family members: All persons in an enrolled family of all ages staying in a home at least four nights weekly, on average.

Household member: Family members (see definition above) who are at least 18 years of age and who contribute to the support of the enrolled family. Some home visiting models may only collect information on a single index household member.

Improvement: Improvement occurs when a measurement meets the definition when comparing Program Period 3 to Program Period 1.

Program Site: One of four communities in Connecticut receiving Home Visiting funds, including: Ansonia/Derby, Windham, New London, and New Britain.

Primary caregiver(s): is a/are member(s) of the enrolled family who provides at least 20 hours of care weekly to an child in the family and has(ve) primary responsibility for the health, safety and comfort of that child. The caregiver may be the mother (maternal) and/or father (paternal), or other legal guardian, such as a grandparent, aunt or uncle.

Program period: A twelve-month timeframe of program activities. There are four distinct program periods: **Year 1** (10/1/11 - 9/30/12); **Year 2** (10/1/12 - 9/30/12); **Year 3** (10/1/12 - 9/30/13); and **Year 04** (10/1/13 – 9/30/14). Although constructs will be developed annually, improvement (see definition above) will be assessed from Year 01 through Year 03.

NFP: Nurse Family Partnership model of home visiting; **PAT:** Parents as Teachers model of home visiting; **EHS:** Early Head Start model of home visiting.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
Benchmark I. Improved Maternal and Newborn Health					
(i) Prenatal care	Annually, the percent of pregnant maternal primary caregivers in enrolled families receiving prenatal care in the first trimester of pregnancy.[1,2] Outcome	**Numerator:** number of pregnant maternal primary caregivers in enrolled families during the program period who received prenatal care in the first trimester of pregnancy, among all Program Sites combined. **Denominator:** number of pregnant maternal primary caregivers in enrolled families during the program period, among all Program Sites combined.	**Home visitor to ask of maternal primary caregiver:** *Are you currently pregnant or have you been pregnant within the past 12 months? Y/N* *What is/was your due date? (mm/dd/yyyy)* *For the pregnancy described above, how many weeks or months pregnant were you when you first went for Prenatal Care?* *Weeks: _____* ***OR*** *Months: _____* ***OR*** *☐ Did not go for PNC*	**PAT:** LSP: Health and Medical Care #17-Prenatal Care, Personal Visit Record. **NFP:** Maternal Health Assessment Form. NFP collects this data at Intake only. NFP reports on the % of clients who receive care in the first, second and third trimesters. **EHS:** EHS Program Information Report Data, Item C12a.	Increase the percent of pregnant primary caregivers in enrolled families who receive prenatal care in the first trimester of pregnancy, during Program Period 3 compared to Program Period 1.
(ii) Parental use of tobacco	Annually, the average amount of cigarettes smoked daily by enrolled families during the program period, by family relationship. Outcome	**Numerator:** total number of cigarettes smoked in an average day among enrolled family members during the program period, among all Program Sites combined, by family relationship. **Denominator:** number of enrolled family members, among all Program Sites, by family relationship.	**Home Visitor to ask of each family member:** *How many cigarettes do you smoke on an average day? (A pack has 20 cigarettes)* _____ cigarettes **OR** _____ packs	**PAT:** LSP: Mental Health & Substance Use/Abuse #25-Tobacco Use. **NFP:** Health Habits Form. NFP only collects smoking habits for clients, not other household members. **EHS:** Full Assessment/Intake Form; Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Reduce the average amount of cigarettes smoked by enrolled families, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(iii) Preconcep-tion care	Annually, the percent of postpartum maternal primary caregivers in enrolled families who receive at least one medical inter-conception/ preconception care visit by six months pospartum.[3,4] Outcome	**Numerator:** number of postpartum maternal primary caregivers in enrolled families who receive at least one medical inter-conception/ preconception care visit during the program period, among all Program Sites combined. **Denominator:** number of postpartum maternal primary caregivers in enrolled families during the program period, among all Program Sites combined.	*Has your postpartum client had a visit with a doctor, nurse, or other health care worker?* Please count only discussions, not reading materials or videos.	**PAT:** Self report, documented on the Recruitment and Enrollment Record. **NFP:** collects information on *inter-conception* care on the Use of Government and Community Services (option #18—Primary Care Provider—well client (prenatal, postpartum, and well-women care). NFP collects information on whether clients received postpartum/well-women visits at 4 points in time for this construct: Infancy 6 and 12 months, Toddler 18 and 24 months. **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Increase the percent of postpartum maternal primary caregivers in enrolled families receiving at least one medical inter-conception or preconception care visit by six months postpartum, during Program Period 3 compared to Program Period 1.
(iv) Inter-birth intervals	Annually, the percent of maternal primary caregivers in enrolled families who are provided information or education on the benefits of inter-birth spacing.[5] Process	**Numerator:** number of maternal primary caregivers in enrolled families with a previous delivery who were provided information or education on the benefits of inter-birth spacing, among all Program Sites combined. **Denominator:** number of maternal primary caregivers in enrolled families with a previous delivery, among all Program Sites combined.	Birthdates of all children among enrolled families. Due dates of current pregnancies. *Did enrolled mothers receive information or education on the benefits of inter-birth spacing?*	**PAT:** Self-reported, documented on Recruitment and Enrollment Record and updated annually. **NFP:** NFP reports on the % of enrolled clients who have a subsequent pregnancy at 6 months, 12 months, 18 months and 24 months after the birth of their first child**.** **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Increase or maintain the percent of maternal primary caregivers in enrolled families who received information or education on the benefits of inter-birth spacing, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(v) Screening for maternal depressive symptoms	Annually, the percent of maternal primary caregivers in enrolled families who are screened for depressive symptoms using an evidence-based screening tool. Process	**Numerator:** number of maternal primary caregivers in enrolled programs who are screened for depressive symptoms using an evidence-based instrument during the program period, among all Program Sites combined. **Denominator:** number of maternal primary caregivers in enrolled families during the program period, among all Program Sites combined.	*Was the client screened for maternal depressive symptoms using an evidence-based screening tool? Y/N* *What tool was used?* *Date screened: (mm/dd/yyyy)* *Did she screen positive? Y/N* *If she screened positive, was she referred for treatment? Y/N*	**Examples:** Edinburgh, PHQ-9 **PAT:** Edinburgh **NFP**: Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire-9 to screen for maternal depression. NFP records the date that the screening was completed and also if the client was referred for treatment. Required collection at Pregnancy 36 weeks, Infancy 1-4 weeks, Infancy 4-6 months, Toddler 12 months. Optional at all other times. **EHS:** Edinburgh	Increase or maintain the percent of maternal primary caregivers in enrolled families who are screened for depressive symptoms using an evidence-based instrument, during Program Period 3 compared to Program Period 1.
(vi) Breast-feeding	Annually, the percent of postpartum maternal primary caregivers in enrolled families who initiate breastfeeding.[4] Outcome	**Numerator:** Among maternal primary caregivers in enrolled families who had a delivery during the program period, the number who initiate breastfeeding, among all Program Sites combined. **Denominator:** number of maternal primary caregivers in enrolled families who had a delivery within the program period, among all Program Sites combined.	Date of Screen *Birthdate of all family members.* *How long did you breastfeed your infant?* Weeks: _____ **OR** Months: _____ ☐ Less than 1 week ☐ Never *Are you currently breastfeeding your infant?* Y/N	**PAT:** not collected. **NFP:** report on the % of clients who initiated breastfeeding and those who continue to breastfeed (do not distinguish from exclusively versus non-exclusively) at 6, 12, 18 and 24 months. NFP also reports on (1) the # of infants who were exclusively breastfed; (2) the median age in weeks when infants were no longer exclusively breastfed; and (3) # and % of clients who were exclusively breastfed until at least 6 months. **EHS**: not collected.	Increase the percent of postpartum maternal primary caregivers in enrolled families who initiate breastfeeding, during Program Period 3 compared to Program Period 1.
(vii) Well-child visits	Annually, the percent of children in enrolled families who are up-to-date on medical well-child visits during the program	**Numerator:** number of children in enrolled families who are up-to-date on medical well-child visits during the program period, among all Program Sites combined.	Birth date of enrolled children (mm/dd/yyyy) Date of screen (mm/dd/yyyy), Date of each well-child visit (mm/dd/yyyy), by recommended	**PAT:** LSP: (Health & Medical Care #20 – Child Well Care), Child Well Care Score of 5=keeps regularly CHDP/well-child appointments with same provider. **NFP:** Infant Health Care Form	Increase the percent of children in enrolled families who are up-to-date on medical well-child visits, during Program Period 3 compared to Program

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
	period.[6] Outcome	**Denominator** number of children in enrolled families during the program period, among all Program Sites combined.	schedule of visits.	records whether or not the child was taken to his/her 6 month, 12 month, 18 month, or 24 month well-child visit. **EHS:** EHS Program Information Report Data, Item C8; collected annually. Number of children who are up-to-date on a schedule of age-appropriate preventative and primary health care according to your state's EPSDT schedule for well child care.	Period 1.
(viii) Maternal and child health insurance status	Annually, the percent of eligible maternal primary caregivers and infants/children in enrolled families who have health insurance during the program period.[7] Outcome	**Numerator:** number of eligible maternal primary caregivers & infants/children in enrolled families who have health insurance during the program period, among all Program Site combined. **Denominator:** number of eligible maternal primary caregivers & infants/children in enrolled families during the program period among all Program Sites combined.	**See Benchmark V (iii) data collection notes**	**See Benchmark V (iii) data collection notes.** **NFP:** Demographic Pregnancy Intake Form. Use of Government and Community Services Form—Intake, Infant's Birth, Infancy 6 and 12 months, Toddler 18 and 24 months. NFP collects data on whether clients have private, public or no insurance. NFP collects data on whether client or child has Medicaid, SCHIP or private insurance on Use of Government and Community Services Form.	Increase the percent of eligible maternal primary caregivers and infants/children in enrolled families who have health insurance, during Program Period 3 compared to Program Period 1.
Benchmark II. Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits.					
(i) Emergency Department visits: <u>Children</u>	Annually, the average number of Emergency Department (ED) visits by children in enrolled families during the program period, for all causes.	**Numerator:** number of ED visits among children in enrolled families during the program period, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among Program Sites	*Within the past 12 months, how many times did each child in the family visit the ED? (provided by primary caregiver)*	**PAT:** Participant report, documented on Personal Visit Record. **NFP:** Infant Health Care Form (Infancy 6 and 12 months, Toddler 18 and 24 months), asks about ER utilization for injury or ingestion. Use of Government and Community Services Form records	Reduce the average number of ED visits by children in enrolled families for all causes, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
	Outcome	combined.		if the infant/toddler was seen by the primary care provider due to illness. No data is collected on other children in the household. NFP records the # of children who went to the ER once in past 6 months, twice in past 6 months and three times in past 6 months, at set points in time. Includes for reasons of injury or ingestion, not illness. **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	
(ii) Emergency Department visits: <u>Women</u>	Annually, the average number of Emergency Department (ED) visits by maternal primary caregivers in enrolled families during the program period, for all causes. Outcome	**Numerator:** number of maternal primary caregivers in enrolled families having at least one visit to the ED for all causes during the program period, among all Program Sites combined. **Denominator:** number of maternal primary caregivers in enrolled families during the program period, among all Program Sites combined.	*Within the past 12 months, how many times did the maternal primary caregiver in the enrolled family visit the ED (*provided by adult female household members)*?*	**PAT:** Participant report, documented on Personal Visit Record. **NFP:** not currently collected. **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Reduce the ED visits by maternal primary caregivers in enrolled families for all causes, during Program Period 3 compared to Program Period 1.
(iii) Health and safety information or training provided	Annually, the percent of enrolled families who receive health and safety information from the home visitor during the program period.[8] Process	**Numerator:** number of enrolled families who receive health and safety information by the home visitor during the program period, among all Program Sites combined. **Denominator:** total number of enrolled families during the program period,	*Did home visitor provide families with health and safety information during the program period (provided by enrolled family)?* *Dates of discussion (mm/dd/yyyy)* *Topics of discussion*	**PAT:** Handouts that are given to parent and discussion on these topics are recorded on the Personal Visit Record. **NFP:** Home Visit Encounter Form. NFP records whether nurses provide education on prevention of injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury,	Increase or maintain the percent of enrolled families who receive health and safety information from the home visitor, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
		among all Program Sites combined.		child passenger safety, poisonings, fire safety (including scalds), water safety, playground safety, etc. during the home visit (Y/N). **EHS:** EHS Program Information Report (PIR) Data, Items C40k and C40m.	
(iv) Incidence of child injuries requiring medical treatment	Annually, the percent of children in enrolled families who have one or more injuries requiring medical treatment during the program period.[9] Outcome	**Numerator:** number of children in enrolled families who have one or more injuries requiring medical treatment during the program period, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	*Within the program period, did any enrolled child have any injuries (falls, bumps, bruises, cuts, burns, accidental ingestion of pills or liquids,* etc.) *requiring a doctor's visit, ED visit, or hospitalization*? *If yes:* *How many injuries required a doctor's visit, ED visit, or hospitalization?* *Child's name* *Number of injuries*	**PAT:** LSP: Relationships with Child(ren) #8 – Safety **NFP:** On the Infant Health Care Form, and recorded periodically throughout program enrollment, if an infant/toddler was taken to the ER or injury or ingestion, and if treatment was needed (Y/N only). Specifics on treatment and F/U are included in the client's chart. Also, on the Infant Care Form, if the child was taken to the ER for a reason other than injury or ingestion and record the date and reason. No data is collected on other children in the household. **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Reduce the percent of children in enrolled families who receive medical treatment as a result of injury, during Program Period 3 compared to Program Period 1.
(v) Reported suspected maltreatment for children in the program (includes substantiated and unsubstantiated reports)	Annually, the percent of suspected maltreatment cases among children in enrolled families, by type of maltreatment, by age group.[10]	**Numerator:** total number of suspected cases of suspected maltreatment among children in enrolled families, among all Program Sites combined, by type of maltreatment, by age group. **Denominator:** total	*Within the program period, the number of children in the family for whom family members indicated had been reported to authorities as suspected victims of child maltreatment (provided by family members).* *Maltreatment type (i.e., neglect, physical abuse, sexual abuse,*	**PAT:** 1. Personal Visit Record; 2. LSP: (Relationship with Child(ren) #6 – Discipline); 3. Affiliated Performance Report (APR, Section VI, Q4). **NFP:** Maternal self-report or nurse report of suspected cases of maltreatment of children in the program using Infant Health Care	Reduce the percent of suspected cases of maltreatment among children in enrolled families, during Program Period 3 compared to Program Period 1, by type of maltreatment, by age group.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
	Outcome	number of children in enrolled families, among all Program Sites combined, by age group.	*emotional maltreatment, other).* *Age group (0-12 month, 13-36 month, 37-72 months)*	Form. No data is collected on other adults in the household. NFP records if client is aware of any referral of client (self) or family to social services for abuse or neglect of child (Y/N, date of referral). **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	
(vi) Reported substantiated maltreatment (substantiated/ indicated/ alternative response victim) for children in the program.	Annually, the percent of substantiated maltreatment cases among children in enrolled families, by maltreatment type, by age group.[11] Outcome	**Numerator:** total number of substantiated cases of suspected maltreatment among children in enrolled families, among all Program Sites combined, by maltreatment type, by age group. **Denominator:** total number of children in enrolled families, among all Program Sites combined, by age group.	*Within the program period, the number of children in the enrolled family who were determined by authorities to be substantiated victims of child maltreatment (provided by family members)* *Maltreatment type (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other)* *Age group (0-12 month, 13-36 month, 37-72 months)*	**PAT:** interview/self-report, Program Manager reports. **NFP:** currently not collected. **EHS:** Ongoing Participant Report; Recorded in individual client records and collected in software data collection system (Child Plus).	Reduce the percent of substantiated cases of maltreatment among children in enrolled families, during Program Period 3 compared to Program Period 1, by maltreatment type, by age group.
vii) First-time victims of maltreatment for children in the program	Annually, the percent of first time victims of maltreatment among children in enrolled families during the program period, by maltreatment type, by age group.[12] Outcome	**Numerator:** total number of first-time victims of maltreatment among children in enrolled families prior to kindergarten, among all Program Sites combined, by maltreatment type, by age group. **Denominator:** number of children prior to kindergarten entry in the enrolled family during the program period, among all	*Within the program period, the number of enrolled children in the family who were determined by authorities to be first-time victims of child maltreatment. (provided by family members)* *Maltreatment type (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other).* *Age group (0-12 month, 13-36 month, 37-72 months)*	**PAT:** interview/self-report, Program Manager reports. **NFP:** Interview/self-report (if mother self-reports). FNP has information available for suspected cases and referrals/reports made, but not collect these data for substantiated cases. No data is collected on other children in the household. **EHS:** Full Assessment/Intake Form; Ongoing Participant Report;	Reduce the percent of first-time victims of child maltreatment, during Program Period 3 compared to Program Period 1, by maltreatment type, by age group.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
		Program Sites combined, by maltreatment type, by age group.		Recorded in individual client records and collected in software data collection system (Child Plus).	
III. School Readiness and Achievement					
(i)Parent support for children's learning and development	Annually, the average degree of support among enrolled primary caregivers about the enrolled child's/children's learning and development during the program period. Outcome	**Numerator:** total Likert score of primary caregiver support of child's/children's learning and development during the program period, among all enrolled families, by relation to child, as reported by home visitor, among all Program Sites combined. **Denominator:** total number of primary caregivers in enrolled families during the program period, by relation to child, among all Program Sites combined.	**Completed by home visitor:** List of primary caregivers in the enrolled family, whether or not a parent, and response to current level of support for child learning and development. *Responses:* *0, poor support;* *1, limited interest;* *2, provides some age-appropriate toys, books and toys;* *3, interested in child development, skills, interests, and play;* *4, uses age-appropriate toys and books, reads and plays with child daily.*	**No known evidence-based assessment available.** **PAT**: PAT parent survey, support for development scores. Personal Visit Records. **NFP**: Observation and self-report; H.O.M.E. Inventory (NFP will report on positive relative change in "Learning Materials" and "Involvement" scores from Infancy 6 months to Toddler 18 months) No data is collected on other adults in the household. **EHS**: Program Information Form, C40m; number of families who received parenting education.	Increase the degree of parental support for child's/children's developmental progress among primary caregivers in the enrolled family, by relation to child, during Program Period 3 compared to Program Period 1.
(ii) Parent knowledge of child development and their child's developmental progress	Annually, the average degree of knowledge among primary caregivers in enrolled families about child development, and the enrolled child's/children's developmental progress during the program period. Outcome	**Numerator:** total Likert score of primary caregiver knowledge about child development and enrolled child's/children's developmental progress during the program period, among all enrolled families, by relation to child, as reported by home visitor, among all Program Sites combined. **Denominator:** total number of enrolled primary caregivers during the program period, by relation	**Completed by home visitor:** List of primary caregivers in the enrolled family, whether or not a parent, and response to current level of knowledge for child learning and development. *Responses:* *0, poor knowledge; 1, limited knowledge; 2, open to information; 3, applies child development ideas; 4, anticipates child development changes.*	**No known evidence-based assessment available.** **PAT**: PAT parent survey; support for development scores. Personal Visit Records. **NFP**: H.O.M.E. Inventory (NFP will report on positive relative change in Total Score from Infancy 6 months to Toddler 18 months). No data is collected on other adults in the household aside from the client. NFP does not use the Likert Scale **EHS**: Program Information Report, C40m.	Increase the degree of parental knowledge about child development and knowledge of child's/children's developmental progress among primary caregivers in enrolled families, by relation to child, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
		to child, among all Program Sites combined.			
(iii) Parenting behaviors and parent-child relationship	Annually, the percent of primary caregivers in enrolled families who complete an evidence-based instrument during the program period that assesses parenting behaviors and parent-child relationship. Process	**Numerator:** number of primary caregivers in enrolled families who complete an evidence-based instrument during the program period for parenting behaviors and parent-child relationship, by relation to child, among all Program Sites combined. **Denominator:** number of primary caregivers in enrolled families during the program period, by relation to child, among all Program Sites combined.	**Completed by home visitor:** List of primary caregiver, whether parent, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, whether referral was made and completed, and dates of referral and completion.	**Examples**: Parent-Child Relationship Index. **PAT**: LSP; #4, 5, 6, 7, 8. Personal Visit Records. **NFP**: observations and client charts. H.O.M.E. Inventory (NFP will report on positive relative change in "Responsivity" and "Acceptance" scores from Infancy 6 months to Toddler 18 months). No data is collected on other adults in the household aside from the client. **EHS**: Program Information Report, C40m.	Increase or maintain the percent of primary caregivers in enrolled families who complete an evidence-based instrument tool for parenting behaviors and parent-child relationship, by relation to child, during Program Period 3 compared to Program Period 1.
(iv) Parent emotional well-being or parenting stress	Annually, the percent of primary caregivers in enrolled families who complete an evidence-based instrument during the program period that assesses emotional well-being or parenting stress. Process	**Numerator:** number of primary caregivers in enrolled families who complete an evidence-based instrument during the program period for parent emotional well-being or parenting stress, by relation to child, among all Program Sites combined. **Denominator:** number of primary caregivers during the program period, by relation to child, among all Program Sites combined.	**Completed by home visitor:** List of primary caregiver, whether parent, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples**: Parent Stress Inventory, Adult-Adolescent Parenting Inventory-2, others as listed in ACF website (http://www.acf.hhsgov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phi.html). **PAT**: Scores for Edinburgh, Protective Factors Survey, PAT Parent Survey, LSP: #26, 28; Parent Stress Inventory; Psychiatric Diagnostic Screening Questionnaire. **NFP**: Edinburgh OR PHQ-9. NFP records the date that the screening	Increase or maintain the percent of primary caregivers in enrolled families who complete an evidence-based instrument for parent emotional well-being or parenting stress, by relation to child, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
				was completed and also if the client was referred for treatment. Required collection at Pregnancy 36 weeks, Infancy 1-4 weeks, Infancy 4-6 months, Toddler 12 months. Optional at all other times. No data is collected on other adults in the household aside from the client. NFP agencies use either the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire-9 to screen for maternal depression. % of clients who screened positive for maternal depression will not be included on the Benchmark Report to states but it is possible to get these data with a special data request. **EHS**: program Information Form: C40c, C40m.	
(v) Child communication, language, and emergent literacy	Annually, the percent of children in enrolled families for whom an age-appropriate evidence-based instrument that assesses child communication, language, and emergent literacy has been completed during the program period. Process	**Numerator:** number of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period for child communication, language, and emergent literacy, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of primary caregiver, whether parent, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples:** ASQ-3, Achenback System of empirically based assessment, Batelle Development Inventory, Bayley scales of infant and toddler development-III, BASC-2, IED-II, DP-3, ECI, Early Learning Accomplishment, others as listed in ACF website (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phi.html). **PAT**: ASQ-3 score, Personal Visit Records. **NFP**: ASQ-3 score (NFP will report "Communication" subscale only for this construct and will report on % of first children screened and	Increase or maintain the percent of children in enrolled families for whom an evidence-based instrument for child communication, language, and emergent literacy is completed during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
				aggregate scoring data for informational purposes). No data is collected on other children in the household. Scores are recorded (though not reported in data reports) and NFP reports on % of infant/toddlers screened at a point in time. **EHS**: Program Information Form; C28.	
(vi) Child's general cognitive skills	Annually, the percent of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period that assesses general cognitive skills. Process	**Numerator:** number of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period for general cognitive skills, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of enrolled children, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples**: ASQ-3, Batelle development inventory, Bayley-III, IED-2, DP-3, Early Learning Accomplishment, others as listed on ACF website (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phi.html). **PAT**: ASQ-3 score, Personal Visit Records. **NFP**: ASQ-3 score (NFP will report "Problem Solving" subscale only for this construct and will report on % of children screened and aggregate scoring data for informational purposes). No data is collected on other children in the household aside from the client's first child. NFP administers Ages & Stages and Ages & Stages-Social Emotional according to their schedules. Scores are recorded (though not reported in data reports) and NFP reports on % of infant/toddlers screened at a point in time. **EHS**: Program Information Form;	Increase or maintain the percent of children in enrolled families for whom an evidence-based instrument for general cognitive skills, is completed during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
				C28	
(vii) Child's positive approaches to learning including attention.	Annually, the percent of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period that assesses positive approaches to learning including attention. Process	**Numerator:** number of children in enrolled families for whom an age-appropriate evidence-based instrument during the program period for positive approaches to learning including attention, is completed among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of enrolled children, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples**: ASQ-3, Batelle development inventory, Bayley-III, IED-2, DP-3, Early Learning Accomplishment, others as listed on ACF website (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phi.html). **PAT**: ASQ-3 score, Personal Visit Records. **NFP**: ASQ-3 score (NFP will report "Personal-Social" subscale only for this construct and will report on % of children screened and aggregate scoring data for informational purposes). No data is collected on other children in the household aside from the client's first child. NFP administers Ages & Stages and Ages according to their schedules. Scores are recorded (though not reported in data reports) and NFP reports on % of infant/toddlers screened at a point in time. **EHS**: Program Information Form; C28.	Increase or maintain the percent of children in enrolled families for whom an evidence-based screening tool for positive approaches to learning including attention, is completed during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(viii) Child's social behavior, emotion regulation, and emotional well-being.	Annually, the percent of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period that assesses social behavior, emotion regulation, and emotional well-being. Process	**Numerator:** number of children in enrolled families for whom an age-appropriate evidence-based instrument is competed during the program period for social behavior, emotion regulation, and emotional well-being, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of enrolled children, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples**: ASQ-3, ASQ-SE, Achenbach, Batelle, Bayley-IIIASQ-3 score, others as listed on ACF website (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_phi.html). **PAT**: ASQ-3 score, ASQ-SE score, Personal Visit Records. **NFP**: ASQ-SE (NFP will report on increase in screening rate using the ASQ-SE as measured over time). No data is collected on other children in the household aside from the client's first child. NFP administers Ages & Stages-Social Emotional according to their schedules. Scores are recorded on % of infant/toddlers screened at a point in time. **EHS**: Program Information Form; C28.	Increase or maintain the percent of children in enrolled families for whom an evidence-based instrument is completed for social behavior, emotion regulation, and emotional well-being, during Program Period 3 compared to Program Period 1.
(ix) Child's physical health and development.	Annually, the percent of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period that assesses physical health and development. Process	**Numerator:** number of children in enrolled families for whom an age-appropriate evidence-based instrument is completed during the program period for physical health and development, among all Program Sites combined. **Denominator:** number of children in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of enrolled children, date of evidence-based screen, identity of evidence-base screening tool, total score, whether positive result, whether positive result, if referral was made and completed, and dates of referral and completion.	**Examples**: ASQ-3, ASQ-SE, Achenbach, Batelle, Bayley-IIIASQ-3 score, , others as listed on ACF website (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_cdi.html). **PAT**: ASQ-3 score, ASQ SE score, Personal Visit Records. **NFP**: Infant Health Care Form (Infancy 6 and 12 months, Toddler 18 and 24 months). No data is collected on other children in the household aside from the client's first child. Nurse records child's weight, height and head	Increase or maintain the percent of children in enrolled families for whom an evidence-based instrument for physical health and development, is completed during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
				circumference—can either be client report or measurement by nurse. NFP reports on % of children screened for weight, height and head circumference. **EHS**: Program Information Form; C28.	
Benchmark IV. Crime or Domestic Violence					
(i) Screening for domestic violence.	Annually, the percent of primary caregivers in enrolled families who are screened for domestic violence risk during the program period. Process	**Numerator:** number of primary caregivers in enrolled families who complete screening for domestic violence risk during the program period, among all Program Sites combined. **Denominator:** number of primary caregivers in enrolled families during the program period, among all Program Sites combined.	**Completed by home visitor:** List of primary caregivers in the enrolled family, date of screening, identity of screening tool, whether positive, if referral was made and completed, and dates of referral and completion, whether safety plan was completed and date of completion.	**Examples**: ACOG Screening Tool. **PAT**: ACOG screening tool, Personal Visit Records. **NFP**: Relationship Assessment Forms; intimate partner violence. No data is collected on other adults in the household. NFP reports on # and % of clients who experience violence. Time periods include Intake, Pregnancy 36 weeks, and Infancy 12 months. **EHS**: ACOG Screening Tool.	Increase or maintain the percent of primary caregivers in enrolled families who are screened for domestic violence, during Program Period 3 compared to Program Period 1.
(ii) Domestic Violence: number of referrals made to relevant services (e.g. shelters, food pantries)	Annually, the percent of primary caregivers in enrolled families who screen positive for domestic violence risk and who receive a referral during the program period. [13,14] Process	**Numerator:** number of primary caregivers in enrolled families who screen positive for domestic violence risk and who receive a referral by a home visitor during the program period. **Denominator:** number of primary caregivers in enrolled families who screened positive for domestic violence risk during the program period.	**See Benchmark IV (i)**	**PAT:** DOVE; structured intimate partner violence visitation program. **NFP:** Home Visit Encounter Form (collected at every home visit). No data is collected on other adults in the household. NFP reports on # and % of clients who were referred for crisis intervention (IPV) services during different program periods. Data on referrals made are collected at each home visit. **EHS:** Program Information Report; C40i.	Among families with primary caregivers in enrolled families who screen positive for domestic violence, increase or maintain the percent who receive a referral by the home visitor, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(iii) Domestic Violence; number of families for which safety plan completed	Annually, the percent of primary caregivers in enrolled families who screen positive for domestic violence risk and who complete a safety plan during the program period.[14,15] Process	**Numerator:** number of primary caregivers in enrolled families who screen positive for domestic violence and who complete a safety plan during the program year. **Denominator:** number of primary caregivers in enrolled families who screen positive for domestic violence during program year.	**See Benchmark IV (i)**	**PAT**: Domestic Violence Enhance Visitation Program, Personal Visit Record. **NFP**: Home Visit Encounter Form (collected at every home visit). No data is collected on other adults in the household. NFP records whether a safety plan was discussed, completed or reviewed during the home visit (Y/N). NFP reports on the increase in the number of safety plans developed compared to those with an identified need. **EHS**: local agency domestic violence safety plan	Among families with primary caregivers who screen positive for domestic violence, increase or maintain the percent who complete a safety plan, during Program Period 3 compared to Program Period 1.
Benchmark V. Family Economic Self-Sufficiency					
(i) Household income and benefits	Annually, the average total dollar amount of gross monthly income and benefits of enrolled families, among all program sites.[16] Outcome	**Numerator:** cumulative dollar amount of gross monthly income and benefits of enrolled families during the program year, among all Program Sites combined. **Denominator:** number of enrolled families, among all Program Sites combined.	**Completed by home visitor:** List of enrolled family members, birthdates, race, ethnicity, monthly gross income, type of medical insurance, U.S. citizenship. List of enrolled family members, monthly benefit reward for SSI, WIC, food stamps, unemployment insurance.	**PAT**: LSP Form; Basic Essentials (#34, Income). **NFP**: Demographics: Pregnancy Intake Form and Demographics Update Form; household income, government and community services. NFP records household income—from the client and any other adult who stays in the house for an average of four nights per week and who contribute to the client's support. **EHS**: Program Information Report; C35, C36, C42.	Increase the average total dollar amount of gross monthly income and benefits of enrolled families, during Program Period 3 compared to Program Period 1.
(ii) Employment or education of adult members of the family	Annually, among enrolled families without change in household	**Numerator:** number of household members who achieve an educational objective, among those	**Completed by home visitor:** List of adult family members, current educational level, planned	**PAT**: LSP; #12, 13, 14, 15, 16. **NFP**: Demographic Pregnancy Intake Form and Demographic	Increase the percent of enrolled families in which household members with an

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
	composition, the percent of household members in the program period who complete an educational or training objective.[17] Outcome	without change in household composition who set an educational or training objective, among all Program Sites. **Denominator:** number of household members who set an educational or training objective, among enrolled families without change in household composition, among all Program Sites.	educational training objective and date of projected entry, programs in which currently enrolled and hours working in program and projected data of completion, date of training completion.	Update Form; client education. NFP records education and employment—from the client and any other adult who stays in the house for an average of four nights per week and who contribute to the client's support. NFP reports on aggregate rates of benchmarks achieved (e.g., program completion, degree attainment) by adult household members at intake compared to 12 months; aggregate hours per month spent by adult household members in educational programs at Intake compared to 12 months; aggregate numbers of adult household members employed at Intake compared to 12 months; aggregate average hours per month worked by adult household members at Intake compared to 12 months. **EHS**: Program Information Report; C33a, C33b, C33c, C34a, C34b, C37a, C37b, C37c, C38a, C38b, C39, C40d, C40e, C40f.	educational or training objective complete the objective, during Program Period 3 compared to Program Period 1.
(iii) Health insurance status.	Annually, the percent of all eligible family members of all ages in the program period who have medical insurance.[18,19] Outcome	**Numerator:** number of eligible family members of all ages who have medical insurance, across all Program Sites. **Denominator:** number of enrolled family members of all ages with at least one member who is eligible for medical insurance.	**See Benchmark V (i).**	**PAT**: LSP; Basic Essentials, #33, medical/health insurance. **NFP**: Demographics: Pregnancy Intake Form, Demographics Update Form. NFP collects data on whether clients and other adults in the household have private, public or no insurance. **EHS**: Program Information Report; C1 and C3.	Increase the percent of all eligible family members of all ages who have medical insurance, during Program Period 3 compared to Program Period 1.
Benchmark VI. Coordination and Referrals for Other Community Resources and Supports.					

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(i) Number of families identified for necessary services	Annually, the percent of enrolled families for whom a needs assessment is completed for necessary services during the program period.[20] Process	**Numerator:** number of enrolled families for whom a needs assessment is completed for necessary services during the program period, among all Program Sites combined. **Denominator:** number of families enrolled during the program period, among all Program Sites combined.	**Completed by home visitor:** List of identified needs, identity of community resource for referral and date of referral, whether referral was completed and date of completion.	**No known evidence-based need assessment available.** **PAT**: Personal Visit Record; all items. **NFP**: Government and Community Services Form; all items. No data is collected on other adults in the household. "Need" is usually recorded in the client's chart, which referrals and service usage are recorded in the data system. Nurses assess needs for ALL clients. NFP does not break down service usage. "Need" is usually recorded in the client's chart, which referrals and service usage are recorded in the data system. **EHS**: Program Information Form; C40a, C40b, C40c, C40g, C40h, C40i and C44.	Increase or maintain the percent of enrolled families for whom a needs assessment is completed for necessary services, during Program Period 3 compared to Program Period 1.
(ii) Number of families that required services and received a referral to available community resources	Annually, the percent of enrolled families with identified needs who are referred to services for those needs**.**[13,20] Process	**Numerator:** number of enrolled families with identified needs who are referred to services during the program period, among all Program Sites combined. **Denominator:** number of enrolled families with identified needs during the program period, among all Program Sites combined.	**See Benchmark VI (i).**	**PAT**: Affiliate Performance Report (Section VI, Q1). **NFP**: Home Visitor Encounter Form; Use of Government and Community Services. No data is collected on other adults in the household. NFP records # and % of clients who receive various types of government and community services (38 specified types listed, with option of writing in three additional types under "other"). **EHS**: Program Information Report; C21d, C22.	Increase or maintain the percent of enrolled families with identified needs who are referred to those needs, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
(iii)Number of completed referrals	Annually, the percent of enrolled families who are referred to needed services and who receive those services during the program period.[13,21] Outcome	**Numerator:** number of enrolled families who are referred to services and who receive those services during the program period, among all Program Sites. **Denominator:** number of enrolled families who are referred to services during the program period, among all Program Sites.	**See Benchmark VI (i).**	**PAT**: Personal Visit Record; Screening Recommendations Record; follow-up on status of referral and whether or not completed. **NFP**: client's chart; number of completed referrals; Use of Government and Community Services. No data is collected on other adults in the household. NFP records # and % of clients who receive various types of government and community services (38 specified types listed, with option of writing in three additional types under "other"). **EHS**: Program Information Report; C15, C18, C19, C22, C22a.	Increase or maintain the percent of enrolled families who are referred to needed services and who receive those services, during Program Period 3 compared to Program Period 1.
(iv)Number of MOU's or other formal agreements with other social service agencies in the community	Annually, the total number of agencies with whom program has formal agreements or memoranda of agreements during the program period.[22] Process	Total count of all social service agencies with whom program has formal agreements or memoranda of agreement during the program period, among all Program Sites combined.	**Completed by Program Manager:** List of resource/agencies for which program has formal agreements, memoranda of agreement.	**PAT**: Program Management Records. **NFP**: Implementing agency documents; number of MOUs developed. NFP does not collect this information in our data system. **EHS:** Program Information Report; C48a, C50a.	Increase or maintain the total number of regular communication, formal agreements and memoranda of agreement that exist in the program, during Program Period 3 compared to Program Period 1.
(v)Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular	Annually, the total number of social service agencies with whom home visitors engage regularly during program period.[23] Process	Total count of all resources and agencies with whom home visitors have communication at least once quarterly, among all Program Sites combined.	**Completed by home visitor:** List of resources and agencies with which home visitor interacts at least quarterly.	**PAT**: Program Management Records. **NFP**: Community Advisory Board meetings; referral sources and linkages, Agency Profile Update Form. NFP does not record referral outreach/contacts in our data system. **EHS**: Early Childhood Task Force	Increase or maintain the total number of social service agencies with which home visitors engage regularly, during Program Period 3 compared to Program Period 1.

Benchmark/ Construct	Performance Measure	Operational Definition	DPH Supplemental Measurement Tool	Model-Specific Measurement Tools	Definition of Improvement
sharing of information between agencies				(ECTF) meetings (agenda, minutes, reports, committee updates, supporting documents); MOUs and Master List of MOUs indicating necessary construct fields (including verified point of contact, resource & referral database/guide); Program Management Records.	

Footnotes

[1] - The first trimester of pregnancy is 1-14 weeks gestation, inclusive.

[2] – Pregnancy includes that which resulted in elected or spontaneous abortion.

[3] – Inter-conception care is preconception care that occurs between pregnancies, and includes a set of interventions that identify and modify biomedical, behavioral, and social risks to a woman's health and future pregnancies. (CDC, *http://www. cdc.gov/ncbddd/preconception/whatispreconception.htm*).

[4] – A postpartum woman is a women who delivered a baby (now alive or dead) within the past two years and who is not currently pregnant.

[5] – Inter-birth spacing is the interval between an index birth and subsequent birth.

[6] - Schedule of well-child visits as recommended by the American Academy of Pediatrics.

[7] - Health insurance includes HUSKY A, HUSKY B, Fee for Service, SAGA, Charter Oak, Medicaid, Medicare, or Private Insurance.

[8] - Health and Safety Information topics will include: safe sleeping, car safety, Shaken Baby Syndrome, and environmental hazards.

[9] - Medical treatment is defined as MD visit, ER visit or hospitalization, as a result of injury (excludes well-child visits).

[10] – A suspected case of child maltreatment is that which has been reported to authorities. Authorities include law enforcement organizations, the State Department of Social Services, State Department of Children and Families, medical personnel, social workers, clergy, and home visitors.

[11] – A substantiated case of child maltreatment is that which has been confirmed by authorities. Authorities include law enforcement organizations, the State Department of Social Services, medical personnel, social workers, clergy, and home visitors.

[12] - First-time victim is a child who has been determined to be a victim of child maltreatment in the program period, and who has never had a prior determination.

[13] - A referral occurs when the home visitor facilitates for the family a warm link or appointment with a community resource to address an identified need.

[14] - A positive screen with an evidence-based screening tool indicates a need for corrective action or referral to professional services.

[15] – A safety plan is a set of strategies to ensure safety when a woman and her family at risk for domestic abuse. An example can be found at (*http://www.montekids.org/programs/butler/families/safety_plan/#worksheet*).

[16] – Federal poverty level is based on family size and monthly or yearly income, and is established by the federal government (*http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html*).

[17] - Potential benefits include: social security income, food stamps, WIC, TANF, and unemployment insurance.

[18] - Educational or training objective can include a high school degree, GED, post-high school education, or a job training program.

[19] - Medical insurance: includes HUSKY A, HUSKY B, Fee for Service, SAGA, Charter Oak, Medicaid, Medicare, or Private Insurance.

[20] - Eligibility for medical insurance excludes only individuals without a documented U.S. citizenship.

[21] –Necessary services include: food, housing, nutrition, exercise, drug abuse, alcohol abuse, access to medical care, financial assistance, job assistance, legal assistance, baby/child items or clothing, job hazards, medical conditions, worship, smoking cessation, breastfeeding, medical home, insurance, WIC enrollment, social service program enrollment, Healthy Homes, child development learning or support, mental health, job training, traditional school. Necessary services exclude those services monitored elsewhere in these measures, and include maternal depression and domestic violence.

[22] – A completed referral occurs when the home visitor receives confirmation from the family that action occurred as a result of a referral.

[23] – Formal agreements include board membership and associated meetings, as well as formal memoranda of agreements.

[24] - Includes referral contacts made on behalf of enrolled families, with whom provider interacts at least quarterly.

Parents as Teachers

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July 19, 2011

Donna C. Maselli, RN, MPH
Connecticut Department of Public Health
410 Capitol Avenue
MS #11 MAT
Hartford, CT 06134-0308

Dear Ms. Maselli:

This letter serves as the approval for the Connecticut state plan for the implementation of Parents as Teachers under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative formula funding opportunity for Fiscal Year 2011.

We appreciate receiving the comprehensive plan for this opportunity and we look forward to the expansions and enhancements to Parents as Teachers' in New Britain. Virginia will also increase its training capacity and increase the state and local continuous The national office is especially pleased with the attention to fidelity, professional development and continuous quality assurance. As the model developer, we stand ready to assist the state office, the Home Visiting Coordinator, affiliates and program staff with training needs and technical assistance, which are critical to yielding good outcomes. Compliance with Essential Requirements is important. Pam Langer, the Parents as Teachers state leader, will continue her fine work with you and can assist with local questions and concerns.

As indicated before, we look forward to a long and rich relationship with the State of Connecticut. Please feel free to engage us in any meetings or discussions related to the MIECHVI and Parents as Teachers. This is a true partnership indeed on behalf of all the children and families that will be served by this effort. Again, thank you.

Sincerely,

Cheryle F. Dyle-Palmer

Cheryle Dyle-Palmer, M.A.
Interim President and CEO

July 19, 2011

Donna C. Maselli, RN, MPH
Connecticut Department of Public Health
410 Capitol Avenue
MS #11 MAT
Hartford, CT 06134-0308

Dear Ms. Maselli,

Based on the information provided to your program developer, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your FY11 state submission for formula funds to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed Connecticut's proposed application and that it includes the specific elements required in the FY11 FOA; and
- NFP NSO is supportive of Connecticut's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

By requesting a model developer letter of support, Connecticut and its designee, agree to provide NFP NSO with a copy of the state application once submitted to HRSA that outlines how NFP will be included and any additional documentation to help support how the State will support implementation of NFP with fidelity to the model.

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the FY11 FOA, NFP NSO expects that Connecticut will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline what supports will be provided by the NFP NSO and the State's obligations, including:

- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:
  - Understanding the 18 required model elements;
  - Using NFP-specific implementation planning tools;
  - Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
  - Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.
- Ensuring that every team of nurses employed to deliver NFP will:
  - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
  - Receive adequate support and reflective supervision within their agencies;
  - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;

  - Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
  - Utilize ongoing nurse consultation for ongoing implementation success.
- Participating in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Ensuring that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes ™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

Nurse-Family Partnership will decline requests to implement NFP with adaptations which may compromise model fidelity. For any evaluation plan that will require participation of the agency staff or clients, the state commits to submit for approval to the NFP Research and Publication Communication (RAPComm). The RAPComm committee works directly with the evaluator to review client and site burden and to assure IRB approval as appropriate. Additional information on the RAPComm process can be found by clicking here.

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of online resources that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,

Erika Bantz
Director of Program Development
Nurse-Family Partnership National Service Office

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Donna C. Maselli, RN, MPH
Connecticut Department of Public Health
410 Capitol Avenue
MS #11 MAT
Hartford, CT 06134-0308

Dear Ms. Maselli,

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

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

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

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

- ***Comprehensiveness, Flexibility and Responsiveness*** of services which allow children and families to move across various program options over time, as their life situation demands.
- ***Transition planning*** respects families' need for thought and attention paid to movements across program options and into—and out of—Early Head Start programs.
- ***Collaboration*** is, simply put, central to an Early Head Start program's ability to meet the comprehensive needs of families. Strong partnerships allow programs to expand their services to families with infants and toddlers beyond the door of the program and into the larger community.

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

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

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

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

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

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

- Developmental screening, ongoing observation and assessment, and curriculum planning
- Medical, dental, and mental health
- Child development and education
- Family partnerships and goal setting
- Community collaborations to meet additional family needs

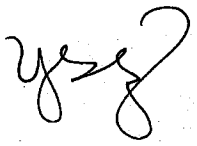
The relationship of the home visitor with parents or expectant parents is central to effective delivery of this program model. Through ongoing interactions in home visits and socializations, this continuity of the relationship becomes

the vehicle through which home visitors support and strengthen parents' or expectant parents' abilities to nurture the healthy development of their children.

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

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

Sincerely,



Yvette Sanchez Fuentes
Director, Office of Head Start

Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program
CFDA # 93.505 State of Connecticut Department of Public Health Formula Grant FY2011
Rev. 9/8/11

PROPOSED NARRATIVE BUDGET JUSTIFICATION

SALARY: **$122,475**

The originally budgeted 1.0 FTE for a Nurse Consultant will be split equally between two existing Nurse Consultants. In addition, 50% FTE for a Health Program Associate is requested to administer the program. The combined proposed effort is 1.5 FTE.

0.5 FTE Nurse Consultant Mary Emerling (HC 28, Step 6) to assist in the implementation of Connecticut's Home Visiting Program to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities, assure full contractual responsibility for fidelity and data collection, and other duties as described in Job Profile.
FY2012, 12-month salary: $39,600

0.5 FTE Nurse Consultant Donna Maselli (HC 28, Step 11) to assist in the implementation of Connecticut's Home Visiting Program to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities, assure full contractual responsibility for fidelity and data collection, and other duties as described in Job Profile.
FY2012, 12-month salary: $45,167

0.5 FTE Health Program Associate (HC 24 Step 11) to assist in the implementation of the Home Visiting Program to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities. Responsible for grants and contracts development, overseeing program and financial expenditure report monitoring and management, and other duties as described in Job Profile.
FY2012, 12-month salary: $37,708

FRINGE: **$81,407**

Fringe for the addition 0.5 FTE Health Program Associate is requested.
FY2012, 0.5 FTE Nurse Consultant: @65% = $25,740
FY2012, 0.5 FTE Nurse Consultant: @ 67.62% = $30,542
FY2012, 0.5 FTE Health Program Associate: @ 66.63% = $25,125

TRAVEL: **$3,000**

Travel for two nurse consultants to attend the administrator's 2-day training session in Denver, Colorado, scheduled for November, 2011.
There is no proposed changed in travel funds.
FY2012, Airfare: $800 per person x 2 persons = $1,600
FY2012, Per Diem: $38 per day x 3 days x 2 persons = $228

FY2012, Lodging: $250 per day x 2 days x 2 persons = $1,000
FY2012, Ground Transportation: $60 x 2 persons = $120
FY2012, Taxes, tips, etc: $16 x 2 persons = $52

CONTRACTUAL: $767,522

Generations Family Health Center, $46,643
Additional funds of $3,147 are requested to permit an increase in client recruitment expense from 5 months to 12 months, and to permit an increase in in-state travel funds for client services. The contract will establish home visiting services in Windham, CT, for home visitors, fatherhood initiatives, literacy support, prepared childbirth educators, and other planning, staffing, supervision, staff training, supplies and equipment, developer fees, travel and all other associated costs with full implementation of the Parents As Teachers affiliate model.

TEAM Inc., $46,643
Additional funds of $8,069 are requested to purchase educational materials and increase client recruitment efforts. The contract was initiated in FY2011, in Ansonia and Derby, CT, for planning, staffing, supervision, staff training, supplies and equipment, developer fees, fatherhood initiatives, literacy support, prepared childbirth educators, travel and all other associated costs with full implementation of the Early Head Start Home Visiting model.

South Eastern Visiting Nurse Association, $335,000
A reduction of $165,000 is requested to the new contract for implantation of the Nurse Family Partnership model in New London, CT to serve approximately 100 at-risk, low-income, pregnant families in the New London area. Total. Three staff are estimated at 39 weeks for the fiscal year, reduced from 52 weeks, and two additional staff are estimated at 13 weeks for the fiscal year. In addition, Nurse Family Partnership Administrative Fees are waived.

Hospital of Central CT, $275,000
There are no proposed changes to this contract. Funds for a new contract to implement the Parents as Teachers model in New Britain, CT. Cost includes planning, staffing, staff supervisors, staff training, supplies and equipment, developer fees, prepared childbirth instructors, travel and all other associated costs with full implementation.

Department of Children and Families, $56,604
Additional funds for a contract initiated in FY2011 for an Early Child Health Information Network Consultant to build on the DPH's comprehensive data sharing and information exchange system and state plan. Includes programming, testing, modifications and other costs.

Planning Consultant, $10,000
Funds are requested for a planning consultant to facilitate two Home Visiting Advisory and ad hoc meetings in FY2012 and 5 meetings in FY2013. There is no proposed changed in the budget.
FY2012, meeting preparation and facilitating: 10 hr/meeting x 2 meetings x $100 per hr = $2,000

FY2012, Preparatory and follow-up phone calls: $100 per hour x 21 hours = $660
FY2012, Meeting nutritional supplements: $20 per meeting x 2 meetings = $40
FY2012, In-state travel: $0.55 per mile x 52 miles x 2 meetings = $57
FY2013, meeting preparation and facilitating: 10 hr/meeting x 5 meetings x $100 per hr = $5,000
FY2013, Preparatory and follow-up phone calls: $100 per hour x 20 hours = $2,000
FY2013, Meeting nutritional supplements: $20 per meeting x 5 meetings = $100
FY2013, In-state travel: $0.55 per mile x 52 miles x 5 meetings = $143

OTHER: **$4,299**

Nurse-Family Partnership Data Transmission Cost, 3,339
Requested funds are adjusted for a decrease rate of extraction to once annually. Create and transmit a delimited text file that contains all raw data from Efforts to Outcomes (ETO™) database for the DPH. Instructions for downloading data will be provided when the data files are ready. Cost includes consultation on data elements and variables, Facilitate necessary data sharing agreements, Project coordination, Analysis of requirements, Solution design, Create interface, Establish repeatable procedures, testing, and production. Includes a one-time set-up fee, plus quarterly transmittal annual fee.
FY2012, Set up fee: $3,275
FY2012, Annual transmittal fee: $64

Nurse-Family Partnership Administrator Training, $960
Requested funds are reduced, because there is a need for only administrator training. Training fee to accompany travel costs associated with administrator orientation training in Denver, Colorado in November, 2011. This is a 1¼ -day face-to-face session. The purpose of the training is to provide an administrative overview of the model intervention and a forjm for administrators to connect with one another and model staff. Tis oritination program includes the following: roles and responsibilities of administrators, operations and sustainability, promoting high quality model implementation, program development, policy and government affairs, strategic relations, finance, marketing, and nursing.
FY2012, $480 x two participants = $960

INDIRECT: **$44,335**
Adjusted for an additional 0.5 FTE Health Program Associate.
0.5 FTE Nurse Consultant: @ 36.2% = $14,335
0.5 FTE Nurse Consultant: @ 36.2% = $16,350
0.5 FTE Health Program Associate: @ 36.2% = $13,650

FY 2011 TOTAL: **$1,026,087**