PROJECT ABSTRACT

Project Title: Connecticut Maternal, Infant and Early Childhood Home Visiting program
Applicant Name: Office of Early Childhood, 165 Capitol Avenue, Hartford CT 06106
Project Director Name: Karen Foley-Schain, M.A., M.Ed., LPC
Contact: Office 860-713-5013, Fax 860-713-7040
Email: Karen.Foley-Schain@ct.gov **Web Site:** www.ct.gov/oec

High rates of poverty, homelessness, crime, domestic violence, maternal depression, child maltreatment, substance abuse, and teen parenting negatively affect parenting, maternal and child health, child development, and school readiness. The goal of this program is to improve health and developmental outcomes for children and parental capacity by expanding Connecticut's high-quality home visiting program. Connecticut is requesting a grant for $9.4 million. Program objectives include: 1) Enhancing and expanding existing MIECHV and state funded home visiting programs, 2) Sustaining progress by integrating MIECHV into the early childhood system, 3) Improving the expertise and competency of home visiting program staff, 4): Assuring quality services and model fidelity. To achieve this, Connecticut will expand its MIECHV and state funded Parents as Teachers (PAT) model and Child First model home visiting programs. PAT works with vulnerable families while the mother is pregnant or shortly after the birth of the baby through age five. The PAT program will be enhanced with a focus on fathers and mothers' intimate partners. Child First is an intensive intervention that works with pregnant women and at-risk children zero to age six and their families. Child First will focus on outreach to high-risk and hard to reach families. The state's total service capacity for the period of 10/1/13 to 9/30/14 was 1,104 families. The current number of eligible families served in that time was 1,113. The average cost per family was $7,515. None of the families currently served will be served with 2015 funds. These funds will be used to expand capacity. The number of new families to be served with FFY 2015 fund is 2,624 over the two years and seven months of the grant.

Connecticut will incrementally expand PAT and Child First home visiting in the following high-risk communities with unmet need: Ashford, Bloomfield, Bolton, Bridgeport, Bristol, Canterbury, Colchester, Danbury, East Hartford, East Haven, Fairfield, Glastonbury, Griswold, Hartford, Killingly, Lisbon, Manchester, Mansfield, Meriden, Milford, New Hartford, New Haven, New London, North Branford, Norwich, Plainfield, Putnam, South Windsor, Southington, Sprague, Sterling, Stratford, Torrington, Trumbull, Vernon, Wallingford, Waterbury, West Hartford, West Haven, Winchester, Windham and Windsor.
The State will coordinate with appropriate health, human services and educational entities to achieve the goals of the programs. Connecticut will participate in the national evaluation and conduct research on its programmatic area of emphasis to identify methods for achieving high quality fatherhood focused home visiting services. The Office of Early Childhood, the lead agency for the grant, will monitor sub-recipients to ensure that local implementing agencies are meeting programmatic and contractual goals. At least one site visit will be held with every local implementing agency once a year. Benchmark and site data will be reviewed quarterly.

Annotation: This project will expand Connecticut's high quality home visiting program to address problems adversely affecting parenting and child outcomes in order to improve the health and development of children.

INTRODUCTION:

The Purpose: The purpose of the project is to build upon the significant experience and history of Connecticut's high quality evidenced-based home visiting program by enhancing and incrementally expanding the efforts of existing local implementing agencies (LIA) which have proven to be effective in improving outcomes for children and families who reside in high-risk communities.

History: Connecticut (CT) has a rich history of implementing high-quality home visiting programs that are part of a comprehensive early childhood system. This history now includes a significant expansion of evidenced based home visiting under the MIECHV formula and expansion grants. Under this expansion the state established new programs within twenty-four implementing agencies. Through these and other efforts the state continues to make significant progress toward implementing a high-quality home visiting program and is ready and able to go to scale. To achieve this goal the state proposes to enhance and expand existing MIECHV and state funded home visiting programs to address unmet need in high-risk communities.

Previous Steps: CT has taken many steps to develop its high-quality home visiting program, beginning with state funding for two LIAs in 1995. Since that time the state funded program, which uses the evidenced based Parents as Teachers (PAT) model, has grown from two to forty two LIAs. The goal of these services was to address the risk factors that made parents vulnerable to abusing and neglecting their children and, ultimately, to reduce the number of children substantiated by the child welfare system as abused or neglected. Today, the program provides services through all of the state's 29 birthing hospitals with expanded programs in two urban areas, Hartford and New Haven. Roughly 8,000 first-time mothers are screened at these hospitals on the maternity ward and in the prenatal clinics, and elsewhere in the community each year. Of those screened more than 2,300 families receive home visiting services from 125 home visitors every year, including 12 male home visitors who work specifically with fathers and mother's intimate partners. Since its inception the state funded PAT program has provided comprehensive home visiting services to 9,598 families. Under the CT MIECHV expansion grant the PAT program was expanded through 14 additional LIAs including hospitals, child guidance clinics, federally qualified health centers, family resource centers, city boards of education, city health departments and other community based organizations.

The Child First model was developed in Bridgeport, Connecticut in 2001 as a community response to the needs of young vulnerable children and their families, especially children with emotional and behavioral problems. These children were living in families with multiple challenges, and were exposed to major stress and trauma. A randomized controlled trial of Child First, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), demonstrated statistically and clinically significant program outcomes for children and families. With these significant outcomes and a growing demand for early intervention and mental health treatment services for vulnerable young children and families, Child First began replicating the model in CT in 2010 through child mental health agencies and hospitals. Replication for the first 10 sites was funded by local and national philanthropy, grants from the State Department of Education (SDE) and Children and Families (DCF), and a Project LAUNCH grant from SAMHSA. These sites today are sustained primarily by state funding through DCF. In 2013,

Child First was replicated and expanded in eight locations with MIECH expansion grant funding CT. Today, Child First has serves approximately 1,000 children a year with 40 teams consisting of a licensed master's level mental health clinician and a bachelor's level care coordinator.

Collaboration with state and other agencies: In 2013, state legislation (Public Act 13-178) called for the Office of Early Childhood (OEC), the new state lead agency for the MIECHV grant, to provide recommendations for coordinating the home visiting programs within the early childhood system. The recommendations, due to the CT General Assembly December 1, 2014, are being developed with the Early Childhood Cabinet, state agencies and others. The recommendations will include: Development of common outcomes across programs; Shared reporting of outcomes and information on existing gaps in services; A core set of standards and outcomes for all programs including a monitoring framework; A core set of competencies and required training for all home visiting program staff; Coordinated training for home visitation and early care providers on cultural competency, mental health awareness, child trauma, poverty, literacy and language acquisition; Home-based treatment option for parents suffering from severe depression; and Intensive intervention services for children with mental, social or emotional issues.

The OEC is the state agency charged with fostering cross-systems integration, coordination, and collaboration at the state and local level in order to enhance the health and well-being of young children, families and communities. The OEC brings together leadership, expertise, and a wide range of early childhood and family support services that were formerly at five state agencies. The goal is to build an integrated early childhood system that includes home visiting services.

The OEC administers the state's Child Abuse and Treatment Act (CAPTA) Title II grant, the Child Care Development Fund (CCDF), Head Start and Early Head Start collaborative office, and the State Advisory Council on Early Childhood and Care authorized by the Head Start Act. The OEC also manages the state's school readiness preschool program and childcare licensing and monitoring staff. The state is planning to transfer the Individuals with Disabilities Act (IDEA) Part C and Part B to the OEC in the spring of 2015. The OEC commissioner is chair of the Early Childhood Comprehensive Systems grant. Through these programs are other efforts, representatives from the Public Health (DPH), Children and Families (DCF), Social Services (DSS), Mental Health and Addiction Services (DMHAS), Education (SDE), the Office of the Child Advocate (OCA) are involved in planning and developing the early childhood system are. In addition, others involved with early care and education, health care, developmental screening, children's mental health, domestic violence, and parents are participating partners.

The problem: There is no single problem facing the vulnerable families in CT, instead there are a multitude of challenges that negatively affect parenting, maternal and child health, child development, and school readiness. In 2010, DPH conducted a statewide needs assessment for the MIECHV grant program. It found that CT had high rates of poverty, unemployment, homelessness, crime, domestic violence, maternal depression, child maltreatment, substance abuse, and teen parenting. Since that time these problems have not abated. In fact, the number of children living in poverty in CT continues to remain stubbornly high, increasing 17 percent since 2008. There are roughly 12,000 children born into poor families each year with one or more risk factors for abuse or neglect or poor child development. About 5,000 children are born to first

time parents with roughly 2,200 are born to teens. About 12 % of the mothers received late or no prenatal care (CT Voices, 2013). In 2013, 15 % of children were living in poverty and the number of Black and Hispanic children below 200 % of poverty was 155,000. The number of women and children receiving WIC (Women, Infants and Children supplemental nutrition program) was 54,284, and the number of children enrolled in Medicaid and CHIP was 333,231. Demographic data shows that the proportion of children at risk due to poverty varies greatly across Connecticut, from less than 1% in some suburban communities to 20% in the urban periphery and rural areas, and more than 38 % in the urban communities. Examples of these outcomes include:

- A high rate of premature births (8 percent) and low birth weight babies (10 percent): Rates are 4 percent higher among racial and ethnic minority groups. (Kids Count Data Base).

- The widest gap in the country for educational performance between its poor and wealthy students: The gap disproportionately affects minority students, primarily African-American and Latino children. National progress tests given to fourth and eighth graders show that poor students in Connecticut performed at dramatically lower levels than their wealthier peers — sometimes up to three grade levels behind (CT Education Reform, Inc).

- High rates of substantiated child abuse and neglect: The Care line at the state child welfare agency received over 96,000 calls in state fiscal year 2013. Fifty percent of these reports involved suspected abuse or neglect, of which over 50 percent were accepted for investigation, and approximately, 6,800 were substantiated (DCF Town Pages).

The Intervention: CT is proposing to intervene with its preventative PAT and early intervention Child Frist home visiting services. CT will rapidly increase enrollment and retention in high-risk communities identified in the statewide needs assessment by enhancing and expanding the capacity of existing state and MIECHV funded LIAs to provide home visiting services.

PAT: Connecticut will expand its PAT program by providing grant funds to 19 LIAs currently using the PAT model. Of these, seven are receiving state funds and 12 are receiving MIECHV funds (five of the MIECHV funded agencies also receive state funds for PAT). The grant funds will be used to hire twenty-five new home visitors, 19 traditional and 6 focused on fathers and men. The home visitors will engage high-risk families while the mother is pregnant or shortly after the baby is born and continue services through the first five years of the child's life. The home visitors will use the PAT model to promote positive parenting, healthy child development and school readiness. In addition, the fathering home visitors will provide PAT services specifically for fathers and mother's intimate partner. The PAT model includes weekly home visits, the use of a 'state of the art' parenting curriculum, wrap-around health and community services for the family.

Child First: CT will expand its Child First home visiting program in four urban areas; Hartford, New Haven, Waterbury and New Britain. Child First is an intensive home visiting intervention that reduces mental health, developmental, and learning problems, and prevents abuse and neglect. Child First uses two professionals working together as a team with a very high risk family in the home: (1) a bachelor's level care coordinator connects children and families to

needed services and (2) a master's level, licensed, mental health clinician who provides a psychotherapeutic intervention. Child First is focuses on the relationship between the primary caregiver (mother, grandmother, foster parent, relatives) and one or more identified children in the home. The model also works with the whole family to create a safe, nurturing environment and connect all members of the family with needed services and supports. Child First works with pregnant women and children zero to age six with emotional and behavioral health issues facing risks that may threaten healthy development including maternal depression and other mental health disorders, domestic violence, homelessness and substance abuse, and other challenges.

The Benefit

The PAT program has been shown to benefit parents and children that participate by promoting parental resilience, knowledge of parenting and child development, and the social and emotional competence of children. The rigorous studies reviewed by HomVEE on PAT showed that the program made a positive difference in the lives of high risk families struggling because of low income, low levels of education, language barriers and other challenges. PAT has also shown to be effective among diverse groups of parents including African Americans, teen and single parents, and Latinas (Wagner, 2001, 1999, 1996). In fact, the research demonstrates the most beneficial effects of the program are for very low-income families with children at the most risk of poor developmental outcomes, including Latina and African American families. For example, the study focused on Latina families, found that the PAT program "increased the mother's sense of efficacy and ability to organize the child's environment in stimulating ways." The research found a clear connection between increased language and literacy promoting behaviors among Spanish speaking mothers and improved scores among the children in receptive language ability. Children of Latina mothers showed positive effects at three years of age on measures of cognitive, communication, self-help, and social development. These findings were confirmed in both univariate and multivariate analyses. The relationship between PAT participation and positive development extend to the full sample in the areas of cognitive, social and self-help development. The study with a high percentage of African American families, showed that PAT is as effective - and likely to be more effective - with families of children who are at most risk of poor developmental outcomes (Wagner, 1996). A study focused on teen parents found significant improvements in parenting and significant increases in their children's cognitive development. The study also found no opened cases of child abuse or neglect and a significant reductions in the in the rate of repeat pregnancies among the teens.

Ongoing evaluation of the program has shown that the program is meeting its goals. The research has shown that the high risk families participating in the home visiting program have low rates of substantiated abuse and neglect, 1.3– 4.4 percent over a four year period, far less than would be expected for a similar high-risk population of families (Damboise, 2010). In addition, the vulnerable families who participate in the program show significant improvements in parenting capacity, attitudes and behavior, make significant gains in completing high school, becoming employed, and in their knowledge and use of community resources, and in meeting the developmental and health care needs of their children (Hughes, 2014).

Child First serves the most vulnerable and at-risk young children and families. It has shown positive results in the areas of child development and school readiness, maternal health,

reductions in child maltreatment, and linkages and referrals, as evidenced by the research reviewed by HomVEE. A Child First randomized controlled trial in 2001 demonstrated that with the Child First intervention, compared to Usual Care controls, Child First children were 68 % percent less likely to have language problems and 42% less likely to have aggressive and defiant behaviors; Child First mothers had 64% lower levels of depression and/or mental health problems; Child First families were 39 % less likely to be involved with child protective services, sustained at 33% at 3 year follow-up; and Child First family members had a 98 percent increase in access to community services and supports.

Similar to the population that participated in the randomized controlled trial, 88 % of families in CT are receiving Medicaid/HUSKY, 61 % are single or teen parents, 43 % of mothers suffer from maternal depression, 28 % have reported domestic violence, 38 % have reported a history of substance use by themselves or their partner, and 38 % have reported incarceration of themselves or their partner (Internal evaluation data, March 2013). Experienced Child First sites are achieving outcomes similar to those in the original randomized controlled trial. Data for the 10 sites showed a clinically significant change in at least one important measure. Eighty-nine of children and families showed improvement in at least one area, 69 % in at least two areas, and 54 percent in at least three areas. In almost all of these areas, these sites have statistically significant results of $p<0.0001$ and a Cohen's D between 0.68 and 1.12 demonstrating large effect sizes. Results of improvement in specific areas showed: 87 percent improvement in emotional/behavioral problems or social competence, 78 % improvement in language development, 80 % improvement in parent-child relationship, and 80 % improvement in maternal depression.

Programmatic Areas of Emphasis: CT will focus on two areas of programmatic emphasis:

- **Emphasis 6: To support a family centered approach to home visiting.** This programmatic emphasis will assist PAT in reaching its desired outcomes by engaging residential and non-residential fathers and mothers' intimate partners in home visiting services focused on gender related matters including employment and education, the father's sense of himself as a leader within his family, and as a nurturing father to his child.

- **Emphasis 5: To reach high-risk and hard-to-engage populations.** Child First families are often socially isolated, with limited access to resources. They frequently are afraid to seek help because of fear that they will lose their children or be deported. Many have had prior experiences with the "system" in which they felt disrespected and poorly treated. In order to engage and serve these families, very significant efforts must be directed to building trust and mutual respect. Child First will focus on finding and engaging these very high risk families.

NEEDS ASSESSMENT

Description of Current MIECHV Program: The CT MIECHV program uses four home visiting models to improve family health and well-being, school readiness and family self-sufficiency, and reduce child maltreatment in 24 high-risk communities across the state identified in the 2010 needs assessment.

Status of the Current program: Today 14 LIAs use PAT, 8 use Child First, 1 uses Early Head Start (EHS), and 1 uses the Nurse Family Partnership (NFP). PAT and Child First are funded through the MIECHV expansion grant. EHS and NFP are funded through the MIECHV formula grant. The state's total service capacity is 1,104. The number is based on the number of families the LIAs agreed to serve in their legal agreement each year. The number of families served in the one year period from 10/1/13 to 9/30/14 is 1,113. The cost per family was $ 7,515. The cost was calculated by dividing the total number of families served into the actual expenses for the same period – 10/1/13 to 9/30/14. The number of families to be served with the FFY 2015 is 2,624.

Data detailing the number of families served from the period of 10/1/13 to 9/30/14, the number of families served to date, the number home visits to date, the cost per family for the formula and expansion grant, the number of continuing and new families for the new grant period, the impact of the new program overall and the number of new families to be served with 2015 funds are each provided by community, model, and LIA in Attachment 1 – Tables 1, 2, and 3. In addition, trend data on enrollment and engagement and the number of home visits is provided in Graphs 1-figures 1 2, and 3. These figures show significant and continued growth of the programs.

Rationale for the Communities to be served: The DPH statewide needs assessment identified a set of community risk-factors that established the need for the PAT and Child First programs. For PAT, it focused on the unemployment rate, high rates low birth weight, and high rates non-private insurance at birth. For the Child First program, it looked at the percent of young children living in poverty, low third grade school achievement, high school dropout rates, and excess rates abuse and neglect. The needs assessment was updated for this grant. The update focused on data that would identify where the priority populations for the MIECHV grant reside, specifically those most likely to benefit from PAT and Child First. The update examined the communities identified in the initial needs assessment and in surrounding suburban and rural communities where poverty has been spreading and re-clustering in CT - areas where the need for services is very high (Katz, B. 2008).

Since the PAT program works primarily with pregnant women and new mothers and their families, data on teen births, and the number of births to mothers on public insurance was reviewed. The most recent data confirms that the need for PAT remains high in the communities currently served and found communities of high risk and unmet need in the surrounding towns. For Child First, the updated needs assessment reviewed the number of children receiving free or reduced price lunch and the number of families on public insurance. The data indicate that the need continues for Child First in the communities it is serving and found communities of high risk and unmet need in the surrounding towns. PAT and Child First will be provided in the communities currently served and in the surrounding towns. In addition, Child First will be expanded in the cities of Waterbury, New Haven and Hartford. The updated needs assessment found very large populations of high-risk families with unmet need that would benefit from Child First services in these communities. These cities have high concentrations of children (age 0 to 4) living in poverty; Hartford 37 %, New Haven 28.9 %, and Waterbury 28.3%. Waterbury ranked third in the state for excess low birth weight and it ranked fourth for the number of teen births. The teen birth rate for Waterbury was more than twice the statewide average. Given this need, PAT home visiting will also be expanded in Waterbury. A list of the communities to be served, with a brief description and the data that provided the rationale discussed above is included in ATTACHMENT 1 – Table 4.

Programmatic Areas of Emphasis

Programmatic Area of Emphasis 6: PAT Family Centered – Father Focused Home Visiting

Why does family centered – father focused home visiting matter to child development and well-being? Many studies have been conducted to better understand the role fathers play in the lives of their children. A meta-analysis of father involvement (University of Guelph, May 2007) shows that infants of highly involved fathers, as measured by the amount of interaction, including higher levels of play and care giving activities, are more securely attached and cognitively competent at 6 months. By one year they continue to have higher cognitive functioning, are better problem solvers as toddlers and are also better academic achievers. Fathers also indirectly influence the physical health and well-being of their children through facilitating optimal health outcomes for mothers when they are emotionally supportive of the baby's mother. Single mothers without the support of the father are twice as likely as married mothers to experience a bout of depression and experience higher levels of stress, suggesting that fathers have a positive impact on maternal health and child well-being. Father-child bonding and attachment has also been shown to be a protective factor against child abuse, neglect and abandonment. While fathers abuse their children less often than mothers do, the severity of the abuse by fathers tends be much greater.

A 2004 ethnographic study about the experience of parents in the state funded PAT home visiting program found that while fathers benefited from home visiting – with some reporting that the experience was transformative – there were a number of barriers to fully engaging them in the services. The barriers included scheduling conflicts, cultural attitudes, the small percentage of fathers who lived in the home with the mother and the baby, and conflicts that grew out of family dynamics and relationship issues. (Black, 2004). To address these barriers, beginning in 2011, the state funded PAT program hired fathering home visitors. By 2013, it had 12 fathering home visitors working in 11 LIAs. To date all of the home visitors hired in this role has been men. The fathering home visitors have made a few changes in program practice. The changes include more evening home visits and meeting with fathers in their home at times when the baby is not present, and working with non-residential parents and mother's intimate partners. In addition, the fathering home visitors focus more on gender related matters including employment and education, the father's sense of himself as a leader within his family, and as a nurturing father to his child.

A three-year study conducted in 2011 (Black, 2011) about the lives of the fathers participating in the state funded PAT program found that they are facing a number of issues in their lives. They have limited education, difficulty finding jobs, lack parental role models, have histories with the criminal justice system – and are unsure of what it means to be a parent. The fathers expressed an interest in learning to create and sustain open communication with their children and in guiding and nurturing them. At the same time they emphasized the importance of their role in disciplining their children and in learning alternatives to corporal punishment. Fathers also expressed interest in getting help to navigate various community systems and the opportunity to learn from other fathers. The researchers found that the fathers benefited from the supportive, empathetic and nonjudgmental relationships a trained male home visitor can provide. In addition, a focus group held in March 2011, found that fathers working with fathering home visitors were

overwhelmingly supportive of the program. They said they benefited from the expertise of the home visitor concerning child development and parenting. Further they received referrals from the home visitors and noted that at times they relied on their help, advice and counsel.

The MIECHV program will be assisted in meeting its desired outcomes with a gender-specific and culturally sensitive approach to the home visiting that promotes the engagement of fathers and men and recognizes their diverse needs. The approach draws from the literature on fathers to provide a framework for understanding of their needs, circumstances and perspectives. Recommendations for promoting positive parenting with high-risk fathers were developed from the Fatherhood Involvement Study (report completed December 2010) and inform the father home visitor role. Those recommendations include:

- Provide access to a male home visitor who has strong interpersonal skills, and who serves as a supportive, nonjudgmental, empathic listener.

- Home visitors should perform the role of advocate or cultural broker, and help fathers navigate dominant institutions, particularly the courts, child support enforcement, prospective employers, workforce training agencies, and banking institutions.

- Establish parenting groups with skilled male group facilitators, who are fathers themselves.

- Teach nurturing parenting strategies and disciplinary practices, which include alternative strategies to corporal punishment.

- Corroborate fathers concerns that their children need to learn the codes that govern violence in some neighborhoods within a context of teaching a philosophy of self-defense.

- Establish collaborative relationships with couple's counselors so that relationship and co-parenting issues can be voluntarily addressed.

In the past two years the state funded PAT program has provided home visiting services to 244 fathers across Connecticut. In 2013, 64 % of fathers remained in the program at least six months, and 45 % remained in the program for at least one year. Another 20 % of the fathers who enrolled in the home visiting services in 2011 continued services for two years. Of 58 fathers entering the program in 2013, 21% of the fathers that enrolled in 2013 were teen fathers and 41% had not yet earned a high school degree or GED. Forty-four percent of fathers reported they were currently employed and 87 % reported they were struggling financially. Participating fathers came into the program with positive attitudes of fathering yet, scored high in rigid parenting. While outcomes for participating fathers are preliminary, they do indicate less rigid parenting attitudes after one year (indicating less risk for abusive behavior) and more community involvement after the first six months of program participation. The fathers typically received two home visits out of an attempted nearly three visits, which is comparable to traditional home visiting programs. The fathering home visitors have been employed for an average of two years, with five of the twelve employed by the program since 2011. These early results are encouraging and support the continuation of the fathering home visiting effort under MIECHV. The MIECHV PAT programs hired 12 male fathering home visitors when the program opened in 2013.

Description of areas 5: To reach high-risk and hard-to-engage populations. Child First families are often socially isolated, with limited access to resources. They frequently are afraid to seek help because of fear that they will lose their children or be deported. Many have had prior experiences with the "system" in which they felt disrespected and poorly treated. In order to engage and serve these families, very significant efforts need to be directed to building trust and mutual respect. Child First will focus on finding and engaging these very high risk families.

Many Child First sites in Connecticut are currently funded by DCF and have been required to carry at least 50 percent of their caseload as families currently involved with DCF. Many more families served have a history of past DCF involvement. MIECHV funded sites have also had a high level of referrals from DCF. Despite the high risk of the population Child First serves, and the inherent difficulties in identifying and engaging this population, all Child First sites have shown a strong, positive track record of engagement. Within our MIECHV funded sites, on average only 3.5 days transpire from the time a team is assigned to a family until the first successful contact. Ninety percent of the time, Child First teams make their first successful home visit with a family within 48 hours of first successful contact. From January to August 2014, of those discharged from the program over two thirds completed a planned discharge. (Another 10-15 percent makes substantial progress in their work with Child First the program, but do not complete the formal termination process.) By focusing on outreach on hard to find and challenging to engage Child First is reaching CT's most vulnerable children.

METHODOLOGY

Goal: CT will continue to make significant progress toward implementing a high quality evidenced-based home visiting program by enhancing and incrementally expanding the efforts of existing LIAs which have proven to be effective in improving outcomes for children and families who reside in high-risk communities.

Home Visiting Models: CT is proposing to enhance and expand its effective evidenced-based prevention focused PAT and intervention focused Child First home visiting programs.

Description of the Models:

Parents as Teachers Model: The goal of the program is to address family expectations, strengths and needs in these target areas**:** Development Centered Parenting addresses developmental topics such as sleep, attachment, nutrition, discipline, routines and transitions, safety and health throughout the child's development; Parent Child Interaction provides opportunities to encourage quality interactions between children, parents and other family members; Family Well Being encourages families to provide healthy environments for parent and children to grow and develop, nurture relationships, and strengthen social-emotional development; Healthy Families promotes the overall health and wellness of families including their physical, social, cognitive and emotional well-being, Parent Life Outcomes promotes parents in achievement of personal and family goals.

Home visiting is free and voluntary. It is offered to pregnant women and new mothers who reside in high-risk communities and are among the priority populations for the MIECHV grant.

Families are identified and offered services prenatally whenever possible or shortly after the birth of their child. With its emphasis on family centered practice, extended eligibility requirements were developed to encourage and facilitate additional involvement by non-resident parents, including fathers, and new significant caregivers for children.

At the first home visit, the clinical supervisor and home visitor begin to establish rapport with the family and gain a better understanding of their needs, any adverse childhood experiences, and their current circumstances through a structured assessment. Home visits are scheduled for one (1) hour to ninety (90) minutes unless special circumstances warrant additional time. Home visits usually take place in the parent's (or primary caregiver) and child's home. The family's home is defined as anywhere the family is staying including shelters, hospitals (if the parent or child is admitted), and family or friends' houses. Other visits that take place outside the home are usually be counted as "out of home or office visits".

The PAT model is curriculum based. It stresses the unique developmental needs of both the parent and child during each stage of child development. Home Visitors prepare for each home visit by reviewing the home visit record from previous visits, identifying topic(s) within the targeted areas to cover, developing a visit plan, reviewing the parent's 'life action plan' to discuss progress and next steps, they prepare and determine if an Ages and Stages Developmental Questionnaire (ASQ-3) or Social and Emotional (ASQ-SE) screening is due for any child in the family, and determining strategies to empower and support the family through life skill development. Home visitors demonstrate, model, and teach parents life development skills, including self-advocacy, problem solving, and negotiation. The PAT model and philosophy is based on family-centered practice. The home visiting program supports the parent(s) within their network of significant others that might include grandparents, siblings, aunts, uncles, partner and others. Home visitors will encourage the participation of significant others in the program whenever it is appropriate while being sensitive to the possibility of complex interpersonal dynamics within these networks. Every child residing in the household is entitled to receive early intervention and support services. Parents who have more than one child usually need more support to ensure child safety and education while balancing the different developmental needs of each child. Based on various factors such as multiple children at varying developmental stages, cognitive abilities of parents, behavioral issues or medical conditions, a family can receive more than one visit per week. The minimum services to be provided to each child and family by the home visitor include the Ages & Stages Child-Development and Ages & Stages Social & Emotional Questionnaires; tracking immunizations and compliance with well child visit compliance; in-home activities using curriculum; providing parents with information and referring them to community resources; educating parents about sibling bonding.

Although program guidelines and policy are created, families are unique and circumstances vary. To meet the needs of various families, additional guidelines and protocols have been established in Connecticut to address challenges related to working with parents with cognitive or developmental delays, providing intensive support for parents in a crisis that threatens a parent's ability to function effectively or become unmanageable for the home visitor, working with a family after miscarriage or death of a child. Each program site holds an annual celebration to recognize all the families participating in the program. Special acknowledgement is given to

families that graduate from the PAT program. Program volunteers, advisory committee members and interns are included in these events and recognized for their work.

Reflective Supervision: Families who participate in the PAT program have complicated lives and complex needs. Providing services for these families presents many challenges for all staff. Clinical supervision assists home visitors to address the complicated issues as well as the experience of the home visitor working in their families' homes. A master's level clinical supervisor provides reflective supervision on one-to-one, in groups and in joint home visits. In addition, the clinical supervisor performs several administrative tasks, teaches new skills and supports the professional development of the home visitor, and helps them to work through their feelings and reactions to their challenging work with families.

Description of Child First: Child First is an intensive home visiting intervention that decreases mental health, developmental, and learning problems, and prevents abuse and neglect. The model works with pregnant women and children zero to age six who have emotional and behavioral issues and are facing risks that may threaten healthy development (e.g., maternal depression, domestic violence, homelessness, parental substance abuse, and/or other traumatic events). Child First is a dyadic intervention that focuses on the relationship between the primary caregiver (mother, grandmother, foster parent, relatives) and one or more identified children in the home. The model also works with the whole family to create a safe, nurturing environment. The Child First model is based upon neuroscience findings on "toxic stress," including the long term health effects of adverse childhood experiences (ACEs) and the impact of environmental stress on early brain development. The Child First model works to decrease the source of this stress and enhance the quality of the relationship between parent and child. Specifically, a nurturing, responsive, parent-child relationship in which a child feels loved, valued, and safe, is able to prevent the devastating effects of toxic stress on both brain and body, promoting child emotional wellness or mental health, cognitive capacity and executive functioning, and physical health. This work forms the basis of the Child First model. Families are referred by a wide variety of community partners or can self-refer. Every Child First LIA is required to create a local Child First Advisory Board and/or actively participate in the local early childhood collaborative(s). This is a fundamental component of the Child First model. These providers are able to identify needs within the families they serve that are beyond their own service mission and expertise. The partnership with Child First means that they have a needed resource to help families with multiple challenges, while continuing to serve the families in their defined area.

Family participation in Child First is completely voluntary. After referral, Child First teams have a protocol which includes persistent efforts to contact and enroll these often hard to reach families with multiple phone calls, letters, and notes at their doorstep as well as meetings at a pediatric appointment, child care, or restaurant in the community. This outreach may last 4 to 6 weeks. Once a family begins services, the Child First team spends a month working with the family to do a comprehensive assessment in order to understand their needs and priorities to and jointly design a Child and Family Plan of Care.

Child First operates with a team consisting of a care coordinator and a mental health and developmental clinician. This team generally visits the family weekly for six to twelve months, though visitation may be markedly increased depending on the needs of the family. The first

month focuses on engagement and assessment resulting in a mutually agreed upon Child and Family Plan of Care. The role of the care coordinator is often critical during the early stage of engagement. The care coordinator helps families identify broad and comprehensive needs, and assists them in finding solutions (e.g. housing, clothing, food, furniture, a better preschool, a medical home for children and parents, education, literacy, jobs, substance abuse treatment, legal aid). Because he/she is working to address the family's most immediate needs, the families feel heard and respected, and the care coordinator is often able to build trust with the family early on, in turn facilitating engagement. The clinician is tasked with working with the family to understand the "why" of the challenges the family wants to address. The clinician is trained in trauma-informed Child-Parent Psychotherapy, and helps parents heal their children from past trauma, and protect them from future traumatic stress by ensuring that the parent-child relationships are loving, safe, and strong. The clinicians do not use a set curriculum for teaching families, but rather a deep, reflective process that helps the caregiver understand what is causing a child's behaviors. Through the parent-child dyadic intervention, the relationship changes to one that is nurturing and protective. The parent understands the child's experience and how to help the child to heal and ensure ongoing healthy development. This often entails therapeutic work with the parent/caregiver to address their own trauma, depression, and other issues that are affecting their ability to create a nurturing environment. For children enrolled in early care and education, the clinician works with the preschool to provide mental health consultation to best support the child.

The following are the objectives of the CT MIECHV grant and the detailed activities that will achieve each of the objectives proposed:

Objective 1: Build on the momentum of existing MIECHV and state funded home visiting programs to rapidly increase capacity and program effectiveness.

Rationale: CT has long-standing state funded PAT and Child First programs that have a proven track record of success and new MIECHV programs that show strong and continued progress. Expanding these programs will ensure that expansion dollars are used to rapidly increase the enrollment, engagement, and retention of new families in the program. In addition, because the MIECHV and state funded programs are currently operating we can hit the ground running on the expansion of the program. Several activities are planned to meet this objective.

Activity 1: Assess and assure program effectiveness in recruiting, enrolling, and engaging families in the program by assessing the continued progress of each site at the time of expansion.

Activity 2: Enhance and expand existing effective MIECHV and state funded PAT and Child First home visiting programs by amending the contracts of PAT LIAs to hire an additional 19 traditional and six fathering home visitors for PAT; similarly, the administrative contract for Child First, Inc. will be amended to sub-contract with 4 LIAs to hire seven staff "teams" for Child First. The number of new families to be served with FFY 2015 funds over the two years and seven months of the program is 2,624. PAT is projected to serve 2,160 new families and 400 new fathers in fathering home visiting, and Child First is projected to serve 464.

Activity 3: Work with LIAs to identify new staff to expand home visiting services as quickly as possible. OEC and Child First, Inc. will work with the LIAs as early as January 2015 to help identify potential candidates to fill positions.

Objective 2: Sustain progress and rapidly increase enrollment in the current and new MIECHV home visiting LIAs by fully integrating MIECHV and the state funded programs into the early childhood system and reducing barriers to service.

Rationale: For local implementing agencies to recruit and enroll families on a regular and ongoing basis they need to be part of a larger network of programs and services for children and families. The OEC will assist the LIAs to:

Activity 1: Establish formal and informal relationships between the MIECHV home visiting program and efforts administered by the OEC and others, Examples include:

- The MIECHV programs will be formally linked through OEC contracts with the "Connections" screening and referral system currently working at each of the state's 29 birthing hospitals and related prenatal clinics.

- A formal referral process will be established with the Help Me Grow Child Development InfoLine administered by the OEC that connects families to 4,000 resources each year.

- A seamless referral process to the home visiting programs will be established with the Healthy Start program administered by the OEC in coordination DSS that helps to enroll 5,000 pregnant and new mothers and children in Husky (Medicaid) each year.

- Strengthen the relationships between MIECHV funded Child First sites and areas offices of DCF to better serve DCF involved Child families.

Activity 2: Require as a part of the contract that all LIAs have clear recruitment plans that include formal relationships with referral resources within and outside of their agencies focused on creating a systematic approach to referrals whenever possible. For example, the chief executive officer of the local implementing agency formally agrees that the intake staff at the prenatal clinic will screen all families for MIECHV program services.

Activity 3: Apply lessons learned to all implementation policies and practice guidelines to reduce unintentional barriers to capacity, recruitment and enrollment, and staffing. Review all policies and implementation procedures with LIAs to reduce or eliminate barriers.

Activity 4: Have new hires working with families quickly by offering pre-requisite training required by the models at frequent and regular intervals.

Activity 5: Work with DCF and the OCA to educate communities about the risk of infant abuse and unsafe sleep for newborns. The DCF, OCA, OEC and others are developing a campaign to promote infant safety and safe sleep. This campaign is a vehicle to raise awareness about this important issue, and at the same time an opportunity to help the community

understand what the MIECHV program does and its importance in vulnerable communities.

Activity 6: Engaging Families with the Community by helping interested parents enroll in any one the four parent leadership training courses offered for free by the State and with a grant from W.K. Kellogg Foundation.

Objective 3: Improve retention by developing the expertise and competency of home visiting program staff by enhancing their training and on-going support.

Rationale: Comprehensive training, coaching, ongoing supports, including opportunities for peer learning, have been shown to be critical for successful program implementation. Studies have shown that when home visitors receive coaching and support they had lower levels of emotional exhaustion and burnout and were more likely to remain employed.

Activity 1: Provide comprehensive training program to all home visiting staff. Provide comprehensive training for PAT and Child First over the first 18 months of hiring.

Activity 2: Enhance engagement of families through a strengths–based and family centered approach to home visiting by enhancing the training for fathering home visitors to include the varied aspects of their broad and complex role including culturally competent, trauma informed and gender specific home visiting.

Activity 3: Child First will take steps to reach out and engage high risk and hard to reach families. Child First sites will continue to work closely with local partners to identify high need families including work with preschools, pediatricians, social service agencies, and homeless shelters. If there are potential referral sources that are not currently making referrals, the LIA will arrange to meet with them and offer a presentation on the program.

Activity 4: Provide coaching and ongoing support, including opportunities for peer learning The OEC and Child First, Inc. will provide coaching for program staff in meetings, over the phone and at site visits. They will hold regular networks meetings to provide opportunities for peer support, peer learning, and problem solving.

Objective 4: Assure quality services, continuous quality improvement, and model fidelity through monitoring, the use of data and site visits.

Rationale: To assure the quality of service, programs must be implemented with a high degree of fidelity to model, implementation issues must be continuously identified and addressed, and data must be carefully monitored to ensure progress.

Activity 1: The OEC state level staff are prepared and fully engaged in working with with the staff at the PAT LIAs and Child First, Inc. to provide timely data, technical assistance and problem solving support.

Activity 2: Provide a structure for quality assurance with the PAT and Child First LIAs to use an Individualized Program Plan to help identify strengths and challenges and develop a plan for improvement. Plans will be addressed through out the year and at site visits.

Activity 3: Support the Continuous Quality Improvement (CQI) plan by providing data, research, and strategies for best practice to the CQI teams. OEC staff will have regular meetings with the team to discuss implementation plans, solve problems and improve services.

WORKPLAN:

Time Line: A detailed timeline is attached (ATTACHMENT 6 – Timeline).

Meaningful Support and Collaboration: The MIECHV grant program has received significant support and involved many stakeholders. The stakeholders include state agency partners, organizations with special expertise, community providers and parents. At the state level stakeholders have been involved in the planning and design of the program through the MIECHV Statewide Advisory Committee, and more recently, the Home Visiting Task Force charged by the legislature with recommendations for systems coordination. A number of the recommendations emerging from this work have been incorporated into the plan and application for the MIECHV program.

In addition, the MIECHV program has worked closely through the ECCS advisory committee to foster coordination and their shared goals. Evaluators from academic institutions and others that have been instrumental in the development of the state funded PAT and Child First programs have had opportunities for input, to speak directly with the program staff, and assist with the development of the application. The results of several studies and focus groups with parents and home visiting program staff have been integrated into the program design. The findings from all these efforts provide a foundation for understanding the perspectives and needs of families. These studies have made an important contribution to the philosophy and approach of the CT home visiting program.

The OEC is lead agency for the Child Abuse Treatment and Prevention Act: Title ll grant – Child Abuse Prevention Grants (CBCAP) - that includes parents and community representatives as an integral part of its work. The public-private partnership that provides direction for the CBCAP grant has been highly involved with home visiting efforts in the state and has been instrumental in bringing a parent perspective, and particularly the perspective of fathers to this work. At the local level, parents and many more diverse community stakeholders are involved on advisory committees of the program sites, and sit on the CQI team committees, providing feedback to local sites and state agency staff. Through a large network of stakeholders, formal structures and on-going relationships the OEC is tapping into a wide range of perspectives and meaningful involvement of those that reflect the cultural, racial, linguistic, gender and geographic diversity of the communities served. The state partners noted in the FOA are each represented on the MIECHV state advisory committee and have demonstrated their agreement and support for the individuals who proposed initiative and to ensure that home visiting is included in the continuum of early childhood services within the state. A letter to this effect signed by the commissioners and directors of the state agencies and programs listed in the Funding Opportunity Announcement is attached (ATTACHMENT 10 – Letters of Support).

Plan to engage community: The OEC will continue to expand on community engagement through the following:

- Using the Strengthening Families Community Café model, OEC staff will bring together the original community groups that played a key role in the selection and implementation of the MIECHV programs. These community café's will allow community members to update their knowledge and understanding of other community partners and the work of the MIECHV funded programs in their community.

- Help Me Grow Networking meetings are held throughout the year in thirteen different communities and provide excellent opportunities to increase collaboration and engagement of community partners. We will strongly encourage MIECHV home visiting staff to attend.

- The OEC will distribute information to the early care providers to support the referral of families to home visiting services. In addition, the MIECHV staff, as a part of its comprehensive training, will be trained to identify and assist families in enrolling in appropriate and high quality childcare.

- The OEC will work with other state partners on the safe sleep and infant safety campaign. It will also help interested parents to enroll in parent leadership training courses as described in the methodology.

Plan for monitoring, program assessment and support, and technical assistance: Programs will be monitored and assessed through a quality assurance system that includes quarterly program reports, bi-annual benchmark report , regular meetings with sites and an annual site visit. Programs will input all program data into the CT MIECHV database (efforts to include Child First are proceeding). The OEC MIECHV epidemiologist will design reports that LIAs can use to monitor their progress in achieving program benchmarks. The OEC staff will review all data and benchmark reports in preparation for site visits. Individual Program Plans will be developed with all LIAs to identify challenges and create plans improvement. They will also facilitate quarterly network meetings for each role. The network meetings will be used to provide technical assistance, solve problems common across sites, and provide opportunities for peer learning. As the administrator, Child First, Inc. will conduct technical assistance sessions with its sub-recipients.

Plan for professional development and training: Ongoing professional development and a system of training staff is an essential component of program development. Comprehensive training for MIECHV PAT program staff is divided into two tiers. The first tier includes trainings that support and enhance skills around curricula as well as the recruitment, engagement, enrollment and retention of families. It is completed in first 18 months of employment. The second tier of training is designed to further enhance both the quality of the home visiting service and the skills of the home visitor around working with families with complex issues.

PAT Tier 1 Training: Training is interactive and experiential based on the adult learning theory, to prepare staff for their role and responsibilities (Speck, 1996). The training covers theories of attachment and maternal bonding and stages of child development; the theory and practice of reflective supervision and group process; approaches to prevent shaken baby syndrome based on the Period of Purple Crying model developed by Dr. Ron Barr (Barr, 2011); skills for screening using Ages and Stages Monitoring Questionnaire and Ages and Stages Social and Emotional Questionnaire. The training also includes Family Development Credential (FDC)

for Family Workers and Leaders that teaches strategies for staff to assist families to build on their strengths and to develop a healthy self-reliance and interdependence with others in their community; Touchpoints © - focused on the developmental and relational elements of the parent-child-provider relationships, and their practical applications; the unique role of fathers in families including their strengths and risks and includes: parenting issues faced by fathers, engagement strategies for co-parenting and family dynamics, parenting skills and child development, skills to encourage parent-child interaction, finding resources for fathers, and the development of plans that address the role of fathers and other males in the home.

PAT Tier 2 training: Training includes Identifying and Working with Parents with Cognitive Limitations that assists providers to recognize how their own values and beliefs about parents with cognitive limitations impact their work and understand how cognitive limitations is seen from a functional perspective; Self and Others focused on their own life, history and culture while learning about others including group dynamics and the stages of human development; multiculturalism for home visitors explore bias and prejudice in the American experience, forces that perpetuate it and forces for change including history, poverty, religion, spirituality, immigration and others; complex Human Behavior explores substance abuse, domestic violence and behaviors related to mental health issues, grief, trauma, teen pregnancy and family planning.

Child First: With the addition of seven new Child First teams, the Child First, Inc. will conduct another Child First Learning Collaborative to start in May 2015. The structure is a combination of face-to-face trainings, new modules of guided on-line learning, and the provision of reflective clinical consultation by expert senior clinical consultants. Because these new staff is being integrated into existing sites with experienced clinical directors and Child First teams, the Learning Sessions will be able to be accelerated. They will include the basic components of the model and the theoretical underpinnings around toxic stress and ACEs, early brain development, typical child development and developmental challenges, attachment, early childhood mental health, executive functioning, child and maternal health, assessment process and measures, data collection, and more. It includes observations of typical development (in the field) and challenging behavior (video) and exercises to consolidate the knowledge.

Four face-to-face Learning Sessions will begin in early May. This will be a very intensive 8 day training in which the actual process of working with very high risk young children and families will be taught interactively. This includes the process of engagement, dyadic work with very young children and caregivers, emotional regulation, Child-Parent Psychotherapy, case formulation, treatment planning, termination, play therapy, use of video in intervention and supervision, etc.

Reflective clinical consultation is an essential component of providing the Child First intervention with fidelity and includes case presentations, formulations, use of process notes, and review of video of actual sessions. The senior clinical consultant from the Child First NPO will meet with each expansion site on a weekly basis initially, progressing to biweekly, based on the rate of integration of the new staff. As soon as new teams complete the first Learning Session, they will begin to work with families who may already be on the waiting list. Initially they will carry a reduced caseload of families, but will rapidly build up to full capacity within six months. In addition to the formal Learning Collaborative, Child First provides up to four special trainings a year and an Annual Conference.

Plan for staffing: Plan includes seven professional staff that will function as a team within the OEC Family Support Services (FSS) division. The team includes a program director (Division Director) responsible for the over-sight and day-to-day management of the program, a program manager responsible for quality improvement activities, two staff responsible for programmatic monitoring activities, one staff responsible for training, the fatherhood programmatic area of emphasis, and coordinating the MIECHV program within the state funded PAT sites, one staff responsible for fiscal monitoring, and one staff responsible for data collection, quality and reporting. All staff will report directly to the program manager.

Plan for contracting: The PAT staffing plan: The OEC will amend and extend contracts with 19 LIAS to expand PAT home visiting services by adding 19 additional traditional home visitors and six additional fathering home visitors to their current programs.

Evaluation: The OEC will amend and extend its contracts with Partners in Social Research, LLC to implement a qualitative and process evaluation of the fathering home visitors program.

Child First services: The OEC will amend and extend its contract with Child First, Inc. to expand funding at four existing Child First LIAs. Seven home visiting 'teams' will be added at these LIAs. Each home visiting team has a master's level mental health and developmental clinician and bachelor's level care coordinator. Administrative staff for Child First, Inc. includes 0.3FTE of Management, 0.5 FTE in Finances for contracting and payments, 0.5 FTE for Data Analysis and Reporting, and Quality enhancement activities, and 0.2 FTE for Data Collection.

Plans for recruiting and retaining participants: Recruitment and enrollment of participants to the program will occur through the three vehicles: Nurturing Connections, outreach efforts, and community collaborations. The MIECHV LIAs will be connected to the Connections staff at the hospitals. This effort has already begun. In one month of working with Connections enrollment in the MIECHV programs jumped 23 %. The OEC will formalize the referral process and expand its use of "Help Me Grow" – the state's centralized point of entry that compliments local efforts and makes referrals easier for providers. PAT sites are also engaged in local outreach efforts with health and human services organizations. Child First will work with DCF to extend this soure of referral to all MIECHV funded sites, and will work to establish regular monthly meetings with designated DCF liaisons from the DCF area offices.

Continuous Quality Improvement plan: MIECHV CQI activities operate at two levels - individual program site and state-wide. In both cases, the goals are to facilitate the assessment of program activities, performance, and outcomes primarily through the review of data. To date the focus had been on benchmark-related improvements, or have focused on recruitment and/or retention. At the state level, the CQI activities have been to educate staff at the LIAs and assist them as they develop their CQI plans and implement strategies for improvement. CQI activities at the state level will continue to include data analysis to describe programmatic activities and outcomes, including looking for patterns among referrals, client retention, client characteristics, and outcomes models.

Plan to maintain fidelity to model: The PAT and Child First, Inc. plans to maintain fidelity to models includes the CQI process, the Individualized Program Plan (IPP) process, professional

training, technical assistance, contract language, program policies and practice guidelines, curriculum, site visits and other tools which will be used to support and monitor the LIA's fidelity to the PAT model and the implementation of high-quality home visiting. MIECHV PAT LIA's will work with the local PAT chapter. CT has secured a commitment from the PAT model developer for continued technical assistance and guidance.

Plan to collect legislatively-mandated benchmarks: CT OEC MIECHV staff has directed the design, building and roll-out of a custom designed web-based data system. The database captures and manages Form One information (client demographics) and Form Two information (benchmarks). Staff at the PAT LIA's has been trained in the use of the database, and ongoing technical assistance is provided by the database developer and the OEC epidemiologist. The online database has greatly simplified data collection, and has improved efforts at ensuring data reliability since checks and verifications are built into the system. Since the database was built specifically for the Connecticut MIECHV program, custom DGIS reports were designed, further simplifying the process of compiling, checking, and reporting the data. Beyond DGIS reporting, the data system is used for day-to-day activities at both the site level and the state level. At the site level, staff uses the database as a tool to organize their client information which in turn helps them serve their families better, for program monitoring, and for CQI activities. At the state level, the database is also used for program monitoring and CQI activities, and will enable further statewide analysis of the MIECHV Program's service delivery and outcomes across the four program models.

Plan to coordinate with appropriate entities/programs: The OEC will coordinate with the state health care market place, Access Health, and the Title V program to ensure MIECHV home visitors have state specific information necessary to connect families with healthcare. It will also ensure collaboration with appropriate entities and programs to achieve the goals of the programs. The first priority will be contacting and coordinating with those most likely to support enrollment and engagement of families through community awareness of the program, formal and informal agreements, and networking opportunities. The MIECHV team will engage in the efforts of the State Advisory Committee, the Home Visiting Task Force, and support the Help Me Grow breakfasts in MIECHV communities to provide vehicles for communication and coordination with other entities. In addition, at the local level, MIECHV program staff will work with local programs, the members of the continuous quality improvement teams, and health and human services agencies to advance the goals of the grant. These community partners include federally qualified health centers, community health centers, hospitals and clinics. In addition the programs work with WIC, the health insurance assistance personnel for the State Partnership Health marketplace, boards of education, the SDE supporting pregnant and parenting teens program, the local Exchange Clubs, and others.

Description of how the proposed activities would fit into the state administrative structure: The Family Support Services division of the OEC will administer the MIECHV program. It includes several programs designed to promote positive outcomes for children and families including the state funded PAT program and the staff assigned to that the program. The FSS division has gained significant expertise and experience in field of home visiting over the past several years. The MIECHV team will have the support of the entire division. It will work collaboratively within the division to provide training, technical assistance, coaching and

ongoing support to sites, understanding of the programs models and gaining knowledge of the field. The FSS staff assigned to state funded PAT programs that receive MIECHV funding for additional home visiting staff will be responsible for integrating the programs, ensuring their sites are fully informed and prepared to meet all of the MIECHV programmatic and financial requirements. The OEC contracts and fiscal units will support the contracting and payment of sites, and assist in the management of the fiscal aspects of the grant. The work of the grant will be supported by the OEC Commissioner and through the government relations, strategic planning, and communications offices of the agency.

Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the eligible applicant and any other partners at the end of the Federal grant: The project goals, objectives and activities will be incorporated into the ongoing work of the OEC and other partners during and at the end of the Federal grant. The OEC is committed to evidenced based-home visiting as evidenced by its significant investment and effort to support the state funded PAT program, federally funded Early Head Start office, the IDEA (part C) program and now the MIECHV program. Through the MIECHV State Advisory Committee, the Home Visiting Task Force, the ECCS, and the CBCAP Public –Private partnership the OEC assures that the goals, objectives and activities of the project will not only be incorporated into its efforts, but the efforts of these groups, and the partners and stakeholders will be prioritized.

Logic Model: Please see the Logic Model for the program (ATTACHMENT 8 –Logic Model)

RESOLUTION OF CHALLENGES:

Challenges for PAT: The single largest challenge for the PAT was the 'newness' of the program. All but one local program started from scratch. Starting a home visiting program from scratch comes with many demands including, hiring, training, and managing an entirely new team of staff - a staff that may have never worked in a home visiting program before. It also requires establishing and adapting the needs of the new program to the protocols and procedures of an unfamiliar local implementing agency – an agency that is new to all of the program staff and a program that is new to the management; training all of the staff, helping them grow into their roles, building their knowledge of the program model, and skill to engage the population of families served; this must be done all while working to have the program become known in the community; develop relationships and referral systems; and build caseloads. The program sites are well on their way, as evidenced by the trend data, to becoming established programs, with experienced and competent staff, embedded and embraced by their organizations, and recognized and trusted in their communities. To address this challenge, no new programs will be funded under this grant. Instead we will build on the momentum of existing MIECHV and state funded home visiting programs to rapidly increase capacity and program effectiveness.

There are a number of lessons learned from the early implementation of the PAT program. For example, the screening tool used to identify families inadvertently established requirements that narrowed the priority population for the grant by establishing additional conditions for eligibility; the initial window for recruiting pregnant mothers was very narrow – from the time pregnancy was known to the end of the second trimester; a randomized control study was launched that meant that for every father enrolled in the program another father had to be placed

in the control group – cutting the number of fathers eligible for home visiting in half; the staffing didn't include a designated staff for recruitment; the initial service area were too small. These and other barriers will be addressed by reviewing all implementation policies and practice guidelines to reduced unintentional barriers to capacity, recruitment and enrollment, and clearly informing the program sites of the changes to policy and practice guidelines.

Challenges for Child First: The primary challenges that Child First sites have encountered identifying qualified staff either due to new positions or turnover. There is a serious shortage of master's level, early childhood, mental health clinicians, especially those who are bilingual. To address this the Child First National Program Office is building a resource bank of potential candidates and supports affiliate agencies in the hiring process to help vet qualified candidates.

The Child First NPO is providing sites with additional clinical consultation by senior clinical consultants. This reflective consultation will better support their staff in their day to day clinical work and give guidance and support with staffing changes. Child First is developing a shared resource of potential candidates for Child First openings. The NPO has helped sites identify appropriate clinical director candidates for affiliate agencies when there has been turnover and provides weekly support as new clinical directors begin their work for up to six months.

Barriers going forward: The OEC and its partners in this project recognize that replication and enhancement of the PAT and Child First evidenced based home visiting program, particularly at scale, presents a number of important challenges. To bring the program to the next level, 'buy-in' is needed from a significant number of stakeholders at the state, local, organizational, community and neighborhood level. This will require that everyone involved has a clear understanding of how the program works, why it is valuable, and how it should be supported. The large number of people and organizations involved in this effort also present logistical and communications issues. To address the challenges of program expansion the following principles will be observed:

Core services and program implementation strategies are well understood and communicated. Strategy: Provide clear information about the program philosophy, values, approaches and intended outcomes of the evidenced based practice to all parties implementing the program and all of the partners we are seeking to engage.

Component parts of the program are well coordinated and communicate effectively
Strategy: Inform all stakeholders about the scope of the entire plan. Invite feedback and open discussion about how various aspects of the program work together to coordinate efforts. Solve problems and adjust course as issues emerge.

Recognize that planning and implementation take place at different levels and require adequate time and resources. Strategy: Develop realistic timeframes for coordinating activities at the state and local level. For example, work with each site to plan a timetable to develop relationships, and create formal and informal partnerships.

All aspects of the program and program implementation are culturally sensitive.

Strategy: All staff involved need to be aware of cultural differences that will affect implementation of the project. These differences cannot be overlooked, but must be embraced and be respected in the process of planning, training and implementation.

Communities and other stakeholders are well informed, and are part of the decision-making and the implementation of the program. Strategy: Community forums, planning meetings, and discussions with stakeholders are part of the planning and implementation process. Aspects of the program are discussed with the stakeholders before decisions are made.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

Evaluation for Programmatic Areas of Emphasis 6: Family Centered – Father Focused Home Visiting: Upon receiving the MIECHV Competitive Grant in March 2012, Connecticut held a series of community forums to identify agencies and organizations best positioned to house MIECHV-funded Parents as Teachers (PAT) home visiting sites. Between the spring and fall of 2013, following a period of planning and workforce development, PAT sites opened their doors to families, offering not only traditional PAT home visitation and monthly socialization groups but also father-focused home visitation and fatherhood support groups aimed at engaging both resident and non-resident fathers.

The implementation of PAT programs has been accompanied by a process and outcome evaluation, which commenced in 2013 and is slated to conclude in the spring of 2016. The ongoing process evaluation is aimed at providing descriptive information about home visiting sites. It includes surveys with home visitors and brief telephone interviews with families. Results of a staff survey conducted in December 2013 indicate a presence of positive social dynamics within PAT sites. Namely, both traditional and father-focused home visitors reported (on multi-item measures with scores ranging from 1 to 6) relatively high levels of satisfaction with interpersonal relations among coworkers (average of 5.2), supervisor support for work (average of 5.0), and supervisor support for personal and family issues (average of 5.0). Additionally, staff reported moderately high levels of overall job satisfaction (average of 4.6).

In line with positive social dynamics within home visiting sites, preliminary findings from brief telephone interviews conducted between June and October 2014 suggest that both mothers and fathers are satisfied with the services they've been receiving. Over 90 percent reported that they would recommend their MIECHV PAT home visiting program to "a friend in need of similar help" and over 70 percent reported that they were "very satisfied" with home visitation. Whether satisfaction with services will translate to positive outcomes for the families remains to be seen. Since October 2013, 150 mothers and fathers have enrolled in the outcome evaluation designed to explore the added value of father-specific services. One-year follow-up interviews will be conducted starting October 2014 with a goal of collecting outcome data on life skills, parenting practices, co-parenting, and mental health.

Successes notwithstanding, it is important to acknowledge difficulties with implementing father-focused home visiting. Hiring and retaining qualified father home visitors has proven to be a challenge: five father home visitors had to be let go of within weeks of hire and another five left their position during the first year of program implementation. Staff survey responses from

December 2013 suggest that the reasons for job dissatisfaction among father home visitors included low pay; slow pace of father recruitment; caseload reductions associated with father assignment to the control group rather than the fatherhood services group; and, in a few instances, difficult relationship with program supervisor.

Successes and challenges during the first round of MIECHV funding provide a context for the present evaluation proposal. Going beyond descriptive research, Connecticut proposes a study to identify and explore the ingredients needed to support high quality fatherhood services.

Research Goals and Questions: The overarching purpose of the proposed process evaluation is to explore and better understand the factors needed to support father-focused home visiting in the context of PAT programs. In particular, the evaluation will seek to fulfill the following goals: (1) to identify and document factors that facilitate father-focused home visiting; 2) factors that pose barriers, and factors that promote positive outcomes among participating fathers; 3) to explore unintended variability across home visiting sites in the implementation of father-focused home visiting; and 40to provide information about the ways in which home visiting programs engage fathers in positive parenting and address fathers' needs. Given these goals, the proposed evaluation will provide answers to the following research questions:

(1) What are the key characteristics of participating home visiting programs and how do these vary of the course of the grant?
(2) What factors facilitate or impede the implementation of father-focused home visiting within participating home visiting sites?
(3) What are the sources of unintended variability among home visiting sites in the implementation of father-focused home visiting?
(4) How do participating home visiting sites engage fathers in home visitation?
(5) How do father home visitors implement curricula and service guidelines in their work with enrolled fathers?
(6) How do participating fathers experience home visitation?

Evaluation Design: The proposed evaluation is informed by a systems-based conceptual framework, which likens social units of varying levels of complexity (e.g., families, home-visiting programs, communities, corporations) to a system—that is, a composition of parts that are connected by a web of relationships and that together form a cohesive whole (Bertalanffy, 1969; Bronfenbrenner, 1979; Bubolz & Sontag, 1993; Stufflebeam, 2002; Tseng & Seizman, 2007). In their joint action, the parts that comprise a system absorb inputs, process them in some way, and produce outputs. Inputs are the resources needed to achieve the desired outputs. In the case of home visitation, inputs includes curricula and protocols that guide service delivery, policies for recruiting and retaining staff, training and professional development opportunities, and so on. Outputs are activities, products, or services that reach targeted participants or populations. Examples of outputs produced by home visiting programs include personal visits, parent education, socialization groups, and case management delivered to enrolled families. Inputs are transformed into outputs through the patterns of transaction among people or groups of people within social settings (Tseng & Seidman, 2007). These patterns of transaction include group dynamics, dyadic relationships, social norms, and organizational culture within sites and the larger organizations in which the sites are housed. Everything taken together, the theoretical

perspective that informs the proposed evaluation highlights three components: (1) inputs, (2) processes, and (3) outputs.

Consistent with the systems perspective, the proposed evaluation will use a mixed methodological approach to answer the research questions of interest. In particular, qualitative methods—in-depth individual interviews and focus group interviews—will be used to develop an understanding of social processes within home visiting sites; to uncover sources of unintended variability in the implementation of father-focused home visiting; and to explore father-focused home visiting from the perspective of supervisors, home visitors, and enrolled fathers. Quantitative methods will be used to document and measure changes in system properties over time and to study the effects of unintended variability (as uncovered through the use of qualitative methods) on fathers' engagement in positive parenting. The combined use of qualitative and quantitative methods will allow for more complete research results and a more thorough understanding of system properties and dynamics.

Data Sources and Data Collection: To develop a holistic understanding of father-focused home visiting, data will be collected from home visiting site supervisors, father home visitors, and participating fathers within MIECHV and state-funded PAT sites. State-funded PAT sites have been implementing father-focused home visiting since 2011. They will be included in evaluation to allow for adequate sample sizes and to extend the pool of experiences from which to search for ingredients needed to support high quality father-focused home visitation. All supervisors (n = 32) and father home visitors (n = 32) will be invited to participate in the evaluation. Among the fathers enrolled in home visitation, a subset of about 60-70 will be invited to participate in in-depth individual interviews and all ($n \approx 320$) will be asked to participate in a data sharing agreement by which their assessment scores would be released to the evaluators for analyses.

Web-Based Staff Surveys. Staff at each participating site—32 supervisors, 96 traditional home visitors, and 32 father home visitors—will be asked to complete confidential web-based surveys 4-6 months upon grant receipt and annually thereafter. The purpose of the surveys is to obtain descriptive information about site inputs, social processes, and outputs. In particular, surveys will include single-item measures of the following:

(1) staff professional background characteristics (e.g., educational background, current training, professional licenses);
(2) social background characteristics (e.g., age, sex, child caregiving experience);
(3) employment history (e.g., prior experience with home visiting);
(4) current employment (e.g., length, position, caseload, satisfaction with pay, satisfaction with employee benefits);
(5) service provision (e.g., language, caseload size, perceived competencies, strategies to maintain family engagement, home visit planning, and perceptions of service effectiveness);
(6) supervision (e.g., frequency of meetings, supervision format, supervisor feedback, supervisor competence); and
(7) professional development and training.

In addition to single-item questions, staff will be asked to complete standardized assessments of work role perceptions. This will include subscales from Spector's (1985) Job Satisfaction Survey

(JSS), the Michigan Organizational Assessment Job Satisfaction Subscale (MOAQ-JSS; Cammann, Fichman, Jenkins, & Klesh, 1979, 1983), and the pay subscale from Job Descriptive Index. Additionally, items developed in Duggan, Fuddy, Burrell, and colleagues' (2004) evaluation of a statewide home visiting program will be adapted and used to assess perceptions of competence with providing home visiting services (home visitor version of the questionnaire) or with providing support to home visitors as they provide services to families (supervisor version of the questionnaire). Lastly, surveys will include open-ended questions about perceptions of work role, job satisfaction, and perceptions of intervention effectiveness.

In-Depth Interviews with Site Supervisors. In-depth, semi-structured interviews will be conducted with home visiting site supervisors ($n \approx 32$) at two time points: about a year upon grant receipt and a year thereafter. It is expected that the interviews will take about 1-2 hours to complete. The purpose of the interviews is to learn about father-focused home visiting within each participating site from the perspective of the site supervisor. In particular, supervisors will be asked about practices surrounding father enrollment and engagement in home visiting services; supervisor perceptions of challenges and success with implementing father-focused home visiting; perceptions of father home visitor effectiveness; perceptions of training received by father home visitors; practices to ensure intervention implementation with fidelity; and, relationships and dynamics among staff within their home visiting site.

Focus Groups with Father Home Visitors. Focus group interviews will be conducted with father home visitors about 6 months upon grant receipt and bi-annually thereafter (with a total of about 8 groups, 2-3 at each of the four time points). Each group will take approximately 1-2 hours to complete. It is expected that most father-focused home visitors ($n \approx 25$-30) will elect to participate in this portion of the evaluation. The goal of the focus group interviews is twofold: (1) to learn about the implementation of father-focused home visiting from the perspective of father home visitors, and (2) to provide a vehicle for staff voices to be heard and incorporated into the planning and administration of father-focused home visiting. Focus groups will be used to allow for a dynamic exchange of ideas among participants; to enable group-based constructions of meanings; and to create an egalitarian dynamic, where the power-differential between the researcher and the participants is reduced to a minimum. Initially, discussions will revolve around approaches to incorporating training and service guidelines into the work with fathers and their families; implementing services in the home; and addressing issues such as co-parenting, intimate partner violence, economic instability, and mental health. Additionally, discussions will explore father home visitors' perceptions of (1) their role, (2) the support they receive (or not) for their work, and (3) intervention effectiveness. Subsequent focus group guides will be adapted to reflect the evolution of father-focused home visiting over the course of the grant.

In-Depth Interviews with Fathers Receiving Services. Fathers enrolled in home visitation will be asked to participate in in-depth, semi-structured individual interviews aimed at exploring perceptions of home visiting services in general and father-focused home visiting in particular. Several fathers within each home visiting site will be invited to participate in the interviews, with a goal of recruiting about 2-3 fathers per father home visitor ($n \approx 60$-70 fathers altogether). To construct a sample of fathers, purposive sampling will be used in order to adequately represent various forms of experience that may exist in the larger population (Montell, 1999; Weiss, 1994).

In particular, fathers' enrollment status (i.e., currently enrolled and recently withdrawn), length of service receipt, relationship with the index child's mother, age, and socioeconomic status will be used, at least initially, as factors in sample construction. As data collection and analysis progress, new participants will be recruited based on coding categories identified through initial data analyses (Morse, Barret, Mayan, Olson, & Spiers, 2002. Data collection will continue until existing categories have been replicated and no new themes have been identified—that is, until the point of saturation has been reached (Bowen, 2008). Notably, the interviews will explore the role that home visitation plays in meeting fathers' needs; fathers' alliance (or lack thereof) with their father home visitor; reasons for enrolling in the program and choosing to stay in or leave the program; and the perceived impacts of home visitation.

Father Assessments. Assessments administered to participating fathers as part of service receipt will be analyzed to determine how unintended variability in the implementation of father-focused home visiting influences fathers' outcomes. All fathers enrolled in home visitation will be asked to allow for their assessment scores to be released to the evaluators for analysis. Based on current caseloads, it is expected that this will yield a sample of about 320 fathers. The assessments include the Child Abuse Potential (CAP) Inventory, a 160-item paper-and-pencil instrument with excellent psychometric properties (Milner, 1986) and program-constructed measure of parenting practices and behaviors.

Analysis: *Staff Surveys.* Numeric responses on annual staff surveys will be analyzed to determine central tendency and variability statistics. Bivariate analyses (cross tabulations, chi-square tests, correlational analyses) will be conducted to examine associations between site inputs and outputs. Qualitative data (i.e., responses to open-ended questions) will be "reduced" using a thematic analysis (Aronson, 1994). Data will be reported so as to conceal participants' identity.

Individual and Focus Group Interviews. A combination of Rubin and Rubin's (2005) framework and Novak's (Novak, 1991; Novak & Cañas, 2006) concept mapping will be used to analyze data from individual and focus group interviews with fathers and father home visitors. Rubin and Rubin developed analytic strategies that are specific to social science research. This includes an iterative relationship between data collection and analysis; identification and elaboration of concepts and themes; coding of interview transcripts; and sorting, comparison, and search for the connections among the concepts and themes.

Novak's concept mapping is not specific to social science research but is, instead, a general approach for organizing and representing knowledge. In the context of qualitative data analysis, this approach is helpful in later phases, after concepts and themes have already been identified, refined, and elaborated. In particular, Novak's concept mapping is useful with developing linkages and relationships among the concepts and themes identified in earlier phases of the analysis.

As is consistent with Rubin and Rubin's approach, data analysis will begin with transcribing audio recordings of individual and focus group interviews. Once the transcripts have been completed, a brief summary of each interview will be prepared in order to help crystallize ideas about information provided in the course of each interview. Following a preparation of interview

transcripts and summaries, evaluators will read and re-read each transcript with an eye for concepts (core ideas that may be summarized as nous or noun phrases) and themes (explanatory statements). Reading will be done both within and across the transcripts. Once all the concepts and themes have been identified and inter-relationships among them have been worked-out, a visual map will be created using Novak's approach to concept mapping. Additionally, concepts and themes will be listed, defined, and labeled with codes. The codes will be used to annotate interviews in order to facilitate the retrieval of illustrative quotes. Any additional changes that might arise from coding will be incorporated into the visual map of identified concepts and themes.

Word processing software (i.e., MS Word) will be used to write summaries of focus group discussions, record memos on emerging concepts and themes, and type up transcripts of audio recordings. NVivo, software designed for qualitative social science research, will be used to organize written materials and to code interview transcripts. CmapTools, software developed for creating concept maps, will be used in the final phases of data analysis to construct a map of relationships among concepts and themes.

Father Assessments. Multilevel modeling will be used to explore whether unintended variability in the implementation of father-focused home visiting influences fathers' outcome. Multilevel modeling will be used to account for the hierarchical nature of outcome data (the fact that fathers are nested within home visiting sites) and to provide an analysis of differences in outcomes among home visiting systems (Raudenbush & Bryk, 2002). Variables identified through individual interviews with supervisors and fathers and through focus group interviews with father home visitors will be incorporated in multilevel models to explain any differences in fathers' outcomes among home visiting sites. STATA statistical analysis software will be used to conduct analyses of father assessments.

HRSA Plan Approval and Institutional Review Board (IRB) Approval: This proposal will be presented to the HRSA IRB for approval within a month of grant receipt. The evaluation team will collaborate with a HRSA project officer and technical assistance consultant to incorporate additional ideas and improvements into the evaluation plan. Data collection instruments (surveys, individual interview guides, and focus group guides) will be developed during this time, as well. After the evaluation plan approval has been received from HRSA, protocol applications will be submitted to home visiting site (some sites are associated with hospitals) and state Institutional Review Boards (IRBs). It is expected that the IRB approvals will be granted within 3-4 months of grant receipt.

Evaluation Timeline: The timeline for the proposed evaluation includes the following milestones:

(1) evaluation plan approval by HRSA 1-2 months of grant receipt
(2) data collection instrument development – 1-2 months of grant receipt
(3) IRB protocol development and approval – 3-4 months of grant receipt
(4) web-based staff surveys – 4-6 months of grant receipt and annually thereafter
(5) individual interviews with site supervisors – 12 and 24 months upon grant receipt
(6) focus group interviews with father home visitors – 6, 12, 18, and 24 months
(7) father outcomes assessment analysis – 30 months upon grant receipt

ORGANIZATIONAL INFORMATION

The State Lead Agency - The Office of Early Childhood: The CT Office of Early Childhood (OEC) is the state agency charged with overseeing a coordinated system of early care and education and family support. This agency is well positioned to meet the goals of the grant, to effectively carry out the proposed activities, and embed the program within a comprehensive, high-quality early childhood system. The OEC has a laser-focused mission to support families with young children; it has established a coordinated structure that pulls together staff with experience from across the early childhood system; and it has the resources, expertise, and support from the Governor and state legislature critical for the long-term success of this program.

Mission and Vision: "All young children in CT are safe, healthy, learning, and thriving. Each child is surrounded by a strong network of nurturing adults who deeply value the importance of the first years of a child's life and have the skills, knowledge, support and passion to meet the unique needs of every child". The OEC was created to make this vision a reality. The OEC's mission underscores its focus on building an integrated early childhood systems. It reads "The Office of Early Childhood's mission is to support all young children in their development by ensuring that early childhood policy, funding, and services strengthen the critical role families, providers, educators, and communities play in a child's life". Ensuring the availability of high quality home visiting programs is a critical activity to support this mission. Over time, expertise developed in separate agencies over many years will become synthesized and enrich the system as a whole. As a small example, a screening tool (the Ages and Stages Questionnaire) long utilized by Help Me Grow and the home visiting programs, is now part of the early learning standards for childcare.

Structure: The OEC is structured with the appropriate programs, legislation, management, stakeholder support, committees, strategic plans, data systems, fiscal controls and priorities, partnerships, funding, and culture to effectively support home visiting quality and embed it within a the larger early childhood system of CT. (See ATTACHMENT 11- OEC Organizational Chart). The divisions within of the OEC include: Early Care and Education focuses on the early childhood workforce, supports program improvement, and helps families access high quality early learning experiences; Child Care Licensing monitors child care programs and youth camps to ensure centers operate at or above the required standards - including health and safety; Family Support Services works to strength families to ensure positive child development; and Early Intervention Division (joining the OEC in July 2015) manages IDEA part B and C funds to support the needs of children with disabilities or delays from age zero through five.

Additional home visiting infrastructure structure: The FSS division has a highly trained and experienced staff in the field of home visiting. Since 1995 it has successfully developed and administered a large evidenced based home visiting program and developed an infrastructure that is well suited for achieving the purposes under the grant. The FSS staff has designed and facilitated a high-quality training and credentialing program for home visiting program staff; worked in partnership with academic centers that have conducted evaluations and research on its programs; and provided feedback that has been used to inform and refine practices as the program has developed; and established a quality assurance process to oversee and ensure

adherence to best practices and quality services. In addition however, the FSS will benefit from the early childhood data system that will allow program better understand the needs of the families and the additional services they are using.

Describe how the unique needs of target populations of the communities served are routinely assessed and improved: The needs of the target population are assessed on an annual basis as a part of the OEC efforts for the CBCAP grant. The process typically involves compiling information and outcomes from our own and other studies (i.e., Kids Count, American Community Survey, and CT Children's Report Card) including data on births, birth outcomes and family demographics in the state and feedback form community providers and partners on various efforts. In a special initiative under CBCAP, beginning in 2010 and continuing through this year, the FSS conducted an expansive needs assessment in the state. The needs assessment drew upon available data in Connecticut to assess: The number of families at risk for child abuse and neglect; Characteristics of families and children at the greatest risk; Key issues that raise the risk of child abuse and neglect; Community with higher populations of families at risk; Gaps in prevention focused services.

The assessment included a series of focus groups with state and local experts, providers, families to review existing programs and assess need. The process involved fourteen small discussion groups, a large round-table discussion and statewide forum to assess need and gain information for strategic and program planning efforts. The FSS developed a significant list of needs through this process. **Several efforts to improve the lives of the target population** grew out of this effort noted below:

- **Father home visitors were hired:** the OEC hired and trained 12 fathering home visitors to work in the state funded Pat program in eleven communities across Connecticut.

- **OEC launched the Positive Parenting Program:** Known as Triple P, this program involved the entire community in efforts to make parenting more manageable and easier for parents. Free training and follow-up support was provided to 140 individuals in Hartford and in northeastern Connecticut who work with children and families in many settings – librarians, teachers, childcare providers, guidance counselors, ministers, family center staff, substance abuse counselors, social workers, psychologists, pediatricians, and others. This effort is working to engage the entire community in parenting education, support and prevention.

- **Help Me Grow – Promoting Positive Child Development**: The OEC launched a statewide public awareness campaign to increase awareness of the critical need for universal screening and early intervention. Through these efforts about 300 providers were been trained to use the Ages and Stages Child Developmental screening tool and roughly 800 children registered for developmental and social emotional screening. This effort is working as a part of the ECCS system.

Organizational capacity of any partnering agencies involved in the implementation of the project: Child First has a National Program Office located in Shelton, CT with professional staff dedicated to training, clinical consultation, quality enhancement, data collection and analysis, finance management, and an administrative structure to manage the contract with the State of CT OEC and the subcontracts with the MIECHV-funded sites. Over the past four years, Child First

has demonstrated its capacity to successfully replicate its evidence-based model with high quality implementation and outcomes. This has required developing extensive training, ongoing technical assistance, and strict accountability to fidelity. Child First is actively involved in numerous collaboratives throughout CT including the Early Childhood Alliance and the CT Association for Infant Mental Health, and it has working closely Nurse Family Partnership, PAT, Healthy Families, and HIPPY at the national level.

Unexpended funds: The DPH was the administrative agency for the CT MIECHV formula and expansion grants until October 2014. DPH reported to the OEC, the new administrative agency, that the full amount 2010 and 2011 formula and expansion grant funds have been fully expended. It also reported that there is an unexpended balance of $148,530 or roughly 1% of the budget remaining 2012 expansion grant. These funds will be returned to HRSA.

The DPH reported that for the expansion grant $3,153,845 or roughly 30% is unexpended for FFY 2013, and for 2014, DPH reported an unexpended balance of $8,571,850, the full amount of the grant. The combined total unexpended balance is $11,725,695. These funds are obligated and will be fully expended by January, 2016. The funds will cover the cost of maintaining the existing MIECHV state level personnel and operations, contracts with Child First, Inc., for Child First home visiting services, the LIAs for PAT home visiting services, and Partners in Social Research, LLC, the evaluator for the fatherhood home visiting program.

Describe the availability of resources to continue the proposed project after the grant period ends and the state's demonstrated commitment to home visiting: The state has made a strong commitment and significant investment in evidenced based home visiting. It will use its available resources to pursue three funding strategies to sustain the program, listed below.

Social Impact Financing: The OEC will explore the use of social impact financing to sustain funding and maintain services provided through the MIECHV program. To do this, the OEC will study the large scale implementation of the PAT and Child First home visiting program in Connecticut and elsewhere to determine its positive impact on early childhood outcomes including child maltreatment and the health and development of children. It will determine if these positive outcomes would save remediation costs for the CT and other parties concerned about the well-being of children, including private foundations. If the study shows significant cost savings from the MIECHV programs, the OEC and its partners will pursue funding to sustain the program through the use of a 'social impact bond' and other social funding vehicles. Through the use of a social impact bond, private investors and other funding partners provide the initial capital to scale up successful programs usually funded by government agencies. Under this funding approach, the government does not pay for the expansion; instead it pays for agreed upon outcomes. The social impact bond resolves the common problem of limited government funding – government entities not having sufficient resources to expand proven successful prevention programs – by providing capital from private sources.

This is how it works:

1. A feasibility study is conducted to determine if a large-scale implementation of an evidence-based program in a particular geographic area or community is likely to save costs to a governmental or other entity.

2. Through this process cost savings to the state or governmental or other entity are pegged to specific measurable outcomes.

3. Private investors invest capital upfront to implement the evidence-based program on a large scale.

4. A governmental or other entity establishes a formal agreement with the investor to pay them back, with a premium, if and only if the program achieves agreed-upon results.

5. An intermediary familiar with social impact financing usually helps to manage the project, including contracts with the investors, the government or other entities and service providers.

6. An impartial evaluator is hired to determine whether the agreed upon outcomes are achieved.

Recently, a social impact bond was used to finance the 'scaling up' of the Nurse Family Partnership program in South Carolina. Goldman Sacks and the Doris Duke Foundation are private and philanthropic partners on this venture. In Connecticut, the OEC with the DSS and DCF and two foundations, the Hartford Foundation for Public Giving and the Grossman Family Foundation, are working on feasibility study for a social impact bond for a statewide expansion the Triple P program, and DCF is working on a social impact bond for large substance abuse program. The rigorous evaluations, widespread implementations efforts and benefits of the PAT and Child First programs position them as viable candidates for a social impact bond.

Medicaid Reimbursement: The OEC discussed Medicaid reimbursement as an option for funding the MIECHV program with the Medical Policy Unit at DSS. They found, for a number reasons, that the MIECHV services are not eligible for reimbursement. However, they noted that Medicaid might be an option in the future. In response to the Affordable Care Act certain preventative and administrative services as recommended by physicians or other licensed practitioners may be covered. DSS is expecting guidance from the Centers for Medicare and Medicaid (CMS) and agreed to explore this option further at that time. In addition, Child First has been working with DCF and DSS to establish Medicaid reimbursement for eligible children. Most recently, we learned through the MIECHV sustainability calls that Medicaid is open to proposals for reimbursement. The OEC will pursue this opportunity as well. If the regulations permit, Medicaid is a viable option for Connecticut. The state's investment in evidenced based home visiting is roughly $14 million. At a reimbursement rate of 50% the state would net $7 million which would largely cover the cost of sustaining the MIECHV programs.

State General Fund: While Connecticut has struggled with budget reductions over the past several years, it has continued to make significant strategic investments in early childhood programs and services. It is not unreasonable to propose that the Governor and Connecticut General Assembly consider state general funds to sustain the cost of the MIECHV program when the grant ends. When the state funded PAT program began with just $300,000 dollars several

years ago no one envisioned that the budget would grow to $10.4 million today. Similarly with Child First, it began with philanthropic dollars and now has a state budget of about $4 million. Given the value and importance of home visiting in Connecticut it would be worth pursuing this option. As the MIECHV programs build their presence in communities across the state and show positive impacts for families it is likely that the State will want to maintain these services.

SUBRECIPIENT MONITORING

Programmatic and Fiscal Monitoring: The OEC will monitor LIA compliance with federal programmatic and fiscal requirements. The OEC will meet bi-monthly with PAT LIAs, and quarterly with Child First, Inc., and Partners in Social research, LCC to review program progress, management, staffing, recruitment and retention efforts, community relationships and collaboration, and model fidelity and financial reports. All sub-recipients will be monitored for adherence to federal spending guidelines and Federal Financial Standards. The OEC will also conduct an annual site with each of its contractors. Annual site visits will include a review of all data, plans to address any problems or barriers to service or corrective action.

Data and Fiscal Monitoring: All MIECHV providers will utilize the MIECHV database to collect demographic and benchmark data on all families enrolled. The OEC epidemiologist will monitor the database to ensure clean, accurate data and offer technical assistance for data collection and entry. The epidemiologist will also participate in conference calls and attend program site visits.