

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

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The Connecticut (CT) General Assembly established the Office of Early Childhood (OEC) in an effort to create a consolidated and coordinated approach to CT's early childhood programs. Its efforts include the administration of the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grants Program. In 2010, a CT Department of Public Health (DPH) needs assessment identified communities at risk for poor early childhood outcomes because of high rates of poverty, low school achievement and high rates of school dropouts and child abuse and neglect. Contracts were established with Local Implementing Agencies (LIA) in four high need communities to provide home visiting services using the Parents and Teachers model (CT-PAT) in New Britain and in Windham, the Nurse Family Partnership (NFP) in New London, and Early Head Start Home in Ansonia/Derby. These LIAs are serving 226 families with a total capacity to serve 256 families. An estimated 194 families will continue to receive services and 62 new families will receive services with FFY 2015 funds. The CT MIECHV Program is in compliance with three specific federally required goals, including: 1) to strengthen and improve the programs and activities carried out under the Title V MCHBG through the use of data and Continuous Quality Improvement (CQI) activities. 2) to improve coordination of services for high need communities, and 3) to identify and provide comprehensive services to improve outcomes for families living in at-risk communities. Objectives to support this goal include: increasing the number of enrolled women receiving prenatal care and the number receiving preconception care and information about optimal birth intervals; promoting breastfeeding, well-child visits and immunization; screening for perinatal mood disorders and domestic violence; providing information to enrolled families to improve home safety, reducing child injuries, improving school readiness and supporting children's learning and development; and increasing fathers' involvement in their children's lives.

The State will coordinate with appropriate health, human services and educational entities to achieve the goals of the programs. 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. 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 lead agency 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.

Annotation: This project will enhance 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.

PROJECT NARRATIVE

Section 1: Accomplishments and Barriers

Connecticut (CT) has successfully implemented MIECHV programs as part of a high-quality statewide home visiting program supporting a comprehensive early childhood system. As of September 2013, all four of the Formula-grant (2011)-funded CT Maternal, Infant, and Early Childhood Home Visiting (MIECHV) sites (Ansonia/Derby, Windham, New Britain and New London) had hired and trained staff and had begun delivering home visiting services to families in their respective communities. Outreach efforts include collaborations with local resources and participation in community events. Challenges faced by the Local Implementing Agencies (LIAs) for the development of their respective programs have been addressed through continued teamwork and collaboration, innovative strategies, and ongoing commitment to improving maternal, infant, early childhood and family health in their communities. The Connecticut General Assembly (CGA) codified the Office of Early Childhood (OEC) in statute in May 2014 and gave the OEC the authority to coordinate home visiting services across programs for young children and to administer the Maternal, Infant, and Early Childhood Home Visiting Program authorized under the Patient Protection and Affordable Care Act of 2010, effective October 1, 2014.

Accomplishments: Connecticut's home visiting system for its most vulnerable families – those at risk for poor health outcomes - has been improved by integrating the work of the four CT MIECHV LIAs into communities identified in the State of Connecticut Statewide Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Programs (2010). A community-based forum process that included local maternal, infant, child and family services was used to select the lead agencies and the evidence-based home visiting models. This process allowed communities to engage in the MIECHV implementation from the start and expedited the launching of the programs in targeted communities.

Contracts between the selected agencies for the provision of CT MIECHV services implementing evidence-based home visiting models are now entering their third year of execution. The CT MIECHV staff and the CT MIECHV LIAs staff have established and maintained collaborative relationships allowing for on-going discussion to assess implementation strengths and challenges, identify potential solutions and evaluate outcomes through regular site visits, email and telephone contact and periodic contractor meetings. Site information and current service delivery status is as follows:

Community	Implemented Model	Implementing Agency (Contractor)	Current Program Capacity	Families Served FFY 2014	Home Visits	Cost per Family
Windham	Parents As Teachers (PAT)	Generations Family Health Center	45	32	1291	\$10,692
Ansonia/Derby	Early Head Start – Home	TEAM, Inc.	36	49	2350	\$6,750

	Based Option EHS-HBO)					
New Britain	Parents As Teachers	Hospital of Central CT	75	100	2748	\$4,572
New London	Nurse-Family Partnership (NFP)	Visiting Nurse Association of Southeastern Connecticut	100	107	2736	\$4,826

Cost per family served was calculated by simply dividing the total dollar amount spent during the time period October 1, 2013 through September 30, 2014, by the total numbers of families served in FFY 2014, as shown in the above table.

Through a contract with Partners in Social Research, (PSR) funded with the D89 Expansion grant, the CT Formula Grant (X02) funded MIECHV sites to participate in a process evaluation, the goal of which is to assess implementation of home visiting services in CT. This assessment involves providing descriptive information about site inputs, site outputs, social dynamics, and coordination of care with other service providers. Data for this evaluation are being gathered through, home visitor and supervisor questionnaires, site visits and interviews with site administrators, documentation and records maintained by home visiting sites and structured telephone interviews with providers of other services (e.g., mental health, substance abuse counseling, domestic violence shelters, etc.) in target communities.

To generate descriptive information about site inputs, outputs, social dynamics, and coordination of care with local providers, the MIECHV process evaluation involves data collection from the following sources:

- (1) **Home visitor and supervisor questionnaires.** Questionnaires were administered in December 2013 and will be administered annually thereafter. They include close- and open-ended questions about social processes within home visiting sites, interactions with families, and interactions with other service providers. More specifically, staff questionnaires include single-item questions about staff professional background, current employment, service provision, supervision, training, perceptions of program relationships, assessment of work activity. In addition to single-item questions, questionnaires include multi-item measures that have been widely used and found to be reliable and valid in prior studies including: Job Satisfaction Survey (JSS), The Michigan Organizational Assessment Job Satisfaction Subscale, Supervisor Task subscale and Support for Family subscale from the Supervisor Support measure, and Supervisory Working Alliance Inventory Rapport subscale.
- (2) **Site Visits and Semi-Structured Interviews with Home Visiting Site Administrators.** Site visits and interviews were conducted in the summer of 2013. Follow-up interviews will be conducted annually thereafter to collect factual

information about site policies and practices and to gain a deeper understanding of how sites operate through observation and through semi-structured interviews with site administrators.

- (3) **Records Maintained by Home Visiting Sites.** Service utilization records will be obtained from home visiting sites in March 2015 to assess the patterns of service utilization using de-identified service utilization data in an electronic format. For each participating family, the data will include: enrollment date, termination date, home visiting appointments (kept, cancelled, and missed), referrals to services and home visitor identifier.
- (4) **Structured Telephone Interviews with Community Service Providers.** Brief, structured telephone interviews were conducted with providers of services to which participating home visiting sites might refer families (e.g., mental health, prenatal care, substance abuse counseling, etc.) in the summer and fall of 2014 to collect information about the nature of relationships with home visiting sites from the perspective of community service providers (e.g., point of contact, frequency of contact, flow of referrals) and to assess service availability, accessibility, and coordination.

Please refer to Section 3 for information about the Evaluation being conducted by PSR on a promising approach.

The referral process to the MIECHV services has evolved to include two potential referral streams. Initially, a centralized call line for referral and screening was thought to be the most effective approach to help potential clients reach services. A centralized call line through the United Way of CT (Connecticut Child Development Infoline) has been established with its toll-free number included on CT MIECHV outreach materials and referral forms. CT has learned, however, that a centralized call center is not always the best avenue for potential clients. Because they have become well established in their respective communities, the MIECHV LIAs are frequently the first point of contact for many enrolling families. Enrolled families have expressed their preference in first speaking directly with the agency that could offer services rather than through a referring entity. Also, the LIAs tend to have the most accurate information about local resources and are often in the best position to link eligible and non-eligible families to needed services. The LIAs have long-term relationships with providers such as WIC, food banks, shelters for homeless families, and faith-based organizations, as well as other maternal and child health programs. They have also become known to natural referral sources such as obstetrics and gynecologic (OB/GYN) clinics, pediatricians and other community based providers working with at-risk families. Additionally, home visitors would be trained to assist families to work with Access Health CT, the state's health exchange under the ACA.

Research from the Pew Center for Public Research suggests that the term "home visiting" has a negative connotation for many families because of its association with child welfare. The research further indicates that "parent education and support" are more positively received. The CT MIECHV team is applying this research with revised outreach materials that will use the more positive language.

Eligibility for MIECHV services is determined by using adverse childhood experiences (ACE) screening scores. A higher ACE score indicates an increase in the likelihood of poor health and mental health outcomes in adulthood, as well as lowered social and economic status. Women scoring above a 1.0 for an ACE are eligible for CT MIECHV PAT, NFP or EHS-HBO services. Identifying a potential client's history of childhood neglect and household dysfunction is the primary focus of the ACE screening and includes questions about family substance abuse and incarceration, sexual assault and mental health problems. These may be perceived as invasive questions to ask an individual before establishing a therapeutic relationship. Some clinical supervisors, responsible for administering the ACE screening, expressed discomfort asking sensitive questions for screening. In response to these concerns, CT DPH sponsored a training session for home visitors and their supervisors in November 2013 to learn about how to sensitively administer the ACE screening tool. Discussion about the numerous and damaging effects ACEs have on individuals' health and well-being was part of the training.

Efficient, accurate data collection has been greatly enhanced through the introduction of the MIECHV web-based data system in the fall of 2013. All LIAs have been trained in its use for the reporting of demographic information consistent with HRSA Form 1 requirements. Data input by LIAs staff is immediately available to CT MIECHV staff and allows for up-to-date data analysis of enrollment and demographic information. LIAs data collection and reporting for HRSA's benchmark and construct requirements (Form 2) have been streamlined via an Excel spreadsheet and "Frequently Asked Questions" guide. The spreadsheet and FAQ guide were developed by the CT DPH Epidemiologist in collaboration with Design Options for Maternal, Infant, and Early Childhood Home Visiting Evaluation (DOHVE) and with consultation with LIAs staff. On-site visits were conducted with each of the four LIAs to help ensure that data collected for the benchmark reporting would be accurate and consistent. A contract with the web-based developer was executed for developing the Form 2 benchmark web-based database. The developer worked closely with the CT MIECHV Epidemiologist to ensure the database meets HRSA reporting requirements as well as user needs.

The MIECHV staff 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.

Barriers: Obtaining accurate and complete data collection from three different models each with specific data requirements and from four different communities presented a challenge. It has been a complex process to meet requirements from HRSA, state and local agencies, and the individual model developers. The web-based data system has made a significant contribution to improving data collection for Form 1. By keeping their data up to date, LIAs have HRSA required data for Form 1 readily available in real time. The Form 2 Database was completed and introduced to the LIAs in early fall of 2014. On-going support and training will be offered to LIAs on the new database to ensure clean and accurate data is entered. The CT MIECHV team staff will monitor the Form 2 database regularly. The CT MIECHV team continues to offer

technical assistance for Form 1 especially when unique client or LIAs situations present. CT MIECHV team is also engaging the model developer and agency administrators in the processes of the Form 2 database build. For the NFP program, proprietary data rights have been a challenge to electronic access to the benchmark data. While data input may tend to be duplicative for NFP, it is anticipated that the web-based benchmark system will simplify data reporting for them. For LIAs support during the Form 2 database build, the CT MIECHV Epidemiologist has created an Excel spreadsheet for LIAs to use on an on-going basis to track the benchmark data and allow for easier tallying when benchmark reports are due.

Having three different home visiting models has also been somewhat of a challenge in terms of building a unified program among separate communities for statewide home visiting. The two LIAs implementing distinctive home visiting programs, NFP and EHS-HBO, do not have the benefit of sharing new administrative tools or resources among other implementing agencies in CT as the two CT PAT model implementers that have other CT PAT LIAs with whom to collaborate. All three models, however, are included in training opportunities and contractor meetings. The NFP and EHS-HBO LIAs administrations maintain relationships with their national model developers for support and model guidance. The CT MIECHV team will participate in the Regional NFP Learning Collaborative to gain additional insight in NFP implementation in New England and to bring pertinent information to the CT MIECHV NFP LIA. The CT MIECHV team encourages an open dialogue among the different implementing agencies with regard to their models' approaches, materials and administrative design. The CT MIECHV team recognizes the need to support a coordinated system to serve vulnerable populations, particularly through strong maternal and child health networks, so that the statewide home visiting plan can be effectively implemented.

Section 2: Home Visiting Program's Goals and Objectives

Goals and Objectives

The overarching goal of the CT MIECHV program is to develop a comprehensive, high-quality early-childhood system that promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships. The goals and objectives of this initiative, including progress to date, are as follows:

Goal 1: Strengthen and improve the programs and activities carried out under Title V.

Objectives:

- 1) Establish quantifiable, measurable baseline data;
- 2) Identify and implement a data collection system;
- 3) Establish and monitor data collection and reporting guidelines;
- 4) Conduct ongoing continuous quality improvement (CQI) activities; and
- 5) Conduct process and outcome evaluation.

Progress: CT has established quantifiable, measurable baseline data to corresponding benchmarks and constructs as approved by HRSA. The CT MIECHV Epidemiologist has carefully reviewed all MIECHV benchmarks for clarity to help ensure consistent data collection and accurate reflection benchmark achievements. A web-based data collection system for HRSA Form 1 reporting became operational in the fall of 2013 and has simplified reporting demographic data for all LIAs. The CT MIECHV staff review the contractor program and financial expenditure reports on a scheduled basis. In the summer of 2014, the reporting

schedule was changed from a tri-annual to quarterly schedule to align with HRSA timeframes. Annual benchmark and financial reports are submitted by each site. Site visits include a collaborative review of program progress, identification of strengths and weaknesses, and provision of technical advice. Email, telephone and period contractor meetings enhance the oversight and support CT MIECHV team can offer the LIAs. The CT MIECHV Epidemiologist initiated CQI discussions with LIAs during the winter of 2013/14. Ongoing quarterly site visits to each LIA will include review of CQI plans for home visiting programs based on the CT MIECHV CQI plan approved by HRSA in January 2014. Ongoing CQI activities incorporate: gathering data, monitoring data input into Form 1 of data system for accuracy and timeliness, offering clarification for Form 2 Benchmark reporting via submitted Excel spreadsheets and moving to the new web-based system, establishing measurable objectives based on data review at the local and state level, assessing data based on priorities identified through established criteria for improving the quality and safety of program services, using reports to monitor program implementation to reflect practice, establishing and supporting specific quality improvement initiatives and applying new learning.

Goal 2: Improve coordination of services for at-risk communities.

Objectives:

- 1) Establish memorandums of understanding (MOUs) or other formal agreements with health or social service agencies in the community;
- 2) Establish points of contact between the home visiting provider and all collaborating agencies;
- 3) Establish and maintain a coalition of community service providers;
- 4) Connect individuals and families with needed services;
- 5) Follow-up on referrals to ensure that services were provided;
- 6) Connect participants to health insurance resources;
- 7) Report maltreatment of children;
- 8) Connect participants to possible economic, employment, and education assistance programs;
- 9) Refer participants to relevant domestic violence services;
- 10) Provide referrals to parenting support services as needed; and
- 11) Provide referrals to local and state resources as needed.

Progress: Contracts were executed with the following LIAs (in parenthesis is the evidence-based model): The Hospital of Central CT (PAT), Generations Family Health Center (PAT), Visiting Nurse of Southeastern CT (NFP), and Training Education and Manpower (T.E.A.M.), Inc. (EHS-HBO). Each community has a strong coalition of community service providers that meet regularly. Families are being served; referrals are being made and are followed-up. All four (4) LIAs established clear points of connections with collaborating partners within their communities. Partners include hospitals, child welfare, WIC, Healthy Start, healthcare providers, mental health providers, immunization coordinators, social service providers and others, and have local advisory councils that meet regularly. All families receive a comprehensive assessment on enrollment and are referred to needed services. Follow up activities are tracked to ensure that services are provided.

As described earlier, collaborative efforts among the CT MIECHV team, LIAs, and Child Development Infoline (CDI) have resulted in processes for referral to a centralized call line or directly to the LIAs resulting in dual referral tracks through CDI or through direct referral to the LIAs from local service partners. The LIAs have working relationships with other existing

maternal/child resources such as Nurturing Families Network (NFN), local medical providers, WIC, Family Resource Centers (FRCs), and faith-based organizations, and are able to link clients to services and provide adequate follow-up. For referrals received from CDI, the LIAs report back to CDI as to the outcomes of those referrals. Home visitors will also be trained to assist families to work with Access Health CT, the Connecticut health exchange under the ACA.

Goal 3: Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

Objectives:

- 1) Increase the number of pregnant women enrolled who receive adequate prenatal care;
- 2) Decrease parental use of alcohol, tobacco, or illicit drugs;
- 3) Increase the number of women who receive preconception care;
- 4) Raise awareness of optimal birth intervals;
- 5) Screen participants for maternal depressive symptoms;
- 6) Promote breastfeeding;
- 7) Follow guidelines for well-child visits and immunization schedules;
- 8) Reduce emergency department visits for participants;
- 9) Provide information on prevention of child injuries;
- 10) Assess family members for domestic violence and develop safety plan if necessary;
- 11) Improve parental support for children's learning and development;
- 12) Increase parents' knowledge of child development and of their children's developmental progress; and
- 13) Promote activities that support fatherhood involvement.

Progress: The above objectives include ongoing activities for each of the evidence-based home visiting programs. Within each model, curriculum helps to guide home visitors in planning their parent support and education approaches, providing age or developmentally appropriate screening to help identify areas of concern, refer and engage families with other community systems of support including WIC, HUSKY (health insurance). Case management remains an essential component of all the models to help families meet basic needs. The programs provide services for families in at-risk communities and have staff representative of their community. Each site has mechanisms in place for accessing resources for translation when needed and have policies to assure compliance with the Americans with Disabilities Act (ADA).

Logic model update: the CT MIECHV X02 Formula Grant program is well established in the implementation phase of the program. The Home Visiting Advisory Council (HVAC) meets routinely to receive updates on recent home visiting activities and to offer suggestions for a successful implementation of the plan. The lead agencies are more actively involved with building the infrastructure for their home visiting program, acquiring materials and training with regard to their selected evidence-based model, and implementing their home visiting program while compiling data and information that depicts accountability and fidelity of their implementation processes (*see attachment 8 for the updated logic model of MIECHV programming in CT*).

Section 3: Update on the State Home Visiting Program Promising Approach

Consistent with Connecticut's goal to support a coordinated, family-centered approach to home visiting, the CT evaluation of a promising approach focuses on the value added by fatherhood

initiative enhancements to the CT PAT home visiting sites. The CT MIECHV program has contracted with PSR to conduct an evaluation on the effects of father-focused parenting support and education on family well-being. The fatherhood study, funded as a Randomized Control Study (RCS) with additional MIECHV funds (Expansion D89), includes the New Britain and Windham MIECHV sites. New Britain and Windham each have one father-focused home visitor who exclusively works with fathers enrolled in home visiting services and randomized into the study. These home visitors are PAT trained, and have received father specific training through the National Fatherhood Initiative, 24/7 Dads curriculum. They conduct monthly home visits with fathers and weekly fatherhood group meetings in their respective communities. Enrolling fathers can be challenging. Within the structure of the RCS, which ended enrollment as of October 1, 2014, fathers were only enrolled if their contact information was provided by the enrolling mother who may have been unwilling to do so. Fathers could not be enrolled independent of a target child’s mother as the evaluation measures the mother’s perception of the benefit of the father focused interventions. PSR is continuing conducting process evaluation activities with fathers that were enrolled. Fathers enrolled in the control group, will continue to receive services with only traditional female home visitors, however newly enrolled fathers will be able to receive services from a male home visitor. PSR supports the state fatherhood coordinator in providing training, routine meetings and connecting father home visitors with resources to help them support fathers enrolled in the study.

Section 4: Implementation of the State Home Visiting Program in Targeted At-risk Communities

The MIECHV Formula Grant funds home visiting services in four targeted at-risk communities. Details about the implementation by the LIA in each of these communities follow:

The Hospital of Central Connecticut, located in New Britain houses the MIECHV PAT program in its Family Enrichment Center (FEC). The FEC is a family-friendly center, equipped with space to host groups, individual and family conversations, as well as classes on birthing preparation, breast-feeding and baby care. The PAT program provides support and education to help parents to enhance and gain skills in parenting. The FEC services are offered at no-cost and are voluntary for families in New Britain.

Implementation of the State Home-Visiting Program in Targeted At-Risk Communities					
Name of Community	Name of Implementing Agency	Agency Contract Funding Amount		Evidence-based Home Visiting Model	
New Britain	Hospital of Central Connecticut (HOCC)			PAT	
Service Capacity: 75	# of Clients Served to Date: 131	# of Continued Eligible Clients Projected to be served in the two time periods below:		# of Projected New Families to be Enrolled in the two time periods below:	
Total Number		3/1/15 to	10/1/16 to	3/1/15 to	10/1/16

of Home Visits 9/1/13 – 9/30/14: 2748		9/30/16: 50	9/30/17: 35	9/30/16: 50	to 9/30/17: 40
Work-to-Date with Model Developer	Guidance with use of Visit Tracker Assistance with billing issues with national PAT				
Curriculum and Model Materials	Ages and Stages Bags *Parent and child relationship inventory PAT Curriculum Tote bags to support HV Life Skills Progression [LSP] curriculum Parent & Child Stress Index				
Training & Professional Development	Motivational Interviewing Working with Cognitively delayed families Leadership Training [HOCC] Engaging Families Engaging Fathers Circle of Security Family Development Credentialing November 2014 and ongoing: All trainings will be regularly offered annually for new staff				
Staff, Recruitment, Hiring, Retention	Staff was recruited with support from the HOCC and consists of a home visiting Program Manager, Supervisor, and 3 Traditional Home Visitors., All staff members [with exception of father involvement worker] have degrees in social work, human services, early childhood education, or psychology. As of April 29 th , one staff member resigned to pursue other career options. Historically, this site has long-term team members with limited turnover. The team members' professional and personal growth is supported through a strength-based management philosophy, which contributes to longevity in the workplace. Each home visitor receives a minimum of one and a half (1.5) hour a week of reflective supervision as well as a two (2) hour staff meeting that includes one hour of peer group case review. The supervisor additionally receives a minimum of one hour a week of reflective supervision from the Program Manager. Program Manager receives bi-weekly reflective supervision with the Director of Social Work. The supervisor receives a minimum of 32 hours of continuing education units annually.				
Referral and Services Networks	Word of mouth referrals are common in the close-knit community, as well as home visiting referrals coming from a variety of sources such as private medical/mental health providers and the local food pantry. The two most consistent sources of referrals are hospital-based OB/GYN clinics and the local WIC office.				
Participant Recruitment and Retention	Priority is given to those with higher ACE scores. Assessment of open cases that have delivered and have children in year two will be re-assessed, and whenever appropriate will graduate to every other week visits. HOCC's public affairs office supports the marketing and outreach efforts for programming. Additionally, the hospital print center supports printed materials. Family "socials" involve activities inclusive of a variety of preferences: Stress reeducation, nutrition, car seat safety, storm preparedness safety, reading, developing a child's brain. In the past year				

	(10/1/2013-9/30/2014) 45 families were discharged from services. Reasons for discharge include: miscarriage, relocation, unable to reach, or other (scheduling difficulties, opted out, aged out).
Status of Current and Projected Caseload	Three home visiting positions are funded through this project. Each HV has a case load of 12-15 families and provides a minimum of one 90 minute home visit weekly.
Coordination Between Home Visiting Agency and Existing Programs and Resources	The HOCC has 27-year history of effectively conducting outreach activities. Integration into the local WIC program has aided in the number of families enrolling into services. All expectant mothers (28 weeks and under) are referred to HOCC's services via HOCC OB/GYN clinic. The outreach coordinator has computerized access to all patient records that are referred for services and screens for eligibility. The outreach coordinator then meets with patient at time of appointment, discusses any further screening clarifications needed, explains supportive services and makes an appointment for enrollment with Clinical Supervisor or refers the client to other appropriate services, such as Child FIRST, NFN, or FRC. Additionally, the program's advisory council is represented by community agencies including health and wellness, job readiness, literacy, childcare, K-12 education and secondary education. Newly added to services at our center to support families are two programs. There is a contracted Licensed Clinical Social Worker (LCSW) who is able to enhance our support to families by providing in-home clinical interventions with the goal to bridge families to local counseling services and or clarify mental health needs and interventions to better support their parenting abilities and reduce stress and violence in homes. There are added supports for trainings, groups, outreach events to promote opportunities for self-regulation and healthy relationships through, health and fitness [includes gym memberships] and classes for yoga, meditation and communication, self-regulation and stress reeducation.
Anticipated Challenges for Maintaining Quality and Model Fidelity	An anticipated challenge is managing demand in relation to level of funding. With the staff turnover, families have been reassigned and discharged to other services to provide these families with programing to continue with the support they desire. A minimum of 4 referrals for services are received each week. Moreover, New Britain High School has 50 pregnant and parenting mothers as well as several young fathers who may or may not fall into the catchment of this program. This has been a challenge to provide services to this community as capacity and program limits at times put limits on the ability to serve some families. HOCC has been challenged with the budget streams for this project. HOCC has provided support to cover expenses and intends to respond to this challenge by maintaining fidelity to the program and serving families consistently while working closely with the CT MIECHV Team.

Visiting Nurse Association of Southeast CT (VNASC), located in New London, began the planning process to respond to the growing teen pregnancy rate in the community, in 2004. The Teen Pregnancy Prevention Task Force at the VNASC became aware of the NFP model through various reports and after further investigation of the model and communication with the researcher David Olds, it was determined that VNASC funding could not support the program. The decision was made to begin a program that followed the guiding principles of NFP and to as closely as possible follow the model. The available funding allowed for 20 to 30 women to be admitted to the program, which VNASC named the *Nurse/Family Care Program*. The

program has been widely accepted by patients, with the main referral source being Lawrence and Memorial Hospital (LMH) and the local Obstetric community. MIECHV funding has allowed VNASC to enter into a formalized relationship with the NFP model developers, provide better training for their staff and implement the NFP model with fidelity.

Implementation of the State Home-Visiting Program in Targeted At-Risk Communities					
Name of Community	Name of Implementing Agency	DPH/Agency Contract Funding Amount		Evidence-based Home Visiting Model	
New London	Visiting Nurse Association of Southeastern CT (VNASC)	\$401,000.00		Nurse-Family Partnership	
Service Capacity: 100	# of Clients Served to Date : 130	# of Continued Eligible Clients Projected to be served in the two time periods below:		# of Projected New Families to be Enrolled in the two time periods below:	
Total Number of Home Visits 10/1/13 – 9/30/14: 2736		3/1/15 to 9/30/16: 50	10/1/16 to 9/30/17: 50	3/1/15 to 9/30/16: 90	10/1/16 to 9/30/17: 70
Work-to-Date with Model Developer	Supervisor participates in monthly nurse consultant telephone calls and monthly community of practice conference calls with the northeast region NFP sites. These are led by a regional nurse consultant. During the monthly nurse consultant calls, operational efficiency is discussed reflecting about a year’s worth of cumulative activity inclusive of the prior month’s data. The cumulative data is summarized from bench-mark related data provided from the VNASC site to the web-based Social Solutions site. NFP National Service Office (NSO), on the first of each month, circulates the NSO Monthly Communication that includes updates on the following topics: Nursing Practice, Public Policy, ETO (database) Reminders and Tips, and Marketing and Communications. This VNASC site (11-12-2013) has, also, worked the NSO and CT DPH-MIECHV leadership to discuss Medicaid reimbursement for home visit services as an approach to developing sustainability.				
Curriculum and Model Materials	Any and all new and updated materials recommended by Nurse-Family Partnership NSO are provided, on-line, at no additional cost to the participating site. It is the responsibility of the local implementing sites to update the material.				
Training & Professional	April 2012, initial Nurse-Family Partnership (NFP) training in Denver for all three nurses and the program supervisor. One nurse (10-2012) relocated to another state. Two new nurses were added during the first half of 2013; they received initial NFP program training in Denver. Additional supervisor training in Denver (2012) was followed by an educational conference in Denver during May 2013. 9-9-2013: CT Breast Feeding Coalition annual conference				

	<p>10-9-2013: CT DPH MIECHV database training – program supervisor 10-16-2013: Infant Loss workshop sponsored by Lawrence & Memorial Hospital 10-30-2013: Ages and Stages training sponsored by the Children’s Trust Fund <i>Help Me Grow</i> Campaign 11-19-2013: MIECHV ACES and Edinburgh training 12-9-2013 to 12-12-2013: MIECHV <i>Circle of Security</i> training 1-27-2014: MIECHV <i>Motivational Interviewing</i> training 3-21-2014: <i>Crucial Conversations</i> training for program supervisor sponsored by Lawrence & Memorial Hospital 5-29-2014: NFP Motivational Interviewing update 6-2-2014: Identifying and Working With Parents Who Have Cognitive Limitations sponsored by the CT Dept. of Children and Families (DCF) 6-11-2014: MIECHV annual training conference 9-30-2014 to 10-2-2014 MCH 2014 conference featuring a 1-day NFP training workshop. November 2014 and ongoing: All trainings will be regularly offered annually for new staff.</p>
Staff, Recruitment, Hiring, Retention	<p>Staffing is a full complement of four nurses and one supervisor. The one Spanish-speaking nurse was on maternity leave between February and May 19, 2014. This has impacted the ability to accept new referrals. During her absence, the other three nurses visited a few of her clients according to the NFP recommended schedule. Most of her enrolled mothers did not want to be visited by another nurse, since the strong and deep relationship had been developed by the nurse on maternity leave. The nurse supervisor schedules, each week, with each nurse for one-on-one supervision using motivational interviewing and reflective practice approaches. This is required by Nurse-Family Partnership. There might be weeks when this does not happen due to planned nurse time-off, illness or holidays. At the recommendation of NFP, there is either a weekly team meeting or case conference. The team meetings are supervisor led, while the case conferences are nurse home visitor led. This works well in two ways to support retention: through communicating about the NFP program in general, its strengths and challenges, and to recognize the individual strengths and competencies of each nurse as they contribute to the potential outcomes of an individual mother/child dyad.</p>
Referral and Services Networks	<p>Maintaining a continuous and effective referral network is a challenge, although progressing with the private OB/GYN providers. The nurse home visitors regularly visit their offices. To the extent possible, weekly outreach to WIC offices is provided by the nurse home visitors who are trying to build case load. The program, now two years in existence, is beginning to receive referrals from word-of-mouth; mothers who have nurse home visitors and recommend the program to a friend. If a referral is for a Spanish-speaking mother, they might have to go onto a wait list until there is an opening in the caseload of the Spanish speaking nurse. The NFP curriculum materials are available in English/Spanish so that if there is a working knowledge of English by Spanish speaking mothers, other than a Spanish language nurse may be able to serve the mother. The catchment area is rich with multiple cultures and languages. VNASC is exploring a relationship with a local college for language translators.</p>
Participant Recruitment and Retention	<p>Participant recruitment continues to be a challenge. Providers report that some pregnant mothers are reluctant to engage in a home visitation program and decline the opportunity for referral. However, experience indicates that when referred families have an initial exploratory visit, the mother (and father of the baby) gain the confidence from their nurse and will usually enroll. NFP nurse home visitors do regularly visit provider offices to make contact and leave program materials and referral forms. A very successful recruitment strategy is to regularly visit the WIC clinics, speak with the</p>

	<p>prospective enrollees and schedule enrollment appointments right then. The New London WIC staff welcomes the NFP program; one of their newly pregnant first time mothers asked to enroll into the NFP program, but was income ineligible. A successful strategy is to regularly consult with the provider office nursing staff to discuss the care plan for the provider’s patient. This nurse-to-nurse collegial relationship is rich for nurses at both locations and, secondarily, mutually affirms the challenge of working with the difficult clients and situations.</p> <p>VNASC’s attrition numbers have been quite low and recognized as such by the NFP nurse consultant. In the past year (9/10/13 – 9/30/14, 21 families have exited the program. When analyzing the factors that contribute to attrition, there are some that NFP and VNASC might influence. This NFP program is implemented in a service area that includes the U.S. Naval Submarine Base – New London. Some enrolled mothers have suddenly found themselves relocating. If they are going to a location where there is an existing NFP program, with their permission, a program to program transfer is arranged. If there is no NFP program, attempts are made to connect them with another family support program in their new area. Other NFP enrolled mothers have dis-enrolled under pressure from their own parents (usually the client’s mother), especially if the NFP mother has moved into her parent(s)’ home. There have been a couple of mothers who have been dis-enrolled when they became “lost to service” particularly if they were teenaged, living within highly dysfunctional families or in DCF custody. These enrollees might experience mental health/school challenges that are preventing them from voluntarily and successfully participating in the home visitation program. Speaking to the success of NFP supporting the individual enrollee’s personal goal, some mothers have returned to school or work, which challenges their ability to regularly meet with their nurse home visitor. These mothers are offered alternative visit schedules (encouraged by the NFP NSO) at a mutually convenient location, unless it is time for a scheduled screening when it is necessary to include the infant/child.</p>
<p>Status of Current and Projected Caseload</p>	<p>Each nurse home visitor is working towards a case load of 25 clients, which challenges them because of the complexity of the individual client situations. On average, the caseload is 18. The nurse home visitors work a 37.5 hour work week; NFP typically recommends a 25-client caseload for a 40-hour week. NFP NSO is considering the practicality of a 25-client case load and may adjust their recommendation.</p>
<p>Coordination Between Home Visiting Agency and Existing Programs and Resources</p>	<p>In addition to referral and services networks for clients, the NFP program supervisor participates in a bimonthly Parent Education Network at Lawrence & Memorial Hospital (L&M), attends the Lactation Task Force monthly meeting at L&M, participates in the L&M “Baby Shower”, and attended the Southeast Early Childhood Collaborative. VNASC has worked successfully with Mother’s Retreat, a substance abuse residential treatment center located within the service area. CareNet is a charitable organization that provides not only referrals, but baby equipment and supplies to mothers; The New London Rotary through their “DO GOOD” committee provided funds to purchase a bed and baby supplies for an indigent and homeless mother. The New London Rotary regularly provides infant-toddler books to support NFP efforts toward early literacy and language development. Read to Grow, a statewide organization that supports early literacy provides NFP with new and gently used books to give to mothers. The local Episcopal Church’s ladies quilting group lovingly sews hand-made quilts for babies. Others in the community donate toys to help with child assessments and for gifts. VNASC NFP applied for and received from the William T. Christopher Fund for Children’s Health a grant to decrease maternal/parent isolation through “play group” type activities to promote infant/toddler brain development and mental health and early literacy. Additionally, it will support</p>

	CPR and first aid education to the NFP participants, and provide other educational programs over a one-year period. Program activities include provision for a Spanish-language translator. This is a collaborative, at the request of NFP, with the UCONN Graduate Program of Human Development and Family Studies. On a CT state-wide level, the NFP program supervisor participates in meetings of the CT DPH Coalition to Improve Birth Outcomes. This participation is a natural extension of the goals of MIECHV. Volunteers on the quarterly NFP Community Advisory Committee, some of who are service providers are a source of networking and referrals.
Anticipated Challenges for Maintaining Quality and Model Fidelity	<p><u>Funding</u></p> <ul style="list-style-type: none"> Sustainable funding sources due to uncertainty of continued MIECHV funding Challenge to attaining and necessity to acquire third-party, including Medicaid, payment for NFP nurse home visitor nursing and case management. Such an investment in NFP nursing services will improve birth outcomes, improve infant-toddler health reducing the cost of health/medical care, promote mother/child attachment, reduce child and mother maltreatment, improve schools readiness ultimately reducing remedial and behavioral services, and improve school performance. It all begins pre-conceptually and prenatally. <p><u>Referrals:</u></p> <ul style="list-style-type: none"> It is anticipated that as the successful NFP outcomes become apparent in the community, the number of referrals will increase until a wait-list is established. That may result in providers referring clients to other programs. <p><u>Training:</u></p> <ul style="list-style-type: none"> Complex and difficult families enrolled in the NFP program could edge nurses towards “burnout”. High quality and useful training must continue to be provided by the CT MIECHV program and NFP program model to prevent NFP program and other MIECHV program disequilibrium from staff discontent or turn-over.

Generations Family Health Center, Inc. (GFHC), located in Windham, is the lead agency for this home visiting program. GFHC is a Federally Qualified Health Center (FQHC) providing accessible, high quality primary, oral and mental health care services, as well as access to resources to meet the basic needs of individuals of all ages, regardless of ability to pay. Also of note, is GFHC’s status as a Qualified Entity (QE) for processing HUSKY A (Medicaid) presumptive eligibility (PE) applications for pregnant women and children, allowing treatment and care to begin immediately. Site visits and written reports provide the following updates:

Implementation of the State Home-Visiting Program in Targeted At-Risk Communities			
Name of Community	Name of Implementing Agency	DPH/Agency Contract Funding Amount	Evidence-based Home Visiting Model
Windham	Generations Family Health Center, Inc.	\$150,000	Parents As Teachers
Service Capacity: 45	# of Clients Served to Date: 66	# of Continued Eligible Clients Projected to be served in the two time periods below:	# of Projected New Families to be Enrolled in the two time periods below:

Total Number of Home Visits 10/1/13 – 9/30/14: 1291		3/1/15 to 9/30/16: 15	10/1/16 to 9/30/17: 45	3/1/15 to 9/30/16: 40	10/1/16 to 9/30/17: 15
Work-to-Date with Model Developer	Annual PAT Conference October 2013				
Curriculum and Model Materials	All required materials have been secured for the programs continued implementation. Materials include blocks, baby mirror, blankets, rattles and other baby items.				
Training & Professional Development	September 18, DPH MIECHV training; November 19, 2013 DPH MIECHV training; December 6 2013 DPH MIECHV training November 2014 and ongoing: All trainings will be regularly offered annually for new staff.				
Staff, Recruitment, Hiring, Retention	The human resources department is responsible for recruitment and training. There has been no staff turnover during this reporting period. Efforts to ensure high-quality supervision include: a minimum of 1 hour per week of individual supervision for the manager, supervisor and home visitors; monthly department meetings; bi-weekly staff meetings where peer reviews are completed. Role play is practiced and discussion of case scenarios takes place at the bi-weekly staff meetings. Each staff member participates in 30 hours of continuing education through both internal and external trainings.				
Referral and Services Networks	Generations has a long time working relationship for referrals and services with the following entities: Nurturing Families Network, State Healthy Start, Child FIRST, Head Start, WIC, Windham Regional Community Council (WRCC), Windham Area Interfaith Ministry (WAIM), Windham Public Schools, Prenatal clinic, Mansfield OB/GYN, Parent Engagement Meeting, Early Childhood Regional Workgroup, and Head Start Advisory Board. An advisory board meeting is held every quarter to discuss referrals, recruitment, program development and fidelity to evidence-based models. Members include community service providers and two families currently enrolled in the program.				
Participant Recruitment and Retention	Word of mouth referrals are common. Family recruitment is secured through outreach at the following locations; WIC, prenatal clinic, Mansfield OB/GYN, Willimantic Library, hair salons, youth camps, Women’s Health Center of Eastern Connecticut, WAIM, Head Start, Windham public school, area churches, WRCC, laundry mats, restaurants and grocery stores. Willimantic is a transient population and every effort is made to retain families. Staff has a flexible work schedule and conduct home visit on a weekly, bi-weekly or monthly schedule to meet the needs of the families. Home visits are also scheduled in the evening to accommodate working family’s schedule. Attrition rate: In the past year (10/1/13 – 9/30/14), 7 families exited home visiting services. Attrition reasons include: relocation, no contact or aging out of the program.				
Status of Current and Projected Caseload	Generations currently has only two traditional home visitors serving the 27 families enrolled in home visitation. The agency plans to hire another traditional home visitor and anticipates recruitment of 18 more families to reach capacity.				

Coordination Between Home Visiting Agency and Existing Programs and Resources	As part of a FQHC families are priority for internal referral for medical, dental and behavior health. Families also benefits from the non-clinical programs offered by Generations including care coordination, SNAP, Affordable Care Act, Husky information and outreach and Healthy Start. Generations services continue to be integrated in several community partner agencies such as; WIC, prenatal clinic. Community networks include; NFN, DCF, United Services, Access Agency, State Healthy Start, Child FIRST, Head Start, WIC, WRCC, WAIM, Windham Public Schools, Prenatal clinic, Mansfield OB/GYN, Parent Engagement Meeting, Early Childhood Regional Workgroup, and Head Start Advisory Board.
Anticipated Challenges for Maintaining Quality and Model Fidelity	A challenge continues to be securing prenatal referrals. To address this, Generations increased outreach to Planned Parenthood, The Women’s Health Center of Eastern Connecticut, Mansfield OB/GYN and Prenatal Clinic. Providers are invited to lunch to allow for one on one time to discuss the MIECHV program in detail. This also gives providers a chance to meet staff and be confident in what they were referring to.

TEAM, Inc. Early Education, located in Ansonia/Derby, houses the Early Head Start-Home Based Option (EHS-HBO) model. TEAM, Inc. coordinates through the Valley Early Childhood Task Force, part of the Valley Council for Health and Human Services (VCHHS), charging the group to assign roles and responsibilities as a MIECHV Advisory Committee. The VCHHS is a partnership network of approximately fifty (50) non-profit health and human service agencies serving the residents of the Lower Naugatuck River Valley – including Ansonia and Derby. Its mission is to improve quality of life by working collaboratively to identify and respond to community needs. Site visits and written reports provide the following updates:

Implementation of the State Home-Visiting Program in Targeted At-Risk Communities					
Name of Community	Name of Implementing Agency	DPH/Agency Contract Funding Amount		Evidence-based Home Visiting Model	
Ansonia/Derby	TEAM, Inc. Early Education	\$250,000		Early Head Start Home Based Option	
Service Capacity: 36 families	# of Clients Served to Date: 71 clients	# of Continued Eligible Clients Projected to be served in the two time periods below:		# of Projected New Families to be Enrolled in the two time periods below:	
Total Number of Home Visits 10/1/13 – 9/30/14: 2350		3/1/15 to 9/30/16: 20	10/1/16 to 9/30/17: 25	3/1/15 to 9/30/16: 30	10/1/16 to 9/30/17: 22
Work-to-Date with Model	The MIECHV/Early Head Start Manager continues to connect with Missy Repko, ECE & Infant/Toddler Specialist for the Region 1 Head Start Training and Technical Assistance Network who provides technical assistance in one on one meetings, phone conversations and e-mails with the MIECHV/Early Head Manager. Areas of discussion				

Developer	<p>included but were not limited to: Early Head Start Performance Indicators, Early Head Start School Readiness Goals, Early Head Start Professional Development and Early Head Start Consultants for professional development.</p> <p>The MIECHV/Early Head Start staff participated in Early Head Start professional development provided by state and regional Head Starts including: Center on the Social and Emotional Foundations for Early Learning (CSEFEL), New England Head Start Association Conference and numerous Early Head Start webinars. The MIECHV/Early Head Start Manager continues to attend quarterly state Early Head Start meetings.</p>
Curriculum and Model Materials	<p>Parents as Teachers (approved users of curriculum). New hire attended PAT approved user training two weeks after start date.</p>
Training & Professional Development	<ul style="list-style-type: none"> • Family Development Credential Training (one Home Visitor – 80 hours 10/1/13 – 11/15/13 certification received) • Baby Massage Coaching workshop (9/20/13) • Child & Adult Care Food Program (CACFP) training for infants (10/17/13) • Trauma Informed Community Collaboration (DCF-10/23/13) • Parents Interacting with Infants (PIWI) training through the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) (10/28/13) • Mental Health First Aid Training through BHCare (11/7/13 & 11/8/13) • Circle of Security training (12/9/13-12/13/13) • Motivational Interviewing training (1/27/14) • Parents as Teachers training (new hire-curriculum approved user 2/11/14-2/13/14) • Baby Massage Coaching workshop (new hire 2/26/14) • 15th Annual New England Fathering Conference (3/12/14-3/14/14) • New England Head Start Association Conference (4/8/14-4/10/14) • Ages & Stages 3 and SE training (new hire 4/10/14) • Lactation Consultant training (RN 3/24/14-3/28/14) <p>November 2014 and ongoing: All trainings will be regularly offered annually for new staff.</p>
Staff, Recruitment, Hiring, Retention	<p>One of the MIECHV/Early Head Start Home Visitors took a position as Family Support Specialist with Head Start. A new hire began as Home Visitor on January 23, 2014. The transition was extremely smooth due to the fact that this was an internal move for the previous Home Visitor. Head Start allowed her to work for both Head Start and Early Head Start to provide a seamless changeover. The new hire was able to shadow the previous Home Visitor and continues to get information on her caseload as they have adjacent offices. The MIECHV/Early Head Start Manager shares office space with Home Visiting staff which allows constant communication and supervision. The Manager has 12 years of supervisory experience and has also participated in trainings which include reflective supervision, motivational interviewing and coaching. Continued trainings have ensured high quality supervision.</p>
Referral and Services Networks	<p>To support the Home Visitors, service networks have been continuing with Birth to Three, DCF, Nurturing Families Network, Child FIRST, Naugatuck Valley Health District and the Lower Naugatuck Valley Parent Child Resource Center – all of whom are available to accompany MIECHV/Early Head Start Home Visitors on home visits to serve at-risk families. These organizations have referred families to MIECHV/Early Head Start as well as MIECHV/Early Head Start referring to these organizations to meet the families’ needs. Other service networks throughout the Valley have reached out to MIECHV/Early Head Start providing the families with much needed food, toys</p>

	and monetary gifts throughout November and December 2013. These agencies include: CT Partnership for Children in Seymour (Thanksgiving baskets); TEAM, Inc. (Community Action Agency – Toys for Kids and monetary gift donations); and Valley United Way (corporate donations for 15 families of gifts and money);
Participant Recruitment and Retention	<p>Measures used to ensure outreach to the community included distribution of flyers during preschool orientations, at public libraries, Griffin Hospital Birthing Center, OB/GYN offices, pediatric offices, high schools, community organizations, DCF, Birth to Three, Valley Regional Adult Education, newsletters, websites, 211 Info Line and various community activities such as: Ansonia Harvest Festival (10/5/13); Shelton Day (10/6/13); Play & Learn Fair Ansonia (4/5/14).</p> <p>The Family Support Staff for Head Start work very closely with the MIECHV/Early Head Start Home Visitors in recruiting families that enroll in Head Start with a 3 or 4 year old that are also eligible for MIECHV/Early Head Start with a pregnant mom or a sibling that is younger than 3.</p> <p>Recruitment for families has also relied on the newly formed Valley Diaper Bank that is operated through the Valley Family Resource Center. Funding was obtained in October 2013 from the Valley Community Foundation to begin the Valley Diaper Bank. MIECHV/Early Head Start families are automatically eligible for the Diaper Bank and receive their monthly diapers and wipes during playgroup once a month if in good standing with attendance of home visits and group socializations. Besides recruitment, the Valley Diaper Bank has been an important caveat in the retention of MIECHV/Early Head Start families. Diapers and wipes are a huge need for these low income families and they provide an excellent incentive for family participation in the program. Participant attrition for the past year (10/1/13 – 9/30/14) was 13 families.</p>
Status of Current and Projected	To date, the caseload of each of the 3 Home Visitors is 12, 12, and 11 with one eligible family in intake. The limit for each Home Visitor is 12. As children transition into a preschool program and exit MIECHV/Early Head Start, the program will draw from its wait list to fill those slots. The projected caseload for each Home Visitor is 12 families.
Coordination Between Home Visiting Agency and Existing Programs and Resources	<p>Naugatuck Valley Health District (NVHD) is contracted with MIECHV/Early Head Start to provide ongoing staff development with an RN twice a month with MIECHV/Early Head Start staff who then bring the health and safety information into the enrolled families' homes each week during the home visit. The RN is also available for phone consultation with staff and offers health presentations for the parents. (Funding for the RN is through D89 Expansion Grant.) Funding from the Valley Community Foundation (NVHD) supported the formation of a Maternal Health Coalition of which the MIECHV/Early Head Start Manager is an active member. The tasks of this Maternal Health Coalition include: assessing the status of perinatal and inter-conceptual maternal care in the Valley; identifying gaps in health care services; determining ways to decrease the incidence of sexually transmitted infections; providing awareness and education regarding the need for early prenatal care; and reviewing other health issues impacting women in the Valley. The Lower Naugatuck Valley Parent Child Resource Center (PCRC) is contracted with MIECHV/Early Head Start to provide ongoing staff development, trainings and support in the area of mental health. Child First operates through PCRC and has a referral process in place with MIECHV/Early Head Start. Child First has referred to MIECHV/Early Head Start and MIECHV/Early Head Start has referred to Child First. MIECHV/Early Head Start also collaborates with BHCare in Ansonia. This non-profit behavioral health care provider serves individuals, families and children affected by mental illness, domestic violence and substance abuse. Birth to Three continues to work closely with MIECHV/Early Head Start by providing one of its Home Visitors to accompany MIECHV/Early Head</p>

	<p>Start staff on home visits where developmental delays are a concern. Early Head Start performance indicators require that Early Head Start have 10% of its enrollment fall into the category of special needs. The program is currently meeting that requirement by serving 4 families through the Birth to Three system. The local DCF office in Milford has a referral process with the families that they work with to refer them to the MIECHV/Early Head Start program. The MIECHV/Early Head Start Manager meets quarterly with the local DCF/Head Start Collaborative and has participated in Trauma Informed Community Collaboration with the DCF office in Milford in addition to many other collaborative agencies. MIECHV/Early Head Start collaborates with the Spooner House, the local homeless shelter, to serve pregnant women and families that have children birth up to 3 years old. MIECHV/Early Head Start Home Visitors conduct the weekly home visits at the homeless shelter and the program pays for the local transit company to transport these families to the group socializations twice a month. The MIECHV/Early Head Start Manager serves as co-chair of the Ansonia School Readiness Council and co-chair of the Derby Early Childhood Council. Both Councils have been working on community plans through the William Caspar Graustein Memorial Fund's Discovery projects and has MIECHV/Early Head Start outcomes threaded throughout the Education, Health, Safety and Family subcommittees of both the Ansonia and Derby community plans. Each Council's agenda has a regular report from MIECHV/Early Head Start along with the Early Childhood Task Force, a subcommittee of the Valley Council of Health and Human Services. All of the these connections, along with Early Head Start state quarterly meetings and Health & Nutrition State Manager's meetings, keep the MIECHV/Early Head Start program aware of continued staff development on the topic of early childhood issues.</p>
<p>Anticipated Challenges for Maintaining Quality and Model Fidelity</p>	<p>There are no anticipated challenges for maintaining quality and model fidelity. The MIECHV/Early Head Start program maintains fidelity to the Early Head Start Performance Standards and other regulations set forth by the Office of Head Start. Data will be reported out in the 2013-2014 Head Start Program Information Report (PIR) from the Office of Head Start. The PIR represents the structural elements necessary for model fidelity and supports the growth of the Early Head Start model. The 2013-2014 PIR was submitted August 31, 2014. This document has aggregated information on Head Start and MIECHV/Early Head Start. A copy of this year's PIR was submitted to CT MIECHV Program upon its completion at the end of August.</p>

Programmatic and Fiscal Monitoring: The OEC will monitor LIA compliance with federal programmatic and fiscal requirements. The OEC will meet bi-monthly with the LIAs, and quarterly with 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.

Section 5: Progress Toward Meeting Legislatively Mandated Reporting on Benchmark Areas

Connecticut's MIECHV Program includes the collection of data on legislatively-mandated benchmarks (*See Attachment 7*) that measure program outcomes in each of the four selected communities. Tremendous progress has been made in refining and improving the data collected for benchmarks, as outlined below (*see attachment 7 for Benchmarks*).

- Initial collection of benchmark information revealed areas of possible ambiguity and/or measures where further clarification was needed. Each benchmark was reviewed with particular attention to whether data collected by the LIAs corresponded exactly to how the benchmark was written. Clarifications and small amendments were drafted and shared with DOHVE on 2/26/2014. The CT MIECHV Epidemiologist conducted site visits at each of the four local LIAs to review and discuss the benchmark clarifications and assure that each LIA was collecting data in the same way. Documents that explained and clarified the benchmark data collection were drafted for the LIAs to use as references.
- The Form 2 database was completed in early fall 2014. Training and technical assistance was provided to the LIAs by the MIECHV Epidemiologist and the database developer. Significant attention was given to the design of the database to achieve the following goals:
 - Capture all the data needed for the legislatively-mandated benchmarks;
 - Be as user-friendly as possible;
 - Ensure that data from “Form One” (demographic) can be linked with “Form Two” (Benchmark) data;
 - Capture data that goes beyond the required benchmark information that will be useful for program analysis and CQI efforts, as well as overall epidemiologic analysis of the Connecticut MIECHV Program. This capture of additional data must be done balancing the desire for more information with an understanding of what is feasible for staff to do at the site level;
 - If possible, build in compatibility with at least one of the program models’ data systems that currently capture program implementation data (for example numbers of home visits, additional family risk factors, etc.) Linkage with the model-specific data will further expand the possibilities for data analysis and understanding of the MIECHV Program in Connecticut.
- A new instrument was created for home visitors to keep with each family’s file. This 7-page document was a tool for the LIAs to use to record each family’s Form 2 benchmark information while the Form 2 database was under construction.
- The Form One database is complete and in use by three out of four of the LIAs. The fourth LIA pulls the relevant data collected in their model-specific database.
- The database, which includes Forms 1 and 2 were available for LIAs to input data for the 2014 Benchmark report.
- The DGIS Benchmark report was submitted on October 30, 2014.
- 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.
- Ongoing support, training and technical assistance will be provided to LIAs.

Section 6: State Home Visiting Continuous Quality Improvement Efforts

The CT MIECHV recognizes that a well-designed CQI program will strengthen services within the home visiting program and result in more effective program implementation and improved participant outcomes. The review of the benchmark data measures and continuing discussions

with the LIAs about their data collection have been a cornerstone of the CQI process. Ensuring that the data are complete and collected consistently within an agency, across agencies, and across program models is the foundation required before meaningful interpretation of the data can take place.

In addition to refining the data collection and reporting process, further progress with CQI includes:

The CQI Plan was submitted to HRSA in November 2013 with final HRSA approval in January 2014.

- Site visits to each of the LIAs have included discussions about CQI and how plans can be developed at each site. Discussions have included using existing staff and agency structures (for example, advisory boards) to approach CQI and integrate it into daily work. Discussions have also included the formulation of preliminary goals; these have included increased efforts at recruitment, and increasing rates of prenatal care. The CT MIECHV team has shared customized reports of outcome data with the LIAs, in some cases comparing individual LIA data with overall program averages. The use of agency-level data, generated both by the CT MIECHV and by the LIAs, will increase over time as the quality and volume of data increase, and as CQI efforts become more sophisticated.
- Each of the three program models are also required to submit reports to their respective model developers. In some cases these reports include elements that could dovetail with CQI efforts. Discussions are on-going to explore ways to capitalize on and expand upon those model-specific data collection and review processes as well.

Section 7: Administration of State Home Visiting Program

The Connecticut Office of Early Childhood (OEC) was legislatively established in May 2014 to develop and administer a coordinated system of early care and education for young children (from birth to age eight) to ensure optimal health, safety and learning for each child. The OEC is the identified lead agency for home visiting services and in the X02 Formula Grant application. *Please refer to Attachment 4.*

The estimated unobligated balance of HRSA formula funds awarded in FY 2013 is: \$0.00

The estimated unobligated balance of HRSA formula funds awarded in FY 2014 is: \$0.00