AFFORDABLE CARE ACT (ACA)
MATERNAL, INFANT AND EARLY CHILDHOOD
HOME VISITING (MIECHV) PROGRAM

Nebraska Updated State Plan for a State Home Visiting Program

JUNE 7, 2011

INTRODUCTION

This Updated State Plan is being submitted by the Nebraska Department of Health and Human Services (NE DHHS) in accordance with the requirements set forth in the Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program, OMB Control No. 0915-0336, issued on February 8, 2011. This Updated State Plan follows two previous submissions, Nebraska's grant application dated July 8, 2010 and its Statewide Needs Assessment dated September 20, 2010.

NARRATIVE:

SECTION 1: IDENTIFICATION OF THE STATE'S TARGETED AT-RISK COMMUNITY(IES)

Nebraska has identified the counties of Scotts Bluff, Morrill, and Box Butte as the communities targeted for implementation of the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program. In this section, information will be provided on a 3-level process used to identify these counties, followed by more detailed information on each of the counties and the region of Nebraska in which they are located.

Through its Statewide Needs Assessment completed September 20, 2010, the Nebraska Department of Health and Human Services identified 17 counties with the highest risk for poor outcomes that could potentially be addressed though home visitation, as per requirements of the ACA. The identification of these counties was considered the **First Level for Describing Need: Counties at Risk.** A copy of Nebraska's needs assessment document may be found at http://www.dhhs.ne.gov/LifespanHealth/Home_Visitation/DOCS/EHBSubmission09-20-2010.pdf. Following is a summary of this first level of assessment.

The 17 counties were found to be at highest risk for poor outcomes based on having scored in the top 10% of two or more factors. County scores were ranked from highest to lowest for each of 8 factors, with higher scores indicating higher risk. Counties with scores within the top 10% (top 9 counties) of a factor were identified as being "at risk" on that factor. Counties were then assigned a final score based on the following criteria:

1 = if a county scored within the top 10% for two factors
2 = if a county scored within the top 10% for three factors
3 = if a county scored within the top 10% of four factors

4 = if a county scored within the top 10% of five factors
5 = if a county scored within the top 10% of six or more factors

The following table lists the 17 counties and scores for each.

County	Child Welfare	Juvenile Crime	Economics	Education	Health Outcomes	Pregnancy Outcomes	Social Welfare	Behaviors	Number of factors	Level 1 Score
Scotts Bluff	√	√	√		√		√	√	6	5
Hall	√			√			√	√	4	3
Lincoln	√	√				√	√		4	3
Colfax				√			√	√	3	2
Dakota				√			√	√	3	2
Dawson				√	√			√	3	2
Douglas	√	√						√	3	2
Thurston			√	√				√	3	2
Box Butte		√					√		2	1
Boyd		√				√			2	1
Buffalo	√	√							2	1
Gage				√	√				2	1
Jefferson	√						√		2	1
Lancaster	√						√		2	1
Morrill		√				√			2	1
Nemaha		√	√						2	1
Richardson			√		√				2	1

The quality and capacity of existing early childhood home visiting programs in at-risk communities was initially described as part of the September 20, 2010 needs assessment. Twenty-seven home visiting programs were identified in the 17 at-risk counties, based on information available through a survey process. There were numerous limitations to the information collected and reported at that time:

- ◊ significant variability existed in how programs interpreted and responded to survey questions;
- ◊ there was a probability that one or more programs did not receive or respond to the survey;
- ◊ some of the first Supplemental Information Request (SIR) stipulated elements were not adequately addressed in the survey instrument; and
- ◊ the survey instrument was not sufficiently detailed to collect county specific data for those programs that served multiple counties.

Because of these limitations, a 2nd level of analysis followed the submission of the September 20, 2010 Statewide Needs Assessment - **Level Two for Describing Need: Extent to Which *Existing Home Visiting Programs Address Risk.*** A brief description of the methodology follows, and a complete description is found as Attachment 3.

This second level of assessment was constructed with three separate steps. The first step determined "penetration" of existing programs - the number of at-risk children in the county actually being served by a home visiting program. Penetration was measured by the ratio of children 0-5 living in poverty being served by the program compared to the estimated number of children 0-5 living in poverty in the county. This criterion was scored so that counties serving a lower percentage of children received a higher score:

0 = Higher than 50% penetration
1 = 20% or higher penetration
2 = 10% or higher penetration
3 = 0-10% penetration

The second step assessed whether the home visiting program(s) were using a formal model-based approach to address the county-specific risks identified in Level 1. This criterion was scored so that programs with fewer targeted activities received a higher score:

0 = addressing all risks with a model
1 = addressing some/most of the risks with a model
2 = addressing some of the risks
3 = addressing none of the risks or not offering enough visits to address risks

The third step combined the scores from steps 1 and 2 to provide a county score for Level Two.

Next, scores for Level One and Level Two were added together, to identify the counties with both the highest needs based on both at-risk families and the biggest gaps in serving those families. Based on combined scores from the Level One and Level Two Analysis, Scotts Bluff County was identified as the community which would most benefit from the ACA Home Visiting Program. Below is a table with the combined scores.

County	Level 1	Level 2	Total
Scotts Bluff	5	3.5	8.5
Thurston	2	6	8
Boyd	1	6	7
Morrill	1	6	7
Nemaha	1	6	7
Dawson	2	4	6
Douglas	2	3.11	5.11
Buffalo	1	4	5
Lincoln	3	2	5
Hall	3	1.12	4.12
Jefferson	1	3.1	4.1
Dakota	2	2	4
Richardson	1	3	4
Gage	1	2.67	3.67

Box Butte	1	2.19	3.19
Colfax	2	0.08	2.08
Lancaster	1	1.03	2.03

The **third and final level of the needs assessment** was to determine readiness and feasibility of implementing evidence-based home visitation in the identified community. In consultation with community stakeholders from Scotts Bluff County and the Panhandle Region it was determined that the counties of **Scotts Bluff, Morrill and Box Butte will be targeted for implementation**. All three counties were identified in the Level One Analysis as being at-risk. A three-county service area offers economy of scale and will maximize the existing service systems, partnerships, and networks that are currently in place within this region in western Nebraska.

To better understand the needs of the 3 identified counties and why they were collectively identified to be the targeted communities, some understanding of the *Panhandle Region* is important. The *Panhandle* is an 11 county region of western Nebraska. This region is remote in terms of distance from major population centers such as Omaha or Lincoln (400 miles from its largest city, Scottsbluff, to Lincoln, the State Capital), and 6 of the 11 counties are considered frontier (6 or fewer persons per square mile). The Panhandle's climate and terrain are more similar to that of Wyoming than to that of central and eastern Nebraska, characterized by wide open spaces, rolling hills and bluffs, and a comparatively arid climate.

This 14,810 square mile region has a population of 85,468 persons, down nearly 5000 from the 2000 Census. More than 43% of the population resides in Scotts Bluff County. According to a 2006 study at the Center for Applied Rural Innovation at the University of Nebraska Lincoln, depopulation is still an issue of significant concern in much of America's non-metropolitan Great Plains region. Nebraska has routinely been cited as a prime example of rural depopulation and that phenomenon's effect on social and economic conditions. Between 1950 and 2000, the 43 most rural Nebraska counties saw a decline in total population of 40%, while the state's metropolitan counties doubled in size. In the decade since the last census, the Panhandle has seen a nearly 10% drop in population, with every county in the Panhandle losing population. Rural depopulation has now reached a point at which the continued viability, and indeed the existence, of many communities and institutions in rural Nebraska and the Panhandle are very much in question.

Panhandle residents are poorer than those living in other parts of Nebraska and the nation. Forty-one percent of area children live in poverty in single-parent homes; 58% of those in poverty in the region live in families with two parents. Nearly 14% of Panhandle residents have incomes at/or below the federally defined poverty level. One of the 11 counties has one of the nation's 10 lowest per capita personal incomes. The proportion of residents living in poverty was generally higher for racial/ethnic minority groups than for whites.

Preschools and child care facilities in the Panhandle vary widely, with some estimates that more than 60% of the daycare homes being unlicensed, compared to about 50% for the state. There are 73 family child care home I providers, 48 family child care home II providers, 57 child care centers and 16 licensed preschools. Because of the high number of single parents and parents working two jobs, day care is an extremely difficult issue for many in this area.

The economic bases for most communities in western Nebraska are agriculture or the railroad, with limited manufacturing and retail. One in three Nebraska jobs is tied to agriculture. In the past year, the demand for agricultural products and the continued growth of this industry helped limit the effects of the national economic slowdown in our communities. However, while agriculture has enjoyed a recent upswing in commodity prices, the number of farmers supporting families on off-farm jobs and two family members working full time continues to increase.

Despite or because of these many challenges, rural communities band together to develop programs and funding opportunities through coalitions. For the Panhandle region, these include the Panhandle Partnership and the development of the Panhandle Public Health District. The eight local hospitals work together on many projects. Specialists from the regional hospital and other larger hospital in in the state and surrounding states visit many of the local hospitals on a regular schedule to see patients near their home, assuring appropriate levels of care. These and other health and human services agencies continue to work well together, developing assessments, building capacity, sharing training and making plans to assist the young people in their communities and the older individuals they serve.

Of particular relevance to early childhood systems and to the effective implementation of the ACA home visiting program is the *Panhandle Partnership for Health and Human Services*. This partnership was formed in 1998 to meet the collective needs of this remote and rural part of the state. The purpose of the Panhandle Partnership for Health and Human Services, Inc. is to:

- ◊ Promote communication of area data, services and opportunities;
- ◊ Conduct regional assessment;
- ◊ Share resources and training;
- ◊ Collaborate in creative planning;
- ◊ Evaluate for regional impact and outcomes;
- ◊ Prioritize and create regional goodwill; and
- ◊ Advocate for policy changes to meet the needs of our rural area.

Early collaborative work of the Panhandle Partnership included the development of the Children's Outreach Project, a home visitation program that will be described later in this plan. Other accomplishments include: enhanced collaborative infrastructure for member communications; collaborative partnership to redesign the mental health system; physician peer review implemented in all hospitals; first Regional Public Health Assessment and Planning process and Community Health Improvement Plan; and the creation of a training academy to address the training needs of the health and human services work force. Including all 3 at-risk counties in this region optimizes this collaborative infrastructure and extends the impact of the evidence-based home visiting program.

Members of the Partnership represent a wide range of stakeholders that have been actively engaged in preparing this plan and they will be key factors in its successful implementation. This long standing partnership will be essential for systems development and building the infrastructure necessary for the success of Nebraska's ACA home visiting program.

- **<u>Assessment of Needs and Existing Resources in Targeted Communities</u>**

The following narrative describes the needs and resources specific to each of the 3 targeted counties: Scotts Bluff, Morrill, and Box Butte.

- **Community Strengths and Risk Factors**

Scotts Bluff County is the most populous of the 3 counties, with a population of 36,554. This county was identified with the highest score in the Level One Analysis, scoring in the top 10% for 6 risk factors: Child Welfare, Juvenile Crime, Economics, Health Outcomes, Social Welfare, and Behaviors. Attachment 4 displays the applicable data on which this county's Level One risk score was based. Adding both the Level One and Level Two scores, Scotts Bluff County ranked the highest for potential need for ACA home visiting services, with a combined score of 8.5.

Of particular note is that Scotts Bluff County ranks 3rd in the state for child welfare and juvenile crime related risk indicators. For instance, the rate of substantiated child abuse/neglect reports is 12.5 reports / 100,000 children compared to a rate of 7.2 for the State. Juvenile arrests per 1000 juveniles are 65.2 for Scotts Bluff County, with a State rate of 35.0. The out of home placement rate is double for this county compared to the rest of the state (25.0 compared to 12.4).

In reflecting on these data, community stakeholders believe that these statistics do not fully reflect the extent of these problems. Families are highly mobile in this region, posing difficulties for a limited numbers of caseworkers to provide and document services as families move within and between counties.

Among the factors contributing to the relatively high rates for child welfare and juvenile crime related risk factors are extremely limited services available to at-risk children and youth without getting child welfare and juvenile justice involved. And even when children and youth are part of these systems, some of the needed services are difficult to access. The area's current economic situation, as well as generational issues, is among the socio-economic factors impacting outcomes for children and youth in this county.

Compounding needs in this county is the in-migration of families from across the region and from surrounding states, seeking and expecting more services and resources in Scotts Bluff County. This county, with the cities of Scottsbluff and Gering, is viewed as a hub for business and commerce. These families may eventually settle in surrounding towns and villages in the county, such as Minatare, Morrill, Lyman, and Henry. Very limited public transportation then poses significant barriers to accessing services in Scottsbluff and Gering, and these communities have few services of their own and may not even have a grocery store.

To address these many needs, *Scottsbluff County* has a wide range of assets. These include Regional West Medical Center (RWMC) which is the primary regional referral center serving western Nebraska and parts of adjoining states, serves as the hub for the areas critical access hospitals, and is the region's trauma center; Community Action Partnership of Western Nebraska (CAPWN) which provides services to over 9,000 individuals, children and families and is home to a federally qualified health center; Western Nebraska Community College which supports the training needs of the region's health and human service agencies; Scotts Bluff County Health Department providing a wide range of public health services; mental health services through

Region I of Nebraska's Network of Care for Behavioral Health: and early childhood services that include Head Start & Early Head Start (provided by CAPWN) and the Early Development Network (Part C IDEA, provided through the Educational Service Unit or ESU). Emerging assets include a new local Spanish-language television station.

Scotts Bluff County's health and human services needs are also addressed through stakeholder participation in the Panhandle Partnership, previously described. The Partnership exemplifies the ability of providers to work together, pool resources, and achieve common goals. The Partnership and its members are currently engaged in a child wellbeing initiative sponsored by the Nebraska Children and Families Foundation (Nebraska's CB-CAP agency). This initiative has fostered substantive assessments of needs and assets as they impact the wellbeing of all children, laying ground work for the systems and infrastructure development what will be so important to the success of the ACA home visiting program in this county.

Morrill County is the most rural of the 3 counties with a population of 4,989, and is considered "frontier" with only 3.8 persons per square mile. The Level One analysis identified this county as having scored in the top 10% of these 2 risk factors: Juvenile Crime and Pregnancy Outcomes. Attachment 5 displays the applicable data used in this analysis for Morrill County. Adding Level One and Level Two scores, Morrill County was among the 5 highest scoring counties in the state, with a score of 7.

This county, like Scotts Bluff County, ranked high for juvenile crime, being 5th in the state for this risk factor. Its juvenile arrests rate is 48.1 (arrests / 1000 juveniles) compared to 35.0 for the state. Then, its juvenile drug-related arrests rate is almost 4 times that of the state (9.6 arrests / 1000 juveniles compared to 2.5 for the state). A significant risk factor for Morrill County was pregnancy outcomes, with a ranking of 5th in the state for this factor. Of note for this county is its rate for low birth weight babies (8.6% compared to 6.9% for the state), very low birth weights at 3.2% compared to 1.1%, and an infant mortality rate of 10.1 compared to the state's rate of 6.0. A possible correlation is Morrill County's rate of inadequate prenatal care (Kotelchuck index) at 17.6%, with the state rate being 11.1%.

Employment and economic factors are of particular significance in this county with few major employers. Persons with incomes less than the poverty level represent 15.2% of the county's population (10.3% for the state). Major employers are the nursing home, hospital, and schools, with a ethanol plan being among the few manufacturing employers. Like Scotts Bluff County, Morrill County has small towns, such as Bayard and Broadwater, which have limited services and access to public transportation. Stakeholders have observed that this county is a cross roads for drug trafficking in the region and they believe that young people drop out of school because they can make more money running drugs than entering the work force.

Morrill County is within the catchment area for the services and programs available in Scotts Bluff County, such as Regional West Medical Center and Community Action Partnership of Western Nebraska, though families face the challenge of travelling to obtain some of these services. Morrill County is served by a regional health department, Panhandle Public Health District, which has an office in Bridgeport. This county also has a hospital in Bridgeport, the Morrill County Community Hospital. The Prairie Winds Community Center offers a wide range

of intergenerational services, including a preschool and before and after school activities for youth.

Access to early childhood services are somewhat more limited for this county, with Early Head Start not available. Home visiting, through the Children's Outreach project, served 12 families in Morrill County the past year. This program will be described in more detail later in this plan. Early Intervention services (Part C IDEA) are provided by Western Community Health Resources. Morrill County is also included in the Panhandle Partnership and its Child Wellbeing initiative.

Box Butte County has a larger population than Morrill County but is less populous than Scotts Bluff County with a population of 11,043. It had a marked decrease in population as measured in the last census. Box Butte County scored in the top 10% for these 2 risk factors: juvenile crime and social welfare. Attachment 6 displays data for Box Butte County. Adding Level One and Level Two scores, Box Butte County had a relatively lower score for need, 3.19. Its proximity to Scotts Bluff County and Morrill County and its shared use of service systems places this county in a position to maximize ACA home visiting services and infrastructure development in this rural, far west region of the state and is thus being included as a targeted community.

For the 2 risk factors that Box Butte County scored in the top 10%, its actual ranking for both was 2nd in the state. Juvenile arrests, juvenile drug arrests, juvenile driving under the influence of alcohol (DUI), and juvenile violent crime arrest rates were all substantially higher than state rates. For all social welfare indicators, again Box Butte County has higher rates than for the state (aggravated domestic violence complaints, domestic violence crisis line calls, simple domestic violence complaints, and single parent households). Again, see Attachment 6.

To further illustrate the needs of this county, a closer examination of the Nebraska Risk and Protective Factor Student Survey conducted in 2007 shows that Box Butte County has higher rates of both binge drinking among its youth (21.6% of survey youth) compared to both the Panhandle Region (14.9%) and the state (12.3%).

The socio-economic climate is somewhat different for Box Butte County, compared to other counties in the region. This county depends somewhat less on agriculture as an industry, with the railroad being a major employer in Alliance, its largest town. Lay-offs in the railroad industry have a particular impact on families. Even if employment rates are stable within this county, layoffs elsewhere in the Burlington Northern & Santa Fe Railroad system can result in persons with seniority from across the United States being relocated to this county, bumping less senior employees. This dynamic impacts social cohesion within the community, and provides challenges for both new families to find the services they need and among service providers to keep up with the fluctuating demands. Further, many railroad workers commute into this county resulting in long hours and separations from families.

Stakeholders in this county and in the region have identified access to youth services, particularly behavioral health services, to be a challenge for these families. Box Butte County

recently experienced the closure of the Boys Ranch, a group home that had been serving 20 – 30 youth in a residential setting.

Among *Box Butte County's* assets is Box Butte General Hospital, a 25 bed critical access hospital. It is also served by the Panhandle Public Health District. Northwest Nebraska Community Action Partnership serves this county, providing Early Head Start home based services to 9 families. Additional services such as WIC, family planning, home visits through the Children's Outreach program, immunizations, and Early Development Network (Part C IDEA) services are provided by Western Nebraska Community Health Resources. Alliance and Hemingford schools host center-based preschools. As with Scotts Bluff and Morrill County, Box Butte County is included in the Panhandle Partnership and its many initiatives, including the Child Wellbeing project.

- **Characteristics and Needs of Participants**

The following table summarizes some of the major demographic characteristics for the three counties.

	Scotts Bluff	Morrill	Box Butte	State	Year(s)
Children ages 0-5	2,760	317	767	134,717	2009
White, not Hispanic	77.5%	86.7%	83.8%	83.9%	2008
Black	0.6%	0.1%	0.6%	4.6%	2008
American Indian	2.7%	1.1%	3.8%	1.1%	2008
Hispanic	19.1%	11.8%	10.3%	8.0%	2008
Percent < Federal Poverty Level	13.1%	12.4%	8.0%	7.9%	2005-2009
Percent Teen Births	4.7%	3.5%	3.3%	2.7%	2003-2007
Percent Single Mother Head of Household	30.4%	19.0%	26.6%	21.2%	2005-2009
Percent of persons 25+ with <9th Grade Education	5.4	5.4%	4.4%	4.3%	2005-2009

As noted earlier, these counties are characterized by mobile families seeking employment, housing and services. For Hispanic families, migration into the region began decades ago, with many of these families now being the 3rd and 4th generations to live in their communities. These families came to work in the sugar beet and bean agribusinesses. Agriculture related work continues to draw Hispanic families, particularly from Central America. The needs of Hispanic families thus vary widely, in terms of language, culture, and connectedness with the communities in which they live.

Native American families in the region may reside part of the year in the Rosebud and Pine Ridge Indian Reservations in South Dakota, or they may travel there for services. Consequently, continuity of services and effective referrals are a challenge for these mobile families. But even more critical for Native American families are important perceptions regarding home visiting and other services available within the region.

A focus group was conducted by the Chadron Native American Center as part of the regional Mobilizing for Action through Planning and Partnership (MAPP) Process. In responding to questions about home visiting programs and services for children the fifteen participants noted that any home visiting programs should be culturally-based and have Native American staff. Participants noted that home visits from NE DHHS child welfare workers and other subcontractors result in children being removed from the home, and the home should be "some where we feel safe." Participants also suggested using a "group model" meaning that in Native Communities teaching parenting skills and helping families can be achieved within the larger extended family/community. Participants also noted that violence has increased in Scottsbluff and Gering in the last ten years. They also believe there to be a competition for resources between Hispanics, migrants and Native Americans. Native Americans feel that they do not get their share of resources because so many employees are Hispanic, and the Native American participants stated they would like to have Native American advocates.

Earlier in this plan, the unique challenges faced by all families in this rural, geographically remote region of the state was described. To gauge community residents' perspective on health related issues, a Community Health Survey was conducted as part of the region's public health assessment in 2011. Preliminary results are found as Attachment 7. Of particular notes is that 51% of the 547 respondents described their community as "somewhat unhealthy" and an additional 10.4% rated it as "unhealthy" or very "unhealthy." Over 40% agreed or strongly agreed that it is sometimes a problem to cover their share of costs for medical care. Employment is a major concern for residents, with over 43% disagreeing or strongly disagreeing that jobs are available. These responses suggest an interrelationship between poverty and lack of employment with the perceptions of unhealthy environments.

Survey results of particular relevance to maternal, infant and early childhood populations included opinions on what the 3 most important health problems are in their communities. 18.5% identified child abuse/neglect, 14.0% domestic violence, 15.6% mental health problems, and 19.2% teenage pregnancy as being among the top 3 problems.

To specifically assess issues related to child well being, Community Context Problem Mapping, was conducted by the Panhandle Partnership. Through this process, participating stakeholders were presented a problem definition: "Panhandle communities are not safe and nurturing environments for all children." This problem statement was part of a process to facilitate identification of factors impacting outcomes for families. Stakeholders went on to discuss and identify behavioral factors, contributing factors and root/community causes contributing to this problem. The summary of this mapping process is found as Attachment 8.

The lessons learned from all of these assessments is that rural communities and the families that reside there face many challenges. Poverty, unemployment, under employment requiring parents to work multiple jobs, long distances to travel to jobs and services, outmigration, erosion of services as populations decline, and lack of shared community norms/values to address the growing problems are among these challenges. Community stakeholders believe strongly that effective early childhood services, such as home visitation, will be part of system of preventive services needed to begin breaking the cycle of generational problems and to begin building stronger families and communities.

- **Existing Home Visiting Services in Targeted Communities**

The following table summarizes the currently available home visiting services in the three counties.

	Scotts Bluff County	Morrill County	Box Butte County
Early Head Start Home Based			
Families served/year	20	Not available in this county	18
Eligibility/targeting	As per Federal criteria		As per Federal criteria
Model/intensity	Federal standards		Federal standards
Children's Outreach Program			
Families served/year	Not available in this county	12	32
Eligibility/targeting		All newborns	Pregnant or child under 6 with referral
Model/intensity		Locally developed; 1-2 visits for all newborns	Locally developed; extended visits, 1/week over 6-9 months with wrap around services
Regional West Medical Center's Home Care			
Families served/year	345 (50% of deliveries)	Not available in this county	Not available in this county
Eligibility/targeting	Families of newborns; requires referral from physician; automatic referral for NICU babies; charges for services impacts acceptance		
Model/intensity	Locally developed; 1-2 visits		

Early Head Start Home Based Services are provided in Scotts Bluff County by the Community Action Partnership of Western Nebraska (CAPWN), and in Box Butte County by Northwest Community Action Program. Both programs have waiting lists, 20 and 15 families respectively. Both programs deliver home based services in accordance with federal performance standards.

The *Children's Outreach Program* was developed in 1998 as a collaboration of all area hospitals, home health agencies, and CAPWN to provide visits to all families with a screening and referral process. For CAPWN it was the opportunity to follow up on prenatal care provided through its FQHC. Initial goal was to see 80% of all newborns and this goal was achieved for many years. In 2001, the program added extended services for high risk families (to address mental health needs & child abuse concerns) through the Healthy Community Access Program grant. Over time, this and other funding sources were lost. Some of the original providers have continued to work together to find ways to sustain some of the services. For instance, a wrap-

around component for at-risk families served in Box Butte County was added with the support of a grant. This grant expires in June 2011.

Regional West Medical Center's Home Care had been a part of the Children's Outreach Program. This program now offers all new moms this service, but requires a home health order written by a physician. When this program was a part of the Children's Outreach Program, 90% of the new moms received home visits. Now only 50%-60% do so. These visits are billed as a home health service, which Medicaid routinely pays, private insurance may/may not pay, and mom may have to pay herself. This program has one staff person, who provides two visits, the first 48 hours after mom and baby are discharged, and the second usually before baby goes back in for a checkup.

In summary, local providers have been innovative and resourceful in providing some level of home visiting services within the 3 counties. Only the Early Head Start Home Based program utilizes an evidence-based model. The other programs have developed interventions that are feasible within available resources. The investment of ACA MIECHV resources into these 3 counties will be an incredible opportunity to make intensive, evidence-based home visiting services available to more at risk families.

- **Existing Mechanisms for Screening, Identifying and Referring Families to Programs**

With the creation of the Children's Outreach Program in 1998, this regional project had a goal to provide home visits to 80% of all newborn. This "universal" home visiting program serving the entire Panhandle region was successful in meeting this goal for many years. But as previously stated, loss of grant funds resulted in scaling back the reach of this program.

Processes for screening, identifying, and referring families to home visiting services now vary by county. For home visiting provided in Scotts Bluff County by the Regional West Medical Center (RWMC), infants delivered at this facility require physician referral to Home Health in order to receive home visits. There is an automatic referral for NICU babies. As previously stated, these families (or their 3rd party payer) are charged for these services. RWMC also refers babies born in Scottsbluff but from other Panhandle counties back to the home county. Mothers are asked if they would like a home visitor to come see them within 48 hours. If yes, appropriate HIPPA releases are signed and a referral sent.

In Box Butte County, home visits are no longer universally offered to families of newborns by the Box Butte County Hospital. This hospital discontinued home visits because of difficulties scheduling visits within the limited availability of nursing staff. The hospital now offers families the option of stopping in at the hospital for health checks. Extended visits with wrap around services are available in Box Butte County through a component of the Children's Outreach Program offered by Western Community Health Resources. Eligibility for these services include: resident of the county and family expecting a child or have at least one child under the age of 6. This component has a child abuse and neglect focus with the goal to intervene with families before things get difficult enough that they need to enter the Protection and Safety System. Screening and entry criteria are based mostly on those of the referral sources: NE DHHS, hospitals, counselors, court system, WIC, and Family Planning.

Morrill County residents are served by the Children's Outreach Program, with a Morrill County nurse receiving referrals from Regional West Medical Center and Western Community Health Resources.

Screening, identification and referral processes to the two Early Head Start Programs are often initiated by schools, particularly for pregnant students. Both programs also rely on word of mouth and personal networks for their referrals. Program staff members often actively recruit within the towns and neighborhoods where they live. Referrals from community agencies have declined, in part because of the waiting lists for Early Head Start services.

In summary, processes for screening, identifying and referring families to existing home visiting services vary by community and program, and these processes are generally informal. In rural communities, fewer providers are available and each has close, ongoing working relationships with the others. These providers have utilized these relationships and made them work in an informal manner. With the introduction of the ACA home visiting program, and an evidence-based model targeting at-risk families, it will be an important early step for these three communities to determine screening criteria and referral algorithms that facilitate entry into the most appropriate home visiting program.

The existing "universal" home visiting program for all newborns will still have relevance and purpose in these communities. These initial 1-2 visits will provide an excellent opportunity to identify those families most in need for extended visits through the ACA home visiting program. A suitable algorithm for screening and referral, if in place within Early Head Start Programs, will also allow those programs to manage their waiting lists and to guide those families not eligible for their services but who are at risk and in need of an evidence-based home visiting intervention.

- **Referral Sources Currently Available and Needed in the Future**

As previously described, a wide range of resources are available to families in these communities. WIC, family planning, and immunizations are accessible to residents in all 3 counties, either through Community Action Partnership of Western Nebraska or Western Community Health Resources. In addition, immunization services are available through the local hospitals in Morrill and Box Butte counties. Early Development Network services (Part C IDEA) are available in Scotts Bluff County through Educational Service Unit #13 and in Morrill and Box Butte County through Western Community Health Resources.

The 3 counties are served by 3 hospitals, Regional West Medical Center, Box Butte General Hospital, and Morrill County Community Hospital. All are members of the Rural Nebraska Health Care Network (RNHN), a consortium of nine rural hospitals and related clinics in western Nebraska. This consortium has played an important role in building and sustaining health care infrastructure in the area, such as medical technology networks.

There has been a significant change in regional resources for youth in the past three years due to NE DHHS redesign of child welfare services, the move to out of home care reform, and

decreases in funding for agencies. Focused stakeholder discussions for the Child Well Being Initiative (2010), Comprehensive Juvenile Justice Assessment and Plan (2011) and ACA Home Visiting Program (2011) suggest that inadequate front end resources for children, youth and families may be a contributing factor for high numbers of children in out of home care, high juvenile arrest rates, and high numbers of runaway and homeless youth.

NE DHHS contracts for in-home support services for abuse and neglect cases in the region. There is a shortage of foster care homes and treatment homes. Court Appointed Special Advocates (CASA) and Guardians Ad Litem are available in Scotts Bluff County.

The Regional Comprehensive Juvenile Service Assessment provides the foundation for community based prevention. It calls for the development of local "at risk" systems of care for children and youth. The intent is screening, prioritizing for assessments, and family centered planning and services. It is expected that the process will, overtime improve early outcomes, and result in effective triage and referrals for higher end services. The plan also calls for a multi county Diversion Program, and a Day Reporting Program in Scotts Bluff County (with GED and additional life skills services), and the development of Alternative Schools with an emphasis on academics and emotional development.

Current resources for children and youth in the region include: Transitional Living Programs (mental health and runaway homeless youth), Independent Living Programs (CPS Transition), a Youth Shelter, and Detention Center in Scotts Bluff County. There is no residential treatment for youth in the area.

The region has responded to the decrease in resources by strengthening collaboration for prevention systems. Leaders in the Substance Use Prevention Coalition, Juvenile Justice Assessment and Planning project, Child Well Being initiative, Suicide Prevention, and P-16 project (Education) are working to braid resources and develop some common strategies. Healthy Communities Healthy Youth, a three stage Search Institute initiative with a Developmental Assets foundation is currently being implemented in the region to address community context, inclusion, and outcomes.

Region I Behavioral Health Authority plans, coordinates, and develops capacity to create a balanced network of mental health and substance abuse services for children and adults in the Nebraska Panhandle. Local Crisis Response Teams provide a community response alternative to Emergency Protective Custody. Additional services include: Short-Term Residential, Outpatient Services, Community Support, Intensive Outpatient, Day Rehab, Day Support, PATH (Emergency Housing Assistance), Supported Employment, Youth Transition Program, Emergency Protective Custody, and Inpatient Psychiatric Services. In 2011 community focused meetings, professionals and citizens noted that access and adequate resources for assessments/evaluations due to cost and provider shortages.

All 3 counties are state-designated shortage areas for psychiatry and mental health. Then, payment sources for assessments and treatment are limited for many families, including those who could benefit from telehealth. Persons in the criminal justice system are given priority for services, resulting in long waiting times for other individuals. This results in deferred care and

escalating impacts on both parents and children. Too often, children and youth end up in the child welfare or juvenile justice system as the only means for receiving the services they need.

Some of the consequences of these gaps in the mental health system are high usage of psychotropic medications among children. Medications may be the sole form of intervention for children, with compliance being an ongoing challenge.

Some solutions have been identified for specific populations. In 2010 the Ogallala Sioux Tribe, Pine Ridge, South Dakota (directly north of the Panhandle) began a five year Access to Recovery program. Nebraska's Panhandle was included in the program scope which eases access and choice for Native Americans (10 – 80) seeking treatment for any addiction. The voucher program provides participants with a choice of providers covering a range of inpatient and outpatient therapies as well as family and individual support, including transportation. Access to Recovery is funded for five years.

As previously stated, over half of child care services are provided by unlicensed individuals, raising questions and concerns regarding the overall quality of care. Both Early Head Start Programs have waiting lists, as does center-based Head Start. Some of these gaps are being addressed through Nebraska's Sixpence Early Learning Fund, which is supporting center-based care in Box Butte County and Nebraska Department of Education's Early Childhood Grants to school districts in Scotts Bluff that support early childhood programs in schools.

- **Plan for Coordination Among Existing Programs and Resources**

As part of the Panhandle Partnership, stakeholders in the three counties of Scotts Bluff, Morrill and Box Butte have been actively engaged in the Child Wellbeing initiative. This initiative, sponsored by the Nebraska Children and Families Foundation (NCFF), has mapped the array of services for children and families resulting in a description of the prevention system for the region. The collaborative work under this initiative will be the basis of coordination among existing programs and services. See http://www.pphd.org/ChildWellBeingCoalition.html.

The Panhandle Partnership's hallmark as been coordination and collaboration. An example of one of the products of this collaborative work is the Panhandle Partnership Training Academy, http://www.trainingacademy.info/. This training academy will provide the environment for coordinating training and technical assistance not only for the ACA home visiting supported staff but also for staff within other relevant programs that will coordinate with and provide a continuum of services to at-risk families.

- **Local and State Capacity to Integrate Proposed Services into an Early Childhood System**

At the state level, Nebraska early childhood partners have been working together to bridge historically siloed early childhood systems for some time. The Early Childhood Interagency Coordinating Council (ECICC) was created in 2000 to advise and assist the collaborating agencies in carrying out the provisions of the Early Intervention Act, the Quality Child Care Act and other early childhood care and education initiatives under state supervision. The ECICC is

also identified by the governor as the State Advisory Council on Early Childhood Education and Care to meet the federal requirements of the Improving Head Start for School Readiness Act. To obtain more information about ECICC and view current membership: http://www.education.ne.gov/ecicc/

The Early Childhood Comprehensive Systems (ECCS) Grant has enhanced systems level planning and implementation since its inception in 2003. Early Childhood stakeholders have continued to embrace collaboration and alignment of priorities as the most efficient method for systems development to enhance services for children and families. The ECICC is the advisory body for the ECCS initiative, which is Nebraska stakeholders named, Together for Kids and Families (TFKF) and the ECCS strategic plan was adopted by the ECICC as the state strategic plan for early childhood. Additionally, the Early Childhood Systems Team (ECST) was established as a formal standing committee of the Governor appointed Early Childhood Interagency Coordinating Council in 2009. The team is co-led by two Governor appointed members of the ECICC and comprised of diverse early childhood stakeholders with the opportunity for additional stakeholders to participate. The purpose of the Early Childhood Systems Team is to create ongoing collaboration across public and private agencies through which early childhood systems needs for children (prenatal through age eight) will be identified and addressed through strategic action plans. The organizational structure for TFKF was created to ensure cross-system representation and communication in a variety of early childhood arenas. For additional information about Together for Kids and Families: http://www.hhs.state.ne.us/LifespanHealth/Together-Kids-Families.htm

During the past year the ECICC and the Systems Team have been utilized as sources of information in the development of the Home Visiting Needs Assessment and this Updated State Plan. Increasing access to home visiting services has long been a strategy of the TFKF strategic plan and the work that was completed prior to the ACA funding provided a solid foundation for the Needs Assessment. Stakeholders have embraced the idea of integrating home visiting into an effective and comprehensive early childhood system. As the work continues early childhood stakeholders will continue to promote coordinated planning and shared accountability across the agencies that fund home visiting and other early childhood programs.

At the local level, essential components have been described earlier in this plan, such as Head Start and Early Head Start in 2 of the 3 counties and Early Development Network services in all three counties (Part C IDEA). Representatives of these programs have been actively involved in preparation of this Updated State Plan, and remain committed to building a continuum of early childhood services, including the ACA home visiting program.

Also described earlier in this plan was the limited availability of licensed child care, with over 60% of care being provided by unlicensed providers. To consider how the ACA home visiting program as part of an early childhood system could begin to address the needs of these providers, an additional resource within the region needs to be described, its Regional Early Childhood Professional Development Partnership.

All areas of Nebraska are served by either an Early Childhood Professional Development Partnership (ECPDP) or a Regional Training Coalition (RTC). These coalitions and partnerships

are local networks consisting of early childhood professionals working collaboratively to support professional development for early childhood caregivers/teachers in home, center, and school-based programs. Grant funds are awarded by the Nebraska Department of Education to ECPDPs and RTCs to assist collaborative efforts to achieve high quality, affordable, accessible training for all those who work with young children and their families. These training coalitions are designed to meet training needs identified in their areas by:

- ◊ Coordinating existing and new training opportunities;
- ◊ Collaborating to provide training that is open to staff and parents from all types of early childhood settings;
- ◊ Promoting professional development and program improvement; and
- ◊ Increasing the use of technology to facilitate collaboration and professional development.

The Early Head Start Programs serving the 3 targeted counties have long worked with the Panhandle Early Childhood Professional Development Partnership. The ACA home visiting program will also become a collaborative participant in this partnership, playing an active role to include child care providers and preschool staff to be a part of curriculum and other trainings to be offered locally as evidence-based home visiting is implemented. The ACA home visiting program can also play a role in doing outreach to private programs, especially unlicensed providers, to better connect them with other sources of training to improve quality of care.

Finally, the Child Wellbeing Initiative has previously mapped and described the Panhandle regions prevention system, particularly as it relates to youth (http://www.pphd.org/ProgramData/ChildWellBeing/prevention%20system/PanPrevSys_Description%20final.pdf). Community stakeholders are poised to now focus on young children and their families. The ACA home visiting contractor, Panhandle Public Health District, has been an active participant in this initiative, and will provide the avenue for including the ACA home visiting program in mapping existing and developing enhanced early childhood systems in the region.

- **List of Communities Identified as At_Risk but not Selected for Implementation**

As described earlier in this plan, 14 other counties were identified as being at risk. Those counties were: Hall, Lincoln, Colfax, Dakota, Dawson, Douglas, Thurston, Boyd, Buffalo, Gage, Jefferson, Lancaster, Nemaha, and Richardson.

SECTION 2: STATE HOME VISITING PROGRAM GOALS AND OBJECTIVES

The goals for Nebraska's ACA Home Visiting Program are:

- ◊ Implement ACA home visiting with fidelity as one of a continuum of service options in a coordinated system for all children, youth, and families in the target communities.
- ◊ Make measurable improvements in the lives of children and their families in the local target communities.

- ◊ Home visiting is accepted as a positive asset of all strong families and healthy kids in the target communities.

The program objectives are numerous, iterative, and multidimensional.

In the area of implementation of Healthy Families America:

- ◊ By June 17, 2011, Panhandle Public Health Department (PPHD) executes contract with Healthy Families America for home visiting activities in three Nebraska counties.
- ◊ By June 24, 2011, PPHD purchases selected curriculum to use in local HFA model implementation.
- ◊ By July 30, 2011, PPHD begins community self-assessment process guided by HFA and applies for HFA affiliation.
- ◊ By July 30, 2011, PPHD schedules curriculum training to be conducted by Oct. 30, 2011 for local home visiting personnel.
- ◊ By August 31, 2011, a minimum of five home visitors are identified and hired.
- ◊ By Oct. 31, 2011, initial HFA training, curriculum training, and fidelity standards training conducted for at least five home visitors, supervisor(s) and local site coordinator, state coordinator and others of the project implementation team.
- ◊ By September 30, 2012 at least 50 local families are enrolled and receiving visits from trained home visitors.

In the area of service delivery to families by trained home visitors:

- ◊ By August 31, 2011, minimum of five (5) home visitors are identified and hired.
- ◊ By October 31, 2011, initial training by HFA in model implementation and curriculum delivery has been conducted for a minimum of five (5) home visitors.
- ◊ By November 30, 2011, marketing plan for eligible family recruitment is implemented.
- ◊ By December 31, 2011 trained home visitors are available for service delivery.
- ◊ By June 30, 2012, at least 75% of active home visitors have participated in at least one professional development event.
- ◊ By September 30, 2012 at least 50 local families are enrolled and receiving visits from trained home visitors.

In the area of implementation of a data system tied to a CQI plan and benchmark measures:

- ◊ By July 30, 2011, state executes contract with University of Kansas for data management system and oversight of implementation of data plan.
- ◊ By Nov. 30, 2011, local HFA personnel are training in data collection procedures and CQI.
- ◊ By Dec. 31, 2011, data system and CQI plan are in place and ready for home visiting and data collection.

- ◊ By Jan. 31, 2012 and ongoing: data collection has begun by 100% of active home visitors.
- ◊ By September 30, 2012, data collection has occurred in a minimum of 50 eligible families.

In the area of development of local systems for intake/identification of eligible families, and coordinated resource and referral processes:

- ◊ By July 30, 2011, Panhandle Public Health Department (PPHD) presents a plan for a coordinated resource and referral network for community services and programs.
- ◊ By Sept. 30, 2011, PPHD presents a marketing plan for home visiting services in the target communities.
- ◊ By Nov. 30, 2011, PPHD presents a plan for intake, recruitment, and enrollment processes for eligible families.
- ◊ By Dec. 30, 2011, intake and referral systems are in place and ready for activation.
- ◊ By September 30, 2012 at least 50 local eligible families are enrolled and receiving visits from trained home visitors.

In the area of **state assurance of compliance and fidelity**:

- ◊ Starting by June 30, 2011 and ongoing: State coordinator conducts bi-weekly telephone conference calls with local project team.
- ◊ Starting by July 31, 2011 and ongoing: State coordinator monitors contract deliverables for local and other partners.
- ◊ Starting by August 31, 2011 and ongoing: State coordinator conducts monthly video conference or on-site monitoring visit with local project team.
- ◊ By Oct. 31, 2011, state coordinator participates in HFA implementation training, curriculum, and fidelity standards.
- ◊ By November 30, 2011, state coordinator and local project personnel are trained in data collection and CQI.
- ◊ Starting by Jan. 30, 2012 and ongoing: State coordinator assures reporting in a timely fashion per federal and model developer requirements, and local project plan.

The logic model for Nebraska's home visiting program is found as Attachment 9.

SECTION 3: SELECTION OF PROPOSED HOME VISITING MODEL AND HOW MODEL MEETS THE NEEDS OF TARGETED COMMUNITIES

Through a collaborative decision making process, Nebraska DHHS and the targeted communities have selected Healthy Families America (HFA) as the evidence-based model to be implemented. HFA is one of the seven evidence-based models listed in the February 8, 2011 Supplemental Information Request (SIR). This model will be implemented through a sole-source contract, not through a competitive process. The Panhandle Public Health District (PPHD) has been selected as the contractor. Nebraska State Statute, 73-504 establishes exceptions to competitive bidding

requirements. Among the exceptions are contracts for services involving political subdivisions such as local health departments.

- **Selected Model and How It Meets the Needs of the Targeted Communities**

Healthy Families America has been chosen as the evidence-based model based on two primary criteria: 1) feasibility and 2) match of models' demonstrated outcomes with the communities identified risks. The selection process was carried out through active engagement of community stakeholders.

Initially, NE DHHS staff conducted a review of the Home Visiting Evidence of Effectiveness Review (HomVEE) as presented at http://homvee.acf.hhs.gov/Default.aspx. This review focused on demonstrated outcomes and identified risks in Scotts Bluff County, the targeted community with the highest identified number of risk areas. Based on this review, four of the seven models were determined to have the greatest potential for meeting needs: Early Head Start – Home Based Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.

During a meeting held in Scotts Bluff County on April 1, 2011, attended by representative stakeholders from all 3 counties, Nurse-Family Partnership was eliminated from the list of potential models to be considered, based on feasibility. In the 3 rural counties being targeted, limited numbers of qualified nurses within the available work force would make this model very difficult to staff.

Through conference calls and e-mail dialogs, the three remaining models under consideration were further studied as to feasibility and match with community needs/risks. To assess the latter, the following matrix was developed:

County Risks Noted in Level 2 Analysis			Model Specific Demonstrated Outcomes		
Scotts Bluff	**Morrill**	**Box Butte**	**HFA**	**EHS**	**PAT**
-	-	-	Child Dev. & School Readiness	Child Dev. & School Readiness	Child Dev. & School Readiness
-	Pregnancy Outcomes (incl. LBW & VLBW)	-	Child Health	-	-
Economics	-	-	Family Economic Self-Sufficiency	Family Economic Self-Sufficiency	-
-	-	-	Linkages & Referrals	-	-
-	-	-	Positive Parenting Practices	Positive Parenting Practices	Positive Parenting Practices

County Risks Noted in Level 2 Analysis			Model Specific Demonstrated Outcomes		
Scotts Bluff	**Morrill**	**Box Butte**	**HFA**	**EHS**	**PAT**
Child Welfare	-	-	Reductions in Child Maltreatment	-	-
Juvenile Crime	Juvenile Crime	Juvenile Crime	Reductions in Juvenile Delinquency, Family Violence & Crime	-	-
Behaviors	-	-	-	-	-
Health Outcomes	-	-	-	-	-
Social Welfare	-	Social Welfare	-	-	-

This matrix illustrated that Healthy Families America's demonstrated primary and secondary outcomes most closely matched the major risk areas for the 3 counties, and was the only model which had proven outcomes to address juvenile crime, which was the one risk factor common to all 3 counties.

To then consider not only match of demonstrated outcomes to needs/risks but to further look at feasibility and reasonableness to implement, a model scoring matrix was developed. This matrix is found as Attachment 10. In summary, it assessed each model and scored the following:

Ratio of Community Risks & Model Outcomes

5 = Model matches a significant number of community risks & across communities
3 = Model matches a few community risks
0 = Model does not match community risks

Manpower/Staffing Ratios

2 = Community can easily meet staffing requirements
1 = Additional effort required by the community to meet staffing needs
0 = Difficult for the community to meet staffing needs

Ability to Target Families

1 = Model allows flexibility in client eligibility
0 = Model limits who is eligible

Community Outcomes/Priorities

2 = Highly compatible with existing structure
1 = Somewhat compatible
0 = Not compatible

Infrastructure

2 = Builds on existing services
1 = Could be built on existing services with some modifications
0 = Difficult to adapt to existing system of services

This scoring matrix (see Attachment 10) was e-mailed to stakeholders for their independent consideration and scoring. During a conference call held on April 13, stakeholders discussed the scoring matrix and their individual scores. Through this discussion, a consensus was reached and Healthy Families America was selected as the evidence-based model for implementation.

Healthy Families America not only best matches demonstrated outcomes to identified needs and risks, but it also complements existing programs and fills identified gaps. Early Head Start – Home Based Option has been successfully operated in two of the three counties for several years. Its limitations in meeting the needs of families are primarily related to its eligibility criteria. Categorical eligibility for Early Head Start is largely tied to family income. Stakeholders see a real need for a program to serve families in somewhat higher income levels but who have significant needs such as behavioral health issues, domestic violence, or other risks.

Home visiting provided through the Children's Outreach Project and the Regional West Medical Center's Home Care program reach a wider spectrum of families, but the services are primarily of limited duration and intensity (1 to 2 visits) and are initiated after the birth of the infant. Only the wrap-around services provided in Box Butte County (Family Focus component of the Children's Outreach Project) serves families starting in pregnancy and up to age 6. And this locally developed model has been supported under a grant from which is scheduled to expire June 30, 2011. Healthy Families America has the intensity and duration to achieve measurable improvements in the health and wellbeing of at-risk families.

- **Nebraska's Current and Prior Experience with Model**

Nebraska Department of Health and Human Services (NE DHHS), nor any other Nebraska private or public funder of home visiting, has ever promoted or required a specific evidence-based model. Consequently, a wide range of models, many of them locally developed, or locally modified versions of evidence-based models, exist. As part of the Statewide Needs Assessment submitted September 20, 2011 in response to the first ACA home visiting SIR, an inventory of home visiting programs within the 17 at-risk counties was completed. Based on that survey, 7 of the 27 identified programs listed Healthy Families America as a model being used in some manner. The program offered by the Lincoln-Lancaster County Health Department with Cedars Home for Children reported that their program is working towards Healthy Families America accreditation.

Most of the NE DHHS staff members who have been involved in the development of this Updated State Plan have had a steep learning curve in regards to understanding the details of any of the evidence-based models, including Healthy Families America. This lack of expert knowledge is a result of the historically limited role in administering evidence-based home visiting programs. Over the past several weeks, staff members are now more confident that they have the necessary working knowledge of HFA, and with the support of the developer, insight provided by those Nebraska programs already progressing towards implementing HFA with

fidelity, and technical assistance from HRSA, NE DHHS is confident that it will have the expertise to guide successful implementation.

The local contractor selected to implement HFA services in the targeted communities, Panhandle Public Health District, currently supports the Children's Outreach Project, so it thus has first-hand experience with administering home visiting services. Being a local health department, Panhandle Public Health District has personnel with the necessary skills and experience to develop the systems-level aspects of the program (screening/identification of families to be served; referral mechanisms to the program and to other services; data collection and analysis; and continuous quality improvement). With training and technical assistance provided by the model developer, the Panhandle Public Health District has the capacity to design and deliver the HFA model with fidelity.

- **Plan for Ensuring Implementation with Fidelity**

Section 4 provides the details for implementation of the program, including the selected model. The challenges anticipated for carrying out this plan and implementing the model with fidelity include:

- ◊ Both NE DHHS staff and PPHD staff will be simultaneously acquiring the necessary training for HFA and building the necessary expertise; and
- ◊ NE DHHS's ACA Home Visiting Program staff is located 400 miles from the targeted communities.

To address these challenges, a close working relationship between NE DHHS and its contractor will be critical. The contract with the Panhandle Public Health District (PPHD) will include a clearly articulated scope of services with specific deliverables tied to the essential requirements of the ACA MIECHV Program, its authorizing legislation, and the Healthy Families America model. These contractual expectations will be carefully developed and documented through consultation between NE DHHS and the PPHD to assure full understanding of the expectations prior to execution of the contract.

Contract performance will be regularly monitored through frequent e-mail and phone consultation, and regularly scheduled on-site visits by NE DHHS staff to the communities. Consultation with other Nebraska programs who have implemented HFA will be acquired as necessary to augment the training and technical assistance to be provided by the developer.

But more importantly, this contractual relationship will be built on the important collaborative partnerships that the NE DHHS has built with its local health departments, including PPHD. The mutual understanding of the importance of this program and its potential to significantly improve the health and wellbeing of families in the targeted counties will guide the work and support the commitment to implementing a successful program.

- **Anticipated Challenges and Risks of Program Model and Proposed Response**

The obvious and expected challenge for both NE DHHS staff and the local contractor, PPHD, will be acquiring the knowledge and expertise to plan for and implement the HFA model with

fidelity. Training and technical assistance provided by the developer and consultation provided by a Nebraska affiliate, Lincoln-Lancaster County Health Department, has been initiated and will be ongoing throughout implementation.

The recruitment of staff that meet both the standards for HFA and the cultural/language needs of the targeted families in these rural counties may be a challenge, in particular, having family support workers (FSWs) who conduct home visits with families and family assessment workers (FAWs) who conduct family and child assessments as separate staff positions. NE DHHS will work with the model developer to determine staffing options that will be workable in rural communities where staff specialization can be impractical.

The greatest risk associated with this model is its intensity and its focus on at-risk families. Voluntary enrollment in and ongoing participation in the program will be greatly jeopardized if families see this as an intervention they have been singled out for because they, the family, are broken or damaged. This perception arises from experiences with home visits carried out by child welfare workers, which are seen as a step towards the removal of children from the home and/or criminal charges.

It will be imperative to position the HFA evidence-based home visiting program within a continuum of services available to ALL FAMILIES within the 3 counties. The low intensity, universally offered visits to all newborns as part of the Children's Outreach Project have broad acceptance within the communities. Early Head Start has a similar reputation, with families and friends being the primary source of referrals. The system for screening, assessing and enrollment in these programs and the HFA evidence-based program will need to be seamless, and all 3 presented as a range of valuable resources that ALL FAMILIES can potentially benefit from.

Even the title or "branding" of the HFA home visiting program will be critical. An adaptation of "Children's Outreach Project" as a program name and its relationship to the universal newborn visits is under development. Outreach and training to referral sources will need to include information on the benefits of a range of home visiting options and that home visits are of value to all families.

SECTION 4: IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

- **A Description of the Process for Engaging the At-risk Community(ies) Around the Proposed State Home Visiting Plan.**

In Nebraska, the state-level home visiting project team initiated and carried out a needs assessment to identify communities in the state most at-risk, initially using the statutory language from the ACA, and then using the guidance from the first SIR. Prior to the submission of the Statewide Needs Assessment in September 2010, NE DHHS hosted a conference call and then a video conference to present its findings regarding at-risk communities. A dedicated web page was created, and documents were added as they became available, including the September 2010 needs assessment. That web page may be found at:

http://www.dhhs.ne.gov/LifespanHealth/Home_Visitation/Home-Visiting-Needs-Assessment.htm.

During the interim period, between the submission of the Statewide Needs Assessment in September 2010, and receipt of the second SIR in February 2011, NE DHHS staff conducted interviews with the existing providers of home visitation in the 17 counties identified as being at risk. This information was used to complete Level 2 of the needs assessment, as described in Section 1 of this plan.

When the results of this Level 2 analysis became known, the NE DHHS team identified known stakeholders, including policy and research partners, child advocates, and child and community service providers and leaders, who would be asked to serve as the initial local key stakeholder group in the county identified as being at greatest risk (Scotts Bluff County). A number of these individuals had served in earlier phases of the needs assessment as key informants, and so had general knowledge of the project. In addition, this network of informants and stakeholders also provided the name of a trusted and credible local facilitator, invaluable in creating the initial communications network spanning the 400+ miles of rural Nebraska between Lincoln and Scotts Bluff County.

The initial meeting between this local stakeholder group and the state level team took place by telephone in March 2011. An in-person meeting involving state and local members took place in the city of Scottsbluff on April 1. As the NE DHHS team soon came to learn, the local stakeholder community had already undertaken significant progress in their own assessment of needs and an examination of systems impacting child wellbeing. Local partners were aware of the potential of home visiting and readily came to the table for discussion and consideration. A foundation of knowledge and self-awareness of youth and child development needs and risks had already been laid.

And as previously described in Section 1, those stakeholders with interest in child and family outcomes for Scotts Bluff County also had interest in and commitment to the entire Panhandle region. Many of the participating stakeholders traveled from locations across the region because their programs and services have multi-county catchment areas and have a long history of collaborative planning and program development that crosses county lines. What was learned from engagement of these stakeholders representing the Panhandle region included:

- ◊ Recognition that the local at-risk community was part of a rural resource and referral network of critical partners operating on the regional, not local/single town or county level;
- ◊ Communications with local elected policy makers and influential community leaders from within the local at-risk target area was important, recognizing these partners while not involved in project implementation at the service level, would be valuable supporters and interested in the success of the project; and
- ◊ Understanding the organizational relationships that were presenting themselves in this phase of planning was important in laying the groundwork for subsequent planning.

As detailed in Section 1, this consultation with community stakeholders in Scotts Bluff County and the Panhandle region constituted the 3rd level of Nebraska's assessment process, that being the determination of community readiness and capacity. Thus the 3 counties were identified for implementation based not only need, but economy of scale and optimization of the collaborative systems in place within the region.

Local-level engagement has continued throughout the preparation of this Updated State Plan. Commitment to the success of the project has been demonstrated through the willingness of community leaders to participate in planning meetings and conference calls throughout this fast-paced initial program planning period. Even between meetings facilitated by NE DHHS staff, we have learned that the local community stakeholders group has been networking, developing questions and ideas to bring to the next round of conversations. Local stakeholders have been included in the identification of benchmarks, planning for data collection and CQI, and as described earlier, the selection of Healthy Families America as the evidence-based model. The identified service delivery contractor, Panhandle Public Health District (PPHD), is currently and will continue to be NE DHHS's partner in fostering state and community collaboration.

Attachment 11 lists collaborating stakeholders, the organizations and interests they represent, and their roles in program planning.

- **A Description of the State's Approach to Development of Policy and Setting Standards for the State Home Visiting Program.**

The selected model, Healthy Families America, and the soon-to-be selected curriculum each have requirements for delivery consistent with program fidelity as defined by the model and curriculum developers. The expectation on the part of the NE DHHS that these interventions are delivered to fidelity has been stressed throughout all program development activities and processes, and will be translated into performance standards and incorporated into the contractual agreement with PPHD. These standards will also address all relevant statutory requirements, translating them into expectations for the contractor.

Subsequently, PPHD as the local vendor of home visiting services, will be legally and ethically responsible for point of service policy development, implementation, and oversight. In the form of contract deliverables, the NE DHHS will identify expectations for key areas of policy development, requiring that the local level home visiting project will adopt policies in the following areas and make them available for NE DHHS review upon request:

- ◊ Non-discrimination policies;
- ◊ Standards of cultural competency;
- ◊ Child abuse and neglect recognition and reporting;
- ◊ Refusal or termination of services;
- ◊ Transportation policies;
- ◊ Personal safety of home visitors;
- ◊ Supervision of home visitors;
- ◊ Informed consent for services by participants;

- ◊ Assurance that services are understood by participants as voluntary;
- ◊ Confidentiality and privacy;
- ◊ Data sharing and disclosures/consent;
- ◊ Screening and assessments with validated and state-approved tools; and
- ◊ Continuing education for home visitors

Such local policies and procedures will be compatible with and support those required by the model developer.

- **A Plan for Working with the Model Developer and Description of Technical Assistance and Support to be Provided by the Model Developer.**

The Project Coordinator has been in regular communication with Kate Whitaker, Director, Healthy Families America (HFA) Southeastern/Western Regional Office, prior to Nebraska's selection of the HFA model for Nebraska's ACA Home Visiting Program. The Project Coordinator and Regional Director have a good working relationship, and it is anticipated that regular communication will occur with the implementation of the Updated State Plan. HFA is the only evidence based model that Nebraska selected for implementation and this model has years of proven research ensuring that HFA programs are effective in working with families. The model developer has provided many tools in the past months that were useful in the development of the Updated State Plan.

HFA staff will provide training, technical assistance in implementation and quality assurance of this model in Scotts Bluff, Box Butte, and Morrill counties, while also assisting the Nebraska ACA Home Visiting Program in building an infrastructure for a statewide system for advocacy, future funding, training, quality assurance, and evaluation. This state systems approach is instrumental to the successful, long-term implementation of a home visiting program in Nebraska. HFA has developed standards of best practice to help ensure the highest level of central administrative functioning at the state level to ensure fidelity of the HFA model.

The State will request specific technical assistance from the model developer in the following areas:

- ◊ Development of a planning timeline of essential activities for program launch with adequately trained staff;
- ◊ Case management system (Project Information Management System - PIMS);
- ◊ Supervisor training;
- ◊ Continuing education after initial training;
- ◊ Performance evaluation for home visitors and supervisors;
- ◊ Trainer resources;
- ◊ Essential competencies and competency checklists for home visitors;
- ◊ Identification of qualifications of home visitors and home visitor supervisors;
- ◊ Development of quality assurance processes for supervisors: fidelity checks; and
- ◊ Case load development maximum case load targets.

Local stakeholders were diligent in reaching consensus with state internal staff on the HFA model, and they are also involved in determining the curriculum to be used in the Panhandle area. The PPHD has tentatively selected to work with Great Kids, Inc. in order to implement the Growing Great Kids as the curriculum in the new home visiting program. It is important to stakeholders that the curriculum meets the needs of the target population, addresses the risks identified in these counties, and the feasibility of training not only the ACA Home Visitors, but home visitors in the Early Head Start, Children's Outreach, and other area home visiting programs.

- **A Timeline for Model Implementation and Obtaining the Curriculum.**

Since the implementation of the Healthy Families America model, and the selection/implementation of the curriculum are so closely interwoven, the following is the anticipated timeline for the HFA model and obtaining the curriculum.

May 2011: Local stakeholder group considers comparison matrix for three curricula compatible with Healthy Families America.

June 2011:
<u>State level</u>

- ◊ Bi-weekly calls with PPHD (ongoing).
- ◊ Execute contract with PPHD.
- ◊ Define the target population with local partners.
- ◊ Design and develop a quarterly electronic newsletter for stakeholders to begin in July.
- ◊ Monitor contract, interpret federal stature and provide technical assistance to local
- ◊ contractor (ongoing).
- ◊ Monthly scheduled visits onsite or video conference (ongoing).
- ◊ Keep HFA informed of the progress and ensure fidelity of the model (ongoing).

<u>Local level</u>

- ◊ Design and implement an operational and business plan for delivery of HFA.
- ◊ Determine and purchase curriculum to be used with HFA.

July 2011:
<u>State level</u>

- ◊ Ongoing assignments.
- ◊ Site visit for the Panhandle Public Health Summit.
- ◊ Meet federal reporting requirements to be determined by HRSA.
- ◊ Design data collection, analysis, and CQI for NE DHHS benchmarks and meets HFA requirements.

<u>Local level</u>

- ◊ Begin HFA community self assessment.
- ◊ Apply for HFA affiliation.

August 2011:
State level

- ◊ Ongoing assignments

Local level

- ◊ Develop a referral service network framework for enrolled families to other community services and programs.
- ◊ Hire local HFA staff.

September 2011:
State Level

- ◊ Ongoing assignments.

Local Level

- ◊ Schedule and make logistical arrangements for all initial training required for HFA affiliation and start up services including curriculum training.

October 2011:
State Level

- ◊ Ongoing assignments.
- ◊ HFA and curriculum training for internal state home visiting staff.

Local Level

- ◊ HFA and curriculum training for local staff.
- ◊ Begin implementation of local components of data collection plan and CQI.

November 2011:
State Level

- ◊ Ongoing assignments.

Local Level

- ◊ Local HFA staff receives training on data collection and CQI.
- ◊ Develop intake/enrollment processes for eligible families.

December 2011:
State Level

- ◊ Ongoing assignments.

Local Level

- ◊ Referral service network is in place.

- ◊ Home visiting staff in place.
- ◊ Data collection and CQI systems ready for home visiting.

January 2011:

- ◊ Initiate the curriculum during first home visits.

- **Description of How and What Types of Training and Professional Development will be Provided by the State or Local Agencies, or Obtained from the Model Developer.**

State-provided training and professional development

Through a contract with the University of Kansas' Institute for Educational Research and Public Service, state epidemiology staff are developing a REDCap-based project data management system. The HFA PIMS case management system will be an integral component of this larger data system. Staff will develop and provide local-level training on use of the REDCap system, including scheduling, wireless transmission of home-based assessments, reporting and CQI activities.

Local-provided training and professional development

Local-provided training and professional development will include scheduling and making logistical arrangements for all initial training required for HFA affiliation and start up services. This training will be delivered to all supervisors, home visitors, and other relevant staff.

Model-developer provided

HFA technical assistance is available before training is scheduled to ensure that the program is on-track with a plan for implementing the Critical Elements within the structure of their home visiting program. It is widely recognized that model fidelity and program quality provide the foundation for demonstrating outcomes for children and families. HFA offers comprehensive training for implementing the model, including:

- ◊ Assessment: Intensive training is provided to all program staff that will administer the assessment tool and provide supervisory support.
- ◊ Integrated Strategies for Home Visitors: Home Visitors Core Training is an in-depth, formalized training intended for home visitors, supervisors, and program managers.
- ◊ Distance Learning Modules: Affiliated programs have access to distance learning modules through HFA's web-based training system.
- ◊ Program Information Management System (PIMS) training.

It anticipated that HFA staff will travel to the Panhandle region to deliver this training.

Upon completion of primary training, technical assistance training is available from the trainer who conducted the training as well as Prevent Child Abuse America program staff, on an as-needed basis.

- **Plan for Recruiting, Hiring, and Retaining Appropriate Staff for All Positions.**

As stated earlier, service delivery at the community level will be carried out through a contract with the Panhandle Public Health District. At the state level, a full-time project coordinator has been in place since November 2010. See Section 6 for details on organizational structure and staffing.

- **Plan for Recruitment of Sub-Contractor Organizations, and Sub-Contractor Staff Recruiting, Hiring, and Retention.**

To clarify Nebraska's understanding of terms, the Nebraska Department of Health and Human Services is a grantee of the federal agency and not a contractor. Therefore, the legal relationship of the Panhandle Public Health District to the Department is that of a contractor, not a subcontractor.

With that said, the contract agreement with the PPHD will have clear expectations within the scope of services for the recruitment and hiring of staff that meet both the requirements of the Healthy Families America model but also who match the cultural and social needs of the targeted at-risk families. Based on stakeholder input, recruitment will whenever possible reach into the targeted populations with the intent of improving outcomes not only through delivery of services but also through employment and professional development. This desire to employ persons from within those populations for which the services are intended was an important factor in the selection of Healthy Families America as the evidence-based model.

In its role as contract manager, the NE DHHS will regularly review the quality and timeliness of contract deliverables, including the hiring of qualified staff.

The key to retention of qualified staff begins with the hiring process. Selecting persons well suited to the demanding work of home visiting, who appreciate the value of the intervention, and who are representative of the communities and families being served will have greater likelihood of longer retention. Then, the HFA model includes supervision as a critical element: *Critical Element #12 - Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations.* The HFA standards for supervision will not only promote effective visitation, but will provide important support to the staff.

- **Plan for Clinical Supervision and Reflective Practice for Home Visitors and Supervisors.**

Again, the Healthy Families America model provides the framework for clinical supervision and reflective practice. As an essential component, HFA's supervisor : home visitor ratio

requirements have been incorporated into the contractual agreement between NE DHHS and the PPHD. Fidelity to the minimum time and frequency of supervision and reflective practice will be monitored through observation and documentation. Both NE DHHS staff and PPHD staff have initiated consultation with a current Nebraska HFA affiliate, including interviews with that program's supervisor. That affiliate's experiences have reinforced the value and importance of the HFA standards for supervision, and will be used to develop state-level standards and local program procedures.

- **The Estimated Number of Families Served**

To arrive at an estimate of families to be served, the NE DHHS and the PPHD considered the following:

- ◊ Healthy Families America's Critical Element #1, to enroll families during pregnancy or at birth;
- ◊ An annual birth cohort of 765 for the 3 counties (based on 2009 birth data);
- ◊ Over 13% of births to teens;
- ◊ County risk profiles for poverty, abuse and neglect and other factors;
- ◊ Waiting lists for the two Early Head Start programs totaling 35 families; and
- ◊ Enrollment patterns for an existing Nebraska HFA affiliate.

An additional consideration is that these communities have had historically high acceptance rates for universally offered newborn visits (as high as 80% prior to visits becoming a charged service). Though there are many variables that may impact screening, referrals, and enrollment as this new program is implemented, an estimated caseload of 50 families is projected for the period ending September 30, 2012, and a caseload of 125 by September 30, 2013.

- **Plan for Identifying and Recruiting Participants.**

Healthy Families America offers helpful guidance on key steps for starting up a new program. Among the first important steps is the development of the referral network.

A major advantage for the 3 targeted counties is its well developed partnership of health and human service providers. With this ready-made network, a coordinated screening and referral process will be put in place to identify the best "fit" between family and home visiting option.

The recruitment of pregnant women will require some focused attention on the part of PPHD and its referral network. The bulk of existing home visits in the counties are offered to families with newborns. Relatively little outreach has been made to providers of obstetric care or other prenatal services. Informational materials, easy-to-use screening tools, and how-to-refer training will be developed for and delivered to these providers, including clinic personnel, WIC and family planning staff, local NE DHHS child welfare and economic assistance staff, school nurses and counselors, and others who have contact with pregnant women.

The home visitor with the Regional West Medical Center's Home Care project will be able to assess and refer families with newborns, as part of that program's 1-2 visit protocol. Similar

inter-program referral mechanisms will be established with the two Early Head Start programs, to reduce those programs' waiting lists and connect families on a timely basis with the most suitable program.

Healthy Families America has well tested screening and assessment tools which have been shown effective in identifying those families most suited for this model (*Critical Element #2, Use a standardized (i.e., consistent for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse and parental history of abuse in childhood)).* These tools and associated protocols will be utilized by the service contractor, PPHD.

- **A Plan for Minimizing Attrition.**

As stated earlier, an important feature of the program is that it be branded and marketed as a positive service valued by strong healthy families. Both acceptance rates and sustained participation will be negatively impacted should families perceive home visits as "treatment" or potentially punitive. Community wide marketing of home visiting as part of a continuum of early childhood and family services and supports will be a role of not only PPHD but for the Panhandle Partnership as part of its Child Wellbeing strategies.

Once enrolled, families will be actively engaged in establishing their own goals and then participate in measuring results and celebrating positive outcomes. This active participation of the family and interaction with the home visitor is an inherent part of the HFA model. If executed by home visitors who are appropriately selected and trained to meet the cultural and social needs of the at-risk families they serve, continued participation in the program is more likely.

A commitment to quality services and the success of families will be essential not only for the service provider, but for the network of community service providers. Again, a continuum of supports and services will reinforce families' confidence in the program and their trust that home visiting can make a positive difference in the lives of their children.

- **Estimated Timeline for Meeting Maximum Caseload in Each Location.**

Staff for the three county area will be trained together in the HFA model and curriculum, and they will begin home visits in January 2012. Based on this probable start date, an estimated caseload of 50 families is projected for the period ending September 30, 2012, and a caseload of 125 by September 30, 2013.

- **Operational Plan for the Coordination Between Proposed Home Visiting Program and Other Existing Programs and Services in Targeted Communities**

Nebraska's ACA home visiting program will be delivered through a contract with the Panhandle Public Health District (PPHD). This local health department has well established cooperative arrangements with many of the community service providers. In addition, the PPHD is an active

member and participant in the Panhandle Partnership. As previously described in this plan, the Panhandle Partnership has a long history of system building and collaborative program development.

A continuum of services for young children and families will be built on the work of the Panhandle Partnership's Child Wellbeing Initiative. Through this initiative, community stakeholders have assessed and strengthened the Partnership's collaborative leadership capacity, assessed its array of prevention services, and lead planning efforts to integrate and fill gaps, particularly for youth preventive services. Detailed information on the work of the Panhandle Partnership through the Child Wellbeing Initiative may be found at http://www.pphd.org/ChildWellBeingCoalition.html. With the PPHD, the Partnership will continue this work to specifically address evidence-based home visitation as part of the coordinated continuum of services within the 3 targeted counties. So rather than initiate a separate plan for ACA home visiting, an existing planning structure will be utilized.

- **A Plan to Obtain Data for CQI**

The project data collection system (see Section 5) is being designed to include data necessary for the CQI framework which is described in Section 7 of this plan.

- **The State's Approach to Monitoring, Assessing, Supporting Implementation with Fidelity and Quality Assurance.**

The role of the state level project coordinator includes oversight of fidelity and quality assurance. There are numerous processes and partners built into the ACA home visiting program design that will provide the fuel and wheels for the vehicle of quality assurance and fidelity to move down the road of program development. The state level project coordinator will have a regular contact schedule with key partners at the local level to assess for new developments and/or problems. The coordinator will select five signal indicators of fidelity and quality that will be assessed in every contact, and used as a routine assurance check throughout the project course. The state-level project coordinator leads the state-level project team and as a result has frequent and collaborative contact with the data team.

At the state level, the project team will continue to function, with coordination and support from the state coordinator. At this level, Nebraska's ACA Home Visiting Program receives oversight in the area of data system, benchmark measures, and CQI. The necessary partners and program components are shown in Section 7. The data plan is supported by technical assistance and support from the regional ACA team and the model developer. The measures, analysis, and utilization of data are critical to fidelity monitoring and quality improvement at all levels.

- **Anticipated Challenges to Maintaining Quality and Fidelity, and Proposed Response to the Issues Defined**

The initiation of a new program is always challenging. The particular challenges for implementing Nebraska's ACA Home Visiting Program in the counties of Scotts Bluff, Morrill, and Box Butte include:

- ◊ A steep learning curve for both NE DHHS and PPHD in understanding and then mastering the requirements of Healthy Families America,
- ◊ Designing and implementing the needed infrastructure within rural communities in a manner that is reasonable and cost effective, and
- ◊ Developing and managing data and communication requirements that can efficiently span the distance between local service delivery and state-level operations

In regards to the first point, NE DHHS and PPHD staff have initiated regular and frequent consultation with the model developer, even as the contractual agreement is still being finalized. This fact provides evidence of the commitment of PPHD to the success of the project. This collaborative learning process will continue throughout the life of the project.

Solutions to rural infrastructure issues are being sought through consultation with community partners on topics such as office arrangements, adaptation of existing outreach and referral processes, and utilization of the region's Training Academy for hosting HFA and curriculum training. The Panhandle Partnership, previously described, has long been a collaborative force for finding solutions to health and human service delivery in the region's rural and frontier counties, and will continue to be for this ACA home visiting program.

Strategies to build the necessary data collection and analysis capacity are described in more detail in Sections 5 and 7. These strategies draw from the experience of the University of Kansas Institute for Educational Research and Public Service in supporting data systems for home visiting programs in Kansas. Under contract, the Institute will guide NE DHHS in developing data systems that can support benchmarking and CQI processes using REDCap, a program developed by Vanderbilt University through funding from the National Institutes of Health and freely available to university and partners with the infrastructure capacity through an end-user license. REDCap is a secure, web-based application for building and managing online databases and importing existing data from other systems securely. REDCap has a stream-lined process for rapidly developing projects across a variety of domains.

Healthy Families America data tools and procedures will be adapted at the local level, again using methodologies which have been shown to work in rural settings. Along with tapping into experience and expertise of home visiting data systems in Kansas, Nebraska's primary approach is to not create data frameworks from scratch.

In addition, dialog is underway with the range of data sources needed locally and at the state level, and additional consultative and technical support is being provided by in-house NE DHHS resources. Staffing at the local level will include sufficient man hours to support local data responsibilities.

It is anticipated that putting all data collection and analysis systems in place will require additional financial investments that will need to be budgeted from FFY 2011 funding.

- **<u>List of Partners</u>**

Many local public and private partners came together quite quickly after learning that of the potential for a home visiting program in the Panhandle area. The complete list of local collaborators can be found in Attachment 11.

- **Assurances - Program Designed to Result in Participant Outcomes Noted in the Legislation**

Through the selection of Healthy Families America as the evidence-based model, the NE DHHS and its local partners demonstrate their commitment to and assurance that the program will be designed to impact the legislatively defined outcomes:

- ◊ Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes;
- ◊ Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators;
- ◊ Improvements in parenting skills;
- ◊ Improvements in school readiness and child academic achievement;
- ◊ Reductions in crime or domestic violence;
- ◊ Improvements in family economic self-sufficiency; and
- ◊ Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

Healthy Families America has demonstrated effectiveness in positively impacting outcomes 2, 3, 4, 5, 6, and 7, and has Critical Elements that address the first outcome. NE DHHS and PPHD are committed to implementation with fidelity and achieving model accreditation.

- **Assurances - Individualized Assessments Will be Conducted and Services Provided in Accordance with these Assessments**

Again, through Nebraska's selection of the Healthy Families America model, it provides its assurances that individualized assessments will be conducted and services will be based on such assessments. Among this model's critical elements is a standardized family assessment. In addition, the model includes as an essential component that an Individual Family Support Plan (IFSP) be developed for each family that identifies strengths, needs, goals, and objectives. The IFSP must be reviewed in supervision and serve as a guide for services. The NE DHHS and its contractor, PPHD, are committed to implementing these model components with fidelity.

- **Assurances - Services Will Be Provided on a Voluntary Basis**

The NE DHHS provides its assurance that home visiting services will be provided on a voluntary basis. This legislative requirement is included in the contract for services, along with the required deliverable of enrollment procedures that inform families and obtain their consent for voluntary services.

- **Assurances - Compliance with Maintenance of Effort Requirement**

The NE DHHS provides its assurance that complies with the Maintenance of Effort Requirement as defined in Funding Opportunity Announcement HRSA-10-275 as amended July 1, 2010, and the Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program as issued February 8, 2011 and amended on May 9, 2011.

- **Assurances - Priority Given to Serve Specified Eligible Participants**

The NE DHHS provides its assurances that outreach, screening, assessment and enrollment procedures will give priority to and target families that:

  - Have low incomes;
  - Are pregnant women who have not attained age 21;
  - Have a history of child abuse or neglect or have had interactions with child welfare services;
  - Have a history of substance abuse or need substance abuse treatment;
  - Are users of tobacco products in the home;
  - Have, or have children with, low student achievement;
  - Have children with developmental delays or disabilities; and
  - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

The use of HFA screening and assessment tools and methodologies will assure that many of the listed characteristics will be identified. NE DHHS assures that it will monitor screening, assessment and enrollment procedures of its contractor for compliance with this provision.

SECTION 5: PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS

- **Plan for Data Collection**

Overview of Data Collected

NE DHHS will collect data on all benchmarks and their associated constructs as described in the SIR. Data will be collected for all eligible families that are enrolled in the program and receive services with the MIECHV funds. Data collected by NE DHHS for the purpose of the benchmark requirement will be coordinated and aligned with previously established relevant State and local data collection efforts. In addition to benchmark data, NE DHHS will collect individual-level demographic and service-utilization data on participants. Primary data will be collected in the field by the Home Visitor or Assessor, and from Healthy Families America's Program Information Management System (PIMS). Secondary data will be collected by NE DHHS. Data will be collected at intervals appropriate to each construct.

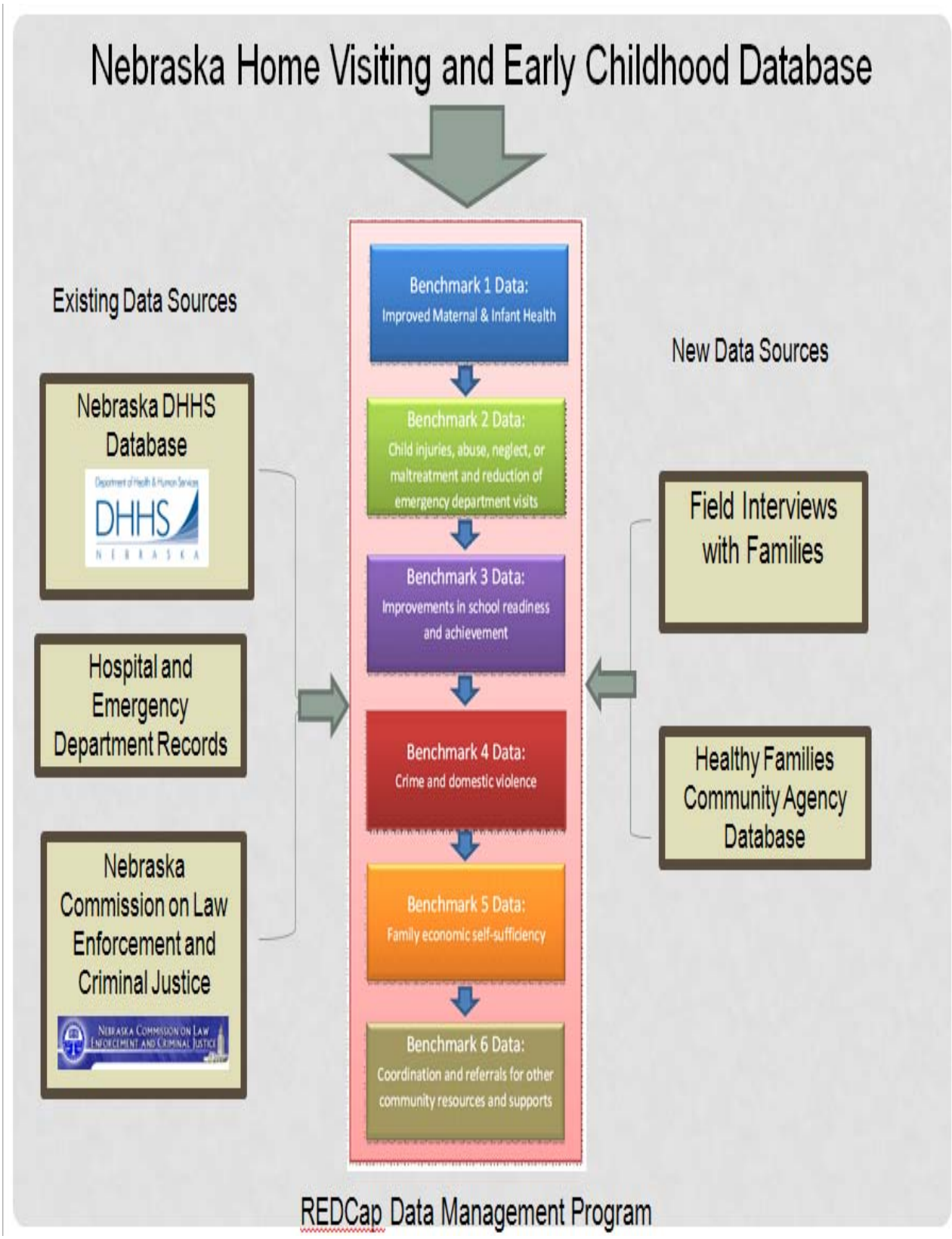
Database and Management System

NE DHHS will establish the **Nebraska Home Visiting and Early Childhood Database** (NHVECD). This comprehensive HIPAA/FERPA-compliant database and management system will be a secure repository of client-level data on those served in the home visiting program. This will be accomplished by using the Research Electronic Data Capture (REDCap) system to create one database that integrates and stores linked client-level data from existing State databases, the local agencies' client management system, the Healthy Families America's Program Information Management System (PIMS), and data collected in the field by home visiting program staff.

The NHVECD will allow the State to collect, monitor, analyze, store, and report on the required MIECHV constructs within the six benchmark areas. The system will be flexible and dynamic in order to allow for future add-ons such as incorporating other home visiting programs, data on child care, Head Start, or other state-wide early childhood programs with a potential to build State and local capacity in early childhood systems and the ability to measure outcomes. The database and management system will also be designed to track cross-system referrals and service receipt - a value to the local early childhood and human service system.

The design and development of the NHVECD will require a coordinated effort with Healthy Families America, the local agencies and organizations that provide services, and existing state or local databases that are not currently linked across clients. The database will also allow for direct data collection with families by trained staff or assessors. Developing and maintaining such a coordinated data collection and reporting system requires not only technical skills in database development and linking data across systems, but also experience and expertise in working with administrative and data staff at all levels to negotiate and access agency data management systems. To implement this plan, NE DHHS has contracted with the University of Kansas' Institute for Educational Research and Public Service which has extensive experience developing and implementing similar programs for that state's home visiting programs.

The following graphic outlines the proposed data collection and reporting system:


Nebraska Home Visiting and Early Childhood Database
Existing Data Sources
Nebraska DHHS Database
Hospital and Emergency Department Records
Nebraska Commission on Law Enforcement and Criminal Justice
Benchmark 1 Data:
Improved Maternal & Infant Health
Benchmark 2 Data:
Child injuries, abuse, neglect, or maltreatment and reduction of emergency department visits
Benchmark 3 Data:
Improvements in school readiness and achievement
Benchmark 4 Data:
Crime and domestic violence
Benchmark 5 Data:
Family economic self-sufficiency
Benchmark 6 Data:
Coordination and referrals for other community resources and supports
New Data Sources
Field Interviews with Families
Healthy Families Community Agency Database
REDCap Data Management Program

Research Electronic Data Capture (REDCap) Overview

This project will utilize the Research Electronic Data Capture system (REDCap) to develop the Nebraska Home Visiting and Early Childhood Database (NHVECD). REDCap was developed by Vanderbilt University through funding from the National Institutes of Health and is freely available through an end-user license to university and partners belonging to the REDCap Consortium. REDCap is a secure, web-based application for building and managing online databases and importing existing data from other systems securely. REDCap has a stream-lined process for rapidly developing projects across a variety of domains. This application will be stored on a secure HIPAA-compliant server at NE DHHS, which has become a consortium member for that purpose.

This application provides a platform for developing an integrated project database that links client-level data collected online, in the field, and through imported agency data. REDCap also provides automated export procedures for seamless data downloads to Excel and common statistical packages (SPSS, SAS, Stata, R), as well as a built-in project calendar, a scheduling module, ad hoc reporting tools, and advanced features such as branching logic, file uploading, and calculated fields. The REDCap system will be specifically tailored to the NHVECD through the contract with the University of Kansas.

Data Use

The data will be collected in order to demonstrate improvements in a minimum of four benchmark areas by three years by showing improvements in at least half if the constructs under each benchmark area. The data will be reported back in aggregate to federal funders. The data collected will also be utilized for CQI to enhance operation and decision-making and to optimize individualized services to clients.

Benchmark Plan

- **Process for development and selection of measurements**

In order to establish the proposed measures, NE DHHS reviewed existing databases, model requirements for data and assessment, local data systems, and the DOHVE TA Compendium of Measurements. Input meetings were held with State-level partners specifically to learn about tools currently in use by the state and across the state, as well as to start to negotiate data agreements. Staff also held meetings at the local level (i.e., Scottsbluff) to share findings from state input, learn about local tools, begin to negotiate data agreements, and to discuss continuous quality improvement. Resulting draft measures were disseminated to participating partners for final review and feedback.

Staff are currently working on multiple data sharing arrangements, notably with:

- ◊ NE DHHS Division of Children and Family Services for the following measures:

- Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
- Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
- First-time victims of maltreatment for children in the program;

◊ Local hospitals Regional West Medical Center (Scotts Bluff County), Morrill County Community Hospital, Box Butte General Hospital (Box Butte County) for the following measures:

- Visits for children to the emergency department from all causes
- Visits of mothers to the emergency department from all causes
- Incidence of child injuries requiring medical treatment;

◊ NE DHHS Public Health Support Unit for birth certificate and hospital discharge data.

NE DHHS staff routinely develop indicator profiles and have developed a template to organize and display the required information relevant to the ***Proposed Measure (Measure, and Reliability/Validity), Proposed Definition, and portions of the Proposed Data Collection and Analysis Plan (Source of the Measure, and Population to be addressed)*** in the following 35 profiles:

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.1: Prenatal care

Measure: Percent of women with LSP prenatal care score of 3 or higher

Definition

Population assessed: All post-partum women

Timing of assessment: 3 months post-partum

Numerator: Number of women with PNC score of 3 or higher

Type: %

Denominator: Number of post-partum women

Improvement defined as: Higher scores in subsequent pregnancies

Assessment Tool: Life Skills Progression Scale - Health & Medical Care / Prenatal Care

Author: Linda Wollesen, R.N., M.A., & Karen Peifer, Ph.D.; Paul H. Brookes Publishing Co

Description: For use with at-risk families of children from birth to 3 years of age, the Life Skills Progression™ (LSP) generates a broad, accurate portrait of the behaviors, attitudes, and skills of both parents and children. (Vendor description)

Number of questions: 1

Type of question: 10-pt scale (0-5)

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: -

Data Source(s): Self-report, OB/GYN records

Rationale: The Prenatal Care subscale of the Health & Medical Care scale combines timing of visits with whether appointments are kept. Cut-off value of 3 reflects minimally acceptable attendance, but also allows for demonstration of improvement. The end-point of the scale assesses post-partum visits, providing additional information on care-seeking behaviors.

Considerations: None noted.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.2: Maternal depression screening

Measure: Percent of women screened for depression

Definition

Population assessed: All women with children 0-5

Timing of assessment: Annually

Numerator: Number of women screened for depression

Type: %

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: Center for Epidemiological Studies Depression scale (CES-D)

Author: Center for Epidemiologic Studies / NIMH

Description: The CES-D is a 20-item self-report adult instrument designed to measure common symptoms of depression that have occurred over the past week, such as poor appetite, hopelessness, pessimism, and fatigue. A score of 22 or higher is positive for depression. (Description from Fisher, C; 2009)

Number of questions: 20

Type of question: 4-pt Likert Scale

HFA Recommended: ☑

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: 3

Data Source(s): Self-report

Rationale: The CES-D has been validated for post-partum women but also for other populations including men.

Considerations: None noted.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.3: Parental use of ATOD

Measure: Percent of adults screened for alcohol abuse

Definition

Population assessed: All adults

Timing of assessment: Annually

Numerator: Number of adults screened for alcohol use

Type: %

Denominator: Number of adults

Improvement defined as: Increase

Assessment Tool: Michigan Alcohol Screening Test (MAST)

Author: Selzer, M (1971)

Description: Developed in 1971, the Michigan Alcohol Screening Test (MAST) is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98 percent accuracy. Questions on the MAST test relate to the patient's self-appraisal of social, vocational, and family problems frequently associated with heavy drinking. The test was developed to screen for alcohol problems in the general population.
Over the years, there have been several variations of the MAST developed, including the brief MAST, the short MAST, as well as a self-administered MAST. (Description from about.com)

Number of questions: 10

Type of question: Yes/No

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: -

Data Source(s): Self-report

Rationale: Widely used for brief screening to determine if client has potential problem and should be referred for more intensive screening and treatment. We propose using the "brief MAST."

Considerations: About.com notes that the questions on the MAST test focus on problems over the patient's lifetime, rather than on current problems. This means the test is less likely to detect alcohol problems in the early stages. We will look into possible alternative use of the parental versions of MAST (F-SMAST and M-SMAST).

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.4: Preconception care

Measure: Percent of women with one or more primary care visits prior to conception

Definition

Population assessed: All women who are pregnant or within 6 months post-partum

Timing of assessment: Enrollment or once per pregnancy

Numerator: Women with primary care visit within 12 months prior to conception

Type: %

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: Documented primary care visit within 12 months prior to conception.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Self-report

Rationale: CDC recommendations for preconception care include that all women of childbearing age receive risk assessment and educational and health promotion counselling as a part of their primary care visits. At the same time as states work to have these topics included in routine primary care, we must also work to increase primary care use by non-pregnant women.

Considerations: None noted.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.5: Inter-birth intervals

Measure: Percent of women with at least 18 months between births

Definition

Population assessed: All previously parous women with a post-enrollment birth

Timing of assessment: At delivery

Numerator: Number of women with at least 18 months between births

Type: %

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: Time from previous live birth (or index birth for women who enter program while pregnant) to subsequent live birth.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Vital statistics

Rationale: Short interpregnancy intervals (less than six months) are associated with increased risk of maternal uterine and placental disorders, and with adverse perinatal outcomes including prematurity, low birth weight and restricted fetal growth.

Considerations: Risks associated with short intervals appear to vary by outcome of the initial pregnancy. Interpreting *birth* intervals rather than *pregnancy* intervals requires assessing other reproductive events during the interval, e.g., miscarriage. Data will be left-censored for women who are not pregnant when they enter the program.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.6: Breastfeeding

Measure: Percent of women with LSP breastfeeding score of 1.5 or higher

Definition

Population assessed: All women who entered the program prenatally, at delivery, or have a subsequent live birth, through 1 year post-partum

Timing of assessment: Every visit through 12 months post-partum or documented termination

Numerator: Number of women with a breastfeeding score of 3 or higher

Type: %

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: Life Skills Progression Scale - Breastfeeding

Author: Linda Wollesen, R.N., M.A., & Karen Peifer, Ph.D.; Paul H. Brookes Publishing Co

Description: For use with at-risk families of children from birth to 3 years of age, the Life Skills Progression™ (LSP) generates a broad, accurate portrait of the behaviors, attitudes, and skills of both parents and children. (Vendor description)

Number of questions: 1

Type of question: 10-pt scale (0-5)

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: -

Data Source(s): Self-report/observation

Rationale: The LSP Breastfeeding Care scale combines duration of breastfeeding with exclusivity. Breastfeeding status at early ages will provide information on whether work needs to be done with local birthing facilities to promote *their* promotion and support of breastfeeding. Further, by inquiring about status at each visit, we will be able to construct time-to-event ("survival analysis") curves that are more sensitive to differences among subsets of women than typical standard cut-offs such as "below 6 months." However, the official reporting cut-off value of 3 reflects acceptable breastfeeding behavior, while allowing for demonstration of improvement.

Considerations: None noted.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.7: Well-child visits

Measure: Percent of children whose immunization status is current at 15 months

Definition

Population assessed: All children 12-15 months

Timing of assessment: Once per child, between 12 and 15 months

Numerator: Number of children with full 12 month immunization status by 15 months

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: At no later than 15 months of age, children should have received all immunizations for 12 month olds. Measured as 1= 0-49% (0-11 doses); 2= 50-99% (12-23 doses); 3= 100% (24 doses). Unknown status to be coded as 1.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Immunization cards; Nebraska State Immunization Information System (NESIIS).

Rationale: Immunizations are administered through primary care providers and thus serve as a proxy for well-child visits as well as actual immunization status. Either through the Nebraska Immunization System (NESIIS) or through family immunization cards, they are easily documented.

Considerations: Not all clinics report yet to the NESIIS. May need to barrier-solve around distribution (and retention) of immunization cards.

Benchmark 1: Improved Maternal and Newborn Health

Construct 1.8: Health insurance

Measure: Percent of mothers and infants with insurance coverage

Definition

Population assessed: All infants and women with children 0-5

Timing of assessment: Annually

Numerator: Number of infants and women with insurance coverage

Type: %

Denominator: Number of infants and women

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: Health insurance coverage is defined as Medicaid full-scope benefits with or without Share of Cost, Medicare, state-subsidized or partial-pay coverage, or private insurance with or without co-pay. Medicaid pregnancy coverage will only be counted during the pregnancy or appropriate post-partum period.

Number of questions: 1

Type of question: 10-pt scale (0-5)

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: -

Data Source(s): Self-report; HV administrative records; DHHS Medicaid.

Rationale: Families without full insurance coverage are less likely to receive preventive care, e.g., childhood immunizations and well-child visits, and more likely to have untreated illnesses. At-risk families are less likely to be aware of the coverage options available to them.

Considerations: Same definition of insurance as for Family Self-Sufficiency insurance construct.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.1: Child emergency department visits

Measure: **Rate of emergency department visits by children 0-5**

Definition

Population assessed: All children 0-5

Timing of assessment: Annually

Numerator: Number of ED visits in past 12 month period

Type: Rate

Denominator: Number of children

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: Admission for any cause of children 0-5 to any of the three area hospital emergency departments.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Hospital records; trauma registry; self-report

Rationale: Emergency Department visits reflect three possible phenomena - lack of a medical home for routine care; acute medical issues; and acute injuries. Interpreting the reasons will assist the home visitors in addressing the child's needs. They are also an external validation of the visitors's own observations.

Considerations: Data will be recorded so as to allow separate examination of ED visits for medical ("natural") vs. non-medical causes. Data will be reported by child age group. Some denominator data may be right-censored for families that drop out of the program.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.2: Maternal emergency department visits

Measure: **Rate of maternal emergency department visits**

Definition

Population assessed: All women with children 0-5

Timing of assessment: Annually

Numerator: Number of ED visits in past 12 month period

Type: Rate

Denominator: Number of women

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: Admission for any cause of mothers of children 0-5 to any of the three area hospital emergency departments.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Hospital records; trauma registry; self-report

Rationale: Emergency Department visits reflect three possible phenomena - lack of a medical home for routine care; acute medical issues; and acute injuries. Interpreting the reasons will assist the home visitors in addressing the family's needs. They are also an external validation of the visitors's own observations.

Considerations: Data will be recorded so as to allow separate examination of ED visits for medical ("natural") vs. non-medical causes. Data will be reported by child age group. Some denominator data may be right-censored for families that drop out of the program.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.3: Prevention information

Measure: **Percent of families who have received prevention information**

Definition

Population assessed: All families

Timing of assessment: Annually

Numerator: Number of families provided information and/or training

Type: %

Denominator: Number of families

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: Information provided to or training of participants on prevention of childhood injuries.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Program records

Rationale: Among the goals of the home visiting program is prevention of injuries, as part of the promotion of healthy lifestyles.

Considerations: Data will be reported by child age group.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.4: Child injuries requiring medical attention

Measure: **Rate of child injuries requiring medical attention**

Definition

Population assessed: All children 0-5

Timing of assessment: At least quarterly

Numerator: Number of injury incidents requiring medical treatment

Type: Rate

Denominator: Number of children

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: Incidence of child injuries requiring medical treatment.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Self-report; pediatric & hospital records

Rationale: Although some degree of injury during childhood is commonplace, monitoring its occurrence will help identify families with excess risk of child harm.

Considerations: Will need to calculate unduplicated (incidents vs. treatments) rates. Data will be reported by child age group.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.5: Screened-in child maltreatment reports

Measure: Rate of assessed maltreatment reports to children 0-5

Definition

Population assessed: All children 0-5

Timing of assessment: At least quarterly

Numerator: Number of children with one or more screened-in maltreatment reports

Type: Rate

Denominator: Number of children

Improvement defined as: Decrease

Assessment Tool: N/A

Author: -

Description: Suspected maltreatment of children after program enrollment date, as determined by a report accepted by Child Protective Services for further investigation. Such "screened-in" reports are not necessarily substantiated, but have met a minimal level of severity or CA/N definition that require formal assessment.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): DHHS/Child Protective Services

Rationale: A screened-in report of child maltreatment is an indication of possibly serious problems in the family. It is also a sentinel event for an immediate quality control assessment - are all appropriate resources being directed to the family? Are safety assessments adequate?

Considerations: Due to the possibility of child harm, we will work with CPS for real-time notification of these reports. Data will be reported by child age group and by maltreatment type.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.6: Substantiated child maltreatment

Measure: **Rate of substantiated maltreatment reports to children 0-5**

Definition

Population assessed: All children 0-5

Timing of assessment: At least quarterly

Numerator: Number of substantiated maltreatment reports

Type: Rate

Denominator: Number of children

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: In Nebraska, substantiated maltreatment includes physical abuse, physical or medical neglect, emotional abuse, and/or failure to protect. Substantiated refers to a preponderance of the evidence.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): DHHS/Child Protective Services

Rationale: A substantiated report of child maltreatment is an indication of serious dysfunction in the family. It is also a sentinel event for an immediate quality control assessment - were all appropriate resources being directed to the family? Were safety assessments adequate?

Considerations: Due to the possibility of child harm, we will work with CPS for real-time notification of these reports. Data will be reported by child age group and by maltreatment type.

Benchmark 2: Prevention of Child Injuries, Child Abuse, Neglect or Maltreatment, and Reduction of Emergency Department Visits

Construct 2.7: First-time maltreatment of program children

Measure: **Rate of first time screened-in maltreatment reports to children 0-5**

Definition

Population assessed: All children 0-5

Timing of assessment: Annually

Numerator: Number of children with a first-time screened-in child maltreatment report

Type: Rate

Denominator: Number of children

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: Children 0-5 with a first time maltreatment disposition of "victim" by Child Protective Services.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): DHHS/Child Protective Services

Rationale: Detecting first-time victims will allow intensive resources and/or prevention to be directed to the family. This will be calculated as a rate as opposed to a percentage, as the number is expected to be relatively small.

Considerations: Data will be reported by child age group and by maltreatment type.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.1 -Parental support for learning & development

Measure: Mean maternal LSP Support of Development score

Definition

Population assessed: All women with children 0-5

Timing of assessment: Every visit through 12 months post-partum or documented termination.

Numerator: Aggregate maternal LSP relationship score

Type: Mean

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: Life Skills Progression Scale - Relationships with Children / Support of Development

Author: Linda Wollesen, R.N., M.A., & Karen Peifer, Ph.D.; Paul H. Brookes Publishing Co

Description: For use with at-risk families of children from birth to 3 years of age, the Life Skills Progression™ (LSP) generates a broad, accurate portrait of the behaviors, attitudes, and skills of both parents and children. (Vendor description)
The LSP Support of Development subscale efficiently combines the concepts of knowledge of child development with application of that knowledge.

Number of questions: 1

Type of question: 10-pt scale (0-5)

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: 2

Data Source(s): Self-report/observation

Rationale: The LSP Relationships with Children / Support of Development subscale allows for demonstration of improvement, moving from poor knowledge and unrealistic expectations to anticipation of change and appropriate reactions.

Considerations: None noted.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.2: Parental knowledge of child development and actual progress

Measure: Mean maternal KIDI child development knowledge score

Definition

Population assessed: All women with children 0-5

Timing of assessment: At least quarterly

Numerator: Aggregate maternal KIDI score

Type: Mean

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: Knowledge of Infant Development Inventory (KIDI)

Author: Educational Testing Service

Description: The Knowledge of Infant Development Inventory (KIDI) is a 75-item instrument that was designed to obtain comprehensive information on parents' factual knowledge of parental practices, child developmental processes, and infant norms of behavior. The KIDI is designed to be easily accessible to persons with limited education and to be culturally neutral. The items can also be grouped into four non-exclusive general categories to obtain more specific information on a person's knowledge on infant norms and milestones, principles of infant development, parenting, and health and safety. The KIDI Scale is accompanied by a 17-item questionnaire (the Catalog of Previous Experience, or COPE) assessing previous experience with infants to correlate with knowledge level assessed by KIDI. (Description from US DHHS/ACF)

Number of questions: 14-75

Type of question: 3-point scale (right/ wrong/ not sure)

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: 1

Data Source(s): Self-report

Rationale: KIDI assesses parental knowledge that can be expected to improve with interaction with home visitor.

Considerations: None noted.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.3: Parenting behaviors and parent-child relationship

Measure: Mean maternal FSC parenting score

Definition

Population assessed: All families

Timing of assessment: Quarterly

Numerator: Aggregate maternal FSC parenting score

Type: Mean

Denominator: Number of women

Improvement defined as: Decrease

Assessment Tool: Family Stress Checklist

Author: Barton Schmitt and Claudia Carroll

Description: (aka Kempe Family Stress Assessment) The FSC assesses parents' risk for child maltreatment and/or caregiving difficulties. It is a 10-domain rating scale that can be completed by service providers such as home visitors, based on the interactions they have had with parents over a period of time. Items on the KSFI assess parents on a number of domains, such as psychiatric and criminal history, childhood history of care, emotional functioning, attitudes towards and perception of children, discipline of children, and level of stress in the parent's life. Parents receive a raw score and are determined to be at low, moderate, or high risk, depending on the cut-offs established by the program administering the scale. (Description from US DHHS/ACF)

Number of questions: 4 domains

Type of question: 0-10 rating

HFA Recommended: ☑

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: 2

Data Source(s): Self-report

Rationale: The Kempe FSC is an integral part of the Healthy Families America service delivery model. Four of its domains - expectations of baby's behavior, discipline, perception of child, and bonding, provide a comprehensive assessment of caregivers' relationship with the child.

Considerations: Could be done separately for other adults in household.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.4: Parental emotional well-being

Measure: Mean maternal FSC stress score

Definition

Population assessed: All women with children 0-5

Timing of assessment: Quarterly

Numerator: Aggregate maternal FSC stress score

Type: Mean

Denominator: Number of women

Improvement defined as: Decrease

Assessment Tool: Family Stress Checklist

Author: Barton Schmitt and Claudia Carroll

Description: (aka Kempe Family Stress Assessment) The FSC assesses parents' risk for child maltreatment and/or caregiving difficulties. It is a 10-domain rating scale that can be completed by service providers such as home visitors, based on the interactions they have had with parents over a period of time. Items on the KSFI assess parents on a number of domains, such as psychiatric and criminal history, childhood history of care, emotional functioning, attitudes towards and perception of children, discipline of children, and level of stress in the parent's life. Parents receive a raw score and are determined to be at low, moderate, or high risk, depending on the cut-offs established by the program administering the scale. (Description from US DHHS/ACF)

Number of questions: 3 domains

Type of question: 0-10 rating

HFA Recommended: ☑

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: 2

Data Source(s): Self-report

Rationale: The Kempe FSC is an integral part of the Healthy Families America service delivery model. Three of its domains - self-esteem, stress and violence, provide a comprehensive assessment of caregivers' level of stress.

Considerations: Could be done separately for other adults in household.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.5: Child's communication level

Measure: **Percent of children 4-60 months screened for communication delays and referred if indicated**

Definition

Population assessed: All children 4-60 months

Timing of assessment: Quarterly

Numerator: Number of children assessed and referred if above cutoff (TBD)

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: **Ages & Stages 3**

Author: Paul H. Brookes Publishing Co.

Description: The ASQ system can be used for two important purposes. First, the questionnaires can be used for comprehensive, first-level screening of large groups of infants and young children. Second, the 30-item questionnaires can be used to monitor development or delays resulting from medical factors such as low birth weight and serious illness, or from environmental factors such as poverty, history of abuse and/or neglect, or teenage parents. Use of the questionnaires is flexible for either first level screening or monitoring programs. Each questionnaire covers five key developmental areas: communication, gross motor, fine motor, problem-solving, and personal-social. (Description from FRIENDS NRC)

Number of questions: 30

Type of question: 3-point scale (yes / sometimes / not yet)

HFA Recommended: ☑

Spanish version available: ☑

Known, acceptable reliability: ☑

Validity level: 2

Data Source(s): Maternal report/observation

Rationale: The ASQ contains 30 items specific to screening for development of communication skills. Children whose score indicates the need for referral but are *not* referred will not be counted in the numerator of this measure. We report this as a process measure (% screened), as the HFA home visiting model emphasizes referral when developmental delays are identified.

Considerations: None noted.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.6: Child's cognitive skills

Measure: Percent of children 4-60 months screened for cognitive delays and referred if indicated

Definition

Population assessed: All children 4-60 months

Timing of assessment: Quarterly

Numerator: Number of children assessed and referred if above cutoff (TBD)

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: Ages & Stages 3

Author: Paul H. Brookes Publishing Co.

Description: The ASQ system can be used for two important purposes. First, the questionnaires can be used for comprehensive, first-level screening of large groups of infants and young children. Second, the 30-item questionnaires can be used to monitor development or delays resulting from medical factors such as low birth weight and serious illness, or from environmental factors such as poverty, history of abuse and/or neglect, or teenage parents. Use of the questionnaires is flexible for either first level screening or monitoring programs. Each questionnaire covers five key developmental areas: communication, gross motor, fine motor, problem-solving, and personal-social. (Description from FRIENDS NRC)

Number of questions: 30

Type of question: 3-point scale (yes / sometimes / not yet)

HFA Recommended: ☑

Spanish version available: ☑

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Maternal report/observation

Rationale: The ASQ contains 30 items specific to screening for development of problem solving and cognitive skills. Children whose score indicates the need for referral but are *not* referred will not be counted in the numerator of this measure. We report this as a process measure (% screened), as the HFA home visiting model emphasizes referral when developmental delays are identified.

Considerations: None noted.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.7: Child's positive approach to learning

Measure: Percent of children 4-60 months screened for learning and referred if indicated

Definition

Population assessed: All children 4-60 months

Timing of assessment: Quarterly

Numerator: Number of children assessed and referred if above cutoff (TBD)

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: Ages & Stages - Social Emotional

Author: Jane Squires, Diane Bricker, and Elizabeth Twombly; Paul H. Brookes Publishing Co

Description: The ASQ:SE was developed to complement the ASQ by providing information specifically addressing the social and emotional behavior of children ranging in age from 3 to 66 months, helping practitioners identify infants and young children whose social or emotional development requires further evaluation to determine whether referral for intervention services is necessary. (Vendor description)

Number of questions: 22-36

Type of question: 3-point Likert scale

HFA Recommended: ☑

Spanish version available: ☑

Known, acceptable reliability: ☑

Validity level: 3

Data Source(s): Self-report/observation

Rationale: The ASQ:SE contains 22-36 items specific to social development. Children whose score indicates the need for referral but are *not* referred will not be counted in the numerator of this measure. We report this as a process measure (% screened), as the HFA home visiting model emphasizes referral when developmental delays are identified.

Considerations: This may not be the best instrument to assess a "positive approach to learning"; we will continue to check options.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.8: Child's social behavior and emotional well-being

Measure: Percent of children 4-60 months screened for emotional well-being and referred if indicated

Definition

Population assessed: All children 4-60 months

Timing of assessment: Quarterly

Numerator: Number of children assessed and referred if above cutoff (TBD)

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: Ages & Stages - Social Emotional

Author: Jane Squires, Diane Bricker, and Elizabeth Twombly; Paul H. Brookes Publishing Co

Description: The ASQ:SE was developed to complement the ASQ by providing information specifically addressing the social and emotional behavior of children ranging in age from 3 to 66 months, helping practitioners identify infants and young children whose social or emotional development requires further evaluation to determine whether referral for intervention services is necessary. (Vendor description)

Number of questions: 22-36

Type of question: 3-point Likert scale

HFA Recommended: ☑

Spanish version available: ☑

Known, acceptable reliability: ☑

Validity level: 3

Data Source(s): Self-report

Rationale: The ASQ:SE contains 22-36 items specific to social development. Children whose score indicates the need for referral but are *not* referred will not be counted in the numerator of this measure. We report this as a process measure (% screened), as the HFA home visiting model emphasizes referral when developmental delays are identified.

Considerations: None noted.

Benchmark 3: Improvement in School Readiness and Achievement

Construct 3.9: Child's physical health & development

Measure: Percent of children 4-60 months screened for health and development and referred if indicated

Definition

Population assessed: All children 4-60 months

Timing of assessment: Quarterly

Numerator: Number of children assessed and referred if above cutoff (TBD)

Type: %

Denominator: Number of children

Improvement defined as: Increase

Assessment Tool: Ages & Stages 3

Author: Paul H. Brookes Publishing Co.

Description: The ASQ system can be used for two important purposes. First, the questionnaires can be used for comprehensive, first-level screening of large groups of infants and young children. Second, the 30-item questionnaires can be used to monitor development or delays resulting from medical factors such as low birth weight and serious illness, or from environmental factors such as poverty, history of abuse and/or neglect, or teenage parents. Use of the questionnaires is flexible for either first level screening or monitoring programs. Each questionnaire covers five key developmental areas: communication, gross motor, fine motor, problem-solving, and personal-social. (Description from FRIENDS NRC)

Number of questions: -

Type of question: -

HFA Recommended: ☑

Spanish version available: ☑

Known, acceptable reliability: ☑

Validity level: 2

Data Source(s): Self-report

Rationale: The ASQ contains 12 items specific to motor development skills. Children whose score indicates the need for referral but are *not* referred will not be counted in the numerator of this measure. We report this as a process measure (% screened), as the HFA home visiting model emphasizes referral when developmental delays are identified.

Considerations: This may not be the best instrument to assess "health"; we will continue to check options.

Benchmark 4: Reduction in Domestic Violence

Construct 4.1: Screening for domestic violence

Measure: Percent of women screened for domestic violence

Definition

Population assessed: All adult women

Timing of assessment: Annually

Numerator: Number of women screened for domestic violence

Type: %

Denominator: Number of women

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: The Healthy Families America project management system (PIMS) screens and records domestic violence using four basic questions covering "Hit, kicked,punched or forced to have sex within past year," "Verbally berated harrassed or intimidated in past year," "Feeling safe in current relatinship" and "Unsafe feelings due to previous relationship."

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): PIMS / Adminstrative screening data; observation

Rationale: Domestic violence is a key assessment in the HFA model. Existing administrative data are adequate to determine need for referral or other action, without adding to burden on respondent or visitor.

Considerations: None noted.

Benchmark 4: Reduction in Domestic Violence

Construct 4.2: Referrals for domestic violence services

Measure: **Percent of women who screened positive for domestic violence that are referred for services**

Definition

Population assessed: All adult women

Timing of assessment: Annually

Numerator: Number of referrals made for women screening positive for DV

Type: Rate

Denominator: Number of women screening positive for DV

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: The State's home visiting database (NHVECD) will record screening results on domestic violence, and track referrals.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): PIMS / Adminstrative screening data

Rationale: The project quality assurance process will monitor whether appropriate referrals are being made, and whether they are followed through.

Considerations: None noted.

Benchmark 4: Reduction in Domestic Violence

Construct 4.3: Domestic violence - Safety Plan

Measure: **Percent of women who screened positive for domestic violence that have a completed safety plan**

Definition

Population assessed: All adult women

Timing of assessment: Annually

Numerator: Number of women who screened positive for DV with a completed safety plan

Type: %

Denominator: Number of women screening positive for DV

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: The State's home visiting database (NHVECD) will record both screening results on domestic violence. Home visitors will work intensively with women who screen positive to insure they have a functional safety plan.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): PIMS / Adminstrative screening data

Rationale: Safety planning is a necessary and important step for someone in an abusive relationship. Abuse and violence can occur without warning. Safety plans help reduce risks in daily life, as well as provide an escape mechanism in the case of an acute situation.

Considerations: There is currently no one, specific safety protocol in use in the Panhandle region. We will work with local DV resources to select a specific tool for use by our home visitors.

Benchmark 5: Improvements in Family Economic Self-Sufficiency

Construct 5.1: Household income and benefits

Measure: Mean household MCAFSS income score

Definition

Population assessed: All families

Timing of assessment: Enrollment and annually. The MFSSS encourages visitor and family to discuss changes.

Numerator: Aggregate household income score

Type: Mean

Denominator: Number of households

Improvement defined as: Stable or improving

Assessment Tool: Missouri Community Action Family Self-Sufficiency Scale - Income

Author: Missouri Association for Community Action

Description: The Missouri Community Action Family Self-Sufficiency Scale was created specifically for Missouri Community Action Agencies to: 1) assist in assessing self-sufficiency progress of families served by case management programs, and 2) provide information for program evaluation. The Scale was designed for use in a semi-structured interview that has the purpose of gathering information about a family's self-sufficiency. Household is defined as all those living in a home (who stay there at least 4 nights/week on average) who contribute to the family income, other than tenants or boarders. Income and benefits are defined as earnings from work or other sources of cash support. (Authors' description)

Number of questions: 1

Type of question: 10 answer categories

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Self-report; administrative records

Rationale: The MFSSS provides a comprehensive yet straightforward ordinal assessment of the often complex picture of a family's financial status.

Considerations: Checking on Spanish translation. Data will be gathered and reported separately by source of income or benefits, and the respective amounts.

Benchmark 5: Improvements in Family Economic Self-Sufficiency

Construct 5.2a: Employment of adults

Measure: Mean household MCAFSS employment score

Definition

Population assessed: All families

Timing of assessment: Quarterly; allows visitor and family to note changes.

Numerator: Aggregate household employment score

Type: Mean

Denominator: Number of households

Improvement defined as: Increase

Assessment Tool: Missouri Community Action Family Self-Sufficiency Scale - Employment

Author: Missouri Association for Community Action

Description: The Missouri Community Action Family Self-Sufficiency Scale was created specifically for Missouri Community Action Agencies to: 1) assist in assessing self-sufficiency progress of families served by case management programs, and 2) provide information for program evaluation. The Scale was designed for use in a semi-structured interview that has the purpose of gathering information about a family's self-sufficiency. Household is defined as all those living in a home (who stay there at least 4 nights/week on average) who contribute to the family income, other than tenants or boarders. (Authors' description)

Number of questions: 1

Type of question: 10 answer categories

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Self-report; administrative records

Rationale: The MFSSS provides a comprehensive, ordinal assessment of household employment status.

Considerations: Checking on Spanish translation. Data to be reported include number of adult household members employed during the month, and average hours/month worked by each adult household member.

Benchmark 5: Improvements in Family Economic Self-Sufficiency

Construct 5.2b: Education of adults

Measure: Mean household MCAFSS educational score

Definition

Population assessed: All families

Timing of assessment: Enrollment and annually. The MFSSS encourages visitor and family to discuss changes.

Numerator: Aggregate household education score

Type: Mean

Denominator: Number of households

Improvement defined as: Stable or increasing

Assessment Tool: Missouri Community Action Family Self-Sufficiency Scale - Education

Author: Missouri Association for Community Action

Description: The Missouri Community Action Family Self-Sufficiency Scale was created specifically for Missouri Community Action Agencies to: 1) assist in assessing self-sufficiency progress of families served by case management programs, and 2) provide information for program evaluation. The Scale was designed for use in a semi-structured interview that has the purpose of gathering information about a family's self-sufficiency.
Household is defined as all those living in a home (who stay there at least 4 nights/week on average) who contribute to the family income, other than tenants or boarders. (Authors' description)

Number of questions: 1

Type of question: 10 answer categories

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Self-report; administrative records

Rationale: The MFSSS succinctly assesses educational activities and achievements on an ordinal scale.

Considerations: Checking on Spanish translation. Data to be reported include education benchmarks achieved by each adult household member, number of adult household members newly participating in educational activities, and hours per month spent by each household member in educational programs.

Benchmark 5: Improvements in Family Economic Self-Sufficiency

Construct 5.3: Health insurance

Measure: Percent of household members with insurance coverage

Definition

Population assessed: All household members

Timing of assessment: Enrollment and annually

Numerator: Number of household members with insurance coverage

Type: %

Denominator: Number of household members

Improvement defined as: Increase

Assessment Tool: N/A

Author:

Description: Health insurance coverage is defined as Medicaid full-scope benefits with or without Share of Cost, Medicare, state-subsidized or partial-pay coverage, or private insurance with or without co-pay. Medicaid pregnancy coverage will only be counted during the pregnancy or appropriate post-partum period. Household is defined as all those living in a home (who stay there at least 4 nights/week on average) who contribute to the family income, other than tenants or boarders.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☑

Validity level: -

Data Source(s): Self-report; HV administrative records; DHHS Medicaid.

Rationale: Families without full insurance coverage are less likely to receive preventive care and more likely to have untreated illnesses. At-risk families are less likely to be aware of the coverage options available to them.

Considerations: Same definition of insurance as for MCH insurance construct.

Benchmark 6: Improvements in Coordination and Referral for Other Community Resources & Supports

Construct 6.1: Families identified as requiring services

Measure: **Percent of families that are positive for need**

Definition

Population assessed: All families

Timing of assessment: Annually

Numerator: Number of families needing services

Type: %

Denominator: Number of families

Improvement defined as: Decrease

Assessment Tool: **N/A**

Author: -

Description: Extensive data on families' needs are documented in the HFA administrative database.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Program administrative data

Rationale: The Healthy Families America home visiting intervention is an evidence-based model specifically designed to work with at-risk families. One of its program goals is to "…offer resources and support." As such, it focuses on identifying the unique parenting needs of families and communities.

Considerations: Will need to examine difference between using initial screening data, versus ongoing measures.

Benchmark 6: Improvements in Coordination and Referral for Other Community Resources & Supports

Construct 6.2: Families receiving referrals

Measure: **Percent of families with positive need that receive appropriate referrals**

Definition

Population assessed: All families

Timing of assessment: Annually

Numerator: Number of families identified with need and receiving a referral

Type: %

Denominator: Number of families identified with need

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: Extensive data on referral patterns for all causes are documented in the HFA administrative database.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Administrative data

Rationale: The Healthy Families America home visiting intervention is an evidence-based model specifically designed to work with at-risk families. One of its program goals is to "…offer resources and support." As such, it focuses on connecting families with the resources necessary to meet their unique parenting needs.

Considerations: Will need to examine difference between using initial screening data, versus ongoing measures.

Benchmark 6: Improvements in Coordination and Referral for Other Community Resources & Supports

Construct 6.3: MOUs with community social services agencies

Measure: Number of MOUs

Definition

Population assessed: N/A

Timing of assessment: Annually

Numerator: Number of active MOUs

Type: Number

Denominator: -

Improvement defined as: Increase

Assessment Tool: N/A

Author: -

Description: Formal Memoranda of Understanding (MOUs) will be signed with community agencies for referrals of eligible families in to the program, and for referrals of clients to external services.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Administrative records

Rationale: The number of *active* MOUs is an indicator of the acceptance of the home visiting program in the target communities, as well as being crucial to its success.

Considerations: Number of MOUs may end up stable at some point.

Benchmark 6: Improvements in Coordination and Referral for Other Community Resources & Supports

Construct 6.4: Agencies sharing information with HV provider

Measure: **Number of agencies with documented sharing arrangements**

Definition

Population assessed: N/A

Timing of assessment: Annually

Numerator: Number of agencies sharing information

Type: -

Denominator: -

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: Number of agreements with community agencies to obtain data on referral outcomes and key project benchmarks.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Administrative records

Rationale: Data sharing arrangements will be needed to obtain data from external agencies on key project benchmarks such as Emergency Department visits and child injuries, the outcomes of referrals, and other outcomes that impact the content of the home visits. These agreements are an indicator of the acceptance of the home visiting program in the target communities, as well as being crucial to its success.

Considerations: May end up stable at some point.

Benchmark 6: Improvements in Coordination and Referral for Other Community Resources & Supports

Construct 6.5: Completed referrals

Measure: **Percent of referrals that are completed**

Definition

Population assessed: All families

Timing of assessment: Annually

Numerator: Number of confirmed, completed referrals

Type: %

Denominator: Number of referrals made

Improvement defined as: Increase

Assessment Tool: **N/A**

Author: -

Description: Data on outcomes of referrals for all causes will be obtained through data sharing agreements and documented in the HFA administrative database.

Number of questions: -

Type of question: -

HFA Recommended: ☐

Spanish version available: ☐

Known, acceptable reliability: ☐

Validity level: -

Data Source(s): Administrative records

Rationale: Outcomes of the referrals of clients to external services will impact the content of the home visits, as well as be an indicator of program effectiveness.

Considerations: Should unit of measure be number of unduplicated families or total number of referrals?

- **Proposed Data Collection and Analysis Plan**

  - **Plan for Data Collection Schedule**

Data will be collected from clients during screening, the assessment process, at enrollment and during home visits while the family is enrolled. Most data will be collected annually and others at three or six month intervals; see Proposed Measure Profiles for specific times. Healthy Families America has its own requirements for frequent data collection which will complement those of the ACA. Data on additional assessment tools for the benchmarks will be collected as described in the "Proposed Measurement Profiles." REDCap's calendar function will track and alert the program/home visitor when specific assessments are required. NDHSS will import data from the program and other databases on a regular basis.

  - **A Plan for Ensuring the Quality of Data Collection and Analysis**

The NE DHHS Lifespan Health Services Unit, MCH Epidemiology Office will administer the NHVECD, oversee the measures, and have responsibility for the data analysis at the State and program level. Relevant NE DHHS staff include the Epidemiology Surveillance Coordinator (0.25 FTE Year 1, 0.10 FTE afterwards), the MCH Epidemiologist (0.20 FTE Year 1, and 0.10 FTE afterwards. A Data Manager Coordinator will be considered when budgeting for FY2011 funds. The local program will require a data manager (0.50 FTE) to oversee and assist with data collection and management.

The overall data quality plan will be based on the four key principles of Timeliness, Completeness, Accuracy and Consistency. Specific details will be organized into a Standardized Data Protocol. The following overview table is adapted from HMIC Data Quality, Abt Associates and Center for Social Policy, 2005.

Principle	Operational definition	Assurance / standardization
Timeliness	Data are collected on an optimal schedule	Standardized Data Protocol with expectations for data collection schedule
	Data are entered into the system soon after collection	Hand-held devices with wireless transfer to central system; electronic transfers from partnering organizations
	Data known to require periodic updates or revisions are flagged in the system	REDCap scheduling flags
	Updates and revisions are entered into the system as scheduled or noted	REDCap scheduling flags
Completeness	All clients are entered into system	CQI / audits
	Data on all services, including intake/enrollment, are entered into system	Exceptions to data completion allowed for specific data items or subpopulations, as documented in

		Standard Data Protocol.
	Files are closed out for clients leaving the program	CQI / audits
Accuracy	Truthfulness from clients; standardized interviewing technique	Training; selection and timing of assessment tools; redundant data sources
	Data entered accurately into system	Training; random verification; minimizing of reporting requirements; refresher training
Consistency	Common interpretation of questions and answers	Training; Peer Review; refresher training; performance incentives
	Common knowledge of what fields to answer	Training; performance incentives

Data quality reports will be generated and reviewed at least monthly at the local level and no more than quarterly at the state level.

- **Plan for Analyzing the Data at the Local and State Level**

Data analysis is an integral part of the Continuous Quality Improvement work described below, and will be conducted with two main objectives. First, descriptive client data are an important part of the quality assurance work described below to determine how well the program is meeting its recruitment and retention goals; these will be used largely at the local level. Secondly, state-level staff will develop a categorization system of clients based on program targets (e.g., by race/ethnicity, geographic location, parental age, child age), establish points of reference for the benchmarks/constructs, and monitor change. This information is key to the quality control work (also described below) and although generated at the state, will be interpreted and used by both local and state level staff.

The program will generate a considerable amount of client, family, and community-level data. An attractive feature of the REDCap data management system is its ability to merge multiple sources of data – whether generated by the program or received from external partners, and produce reports on these multiple levels. We anticipate reporting on the following units of analysis:

- ◊ Specific enrolled pregnant women/mothers
- ◊ Parental / guardian units
- ◊ Children of enrolled families, by age group
- ◊ Families
- ◊ Households

- **Plan for Gathering and Analyzing Demographic and Service-Utilization**

Client demographics and family descriptors are included in HFA core data, and will be available from the program's administrative database. Service utilization data will be obtained from the database and also through REDCap reporting functions.

- ◊ Demographic Data – Race/ethnicity, gender, age, marital status, education levels, language spoken, employment, income level, address, socio-economic status.
- ◊ Acceptance Data – Target Population, referral source, timeframes, linkage to other community services, reasons for decline of services, service intensity.

- o **Plan for Using Benchmark Data for CQI**

The CQI plan reported in Section 7 covers two main areas – program *process* and program *performance*. Continuous measurement of the status of the benchmarks will indicate which *performance* areas are lagging and need further attention and possibly revision. Please see Section 7 for the overall plan.

- o **Plan for Data Safety and Monitoring**

All program staff who handle or have access to identifiable data will sign Confidentiality Agreements and undergo training. All hard-copy data at the local level will be stored in locked facilities when not in use. No individually identifiable information (e.g., master lists, completed questionnaires, flash drives) will be released to persons other than program staff. Data results will be reported only in the aggregate, and will not contain information that identifies individual clients.

The Nebraska Home Visiting and Early Childhood Database will be based in the REDCap Data Management System, and be fully HIPAA and FERPA compliant. While data will flow into the system via secure transfer protocols from local agencies, providers and the home visitors, only NE DHHS staff assigned to the program will be able to access the central data repository. Staff will work with the University of Nebraska – Lincoln to determine and fulfill IRB/Human Subjects Protection requirements.

- **<u>Anticipated Barriers</u>**

Barriers to developing the home visiting plan and monitoring the benchmarks are anticipated in three main areas - sufficient staffing, burden on home visitors and clients from excessive assessments, and accessing injury data.

- ◊ Staffing: We are basing initial staffing patterns on the Healthy Families America (HFA) staffing model. Because HFA requires comprehensive monitoring and tracking of process and outcomes, this should adequately cover any additional needs for tracking the benchmarks and for CQI (see below). We will assess this periodically as we move into implementation and make adjustments as needed.
- ◊ Assessment burden: Assessment tools necessary for the benchmarks have been coordinated as much as possible with existing HFA protocols. Where additional instruments were needed, the tools were selected with a priority to those that covered multiple constructs. Several of the tools are discussion-based rather than formal questionnaires, which will be more comfortable for

both visitors and clients. Finally, REDCap scheduling flags will help optimize the frequency at which the assessments are administered.

◊ Injury data: Patient privacy and confidentiality concerns affect our ability to obtain injury data from private providers. We anticipate reaching agreement with the three area hospitals on data sharing; and are hopeful that this precedent will help reassure local providers to participate as well. As a back-up measure, we are working out agreements to access the Nebraska Hospital Association's hospital discharge database.

SECTION 6: PLAN FOR ADMINISTRATION OF STATE HOME VISITING PROGRAM

- **Lead Agency**

The ACA Maternal, Infant and Early Childhood Home Visiting Program is administered by the NE Department of Health and Human Services, Division of Public Health, in collaboration with the Division of Children and Families.

- **Collaborative Partners**

Key state level collaborative partners include the Early Childhood Interagency Coordinating Council (ECICC), the Nebraska Children and Families Foundation (Nebraska's Title II of CAPTA entity), and the Head Start State Collaboration Office. These partners have a long standing working relationships through many early childhood initiatives and projects through the years. A more complete list of state level partners can be found in Attachment 11.

A list of collaborative partners on the state level can be found in Attachment 11.

- **Overall Management Plan**

The Division of Public Health was responsible for the needs assessment, and has and will continue to be responsible for systems coordination and development, evaluation, performance measurement, and management of the service delivery component. These responsibilities are in line with many existing functions. Its Lifespan Health Services Unit is responsible for the administration of the Title V/MCH Block Grant and its associated needs assessment. It also administers Nebraska's Early Childhood Comprehensive Systems (ECCS) Project, known as Together for Kids and Families. This project has been instrumental in building effective collaborations, including interdepartmental planning for home visitation services. In addition, the Unit has supported home visitation programs in the past and continues to support one currently with Title V/Maternal and Child Health Block Grant Funds.

Division of Public Health staff that will provide in-kind support to the ACA Home Visiting Project will include:

◊ Paula Eurek, Administrator, Lifespan Health Services Unit – Ms. Eurek has been a Division employee since 1983 and in her administrative role since

1995. She received her B.S. in Home Economics-Food & Nutrition from the University of Nebraska. Ms. Eurek will provide broad oversight of the Public Health Division's assigned duties, assuring that these are coordinated with those of the Division of Children and Family Services.

- ◊ Lynne Brehm, MS, Program Coordinator, Together for Kids and Families, Nebraska's ECCS Project - Ms. Brehm has her Masters Degree in Human Development and the Family-Marriage and Family Therapy which she received from the University of Nebraska-Lincoln. She has a wide range of experiences with the Department, starting as a Child Protective Services Worker in 1985. Ms. Brehm will be responsible for assuring the ACA Home Visitation Program is coordinated with early childhood systems building activities that are part of the ECCS project.
- ◊ Jennifer Severe-Oforah, MCRP, MCH Epidemiology Surveillance Coordinator – Ms. Severe-Oforah has her Masters Degree in Community and Regional Planning. She serves as Nebraska's SSDI Program Manager and coordinates needs assessments and reporting for the Title V/MCH Block Grant. Ms Severe-Oforah was instrumental in leading the needs assessment process for the ACA MIECHV project and the development of the benchmarks. She will continue to provide technical assistance in implementing the plan for meeting the benchmarks and the plan for continuous quality improvement.

The Division of Public Health created a new position that has primary responsibility for managing the ACA Home Visiting Program. This new position is funded by the ACA Home Visiting grant. The ACA Home Visiting Program Coordinator is responsible for day-to-day management of the program, assuring that project work plans are developed, implemented and monitored, managing contracts, arranging for needed training and technical assistance for service providers, working with Finance staff to monitor and report expenditures, and being the primary liaison with the Division of Children and Family Services in assuring routine, ongoing communication and coordination on programmatic issues. This position is held by Sue Spanhake. Ms. Spanhake received her B.S. in Home Economics Education from the University of Nebraska, and has been employed by the Department since 1989. Past NE DHHS positions include Community Health Educator, Behavioral Risk Factor Surveillance System (BRFSS) Coordinator, Performance Management Consultant, and Program Manager for Perinatal, Child, and Adolescent Health. She oversaw the Nebraska Perinatal Depression Project, and the was the Project Coordinator for the First Time Motherhood/New Parent Initiative until moving to the ACA Home Visiting Program Coordinator position late in 2010. See Attachment 12 for an abbreviated classification description for the DHHS Program Coordinator, and the resumes of the key positions.

The Division of Children and Family Services will have a key coordination role with the ACA Home Visiting Program. Duties included providing guidance and assistance in selecting evidence-based models based on previous and ongoing work in the area of child abuse prevention and early intervention, coordinating ACA home visiting with its programs to assure complementary delivery of services to at-risk families, aligning resources, and providing

leadership in furthering broad goals to improve child outcomes through partnerships such as the Nebraska Child Abuse Prevention Partnership.

- ◊ In-kind administrative support will be provided by Chris Hanus, Administrator, Child Welfare Unit. Ms. Hanus will provide broad oversight of the Children and Families services Division's assigned duties, assuring that these are coordinated with those of the Division of Public Health. Ms. Hanus has been a NE DHHS employee since 1972, and in an administrative role children and family services since 1978. She received her B.S. in Secondary Education from the University of Nebraska-Lincoln.
- ◊ Shirley Pickens-White, Program Coordinator with the Child Welfare Unit will also provide in-kind programmatic support. Ms. Pickens-White is the current contract manager for the State funded Home Visitation Programs and will be the primary, on-going liaison with the ACA Home Visiting Program Coordinator, to assure that the ACA supported services align with and complement those provided through Children and Family Services. She will also attend all collaboration planning meetings, trainings, and events. Ms. Pickens-White's received her Bachelor of Social Work degree from Fort Valley State University. She has been employed by NE DHHS since 1989 and in her current role as Program Coordinator since 2009.

An organizational chart is found as Attachment 13.

As mentioned earlier, the Panhandle Public Health District was selected as the local contractor to implement ACA home visiting services in the targeted communities. The health district came into existence when the Nebraska Health Care Funding Act was passed in May 2001, and new multi-county health departments were created in Nebraska. The District, with offices in Box Butte and Morrill Counties, has its main office located in Hemmingford, serves eleven counties in the Panhandle region, and provides an array of services which are described at http://www.pphd.org/index.html.

The Panhandle Public Health District will employ the home visitor, provide the organizational infrastructure for project implementation and monitoring, sufficient to meet federal requirements for data, benchmark monitoring, and the continuous quality improvement plans. They will also implement policies to assure quality services are delivered consistent with the goals of the project.

Healthy Families America programs are staffed by well-trained and competent family support workers (FSW), family assessment workers (FAW), and program managers/supervisors. Those employed by the Panhandle Public Health District for the State Home Visiting Program will participate in rigorous training provided by HFA, as well as state level staff. HFA recommendations will be followed including:

- ◊ One FSW should serve no more than 15 – 25 families depending on intensity;
- ◊ One supervisor for every five to six staff persons;

- ◊ Program managers/supervisors spend a minimum of 1.5 to 2 hours per employee each week on formal supervisor and additional time shadowing the FSWs and FAWs.

As mentioned earlier in this plan, the Panhandle Public Health District has personnel with the necessary skills and experience to develop the systems-level aspects of the program (screening/identification of families to be served; referral mechanisms to the program and to other services; data collection and analysis; and continuous quality improvement). With training and technical assistance provided by the model developer, the Panhandle Public Health District has the capacity to design and deliver the HFA model with fidelity.

HFA is dedicated to ensuring that any program that affiliates with the national model adheres to high standards of quality. This is accomplished by first becoming an affiliate, later through the credentialing process, and implementation of the twelve critical elements which are the backbone for any HFA home visiting program.

There were no model-specific prerequisites for implementation of HFA model discussed in the implementation profile available on the Hom VEE website. However, the project coordinator and the PPHD have been in regular communication with the regional HFA director, and NE DHHS received a letter of approval to utilize HFA in Nebraska.

A comprehensive, early childhood system is established in Nebraska and the home visiting program will fit into this existing framework. Therefore, NE DHHS no plans are needed to bolster the State administrative structure at this time.

Other established collaborations with State early childhood initiatives have been described earlier in the plan, including the Early Childhood Interagency Coordinating Council (ECICC), State Advisory Council on Early Childhood Education and Care, Child Wellbeing Initiative, Early Childhood Professional Development Partnership (ECPDP) or a Regional Training Coalition (RTC), and Early Comprehensive Childhood Systems initiative, and the Early Childhood Systems Team.

SECTION 7: PLAN FOR CONTINUOUS QUALITY IMPROVEMENT

The primary purpose of this project is to improve participant outcomes through community-based implementation of an evidence-based home visiting program. As a secondary outcome, we hope to strengthen referral networks among local providers. Implementing a comprehensive yet workable quality control system will help ensure positive outcomes by reinforcing structures that work, and revising those that do not.

<u>Structure</u>
The project CQI team will contain representatives from both the state and local levels:

<u>State</u>

- Data Management Contractor
- Home Visiting Program Coordinator
- MCH Surveillance Coordinator and Epidemiologist

Nebraska Children and Families Foundation representative
Early Childhood Systems Team/ECCS representative

Local

Directors of the Panhandle Public Health District and the Scotts Bluff County Health Departments
Family representatives
Home visitor representatives
DHHS Child Protection Specialist
Regional West Medical Center representative
Other referral partners

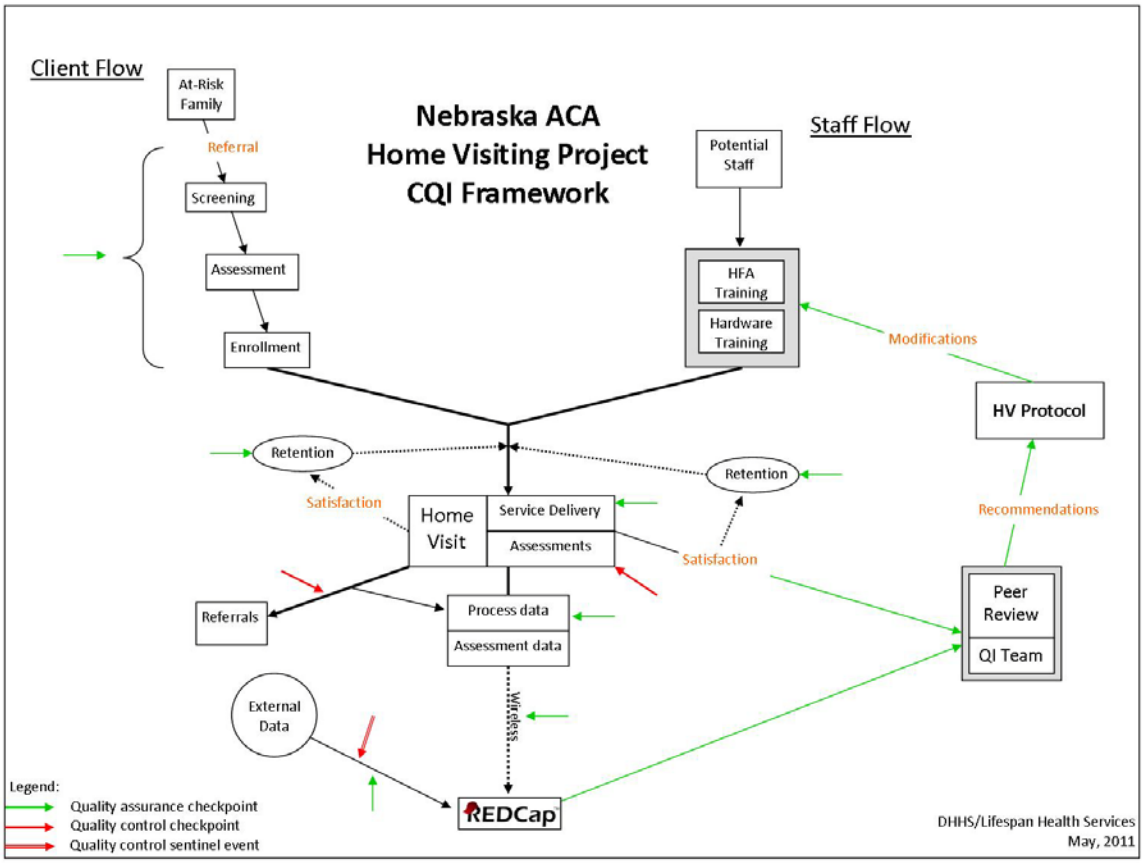
Overall responsibilities of the QI team are to:

- ◊ Establish and maintain a culture of quality
- ◊ Provide oversight of the CQI Plan
- ◊ Set performance targets, monitor change overtime
- ◊ Detect, analyze and resolve problems

Fundamental to development of Nebraska's Continuous Quality Improvement (CQI) plan is remembering that the system is designed to improve the lives of young children and their families. In this program, we will assure the quality of our home visitation program through continuous improvement work on both the process and actual service delivery. The Figure which follows is a basic diagram of the proposed CQI system, using common definitions of Quality Assurance (QA) as *process* oriented and Quality Control (QC) as *product* oriented.

Quality Assurance The green arrows (Figure) indicate *quality assurance checkpoints* –

- ◊ Referrals (in): Are potential clients being referred? Which agencies are providing referrals? Do referrals match targets (demographics, geographical location, etc.)? Are potential clients screened and assessed? Are clients enrolling in the program?
- ◊ Service delivery: Are home visiting content protocols (HFA fidelity, assessments, etc.) being followed? Are service delivery indicators being captured?
- ◊ Retention: How long are clients staying in the program? What is the turnover rate among staff?
- ◊ Referrals (out): Do documented referrals match documented needs?
- ◊ Data delivery: Is wireless transfer of home visit data occurring correctly? Is electronic transfer of supporting data from partnering agencies occurring as planned?
- ◊ Data quality: Is Data Quality Plan being implemented? (See section 5, above.)
- ◊ Quality Review: Are the Quality Improvement teams meeting as scheduled? Do the QI teams have the targeted members, with full participation? Are all necessary data available for the quality reviews? Are QI recommendations being made, implemented and monitored for effect/effectiveness?



Quality Control The red arrows (Figure) indicate *quality control checkpoints* –

- ◊ Service Delivery: Are clients being referred to services?
  - ➢ Screened-in or substantiated reports of child maltreatment are "sentinel events" that will necessitate immediate quality control assessment
- ◊ Benchmarks / HFA (targets?): Are construct measures improving?

Unsatisfactory responses to any of these or other questions will invoke further investigations as to cause and possible remedies. Ishikiwa ("Fishbone") diagrams are likely tools for helping to focus brainstorming and root cause analyses of detected problems. Along with data quality reports (Section 5), CQI reports will be generated and reviewed at least monthly by the local level QI teams and at least quarterly by the state level QI team. Formal reports will be produced annually. Any issues that affect data *content*, however, e.g., conduct of the home visit, will be fed back immediately to the home visitor(s). They and the QI teams will be charged with analyzing, developing and implementing a solution.

SECTION 8: TECHNICAL ASSISTANCE NEEDS

This list below identifies the anticipated technical assistance needs for Nebraska's ACA Home Visiting Program.

- ◊ Plans for a stateside home visiting program that meets requirements, plans for and implements approved programs effectively and with fidelity to evidence-based or promising models.
- ◊ Integration of the State Home Visiting Program into a comprehensive statewide system of support for early childhood.
- ◊ Finalizing selection of assessment tools.
- ◊ Finalize the data collection system and integration of CQI in the local home visiting program. NE DHHS plans to contract with the University of Kansas to design these systems.
- ◊ Implementation of the Healthy Families America model to fidelity at the local level. National HFA will provide the training for Family Support Workers, Family Assessment Workers, and Program Managers/Supervisors.
- ◊ Implementation and integration of the selected curriculum into the local home visiting program. NE DHHS will also collaborate with the HFA model developer and curriculum developer.
- ◊ Topical issues (e.g., substance abuse, mental health, domestic violence, tribal, and rural issues).
- ◊ Home visiting participant recruitment and retention.
- ◊ Sustainability.

SECTION 9: REPORTING REQUIREMENTS

The Nebraska ACA Home Visiting Program provides its assurances that an annual report will be submitted to the US HHS Secretary regarding the program activities carried out under the program, on/before the specified due dates, and conform to the formatting requirements for this report. NE DHHS will seek input from the collaborative partners in the private and public sector listed in Attachment 11. The State Home Visiting Report will address the following:

State Home Visiting Program Goals and Objectives

NE DHHS will report on the progress of each identified goal and objective for the reporting period, including barriers to progress, and strategies used to overcome them. The goals and objectives will be updated and revised if needed, and a summary will be provided describing the State's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided in the State plan, and identify updates/changes to this logic model.

State Home Visiting Promising Program Update

Nebraska selected to implement only the HFA evidence-based model during this funding period, so this reporting requirement is not applicable to Nebraska's ACA Home Visiting Program.

Implementation of Home Visiting Program in Targeted At-risk Communities

The counties identified through the needs assessment were Scotts Bluff, Box Butte, and Morrill. The Program Coordinator for Nebraska's ACA Home Visiting Program will seek input from the local Panhandle partners regarding the barriers/challenges encountered during the implementation phase as well as steps taken to overcome these barriers/challenges. Each of the items below will be addressed in the report:

- Description of how the Panhandle partners were engaged in the State plan;
- Update on the work-to-date with HFA, including the technical assistance and support they provided to the state and local partners;
- Update on the selected curriculum and compatible with the HFA model, and other resources needed based on the timeline in the State Plan;
- Update on the training and professional development activities obtained from HFA, or provided by NE DHHS or the Panhandle partners;
- Update on staff recruitment, hiring, and retention for all state and local positions, including the PPHD contract, and any other subcontracts;
- Update on participant recruitment and retention efforts in Scotts Bluff, Box Butte, and Morrill counties;
- Status of home visiting caseloads in the three targeted counties;
- Update on the coordination between the state home visiting program, Early Head Start, and Children's Outreach, and the Regional West Home Care, including resources available in the targeted counties; and
- Discussion of the challenges to maintaining quality and fidelity in state home visiting program, and proposed responses to these issues.

Progress Toward Meeting Legislatively Mandated Benchmarks

NE DHHS will provide updates on data collection for the six benchmark areas as described in the State Plan, including the constructs, definitions of what constitutes improvement, data sources for each measure utilized, and discussion of barriers/challenges encountered during data collection, and steps taken to resolve them.

The State will develop and acquire a data collection system through a contract with the University of Kansas, and HFA PIMS.

Home Visiting Program's CQI Efforts

Again, NE DHHS will provide an update on the CQI planning and implementing efforts for the home visiting program. Copies of CQI reports developed addressing opportunities, changes implemented, data collected, and results obtained will be provided if applicable. The State will develop and acquire CQI through a contract with the University of Kansas.

Administration of State Home Visiting Program

If there any changes in personnel during the reporting period, NE DHHS will provide resumes for new staff, and an updated organizational chart. An update will provide efforts to meet the legislative requirements ensuring well-trained competent staff including high quality supervision,

and to ensure that the referral and services network in the three county area supports the home visiting program and the families served, and policy updates created by the State to support the home visiting program. Barriers/challenges will be identified and the steps taken to resolve these issues.

Technical Assistance Needs

NE DHHS will report on anticipated technical assistance for implementing the home visiting program or for developing a statewide early childhood system.

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Nebraska Department of Health and Human Services

Division of Public Health

State of Nebraska

Dave Heineman, Governor

May 17, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Division of Public Health has responsibility for administering Title V/MCH. As the Chief Medical Officer, I concur with and support the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

I understand that the counties of Scotts Bluff, Morrill, and Box Butte have been selected as the targeted communities for implementation of the Program. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is to be commended that the choice of communities was based on a careful analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan also addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

We are committed to working with everyone as it implements evidence-based home visiting services in the three selected counties. Collaboration is important in developing effective systems of care, with home visiting being a part of a continuum of services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in Nebraska communities.

Sincerely,

Joann Schaefer, MD
Chief Medical Officer – State of Nebraska
Director, Division of Public Health
Department of Health and Human Services

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Nebraska Department of Health and Human Services

Division of Children and Family Services

State of Nebraska

Dave Heineman, Governor

May 17, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Division of Children and Family Services has responsibility for administering Title IV-E and IV-B child welfare. As the Director, I concur with and support the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

I understand that the counties of Scotts Bluff, Morrill, and Box Butte have been selected as the targeted communities for implementation of the Program. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is to be commended that the choice of communities was based on a careful analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan also addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

The Division of Children and Family Services is committed to working with the Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties. Collaboration is important in developing effective systems of care, with home visiting being a part of a continuum of services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in Nebraska communities.

Sincerely,

Todd L. Reckling, Director
Division of Children and Family Services
Department of Health and Human Services

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DHHS
Nebraska Department of Health and Human Services

Division of Behavioral Health

State of Nebraska
Dave Heineman, Governor

May 17, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Division of Behavioral Health has responsibility for administering Substance Abuse Services. As the Director, I concur with and support the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

I understand that the counties of Scotts Bluff, Morrill, and Box Butte have been selected as the targeted communities for implementation of the Program. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is to be commended that the choice of communities was based on a careful analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan also addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

The Division of Behavioral Health is committed to working with the Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties. Collaboration is important in developing effective systems of care, with home visiting being a part of a continuum of services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in Nebraska communities.

Sincerely,

Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services

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May 31, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Nebraska Children and Families Foundation has responsibility for administering Title II of CAPTA. As the President of the Nebraska Children and Families Foundation, I concur with and support the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

I understand that the counties of Scotts Bluff, Morrill, and Box Butte have been selected as the targeted communities for implementation of the Program. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is to be commended that the choice of communities was based on a careful analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan also addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

The Nebraska Children and Families Foundation is committed to working with the Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties. Collaboration is important in developing effective systems of care, with home visiting being a part of a continuum of services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in Nebraska communities.

Sincerely,

Mary Jo Pankoke, President

Head Start-State Collaboration Office

Eleanor Kirkland, Director
PO Box 94987 • 301 Centennial Mall South • Lincoln, NE 68509-94987
Telephone (402) 471-3501 • Fax (402) 471-0117 • Email: eleanor.kirkland@nebraska.gov
http://www.nde.state.ne.us/ECH/hssco.html

May 19, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Head Start-State Collaboration Office (HSSCO) helps build early childhood systems that engage Head Start/Early Head Start programs in state level initiatives to support school readiness of young children. As the Head Start Early Childhood Systems Director and co-chair of the collaborative state Early Childhood Systems Team, I wholeheartedly concur with and support the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

I understand Scotts Bluff, Morrill, and Box Butte counties have been selected as the targeted communities for implementation of the Program. Involvement of the Head Start/Early Head Start/Migrant Head Start grantee in that region has been and will continue to be important to the success of this effort. I am aware that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is commendable that the choice of communities was based on a rigorous analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

The HSSCO commits to ongoing collaborative efforts with Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties. Collaboration is important to develop effective systems of care, and home visiting is an integral component in

comprehensive services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in communities and to inform future home visiting approaches in Nebraska.

Sincerely,

Eleanor Kirkland

Eleanor Kirkland, MA, CSW
Head Start Early Childhood Systems Director
Nebraska Department of Education
Office of Early Childhood

EARLY CHILDHOOD INTERAGENCY COORDINATING COUNCIL

A COLLABORATIVE EFFORT TO ADVISE STATE GOVERNMENT ON THE IMPROVEMENT OF SERVICES AFFECTING YOUNG CHILDREN AND THEIR FAMILIES

MEMBERS APPOINTED BY THE GOVERNOR REPRESENT:

Parents
Family Child Care
Center-based Child Care
Early Intervention Providers
Primary Education
School-based Programs
School-age Care
Parenting Education
Pediatric Health
Mental Health
Head Start
Higher Education
Extension Educators
Child Care Food Programs
State Agencies

Heather Gill
ECICC Chairperson
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ECICC Facilitator
Phone: (402) 557-6894
Fax: (402) 557-6890
E-mail: terry.rohren@nebraska.gov

Please direct written correspondence to:
Attn: Susan Dahm
ECICC Secretary
P.O. Box 94987
Lincoln, NE 68509-4987
Phone: (402) 471-8204
Fax: (402) 471-0117
E-mail: susan.dahm@nebraska.gov

ECICC Website:
www.education.ne.gov/ecicc/

May 26, 2011

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As you know, the Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health (PH), one of NE DHHS's six divisions.

The Early Childhood Interagency Coordinating Council (ECICC) serves as the State Advisory Council for Early Care and Education. As Chairperson of the ECICC, I was designated to sign the Memorandum of Concurrence on behalf of the Council at the May 13, 2011 meeting. The ECICC concurs with and supports the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the February 8, 2010 Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program.

The Council understands that the counties of Scotts Bluff, Morrill, and Box Butte have been selected as the targeted communities for implementation of the Program. The Council also understands that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated. It is to be commended that the choice of communities was based on a careful analysis of objective data, and that the selected communities have been actively involved in the selection of the model and in preparing the Updated State Plan.

The Updated State Plan also addresses legislatively mandated benchmarks and methods for continuous quality improvement, including the necessary infrastructure to collect and analyze data. In addition, program implementation will involve working with the communities in enhancing referral systems and service linkages and promoting collaboration.

The ECICC is committed to working with the Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties. Collaboration is important in developing effective systems of care, with home visiting being a part of a continuum of services for young children and their families. This program provides an exceptional opportunity to promote maternal, infant, and early childhood health, safety, and well-being in Nebraska communities.

Sincerely,

Heather Gill, Chairperson
Early Childhood Interagency Coordinating Council

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. ACA MIECHV Progra	93.505	$	$	$ 759,694.00	$	$ 759,694.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 0.00	$ 0.00	$ 759,694.00	$ 0.00	$ 759,694.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) ACA MIECHV Program	(2)	(3)		(5)
a. Personnel	$ 97,588.00	$	$	$	$ 97,588.00
b. Fringe Benefits	33,180.00				33,180.00
c. Travel	5,305.00				5,305.00
d. Equipment	0.00				0.00
e. Supplies	0.00				0.00
f. Contractual	574,317.00				574,317.00
g. Construction	0.00				0.00
h. Other	920.00				920.00
i. Total Direct Charges *(sum of 6a-6h)*	711,310.00	0.00	0.00	0.00	711,310.00
j. Indirect Charges	48,384.00				48,384.00
k. TOTALS *(sum of 6i and 6j)*	$ 759,694.00	$ 0.00	$ 0.00	$ 0.00	$ 759,694.00
7. Program Income	$	$	$	$	$ 0.00

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SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
13. Federal	$ 0.00	$	$	$	$
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

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Standard Form 424A (Rev. 7-97) Page 2

Nebraska Department of Health and Human Services Line Item Budget and Justification

Line Items	Year One	Year Two	2.5 mos	(row totals)	% of total
	7/15/10 - 7/14/11	7/15/11-7/14/12	7/15/12 - 9/30/12		
a. Personnel	$41,468	$56,120	$0	$97,588	12.85%
b. Fringe Benefits	$14,099	$19,081	$0	$33,180	4.37%
c. Travel	$1,791	$3,514	$0	$5,305	0.70%
d. Equipment	$0	$0	$0	$0	0.00%
e. Supplies	$0	$0	$0	$0	0.00%
f1. Contractual- Panhandle Public District Health Department, "Prime"		$510,000		$510,000	67.13%
f2. Contractual- University of Kansas; development of web-based, database and data linking using REDCap		$58,817		$58,817	7.74%
f3. Contractual- Panhandle Partnership (Joan Frances, stakeholder facilitation)	$5,500	$0		$5,500	0.72%
f4. Contractual- CQI svcs	$0	$0	$0	$0	0.00%
g. Construction	$0	$0	$0	$0	0.00%
h. Other	$0	$920		$920	0.12%
i. Total Direct Charges	$62,858	$648,452	$0	$711,310	93.63%
j. Indirect Charges	$20,560	$27,824	$0	$48,384	6.37%
	$83,417.79	$676,276.37	$0.00	**$759,694**	100.00%

Budget Narrative

The updated budget for Nebraska's home visiting program contains both the planned and actual expenditures to-date associated with the statewide needs assessment and the updated state plan. This budget is delineated by two 12-month periods of accounting. The FY 2010 budget represents a 24-month period, while acknowledging that there is spending authority for the 27-month period ending September 30, 2012. This budget assumes that additional costs beginning September 30, 2011 will be obligated with the FY 2011 funds when that is awarded. The total FY 2010 award to Nebraska is **$759,694**, which is the projected costs budgeted in Nebraska's Updated State Plan.

Maintenance of Effort Baseline Expenditure:
On March 23, 2010, no projects funded with state general funds that fully met the definition of home visitation as specified in HRSA-10-275 as revised July 1, 2010, Page 7.

Personnel Costs:
DHHS Program Coordinator provides day-to-day management of the project. This 1.0 FTE position was filled October 2010 and thus supported with grant funds for approximately 0.75 of Year One.

Year One
Salary $26.582/hour X 2080 hours/full year X 0.75 years = $41,468

Year Two
Salary (adjusted 1.5% for cost of living increase effective July 1, 2011) $26.981 X 2080 hours = $56,120

Fringe Benefits:
Benefits are estimated at 34% of salaries and include Retirement State Match, OASDI, Life Insurance, and Health Insurance.

Year One	*Year Two*
$41,468 X 0.34 = $14,099	$56,673 X 0.34 = $19,269

Travel:
Year One
Travel costs expended were:

- One out-of-state trip for Project Coordinator for training and/or technical assistance related to evidence-based model selected = $1115 ($365 air fare, $450 for 3 nights hotel, $300 meals, registration fees, miscellaneous)
- Travel costs for stakeholders to attend needs assessment meeting = $676 (8 volunteers X $0.50/mile traveled X avg. 169 miles/round trip)

Year Two
Travel costs are projected for:

- One out-of-state trip for Project Coordinator for professional development in home visiting and/or technical assistance related to evidence-based HFA model = $1500 ($750 air fare, $450 for 3 nights hotel, $300 meals, registration fees, miscellaneous)
- One trip by 3 state-level staff to the Nebraska Panhandle for HFA training (Project Coordinator, ECCS Program Manager, and data staff) = $1,250. Assumes travel in a state car which cost is included in the indirect cost pool.
- One trip by 2 state-level staff to the Nebraska Panhandle related to data system development (Project Coordinator, data staff); lodging, meals, incidentals) = $750. Assumes travel in a state car which cost is included in the indirect cost pool.

Equipment:
None

<u>Supplies:</u>

None

Contractual

Year One

Contractual costs for an organizer with proven trustworthiness in the Nebraska Panhandle region

- 1st contract was to facilitate the initial phone discussions between state-level staff and the stakeholders in the Nebraska Panhandle region. = $1,500
- 2nd contract was to facilitate two, on-site planning meetings between state-level staff and stakeholders representing the three-county region selected for home visiting services. = $4,000

Year Two

- Panhandle Public Health District (PPHD), as Prime contractor, will deliver local management and oversight for home visiting services and associated costs of curriculum, training materials and travel, assessment tools, HFA annual fee, etc. = $510,000. Details follow on pages ____.
- RedCAP data system development (University of Kansas) = $58,817. Details follow on pages ___.
- CQI data analyst projected to begin September 2011; costs will be budgeted with the FY 2011 anticipated award = $0. Budgeted amount for FY2010 is $0.

Other:

Costs associated with state-level engagement with HFA:

Year One

None

Year Two

- HFA training of 3 state-level staff including fees (3 @ $280 = $800) and manuals (3 @ $40 = $120) = $920. Travel costs associated with training of state-level staff are included in the travel line.

Construction:

None

Total Direct Charges:

Year One	*Year Two*
$62,858	$648,452

Indirect Charges:

Nebraska's indirect cost rate is 37% of salaries + benefits. The rate agreement is Attachment ____.

Year One

($41,468 + $14,099 = $55,567) X 0.37 = $20,560

Year Two

($56,120 + $19,081 = $75,201) X 0.37 = $27,824

TOTALS
Year One
$83,918

Year Two
$675,776

TOTAL BUDGET for FY 2010 funds for this period
$759,694

Line item budgets for PPHD and the University of Kansas can be found on the following pages.

PPHD Home Visitation Budget Justification

Personnel Costs $365,760

Wages 11 month	FTE	Rate	Total	
Program Manager:	0.5	$23.50	$22,403	
Supervisor	1	$18.75	$35,750	
Home Visitor 1/FAW	1	$13.50	$25,740	
Home Visitor 2	1	$13.50	$25,740	
Home Visitor 3	1	$13.50	$25,740	
Home Visitor 4	1	$13.50	$25,740	
Home Visitor	1	$13.50	$25,740	
Data Entry/Support	0.5	$10.00	$9,533	
Total Wages				***$196,387***

Benefits 11 month	FICA	Retire	Health	Unemp-loyment	Total	
Program Manager:	$1,714	$1,512	$8,136	$210	$11,571	
Supervisor	$2,735	$2,413	$16,271	$210	$21,629	
Home Visitor 1/FAW	$1,969	$1,737	$16,271	$210	$20,187	
Home Visitor 2	$1,969	$1,737	$16,271	$210	$20,187	
Home Visitor 3	$1,969	$1,737	$16,271	$210	$20,187	
Home Visitor 4	$1,969	$1,737	$16,271	$210	$20,187	
Home Visitor	$1,969	$1,737	$16,271	$210	$20,187	
Data Entry/Support	$729	$644	$8,136	$210	$9,718	
Total Benefits	***$15,024***	***$13,256***	***$113,898***	***$1,678***	***$143,855***	***$143,855***

Administration	FTE	
Kim Engel	0.24	
Sara Sulzbach	0.1	
Total Admin	***7.5% of Total Wages and Total Benefits***	***$25,518***

Non-Personnel Costs $104,461

Cost of Meetings		**$800**
Advisory board quarterly meetings	$400	
$100/meeting x 4 quarters		
Family support group meetings	$400	
$100/meeting x 4 quarters		
Communication Devices		**$5,070**
One time purchases for staff/office		
Cell phones - $100/person x 7 staff	$700	
Office phone system - 1 system w 8 stations	$3,600	

Polycom speaker phone - 1 system	$770	
Office Space		**$9,350**
Rent and utilities - $850/month x 11 months		
Copies of forms/tools		**$5,250**
$50/family/year x 75 families	$3,750	
Misc copies	$1,500	
Copier/Universal Printer		**$7,200**
One time purchase of copier/printer for office		
Computers		**$12,400**
$1550/computer x 8 staff		
Family Support Materials		**$7,500**
$100/family/year x 75 families		
Office furniture		**$13,120**
one-time purchase of furniture for office		
Desks - 8 @ $750 each	$6,000	
Book cases - 8 @ $240 each	$1,920	
File cabinets - 8 @ $300 each	$2,400	
Office chairs - 8 @ $350 each	$2,800	
Advertising and PR		**$2,020**
Advertisments in Box Butte, Morrill and Scottsbluff newspapers		
Audit		**$3,000**
Portion of A-133 audit		
Insurance		**$1,500**
Portion of workers comp, office space, and contents insurance		
Legal		**$1,000**
Mileage		**$18,931**
Travel off site for home visitors training		
13 days @ 120 miles round trip/day x .51	$796	
13 days @ 90 miles round trip @ .51	$597	
Monthly staff Meetings		
11 meetings @ 120 miles round trip/meeting x .51	$673	
11 meetings @ 90 miles round trip/meeting x .51	$505	
Home Visits		
400 miles/month/visitor x 11 months x 5 visitors x .51	$11,220	
Supervisor travel to off site locations		
48 weekly visits @ 120 miles round trip/visit x .51	$2,938	
48 weekly visits @ 90 miles round trip/visit x .51	$2,203	
Communication		**$10,120**
Internet service for Scottsbluff office @ $70/month x 11 months	$770	
Cell phone service for 7 phones @ $90/month/phone x 11 months	$6,930	

Telephone service for 3 lines into Scottsbluff office @ $220/month x 11 months	$2,420		
Office Supplies		**$3,200**	
Routine office supplies, including postage $400/person x 8 staff	$3,200		
Professional Development		**$4,000**	
$500/person x 8 staff	$4,000		
Services			**$34,779**
Healthy Families of America		**$19,418**	
HFA Affiliation	$500		
HFA Annual Fee	$1,350		
Home Visitor/Supervisor Integrated Strategies Core Training	$3,800		
Travel for Trainer	$1,296		
Core Supervisor Training	$1,200		
Family Asssessment/Supervisor Core Training	$3,800		
Travel for Trainer	$1,296		
Core Supevisor Training for Assessment	$1,200		
Wrap Around Training	$0		
Program Information Management System	$600		
Program Information Management System Training	$1,200		
Travel for Trainer	$1,296		
Training Manuals (8 @ $40)	$320		
Training Room AV & refreshments for both weeks of training	$1,560		
8 staff + 1 trainer x 8 days @ $20/day + 2 staff + 1 trainer x 2 days @ $20/day			
Growing Great Kids		**$15,361**	
GGK P-36 months trianing for staff and supervisors	$10,200		
$1275/participant x 8 participants			
Supervisor licensing and materials fee	$1,200		
Parent participation training supplies	$240		
Shipping	$175		
Trainers airfare, hotel, ground transporation	$1,296		
Videos for curriculum implementation @ $450/supervisor	$450		
Training room AV & refreshments for week	$1,300		
8 staff, 1 trainer and 4 family members/day x 5 days @ $20/day			
Spanish Parent handouts and Activities Master Set	$500		

Measurement Tools/Evaluation			**$5,000**
Evaluation consultant		**$5,000**	
AQS materials	$2,000		
Other measurement tools	$1,000		
Evaluation consultant	$1,000		
Database licensing fee	$1,000		
TOTAL YEAR 1 BUDGET			**$510,000**

University of Kansas Proposal for Data Collection

Category	Cost
Personnel (Garstka, Barton, admin)	38,522
Travel	5,568
Other Direct Costs	2,560
Indirect Costs (26%)*	12,137
Total	**$58,817**

*Indirect cost rate subject to change depending on State negotiated rate.

Level Two for Describing Need: Extent to Which Existing Home Visiting Programs Address Risk

This document describes the process by which Nebraska Department of Health and Human Services (DHHS) determined the extent to which existing home visiting programs operating within the 17 counties (identified in Level 1) address specific risks. Level 1 determined the state's counties with the highest risks for poor outcomes that could be addressed though home visitation, as per requirements of the Affordable Care Act (ACA).

The goal of the Level 2 analyses was to evaluate the existing level of services in the counties. The analysis was done in three parts: first, determine how many "at risk" children are currently being served in each county; second, determine whether existing programs were addressing the risks identified in their county; and third, combine the two scores for a final score. Once Level 2 was complete, the level service score was combined with the Level 1 score in order to conclude where the largest unaddressed need exists.

This analysis was limited by the types of data collected at the county and program level, and is only as good as the information that the programs provided to DHHS. Further, the levels of current services are not static - they changes over time, thus these results can only represent a snapshot in time.

Methodology

1. Preparation: DHHS staff spent time exploring methodologies and examining options for objectively measuring counties' current level and type of home visiting services. After a great deal of thought and debate the second level was constructed with three separate steps. The first step determined "penetration" of existing programs - the number of at-risk children in the county actually being served by a home visiting program.

   Penetration was measured by the ratio of children 0-5 living in poverty being served by the program compared to the estimated number of children 0-5 living in poverty in the county. This criterion was scored so that counties serving a lower percentage of children received a higher score:

   0 = Higher than 50% penetration
   1 = 20% or higher penetration
   2 = 10% or higher penetration
   3 = 0-10% penetration

   The second step assessed whether the home visiting program(s) were using a formal model-based approach to address the county-specific risks identified in Level 1. This criterion was scored so that programs with fewer targeted activities received a higher score:

   0 = addressing all risks with a model
   1= addressing some/most of the risks with a model
   2= addressing some of the risks
   3= addressing none of the risks or not offering enough visits to address risks

   The third step, described below, combined the scores from steps 1 and 2 to provide a county score.

2. Data collection. For step 1, county-level data (2008/2009) on numbers of young children at risk were obtained from the US Census Bureau, specifically:

   a) Estimated number of children <5 years[1]
   b) Estimated number of children <5 years living in poverty[2]

   To obtain the additional information needed for step 2, staff developed a telephone interview form that sought information on client demographics and programmatic activities specifically addressing the county's identified risks. Staff requested an interview from all home visiting programs identified during Level 1 and sent the interview questions prior to the call. Information was gathered from 30 of the 32 identified programs. All interviews were conducted during December, 2010 and January, 2011. It is important to note that the programs provided the best estimates possible based on their most current available information. As such, results should be considered a "best estimate" of actual numbers.

3. Analysis. Step 1: Calculations of the estimated number of children <5 years living in poverty served by the program(s) were performed by dividing the number of children living in poverty served by the program(s) by the estimated number of children living at 100% of the poverty level in the county. County-specific level of penetration was scored by the criteria described above.

   Step 2: To assess the degree to which risks were being addressed under a home visiting model, staff utilized data collected from the programs during Level 1 (the initial "Zoomerang" surveys) and the supplemental phone interviews to determine whether the programs are:

   a) Implementing a formal home visiting model
   b) Offering more than one visit
   c) Offering programming and/or activities that address their county's identified risks

   Program-specific levels of "risk addressed" were scored by the criteria described above. Where there was more than one program in a county, its score was weighted by its proportion of the total number of children at risk being served in the county. The overall county score was then the sum of the weighted program scores. For counties with only one eligible home visiting program, the program score is the same as the county score.

   Step 3: The penetration and risk addressed scores were added together, yielding a total Level Two score for each county. Combined Level 2 scores ranged from 0.08 to 6.0.

4. Counties received a final ranking based on the sum of their Level One and Level Two scores.

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[1] US Census Bureau, Population Division, July 2010, Annual Estimates of the Civilian Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009

[2] U.S. Census Bureau, Small Area Estimates Branch, November 2010, Table 1: 2008 Poverty and Median Income Estimates – Counties, Nebraska.

Analysis

Step One of Level Two: Penetration of Existing Programs, by County

	Total Population , 2009 Census Est.			Living in Poverty, 2008 Small Area Est.		Est. "Served" by "program"		
County	ALL	Pop <5	% Pop <5	Pop <5	% Pop <5	Pop <5	% Pop <5	Score
Box Butte	10,891	767	7.0	148	19.3	36	24.3	1
Boyd	2,063	92	4.5	30	4.0	0	0.0	3
Buffalo	45,814	3,337	7.3	586	17.6	15	2.6	3
Colfax	10,332	1,093	10.6	152	13.9	120	78.9	0
Dakota	20,651	2,016	9.8	469	23.3	85	18.1	2
Dawson	25,076	2,175	8.7	532	24.5	10	1.9	3
Douglas	510,199	42,647	8.4	8,243	19.3	1006	12.2	2
Gage	22,653	1,391	6.1	286	20.6	175	61.2	0
Hall	57,487	5,048	8.8	1,123	22.2	560	49.9	0
Jefferson	7,238	389	5.4	87	22.4	29	33.3	1
Lancaster	281,531	20,616	7.3	3,145	15.3	792	25.2	1
Lincoln	35,670	2,541	7.1	466	18.3	186	39.9	1
Morrill	4,911	317	6.5	87	27.4	3	3.4	3
Nemaha	6,856	429	6.3	72	16.8	0	0.0	3
Richardson	8,125	426	5.2	107	25.1	66	61.7	0
Scotts Bluff	36,854	2,760	7.5	687	24.9	143	20.8	1
Thurston	7,306	802	11.0	353	44.0	NA	NA	3
Nebraska	1,796,619	134,717	7.5	24,301	18.0			

Step Two of Level Two: Risks Addressed by Existing Program(s) within Counties*

County	Child Welfare	Juvenile Crime	Economics	Education	Health Outcomes	Pregnancy Outcomes	Social Welfare	Health Behaviors	Weighted Score
Box Butte		0/2					2/2		1.19
Boyd		0				0			3
Buffalo	1/1	0/1							1
Colfax				2/3			2/3	2/3	0.08
Dakota				1/1			1/1	1/1	0
Dawson				0/1	0/1			1/1	1
Douglas	5/7	1/7						6/7	1.11
Gage				1/2	1/2				2.67
Hall	2/2			1/2			0/2	1/2	1.12
Jefferson	1/2						0/2		2.1
Lancaster	3/3						3/3		0.03
Lincoln	1/1	0/1				1/1	1/1		1
Morrill		0/1				0/1			3
Nemaha		0	0						3
Richardson			0/1		0/1				3
Scotts Bluff	1/2	1/2	1/2		1/2		0/2	1/2	2.5
Thurston			2/2	2/2				2/2	3

*The left-hand number represents the number of programs with activities addressing the specific risk; the right-hand number is the total number of programs identified in the county.

Step Three of Level Two: Summation by County of Extent to Which Existing Services Address Risk

County	Penetration	Risk	Total
Box Butte	1	1.19	2.19
Boyd	3	3	6
Buffalo	3	1	4
Colfax	0	0.08	0.08
Dakota	2	0	2
Dawson	3	1	4
Douglas	2	1.11	3.11
Gage	0	2.67	2.67
Hall	0	1.12	1.12
Jefferson	1	2.1	3.1
Lancaster	1	0.03	1.03
Lincoln	1	1	2
Morrill	3	3	6
Nemaha	3	3	6
Richardson	0	3	3
Scotts Bluff	1	2.5	3.5
Thurston	3	3	6

Results
Combined Level One and Two Scores, Ranked

County	Level 1	Level 2	Total
Scotts Bluff	5	3.5	8.5
Thurston	2	6	8
Boyd	1	6	7
Morrill	1	6	7
Nemaha	1	6	7
Dawson	2	4	6
Douglas	2	3.11	5.11
Buffalo	1	4	5
Lincoln	3	2	5
Hall	3	1.12	4.12
Jefferson	1	3.1	4.1
Dakota	2	2	4
Richardson	1	3	4
Gage	1	2.67	3.67
Box Butte	1	2.19	3.19
Colfax	2	0.08	2.08
Lancaster	1	1.03	2.03

Affordable Care Act Home Visiting Program - Nebraska Level One Analysis

Scotts Bluff County

	Factor	Factor Rank	Indicator	County	State
1.	Child Welfare	3rd	CA/N reports (rate)	79.5	65.6
2.	Child Welfare		CA/N reports, substantiated (rate)	12.5	7.2
3.	Child Welfare		Office of Juvenile Services (rate)	6.0	5.1
4.	Child Welfare		Out of Home Care (rate)	25.0	12.4
5.	Child Welfare		State Wards (rate)	30.5	23.2
6.	Child Welfare		Unintentional Injuries (rate)	130.8	116.5
7.	Crime	3rd	Juvenile Arrests (rate)	65.2	35.0
8.	Crime		Juvenile Drug Arrests (rate)	4.4	2.6
9.	Crime		Juvenile DUI (rate)	1.3	0.6
10.	Crime		Juvenile Violent Crime Arrests (rate)	0.9	0.6
11.	Economic	5th	Food Stamps (ratio)	11.5	6.9
12.	Economic		Poverty, All Ages (%)	15.5%	10.3%
13.	Economic		Unemployment Change (% points), 2009-2010	0.2	0.0
14.	Economic		Unemployment (%)	3.9%	3.3%
15.	Education	13th	High School Dropouts (%)	1.5%	0.9%
16.	Education		Education Less than 9th Grade (%)	8.7%	5.4%
17.	Health Behaviors	6th	Adult Smoking (%)	21.2%	20.3%
18.	Health Behaviors		Binge Drinking (%)	10.1%	18.0%
19.	Health Behaviors		Chlamydia Infections (rate)	180.6	290.2
20.	Health Behaviors		Inadequate Prenatal Care (%)	14.6%	11.1%
21.	Health Behaviors		No Prenatal Care (%)	0.9%	0.6%
22.	Health Behaviors		Births to Teens (% of all births)	4.7%	2.7%
23.	Pregnancy Outcomes	32nd	Low Birth Weight (%)	7.1%	6.9%
24.	Pregnancy Outcomes		Very Low Birth Weight (%)	0.8%	1.1%
25.	Pregnancy Outcomes		Prematurity (%)	8.0%	10.6%
26.	Pregnancy Outcomes		Infant Mortality (rate)	6.6	6.0
27.	Health Outcomes	3rd	Poor/Fair Health (%; self-reported)	16.2	12.3
28.	Health Outcomes		Poor Mental Health Days (mean)	3.7	2.6
29.	Health Outcomes		Poor Physical Health Days (mean)	3.9	2.9
30.	Health Outcomes		Premature Death (YPLL)	8,870.1	6,150.9
31.	Social Welfare	4th	Aggravated Domestic Violence Complaints (rate)	3.2	3.0
32.	Social Welfare		Domestic Violence Crisis Line Calls (rate)	32.3	19.8
33.	Social Welfare		Simple Domestic Violence Complaints (rate)	52.5	24.4
34.	Social Welfare		Single Parent Household (%)	9.4	7.8

Affordable Care Act Home Visiting Program - Nebraska Level One Analysis

Morrill County

	Factor	Factor Rank	Indicator	County	State
1.	Child Welfare	13th	CA/N reports (rate)	53.4	65.6
2.	Child Welfare		CA/N reports, substantiated (rate)	9.7	7.2
3.	Child Welfare		Office of Juvenile Services (rate)	5.6	5.1
4.	Child Welfare		Out of Home Care (rate)	11.5	12.4
5.	Child Welfare		State Wards (rate)	15.0	23.2
6.	Child Welfare		Unintentional Injuries (rate)	161.1	116.5
7.	Crime	**5th**	Juvenile Arrests (rate)	48.1	35.0
8.	Crime		Juvenile Drug Arrests (rate)	9.6	2.6
9.	Crime		Juvenile DUI (rate)	0.0	0.6
10.	Crime		Juvenile Violent Crime Arrests (rate)	0.0	0.6
11.	Economic	11th	Food Stamps (ratio)	10.3	6.9
12.	Economic		Poverty, All Ages (%)	15.2%	10.3%
13.	Economic		Unemployment Change (% points), 2009-2010	-0.1	0.0
14.	Economic		Unemployment (%)	3.2%	3.3%
15.	Education	15th	High School Dropouts (%)	1.0%	0.9%
16.	Education		Education Less than 9th Grade (%)	8.6%	5.4%
17.	Health Behaviors	10th	Adult Smoking (%)	24.4%	20.3%
18.	Health Behaviors		Binge Drinking (%)	15.6%	18.0%
19.	Health Behaviors		Chlamydia Infections (rate)	58.0	290.2
20.	Health Behaviors		Inadequate Prenatal Care (%)	17.6%	11.1%
21.	Health Behaviors		No Prenatal Care (%)	0.7%	0.6%
22.	Health Behaviors		Births to Teens (% of all births)	3.5%	2.7%
23.	Pregnancy Outcomes	**5th**	Low Birth Weight (%)	8.6%	6.9%
24.	Pregnancy Outcomes		Very Low Birth Weight (%)	3.2%	1.1%
25.	Pregnancy Outcomes		Prematurity (%)	10.5%	10.6%
26.	Pregnancy Outcomes		Infant Mortality (rate)	10.1	6.0
27.	Health Outcomes	53rd	Poor/Fair Health (%; self-reported)	13.3	12.3
28.	Health Outcomes		Poor Mental Health Days (mean)	1.8	2.6
29.	Health Outcomes		Poor Physical Health Days (mean)	2.8	2.9
30.	Health Outcomes		Premature Death (YPLL)	8,220.8	6,150.9
31.	Social Welfare	25th	Aggravated Domestic Violence Complaints (rate)	2.4	3.0
32.	Social Welfare		Domestic Violence Crisis Line Calls (rate)	32.3	19.8
33.	Social Welfare		Simple Domestic Violence Complaints (rate)	25.2	24.4
34.	Social Welfare		Single Parent Household (%)	6.6	7.8

Affordable Care Act Home Visiting Program - Nebraska Level One Analysis

Box Butte County

	Factor	Factor Rank	Indicator	County	State
1.	Child Welfare	29th	CA/N reports (rate)	48.7	65.6
2.	Child Welfare		CA/N reports, substantiated (rate)	9.1	7.2
3.	Child Welfare		Office of Juvenile Services (rate)	5.0	5.1
4.	Child Welfare		Out of Home Care (rate)	6.1	12.4
5.	Child Welfare		State Wards (rate)	5.2	23.2
6.	Child Welfare		Unintentional Injuries (rate)	161.1	116.5
7.	Crime	**2nd**	Juvenile Arrests (rate)	68.6	35.0
8.	Crime		Juvenile Drug Arrests (rate)	3.4	2.6
9.	Crime		Juvenile DUI (rate)	1.9	0.6
10.	Crime		Juvenile Violent Crime Arrests (rate)	1.1	0.6
11.	Economic	26th	Food Stamps (ratio)	9.4	6.9
12.	Economic		Poverty, All Ages (%)	11.7%	10.3%
13.	Economic		Unemployment Change (% points), 2009-2010	-0.9	0.0
14.	Economic		Unemployment (%)	4.1%	3.3%
15.	Education	71st	High School Dropouts (%)	0.5%	0.9%
16.	Education		Education Less than 9th Grade (%)	5.1%	5.4%
17.	Health Behaviors	11th	Adult Smoking (%)	27.7%	20.3%
18.	Health Behaviors		Binge Drinking (%)	17.5%	18.0%
19.	Health Behaviors		Chlamydia Infections (rate)	98.8	290.2
20.	Health Behaviors		Inadequate Prenatal Care (%)	11.7%	11.1%
21.	Health Behaviors		No Prenatal Care (%)	1.0%	0.6%
22.	Health Behaviors		Births to Teens (% of all births)	3.3%	2.7%
23.	Pregnancy Outcomes	55th	Low Birth Weight (%)	7.3%	6.9%
24.	Pregnancy Outcomes		Very Low Birth Weight (%)	0.7%	1.1%
25.	Pregnancy Outcomes		Prematurity (%)	10.0%	10.6%
26.	Pregnancy Outcomes		Infant Mortality (rate)	0.0	6.0
27.	Health Outcomes	13th	Poor/Fair Health (%; self-reported)	13.6	12.3
28.	Health Outcomes		Poor Mental Health Days (mean)	3.0	2.6
29.	Health Outcomes		Poor Physical Health Days (mean)	3.6	2.9
30.	Health Outcomes		Premature Death (YPLL)	6,222.8	6,150.9
31.	Social Welfare	**2nd**	Aggravated Domestic Violence Complaints (rate)	6.9	3.0
32.	Social Welfare		Domestic Violence Crisis Line Calls (rate)	32.3	19.8
33.	Social Welfare		Simple Domestic Violence Complaints (rate)	51.9	24.4
34.	Social Welfare		Single Parent Household (%)	8.2	7.8

Community Health Survey 2011

Q1. How would you rate your community as a "Healthy Community?"

Answer Options	Response Percent	Response Count
very unhealthy	0.9%	5
unhealthy	9.5%	52
somewhat unhealthy	51.0%	279
healthy	36.7%	201
very healthy	1.8%	10
	answered question	547
	skipped question	0

Q2. I am satisfied with the quality of life in our community (considering my sense of safety and well-being).

Answer Options	Response Percent	Response Count
strongly disagree	0.7%	4
disagree	7.6%	41
neutral	18.4%	99
agree	61.0%	328
strongly agree	12.3%	66
	answered question	538
	skipped question	9

Q3. I am satisfied with the health care system in our community

Answer Options	Response Percent	Response Count
strongly disagree	3.2%	17
disagree	14.1%	76
neutral	23.2%	125
agree	49.8%	268
strongly agree	9.7%	52
	answered question	538
	skipped question	9

Q4. I have easy access to the medical specialists that I need.

Answer Options	Response Percent	Response Count
strongly disagree	3.0%	16
disagree	18.8%	101
neutral	22.5%	121
agree	47.2%	254
strongly agree	8.6%	46
	answered question	538
	skipped question	9

Q5. I am very satisfied with the medical care I receive

Answer Options	Response Percent	Response Count
strongly disagree	1.7%	9
disagree	7.8%	42
neutral	24.3%	131
agree	53.2%	286
strongly agree	13.0%	70
	answered question	538
	skipped question	9

Q6. Sometimes it is a problem for me to cover my share of the cost for a medical care visit.

Answer Options	Response Percent	Response Count
strongly disagree	7.1%	38
disagree	29.4%	158
neutral	20.6%	111
agree	34.0%	183
strongly agree	8.9%	48
	answered question	538
	skipped question	9

Q7. I am able to get medical care whenever I need it.

Answer Options	Response Percent	Response Count
strongly disagree	2.2%	12
disagree	12.3%	66
neutral	14.3%	77
agree	60.2%	324
strongly agree	11.0%	59
	answered question	538
	skipped question	9

Q8. This community is a good place to raise children.

Answer Options	Response Percent	Response Count
strongly disagree	0.6%	3
disagree	3.4%	18
neutral	14.6%	78
agree	51.4%	275
strongly agree	30.1%	161
	answered question	535
	skipped question	12

Q9. I have access to safe and affordable day care.

Answer Options	Response Percent	Response Count
strongly disagree	1.5%	8
disagree	3.6%	19
neutral	63.4%	339
agree	21.7%	116
strongly agree	9.9%	53
	answered question	535
	skipped question	12

Q10. I am very satisfied with the school system in my community.

Answer Options	Response Percent	Response Count
strongly disagree	2.2%	12
disagree	13.5%	72
neutral	29.0%	155
agree	39.1%	209
strongly agree	16.3%	87
	answered question	535
	skipped question	12

Q11. There are adequate after school programs for elementary age children to attend.

Answer Options	Response Percent	Response Count

strongly disagree	3.9%	21
disagree	17.4%	93
neutral	40.4%	216
agree	30.8%	165
strongly agree	7.5%	40
	answered question	535
	skipped question	12

Q12. There are adequate after school opportunities for middle and high school age students.

Answer Options	Response Percent	Response Count
strongly disagree	5.8%	31
disagree	27.7%	148
neutral	40.0%	214
agree	23.2%	124
strongly agree	3.4%	18
	answered question	535
	skipped question	12

Q13. There are plenty of recreation opportunities for children in my community.

Answer Options	Response Percent	Response Count
strongly disagree	7.7%	41
disagree	29.9%	160
neutral	31.0%	166
agree	28.4%	152
strongly agree	3.0%	16
	answered question	535
	skipped question	12

Q14. This community is a good place to grow old (considering elder-friendly housing, transportation to medical services, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.).

Answer Options	Response Percent	Response Count
strongly disagree	2.6%	14
disagree	15.7%	83
neutral	21.5%	114
agree	52.6%	279
strongly agree	7.5%	40
	answered question	530
	skipped question	17

Q15. There are housing developments that are elder-friendly.

Answer Options	Response Percent	Response Count
strongly disagree	1.5%	8
disagree	16.0%	85
neutral	27.4%	145
agree	47.7%	253
strongly agree	7.4%	39
	answered question	530
	skipped question	17

Q16. There is a transportation service that takes older adults to medical facilities or to shopping centers..

Answer Options	Response Percent	Response Count

strongly disagree	2.5%	13
disagree	8.7%	46
neutral	18.5%	98
agree	56.6%	300
strongly agree	13.8%	73
	answered question	530
	skipped question	17

Q17. There are enough programs that provide meals for older adults in my community.

Answer Options	Response Percent	Response Count
strongly disagree	1.9%	10
disagree	11.3%	60
neutral	33.4%	177
agree	46.8%	248
strongly agree	6.6%	35
	answered question	530
	skipped question	17

Q18. There are networks for support for the elderly living alone.

Answer Options	Response Percent	Response Count
strongly disagree	1.9%	10
disagree	18.9%	100
neutral	47.7%	253
agree	28.7%	152
strongly agree	2.8%	15
	answered question	530
	skipped question	17

Q19. There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, affordable housing, reasonable commute, etc.).

Answer Options	Response Percent	Response Count
strongly disagree	11.4%	60
disagree	32.2%	169
neutral	22.7%	119
agree	31.8%	167
strongly agree	1.9%	10
	answered question	525
	skipped question	22

Q20. There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).

Answer Options	Response Percent	Response Count
strongly disagree	9.0%	47
disagree	36.2%	190
neutral	31.0%	163
agree	22.3%	117
strongly agree	1.5%	8
	answered question	525
	skipped question	22

Q21. The community is a safe place to live (considering residents' perception of safety in the home, the workplace, schools, playgrounds, parks, shopping areas). Neighbors know and trust one another and look out for one another.

Answer Options	Response Percent	Response Count
strongly disagree	1.0%	5
disagree	5.1%	27
neutral	11.6%	61
agree	63.8%	335
strongly agree	18.5%	97
	answered question	525
	skipped question	22

Q22. There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need..

Answer Options	Response Percent	Response Count
strongly disagree	0.6%	3
disagree	9.7%	51
neutral	19.4%	102
agree	61.5%	323
strongly agree	8.8%	46
	answered question	525
	skipped question	22

Q23. All residents believe that they, individually and collectively, can make the community a better place to live.

Answer Options	Response Percent	Response Count
strongly disagree	1.9%	10
disagree	21.1%	111
neutral	32.6%	171
agree	41.1%	216
strongly agree	3.2%	17
	answered question	525
	skipped question	22

Q24. In the following list, what do you think are the 3 most important “health problems” in our community? (problems that have the greatest impact on overall community health)

Answer Options	Response Percent	Response Count
aging problems (arthritis, hearing/vision loss)	39.0%	203
cancers	48.1%	250
chid abuse/neglect	18.5%	96
dental problems	6.3%	33
diabetes	29.6%	154
domestic violence	14.0%	73
firearm related injuries	0.6%	3
heart disease and stroke	35.8%	186
high blood pressure	21.2%	110
HIV/AIDS	0.6%	3
homicide	0.4%	2
infant death	0.6%	3
infectious disease (hepatits, TB)	1.0%	5
mental health problems	15.6%	81
motor vehicle crash injuries	6.7%	35
rape/sexual assault	2.1%	11
reespiratory/lung disease	7.7%	40
sexually transmitted diseases (STDs)	5.4%	28
suicide	9.2%	48
teenage pregnancy	19.2%	100
Other (please specify)	13.1%	68
	answered question	520
	skipped question	27

Q25. Of the problems you marked, which one would you most likely work on?

Answer Options	Response Count
	385
answered question	385
skipped question	162

Q26. In the following list, what do you think are the three most important “risky behaviors” in our community? (those behaviors that have the greatest impact on overall community health)

Answer Options	Response Percent	Response Count
alcohol abuse	78.9%	408
being overweight	49.7%	257
dropping out of school	12.2%	63
drug abuse	41.4%	214
lack of exercise	28.0%	145
poor eating habits	25.0%	129
not getting "shots" to prevent disease	1.5%	8
racism	6.2%	32
tobacco use	27.5%	142
not using birth control	8.7%	45
not using seat belts and/or child safety seats	10.3%	53
Other (please specify)	10.1%	52
	answered question	517
	skipped question	30

Q27. What is your zip code?

Answer Options	Response Count
	508
answered question	508
skipped question	39

Q28. What county do you live in?

Answer Options	Response Percent	Response Count
Banner	2.9%	15
Box Butte	24.6%	126
Cheyenne	14.6%	75
Dawes	13.3%	68
Deuel	0.8%	4
Garden	1.2%	6
Kimball	1.0%	5
Morrill	8.2%	42
Scotts Bluff	9.6%	49
Sheridan	19.1%	98
Sioux	4.9%	25
	answered question	513
	skipped question	34

Q29. What is your gender?

Answer Options	Response Percent	Response Count
Female	71.7%	342
Male	28.3%	135
	answered question	477
	skipped question	70

Q30. Your age

Answer Options	Response Percent	Response Count
less than 18 years	1.9%	10
18-25 years	4.7%	24
26-39 years	21.4%	110
40-54 years	34.7%	178
55-64 years	27.1%	139
65-80 years	8.2%	42
more than 80 years	1.9%	10
	answered question	513
	skipped question	34

Q31. Marital status

Answer Options	Response Percent	Response Count
married/cohabiting	75.2%	386
divorced	9.0%	46
never married	8.8%	45
separated	1.6%	8
widowed	5.1%	26
Other (please specify)	0.4%	2
	answered question	513
	skipped question	34

Q32. Are you Hispanic or Latino?

Answer Options	Response Percent	Response Count
yes	4.3%	22
no	95.7%	491
	answered question	513
	skipped question	34

Q33. Which ONE of these groups would you say best represents your race?

Answer Options	Response Percent	Response Count
White	95.9%	492
Black or African-Amerian	0.6%	3
Asian	0.2%	1
Native Hawaiian or other Pacific Islander	0.2%	1
American Indian or Alaska Native	1.4%	7
Other (please specify)	1.8%	9
	answered question	513
	skipped question	34

Q34. Household income

Answer Options	Response Percent	Response Count
Less than $20,000	7.4%	38
$20,000 to $29,000	12.7%	65
$30,000 to $49,000	24.0%	123
$50,000 to $74,999	25.5%	131
$75,000 to $99,999	17.2%	88
More than $100,000	13.3%	68
	answered question	513
	skipped question	34

Q35. Your highest education level

Answer Options	Response Percent	Response Count
less than high school graduate	2.4%	12
high school diploma or GED	33.3%	164
college degree or higher	64.3%	317
Comments		21
	answered question	493
	skipped question	54

Q36. How do you pay for your health care?

Answer Options	Response Percent	Response Count
pay cash (no insurance)	8.8%	45
health insurance (private insurance)	85.8%	440
Medicaid	2.7%	14
Medicare	7.2%	37
Veterans' Administration	2.5%	13
Indian Health Services	0.6%	3
Comments		12
	answered question	513
	skipped question	34

Panhandle Partnership
Community Context Problem Mapping

Process
The Community Context Problem Mapping process began with the participants in the first Child Well Being Assessment and Planning Meeting.

Scope of Findings
It is noted that the process was undertaken by a group of interested parties within the health and human services sector. Additional focus groups or processes were not required for the Child Well Being Assessment. However increased understanding of Community Context would occur from additional problem mapping from diverse groups and community from across the Panhandle.

Definition of Problem
The problem was identified as
Panhandle communities are not safe and nurturing environments for all children.

Three break-out groups then created problem maps of why the Panhandle is not a safe and nurturing community for all children. The groups were asked to discuss and identify components of the following contributing factors.

- Behavioral Factors, the specific actions that cause the problem. If this action had not taken place the problem would not occur.

- Contributing Factors, the circumstances that exist that that lead to or encourage the behavior. If these circumstances did not exist the behavior would not have occurred or would be less likely to occur.

- Root/Community Causes, the larger community decisions, specific norms or formal or informal practices which impact the contributing factors. If these root causes were addressed the contributing factor would not exist.

Break out groups reported back to the large group and several commonalities and additional points were discussed. At that point it was the consensus of the large group that a few people should review all of the work and draft a single version that combined the work of the three groups into a single document for further review.

In compiling a single version the problem statement of "not being a safe and nurturing community for all children" was kept at the forefront. The Behaviors, Contributing Factors, Root/Community Causes from the three participant groups were placed in like groups or clustered by common theme. While many groups had listed the same factors there was not commonality in which category they had placed them in (Behavior, Contributing and Root Causes). Therefore the work group did take some license to move factors between stages in order to cluster. As well, the group determined that in the

clustering some items listed actually provided definition to a larger key topic. As a result, not all factors and consequences listed in the individual group problem maps appear in the final community context problem map. The narrative lists provided below should assist participants in seeing these connections.

Community Context Behaviors and Definitions
Three types of behaviors result in children not being safe and nurtured in the Panhandle.

Physical Violence
Physical violence includes acts which may result in harm to a child. Bullying from peers, sexual abuse/assault, physical contact by a parent or adult, depriving children of food and basic needs for an extensive period of time, crime in communities, and gang activities are example of physical acts of violence which may cause injury or death to a child.

Emotional and Mental Abuse
Emotional and mental abuse includes acts which demean children, impact self esteem, and reduce resiliency. Bullying, withholding basic needs, cyber bullying, parents, adults, and communities minimizing children, isolating children from the community, are forms of emotional and mental abuse.

Neglect
Neglect is failure to provide for the basic physical and emotional needs of children. Neglect is also those behaviors which place a child in undue risk whether the child is injured or not, especially where the child cannot or does not feel safe to correct the situation. For example, having children as passengers when an adult is driving a car under the influence of alcohol is a form of neglect – even if no accident occurs.

Contributing Factors
Contributing factors are the circumstances that exist that that lead to or encourage the behavior. If these circumstances did not exist the behavior would not have occurred or would be less likely to occur.

The combined contributing factors are as follows:

Basic Needs Not Being Met
- Inadequate nutrition
- Clothing
- Shelter
- Poor quality housing (no heat, refrigerators, plumbing, mold)
- Homelessness

Parenting and Demands on Parents
- Parents working multiple jobs
- Decreased supervision/children at home alone
- Low knowledge and skills around child abuse and neglect

- Low knowledge and skills around parent child interaction
- Stress
- Perceived willingness to parent
- Quality of supervision after school

Adult Behavior in the Community
- Poor positive role models
- Inappropriate sexual activity between adults
- Drug abuse
- Alcohol misuse
- Selling illegal drugs
- Children as passengers in vehicles while DUI

Youth Behaviors
- Engage in risky behaviors
- Poor peer influences
- Alcohol and drug use
- Inappropriate sexual behavior of youth
- Disrespect of adults

Youth Development Approaches
- No shared view of youth development in communities
- Limited interest in community service learning
- Lack goals
- Confusion in roles

Social Supports
- Missing links between generations
- Limited social supports/maternal supports low
- Transplanted families lack supports
- Technology lowers direct interaction and supports

Undiagnosed and Untreated Mental Illness
- Of parents
- Of children
- Limited access to professionals
- Payment and policies
- Community understanding of mental illness
- Depression

Department of Health and Human Services
- Lives become worse for children and families reported with child abuse and neglect
- Risk of abuse and neglect increases when in DHHS

- Disconnect with DHHS

Education
- Low (quality) parental involvement in schools
- No sex education in schools
- School drop outs
- Extent to which education valued

Media Messages/Local and National

Root/Community Causes
Root/Community causes are the larger community decisions, specific norms or formal or informal practices which impact the contributing factors. If these root causes were addressed the contributing factor would not exist. Participants identified root causes which were then grouped as follows:

Poverty
- Increased poverty as related to the economy (jobs, living wages, etc)
- Middle class shifting to poverty level

Cycle of Generational Poverty
- Poverty thinking
- Sense of entitlement
- Enabling

Economy
- Increased unemployment rates
- People working more than one (two and three) jobs

Unemployment /Underemployment
- Lack of job skills
- Quality of available work force (work ethic)
- Cost of training staff

Rural Reality
- Geography (our density is similar to Alaska)
- Lack of availability of services (population/cost benefit, and access)
- Decreasing leadership capacity – young people who receive go away to college and don't come back; those remaining may not have had opportunities to develop leadership skills
- Out migration

Community Norms
- Don't have common community norms/values

- Competing cultural norms (violence is acceptable to gang members)
- Communities don't acknowledge children

Lack of Consistent Law Enforcement
- Legal systems change moral code (as we shift definitions in law and application of law society changes)
- Rules change so people's values change
- Lack of community support for law enforcement

Prejudice, Discrimination and Racism
- Not acknowledged and affirmed

Social Justice
- Inequitable application of laws and rules
- Opportunities are not equal

Community Disorganization
- Low of sense of community pride
- Vacant and dilapidated buildings
- Apathy
- Miscommunication
- Blame game
- Community doesn't acknowledge problem
- Community doesn't acknowledge all children
- Alcohol outlet density

Systems Failure (DHHS)
- Poor policy, poor application of policy
- Kids and families have increased fear and decreased trust

Access to Health Care
- Medicaid conditions
- Results in low birth weight babies
- Unable to access pre natal care leads to larger issues for child and community

Access/Acceptance of Health Promotion
- Contraceptives not available
- Contraceptives not taught
- Obesity
- Untreated chronic disease (diabetes, etc)

Identification of Consequences
Participants were then asked to identify the consequences of not addressing the issue of children not being safe and healthy in the Panhandle. Groups were asked to identify consequences in general and were not asked to place in categories of consequences. Consequences were then grouped and placed in categories for review and affirmation at a subsequent meeting.

Direct Consequences
Direct consequences are the specific result of problem. In other words if the Panhandle were a safe and nurturing place for all children these problems would not occur.

- Hunger
- Death
- Suicide
- Physical injuries to children
- Emotional injuries to children (sense of hopelessness, children not feeling valued, less resilience and self sufficiency)
- Poverty and continued cycle of poverty
- All children are at risk

Secondary Consequences
Secondary consequences are the additional results or possible outcomes from the Direct Consequence. If the Direct Consequence did not exist this would not exist.

- Teen pregnancies/unwanted pregnancies
- Increased STDs
- Drug abuse among children and youth
- Alcohol use among children and youth
- Increased crime/vandalism
- Poor School Outcomes
- Teens having to support teens (couch surfing)
- Obesity
- Diabetes and medical conditions
- Increased developmental delays
- Increased behavioral disorders in children
- Children have multiple hurdles to succeed

Community/System Consequences
Community/System Consequences are the impacts on the community/system of the Secondary Consequences.

- Children enter DHHS system
- Juvenile Justice system overload
- Full jails
- Lost revenue to government agencies
- Population decline
- Increased taxes

- Financial cost to community/society
- Declining quality of life
- Higher medical care costs

Linkages with other Child Well Being Efforts

Regional Alcohol Misuse Reduction Efforts
In the 2009 SPF SIG Assessment and Planning process the following themes were identified which relate and further define the work of the Child Well Being Group.

Historical Themes and Trends
The history of settlement of this western area shaped and still impacts the community culture toward alcohol especially:

- Alcohol as a reward for a man's day of work.
- The entitlement of personal domain. "It is my land and I can drink where I want when I want."
- Don't interfere in others business and they won't interfere in yours.

As the area was developed by railroads, oil, and highway construction, a hard working, hard drinking wide open west where anything goes theme was promulgated. Many communities that have work crews from other areas come in still deal with this perception and the ensuing alcohol misuse and fights.

Leadership and decisions were in the hands of the prominent few. Elected leaders and law enforcement were accountable to this group and expectations of preferential treatment were not uncommon. For many individuals this theme carries through to today not only in regard to alcohol related issues but to a myriad of local issues. It is part of the community power structures on which individuals rely and by which some elect their local leadership. In other towns some citizens expect preferential treatment from elected and appointed positions of leadership in communities.

Historically the role of law enforcement relative to alcohol related occurrences was varied. The one thing it was not was an actual "enforcement" of the law role. There are many stories of local officers coming across youth out partying and pulling up a seat and joining them, or pouring out the beer and disbanding. Those too drunk to drive expected officers to take them home. In one community meeting people noted that as recently as the 1950's alcohol disturbances were handled by "slipping the cop a bill." At the large majority of community meetings, and in law enforcement interviews, people noted that this attitude remains a challenge. People truly do not believe enforcement of alcohol laws is the responsibility of local police and state patrol.

Community Readiness to Address the Issue of Alcohol
At the base of these issues are the themes and trends noted in *Major Historical Events and Forces* which are the foundation of community norms and as such impact the regional ability to comprehensively affect change in all three priority areas selected. These historical events and forces have resulted community behaviors and expectations which make change difficult. These include:

- The history of personal behavior in general (not just alcohol use and misuse) has been an "individual behavior choice hands off attitude". Because everyone in the

community knows everyone else's business community members have developed the practice of not talking about the real issues for fear of offending community members and being judged themselves. As one faith leader so aptly described in one community meeting "*We may know all your nasty stuff, but it's okay. People are unwilling to take a stand. It's hard to do anything about it because we know it will have a ripple effect on kids, other family members and others. So as a community we have open secrets. We take the safe way of acknowledging the problem, which is to provide families food and help, while not addressing the actual behavior.*

- What has now occurred is what might be called dysfunctional communities in denial. As noted in one meeting, "*There are so many elephants in the room that you can't fit in the people. If you draw that line, you lose business, you even lose friends*." In addition to substance use/misuse this affects all aspects of personal behavior including domestic violence, business ethics, child abuse and neglect. One community member noted that for many the real fear is "that if we start seriously dealing with one area (alcohol) we will open up the can of worms on other areas."

- The history of prominent citizens expecting elected leaders to treat the elite and their families with preferential treatment to avoid citation and prosecution. Many people point out that this is no different than any other place in the country. "It happens everywhere." It may happen everywhere, but what is different is the transparency of smaller populated areas. In larger cities a citizen may know it is happening, but does not know who the people are who are involved. In small rural communities everyone knows it is happening and who is involved. The result is elitism which also clearly implies that all citizens are not equal and that community efforts (in this case toward alcohol misuse) are really not for community improvement but as an additional control on certain populations. The fundamental question that we must address as a community is "How does our view of elitism put every child at risk?"

- Community readiness must also be addressed through cultural inclusion. While this area is discussed in more detail in *Cultural Diversity* community readiness capacity must also include the opportunity for minority community groups to organize in the way they choose and to provide leadership within their community, including on alcohol prevention. Both Native American and Hispanic communities have identified the need for local community groups within their own culture. It is also noted that the talking circle and personal ownership process used by the Native American community is a model for having the dialogue on community readiness for alcohol prevention. Regional support of these groups and a commitment to an ongoing process of opening the dialogue between cultures on alcohol and numerous related topics will enhance community readiness.

- There is a history in the region of isolation, loss of jobs and livelihoods, verbal and at times physical threats to those who seek to make change or begin to talk about issues. This has occurred with professional people (physicians, dentists, hospital administrators, faith leaders), elected officials, and municipal employees as well as average citizens. This is especially true in many of the smaller counties outside of Scottsbluff and was openly discussed throughout the assessment process. In these circumstances those working for change require conflict resolution skills and support.

NEBRASKA'S ACA HOME VISITING PROGRAM
LOGIC MODEL
May 23, 2011

INPUTS (Resources)	Processes/Activities	OUTPUTS (Products)	Short-term Outcomes	Intermediate Outcomes	Long-term Impacts
State level epidemiology capacity. Existing state and county-level MCH needs assessments Multi-state discussion forums and listserves ACA Home Visiting regional advisors and technical assistance; HFA TA Current NE Children and Families Foundation and EarlyChildhood Systems Development: preventive and collaborative history in the target region. Early Childhood Systems Stakeholders Existing home visiting and MCH infrastructure in NE: • CPS intervention • Home visiting as a TFKF strategy	Epidemiological constructs created to structure HV needs assessment; data acquired DHHS Internal workgroup structure formed and functioning Consultations with key policymakers Identification and selection of target community Communications with key informants and stakeholders in target community; develop stakeholders for active involvement in home visiting Selection of model; interactions with developers Develop application, coordinate a workplan and manage a time line	Level 1 and Level 2 Needs Assessments Model comparison matrix Model selection matrix Data plan CQI plan State Plan submitted Contract with model developers Contract for service (service provider is identified and prepared to deliver quality services) Branding and Marketing Plan: Home visiting is seen as an asset of all strong families. Systemic barriers identified and resolved. Selection of assessment instruments.	State and Local partners have formed a good relationship of mutual trust and respect. Local community has assessed risks and partners with state to address with targeted home visiting. There is a mutual awareness of quality and effectiveness.	Infrastructure improving with measurable change in recruitment, referrals, and retention. Nebraska's ACA Home Visiting Program is operating with fidelity to model requirements. Service recipients: Voluntarily accept home visiting; Participate in or are represented in planning of services (e.g. serving on advisory committee)	Measurable change in 50% of constructs in four of six benchmark areas at the end of three years. Enhanced early childhood systems development at state and local levels. Improved family outcomes as measured in HFA model. Increase community capacity to address needs of high-risk families.

• Knowledge of existing home visiting programs in NE Existing local capacity for HV in Children's Outreach Program . Home visitors are recruited from the local target community Panhandle Partnership Training Academy	Identify organizational mechanisms to do business: training, intake and identification, referral resources, service provision, monitoring for fidelity, data gathering and analysis, CQI plan, retention, advisory committee, service delivery by home visitors.	Training of home visitors Additional communities participate in training opportunities, utilization of data plan, CQI plan, and benchmark assessments.			

MODEL SCORING MATRIX								
	SCORING GUIDE:	5 = Model matches a significant number of community risks & across communities 3 = Model matches a few community risks 0 = Model does not match community risks	No score Actual costs cannot be determined until a model is selected, we have input from the model developer, and training/data system/CQI costs are determined	2 = Community can easily meet staffing requirements 1 = Additional effort required by the community to meet staffing needs 0 = Difficult for the community to meet staffing needs	1 = Model allows flexibilty in client eligibility 0 = Model limits who is elibible	2 = Highly compatible with existing structure 1 = Somewhat compatible 0 = Not compatible	2 = Builds on existing services 1 = Could be built on existing services with some modifications 0 = Difficult to adapt to existing system of services	
	CRITERIA:	**Ratio of Community Risks & Model Outcomes**	**Estimated Costs per Family**	**Manpower/Staffing Ratios**	**Ability to Target Families**	**Community Outcomes/Priorities**	**Infrastructure**	**TOTAL POINTS**
HEALTHY FAMILIES AMERICA (HFA)		7:4 (See #1 below)	$3,348 per year Range $1,950 - $5,768	High School diploma/GED Three levels of staffing 15 children max. per Home Visitor	Programs may select which families they serve	Model addresses issues of importance to the community, such as mental health, juvenile crime, or systems development		
	My scores for HFA:	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**
EARLY HEAD START (EHS)		7:1 (See #2 below)	$4,000 per year	A Bachelors degree may be required in the future. Average of 10 - 12 children per Home Visitor	Must conform to the federal guidelines	Model addresses issues of importance to the community, such as mental health, juvenile crime, or systems development		
	My scores for EHS:	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**
Parents as Teachers (PAT)		7:0 (See #3 below)	Average $2,652 per year	High School diploma/GED Two primary levels of staffing 12 children max. per Home Visitor	Programs may select which families they serve	Model addresses issues of importance to the community, such as mental health, juvenile crime, or systems development		
	My scores for PAT:	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**
PLEASE REFER TO THE MODEL SELECTION MATRIX 4/5/2011								
1. Seven risk areas were identified for Scotts Bluff, Morrill, & Box Butte Counties (Pregnancy Outcomes, Economics, Child Welfare, Juvenile Crime, Behaviors, nceHealth Outcomes, and Social Welfare (7). HFA addresses Child Development & S								
2. Seven risk areas were iden								
3. Seven risk areas were iden								

Home Visiting Internal Team

Name	Title	Program	Division
Paula Eurek	Administrator Project Director	Lifespan Health Services Nebraska's ACA Home Visiting Program	Public Health
Deborah Barnes-Josiah	MCH Epidemiologist	Child Death Review Team	Public Health
Lynne Brehm	Program Coordinator	Together For Kids & Families	Public Health
Rayma Delaney	Federal Aid Administrator	Title V Block Grant	Public Health
Kathy Karsting	Program Manager	Perinatal, Child & Adolescent Health	Public Health
Shirley Pickens-White	Program Specialist		Children & Families
Jennifer Severe-Oforah	Coordinator	MCH Epidemiology	Public Health
Sue Spanhake	Program Coordinator	Nebraska's ACA Home Visiting Program	Public Health

Panhandle Collaborative Public and Private Partners

Name	Title	Affiliation
Bill Wineman	Director	Scotts Bluff County Public Health Department
Sarah Ochoa	Director of Child Development Programs	Community Action Partnership of Nebraska: Early Head Start
Jann Fitts	CEO	Community Action Partnership of Nebraska
Sherry Retzlaff	Community Organizer	Early Development Network: Western Community Health Resources
Amy Richardson	MIS	Northwest Community Action Partnership
DeAnn Koerber	Head Start	Northwest Community Action Partnership
Rachell Delle		Panhandle Mental Health Center
Kim Engel	Director	Panhandle Public Health District
Jean Jensen	Executive Director	Volunteers of America
Joan Frances	Facilitator	Joan Frances Consulting
Todd Sorensen	CEO	Regional West Medical Center
Dan Griess	CEO	Box Butte General Hospital
Julie Morrow	CEO	Morrill County Community Hospital
Lorye McLeod	Executive Director	Northwest Community Action Partnership
Boni Carrell	Executive Director	Rural Nebraska Healthcare Network
Sandy Roes	Director	Western Community Health Resources
Laurie Heiting		Northwest Community Action Partnership
Nici Johnson	Early Development Network Director Scotts Bluff	Educational Service Unit 13
Mary Coon	Home Visiting Nurse	Regional West Medical Center
Martha Stricker		Regional West Medical Center
Barb Beezly	WIC Director	Community Action Partnership of Western Nebraska
Jeff Tracy	Health Clinic Director	Community Action Partnership of Western Nebraska

Rose Rhodes	Resource Developer Supervisor	NE DHHS, Division of Children & Families
Chuck Bunner	Intervention Program Manager	Minitare Public Schools
Sue Ellen	Guidance Counselor	Minitare Public Schools
Tiffany Wasserburger	Assistant Attorney	Scotts Bluff County
Travis Rodak	Attorney	Morrill County
Kathleen Hutchinson	Attorney	Box Butte County
Joe Simmons	Executive Director	Chadron Native American Center
Dave Micheels	Community Health Educator	NE DHHS Health Disparities and Health Equity
Jackie Guzman		University of Nebraska - Lincoln Extension
Gary Hastings	Director	Area Health Education Center
Sharyn Wohlers	Regional Administrator	Region 1 Behavioral Health Authority
Linda Redfern	President	Panhandle Partnership for Health and Human Services
Joy McKay	Director	CAPStone Child Advocacy Center

Key State Collaborative Partners

Name	Title	Affiliation
Eleanor Kirkland	Director	Nebraska Head Start State Collaboration Office
Mary Jo Pankoke	President	Nebraska Children & Families Foundation (Nebraska's Title II of CAPTA)
Becky Veak	Senior Vice President of Early Childhood Policy	Nebraska Children & Families Foundation (Nebraska's Title II of CAPTA)
Jennifer Skala	Associate Vice President of Community Impact	Nebraska Children & Families Foundation (Nebraska's Title II of CAPTA
Cindy Ryman Yost	Senior Vice President of Programs	Nebraska Children & Families Foundation (Nebraska's Title II of CAPTA
Heather Gill	Chairperson	Nebraska Early Childhood Interagency Coordinating Council (ECICC)

STATE OF NEBRASKA
CLASS SPECIFICATION
EST: 10/93 – REV: 03/09

CLASS CODE: C73260

OVERTIME STATUS: N

DHHS PROGRAM COORDINATOR

DESCRIPTION: Under limited supervision, coordinates the administration of various state and federally funded programs throughout the state to include grant/contract administration, budget monitoring, and the development of program policies, procedures, and evaluation criteria to ensure compliance with state and federal regulations; performs related work as required.

EXAMPLES OF WORK: (A position may not be assigned all the duties listed, nor do the listed examples include all the duties that may be assigned.)

Monitors overall program budget and allocation of funds through the ongoing review of accounting documents, review of audits from contracted programs, and on-site evaluation reviews.

Provides training, technical assistance and networking to community leaders, organizations and cooperative projects.

Provides liaison between and confers with various federal and state authorities, policy review staff, and community leaders.

Reviews and prepares written and oral summaries on state and federal legislation.

Drafts legal contracts, evaluates proposals, negotiates contracts and recommends approval.

Makes arrangements for and accompanies federal staff to insure that necessary documents are available for audit.

Organizes annual statewide conference on assigned program issues attended by health, legal, education and other social service community organizations.

Responds to information requests from the public, federal and state agencies.

Provides technical assistance to communities on proposed projects, grant application procedures, program development, and evaluation criteria.

Researches and writes required plans, grants, proposals and reports for timely transmittal to federal and state authorities.

Chairs advisory board(s) responsible for determining priority rating of proposed community projects based on community needs and funding resources.

Writes program policy and procedures consistent with state or federal guidelines.

Coordinates the development of program goals and evaluation criteria with agency staff, community officials, and/or other state government staff.

C73260 – DHHS PROGRAM COORDINATOR (continued)

Responsible for funding recommendations with funds from state and federal entities.

Participates in public hearings on proposed policy revisions.

Prepares grant applications to federal agencies requesting funds to support program initiatives.

Develops corrective action plans for program deficiencies.

Serves on relative community organizations, committees, task forces, and advisory boards.

FULL PERFORMANCE KNOWLEDGE, SKILLS AND ABILITIES REQUIRED: (These may be acquired on the job and are needed to perform the work assigned.)

Knowledge of: applicable federal, state and local programs; federal and state social service regulations and laws; statewide needs in providing customer services (urban, rural, cultural, domestic, sexual, refugee, poverty, etc.); contract administration and accountability.

Ability to: present information on regulations and laws; interpret policy to individuals; communicate effectively and prepare comprehensive reports; develop policies, procedures, and standards consistent with state and federal laws and agency policies and procedures; negotiate contracts and compliance with regulations.

ENTRY KNOWLEDGE, SKILLS AND ABILITIES REQUIRED: (Applicants will be screened for possession of these through written, oral, performance and/or other evaluations.)

Knowledge of: basic accounting and business administration; social work and management theory; the structure of organizations; state, local and federal laws and programs relating to social service programs; available funding sources; human dynamics; learning/teaching techniques.

Ability to: relate well with a diverse number of individuals or organizations; analyze communities present needs and recommend programs to achieve desired results; work with people in a variety of roles (leadership, cooperation, education, networking).

Skill in: persuading others to adopt programs; presenting information to groups or individuals in oral or written form; problem solving; prioritizing; goal setting; conflict resolution.

JOB PREPARATION GUIDELINES: (Entry knowledge, skills and/or abilities may be acquired through, BUT ARE NOT LIMITED TO, the following coursework/training and/or experience.)

Post high school coursework/training in: public administration, business or social behavioral sciences. Experience with the writing of grants and administration of funds and in leading community groups.

SPECIAL NOTE

Overnight travel may be required.

PAULA EUREK
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
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paula.eurek@nebraska.gov

EDUCATION

Bachelor of Science Degree in Home Economics, Major in Food and Nutrition, University of Nebraska - Lincoln; Dietetic Traineeship, Medical University of South Carolina, Charleston, South Carolina.

EXPERIENCE

Employed by the Nebraska Department of Health and Human Services since 1983 (formerly Nebraska Department of Health). Positions have included: Regional Nutritionist; WIC Nutrition Coordinator; State WIC Director; and Interim Director, Maternal and Child Health Division and Nutrition Division. In current position as Administrator, Lifespan Health Services Unit (formerly Office of Family Health), since December 1995. Major program areas within the Unit include the Commodity Supplemental Food Program (CSFP), Immunizations, MCH Epidemiology, Planning and Support, Newborn Screening and Genetics, Office of Women's and Men's Health, Perinatal, Child, and Adolescent Health, Reproductive Health, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The Unit administers a number of grant funded projects, including Breast and Cervical Cancer Screening, Colon Cancer Screening, Pregnancy Risk Assessment Monitoring System (PRAMS), State Systems Development Initiative (SSDI), Early Childhood Comprehensive Systems Grant (ECCS), Newborn Hearing Screening Grants, and Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program Grant.

Prior to joining the Nebraska Department of Health and Human Services, employment included: ARA Food Service in Charleston, South Carolina and Norfolk, Virginia; De Paul Hospital, Norfolk, Virginia; University of Nebraska Medical Center, Omaha, Nebraska; Lincoln Indian Center, Lincoln, Nebraska; Panhandle Community Services, Gering, Nebraska; and private consultant.

LYNNE BREHM, MS
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Lincoln, Nebraska 68508
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EDUCATION:

Master of Science, May 1985
Human Development and the Family,
Marriage and Family Therapy
University of Nebraska at Lincoln

Bachelor of Science, May 1983
Human Development and the Family
University of Nebraska at Lincoln

WORK EXPERIENCE:

Program Coordinator: Nebraska Department of Health and Human Services, Lincoln, Lifespan Health Services. Project Director for Nebraska Early Childhood Comprehensive Systems Grant Project, Together for Kids and Families; November 2003-present

Community Resource Development Specialist: Nebraska Department of Health and Human Services (HHS), Lincoln, Office of Juvenile Services (OJS) Evaluation Specialist; May 2002-November 2003

Resource Developer: Nebraska Department of Health and Human Services (HHS), Lincoln Office Parent Aide Support Services; February 1989-May2002

Project Director: "Nebraska Crisis Care/Take A Break" Grant Project, June 1995-September 1997/ Project Coordinator, October 1993-June 1995

Child Protective Services Intake Caseworker: HHS, Lincoln Office; June 1985-February 1989

Residential Counselor: Youth Service System, Girls Group Home May 1983-June 1985

SPECIAL PROJECTS/ COMMITTEES:

Early Childhood Systems Team, Member of standing committee of ECICC May 2009-Present
Early Childhood Transportation Task Force, Co-Lead of ad hoc committee of the Governor appointed Early Childhood Interagency Coordinating Council (ECICC) October 2007-Present
Data Coalition, member of multi-agency coalition-Chartered 2009 through September 2011
Great Plains Public Health Leadership Institute Scholar, 2010-2011

Jennifer Severe-Oforah
P.O. Box 23041 ~ Lincoln, NE 68542
Home Phone 402-202-4774
Work 402-471-2091

EDUCATION

Great Plains Public Health Leadership Scholor, 2008-2009

Masters of Community and Regional Planning (MCRP), University of Nebraska 1999-2001

Bachelor of Arts, Environmental Science; Biology, University of Nebraska, 1992- 1996

Diploma Lincoln Southeast High school, Emphasis College prep and Art, 1989-1992

EMPLOYMENT HISTORY

Epidemiology Survillence Coordinator, Nebraska Health and Human Services February 2005-Current
Design, implement, and administer public health surveillance systems and/or studies involving the Maternal and Child Health (MCH) population. Provides leadership and direction in response to emering issues and on-going trends in health status and outcomes. Directs the MCH Epidemiology unit conssitings of State Systems Development Intiative, Title V and Needs Assesment data management, Child Death Review Team, and the Pregnanacy Risk Assessment Monitoring System.

Program Coordinator, Nebraska Health and Human Services System April 2002- Febuary 2005

Manage Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) a population-based public health surveillance project that surveys post-partum women about their experiences during and shortly after pregnancy. Supervise staff. Conduct survey research using a random stratified sample that produces weighted data by race/ethnicity for the State of Nebraska. Insure validity and integrity of data collected. Utilize statistical computer software and other data tracking and collating programs. Prepare data for surveillance reports, fact sheets, epidemiological studies, and ad hoc analysis. Promote the use of the data to community and public health organizations across the state. Facilitate Steering Committee. Develop and give presentations to medical and public health providers at local, state, and national level.

Program Coordinator, Nebraska Health and Human Services System January 2000-April 2002

Coordinate demonstration grant improving infrastructure for the health systems delivery of care. Responsible for completing grant objectives and activities. Manage consultants and evaluator work. Compile and prepare federal reports, contracts, and budget. Plan regional and state conferences in addition to producing training for medical providers. Present proposals and accomplishments of the program at the state and national level. Other responsibilities include paticipating and organizing policy and planning initiatives to reduce health disparities, reduce infant mortaility, and promote tobacco cessation among the Maternal/Child population. Designated web content provider.

CDBG Staff Assistant, State Department of Economic Development 1999-2000

Certified CDBG Administrator who assisted in implementation of federal Community Development Block Grant (CDBG). Monitored and tracked grantee performance with grant funds. Assured compliance of federal and state regulations. Prepared federal reports. Completed statistical analysis of Nebraska's CDBG program. Conducted survey and created database of local planning regulations and comprehensive plans for Nebraska's 93 counties.

Recycling Specialist, UNL Graduate Assistant, Lincoln, Recycling Office 1999-2000

Coordinated and implemented city recycling programs including America Recycles Day, Clean Your Files Day, and Christmas Tree Recycling. Compile monthly data to track primary programs. Maintained Resource Directory for Solid Waste Management of Lincoln. Responsible for city's Recycling Hotline. Conducted market research on computer recycling program.

America Reads Grant, AmeriCorp, Lincoln-Lancaster Health Department CSHI 1997-1999

National initiative to insure all children are literate by the third grade. Designed and implemented national pilot program for at risk elementary students that emphasized tutoring and mentoring in English and other skills required for success in the public school system. Designed member biography book. Established school recycling program. Organized Martin Luther King Community Service day. Administered federal food program.

VOLUNTER ACTIVITIES & AFFILATIONS

Member Public Health Leadership Society

Member Citizens Against Racism and Discrimination

Member St. John's Reformed Church, Catachism teacher

AWARDS

October 2005 Recognition of Contributions Above and Beyond the Call of Duty

For work on the 2005 MCH Needs Assessment – Nebraska Department of Health and Human Services Office of Family Health

May 2002 Negussie Negawo Memorial Award for demonstrated special sensitivity and insight into problems affecting minority or economically disadvantaged persons or persons in developing countries.

Sue Spanhake
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Lincoln, Nebraska 68509
402-471-1938
sue.spanhake@nebraska.gov

EDUCATION:

Bachelor of Science, May 1980
Home Economics Education
University of Nebraska at Lincoln

WORK EXPERIENCE:

Program Coordinator: Nebraska Department of Health and Human Services, Lincoln, Lifespan Health Services, Nebraska's Affordable Care Act Home Visiting Program; November 2010-present

Program Manager II: Nebraska Department of Health and Human Services, Lincoln, Lifespan Health Services, Perinatal, Child and Adolescent Health; January 2004-November 2010

Performance Measurement Consultant: Nebraska Health and Human Services System, Lincoln, Department of Finance and Support; 1998-2004

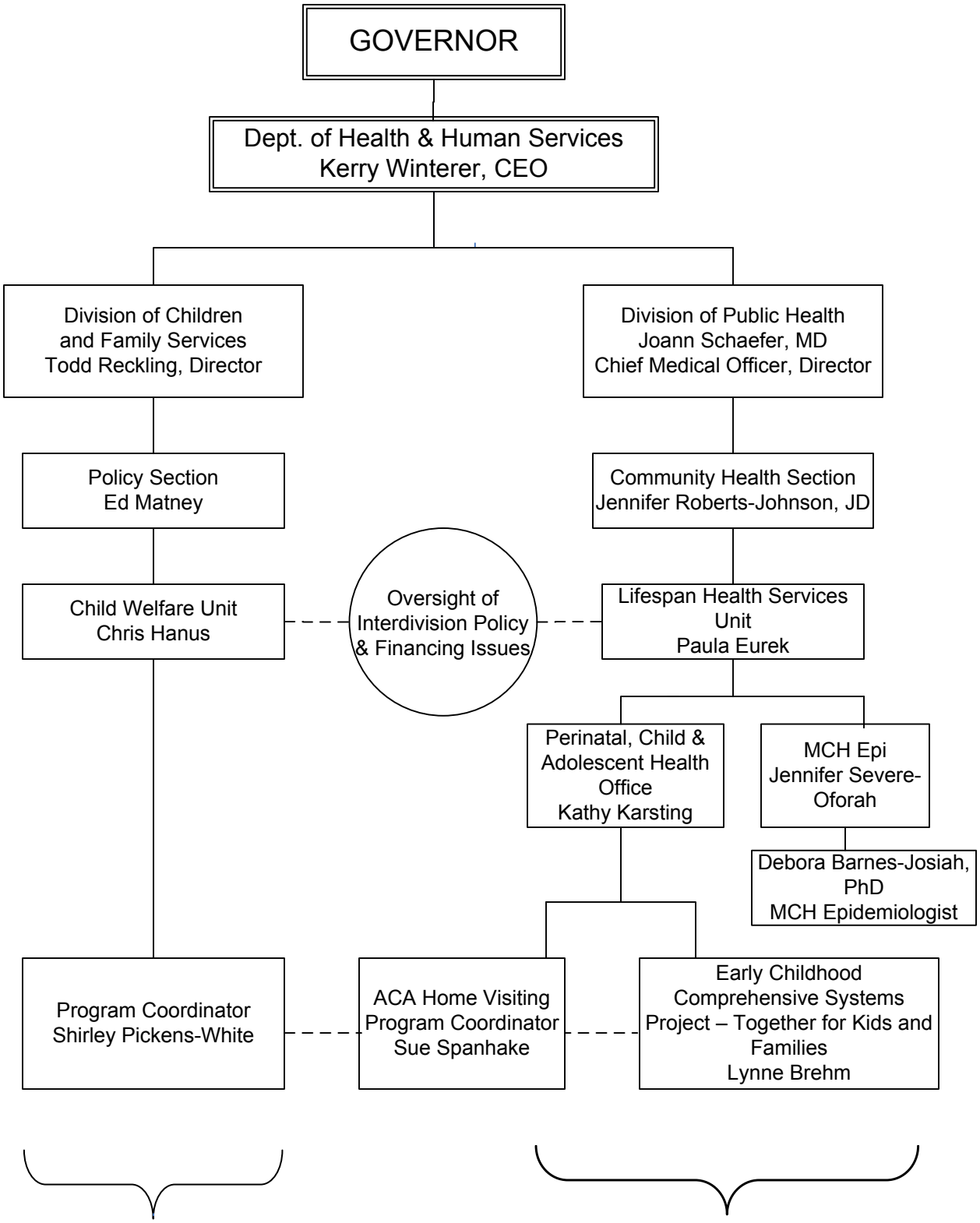
Research Manager: Nebraska Health and Human Services System, Lincoln, Department of Regulation and Licensure; 1989-1998

Instructor: Madison Junior/Senior High School; Madison, Nebraska; 1982-2987

Instructor: Orchard Public Schools; Orchard, Nebraska; 1980-1982

SPECIAL PROJECTS/COMMITTEES:

Behavioral Risk Factor Surveillance System (BRFSS) National Working Group
Project Coordinator, the First Time Motherhood/New Parents Initiative; 2008 – November 2010
Project Coordinator, Nebraska Perinatal Depression Project; 2005-2007
Member, Early Childhood System Team; January 2011- present



- Program Coordination
  - > Alignment with existing programs
  - > Collaborative Planning
  - > Systems Development
  - > Monitoring of outcomes

- Program Management, evaluation, performance measurement
  - > Needs Assessment
  - > Translating Assessment into selection of Models
  - > Establish benchmarks and track
  - > Evaluation design and contract with evaluator
  - > Contracting, training
  - > Financial Management