

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

**Nebraska Application for the ACA MIECHV Formula Grant Program
JULY 21, 2011**

INTRODUCTION

This Application is being submitted by the Nebraska Department of Health and Human Services (NE DHHS) in accordance with the requirements set forth in the Funding Opportunity Announcement for an Application to continue a State Home Visiting Program, Announcement Number: HRSA-11-187, issued on June 21, 2011. This Application builds on three previous submissions, Nebraska's grant application dated July 8, 2010, its Statewide Needs Assessment dated September 20, 2010, and the Updated State Plan dated June 7, 2011.

NARRATIVE

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

Nebraska identified the counties of Scotts Bluff, Morrill, and Box Butte as the communities targeted for implementation of the ACA MIECHV Program. A three-level process was used to identify these counties, and a brief summary of the process.

Through its Statewide Needs Assessment completed September 20, 2010, NE DHHS identified 17 counties with the highest risk for poor outcomes that could potentially be addressed through 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/EHBSsubmission09-20-2010.pdf.

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. 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 complete description is found at http://www.dhhs.ne.gov/lifespanhealth/Home_Visitation/DOCS/Home_Visit_L2_2011.pdf.

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 would 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 maximizes 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 three identified counties and why they were collectively identified to be the targeted communities, some understanding of the *Panhandle Region* (11 county region in western Nebraska) is important. The bullets below highlight some of the challenges faced in the *Panhandle*.

- ◇ Remote in terms of distance from major population centers such as Omaha or Lincoln; 6 of the 11 counties are considered frontier.
- ◇ A 14,810 square mile region has a population of 85,468 persons, down nearly 5000 from the 2000 Census. 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.
- ◇ 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; nearly 14% 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.
- ◇ Preschools and child care facilities vary widely, with some estimates that more than 60% of the daycare homes being unlicensed. 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 are agriculture or the railroad, with limited manufacturing and retail.

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.

Members of the Partnership represent a wide range of stakeholders that were actively engaged in preparing the Updated State Plan and they will be key factors in the successful implementation of the ACA Home Visiting Program. 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.

- ◇ **Assessment of Needs and Existing Resources in Targeted Communities**

The following narrative describes the needs and resources specific to each of the three 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. 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. Other risk factors for Scotts Bluff County include:

- ◇ Third in the state for child welfare and juvenile crime related risk indicators.
- ◇ Community stakeholders believe that these statistics do not fully reflect the extent of these problems, because families are highly mobile in this region.
- ◇ Extremely limited services available to at-risk children and youth without getting child welfare and juvenile justice involved.
- ◇ The in-migration of families from across the region and from surrounding states, seeking and expecting more services and resources in this county.

To address these many needs, *Scotts Bluff County* has a wide range of assets. These include Regional West Medical Center (RWMC), the Community Action Partnership of Western Nebraska (CAPWN), Western Nebraska Community College, Scotts Bluff County Health Department, Region I of Nebraska's Network of Care for Behavioral Health, Head Start & Early Head Start, the Early Development Network (Part C IDEA, provided through the Educational Service Unit or ESU), and the Panhandle Partnership, previously described. 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).

Morrill County is the most rural of the three 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. Adding Level One and Level Two scores, Morrill County was among the 5 highest scoring counties in the state, with a score of 7. Other risk factors facing Morrill County residents include:

- ◇ Ranked high for juvenile crime, being 5th in the state for this risk factor.

- ◇ A significant risk factor was pregnancy outcomes, with a ranking of 5th in the state. 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.
- ◇ Persons with incomes less than the poverty level represent 15.2% of the county's population (10.3% for the state).
- ◇ Like Scotts Bluff County, Morrill County has small towns which have limited services and access to public transportation.

Morrill County is within the catchment area for the services and programs available in Scotts Bluff County, such as RWMC and CAPWN, is served by a regional health department, Panhandle Public Health District (PPHD), has the Morrill County Community Hospital, and 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. 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 population of 11,043, and scored in the top 10% for these 2 risk factors: juvenile crime and social welfare. Adding Level One and Level Two scores, Box Butte County had a relatively lower score for need, 3.19. Other challenges faced in Box Butte County include:

- ◇ 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.
- ◇ Higher rates than for the state for several risk factors (aggravated domestic violence complaints, domestic violence crisis line calls, simple domestic violence complaints, and single parent households).
- ◇ 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%).
- ◇ 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.
- ◇ 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.

Among *Box Butte County's* assets is Box Butte General Hospital. It is also served by the Panhandle Public Health District and Northwest Nebraska Community Action Partnership provides Early Head Start home based services. 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.

o **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 <9 th 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.

Focus group participants associate home visits with child welfare workers, which may result in children being removed from the home. Several assessments were completed recently in the Panhandle region including the regional Mobilizing for Action through Planning and Partnership (MAPP) Process and a Community Health Survey as part of the region's public health assessment in 2011. The lessons learned from the assessments was 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.

o **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			
<i>Families served/year</i>	20	Not available in this county	18
<i>Eligibility/targeting</i>	As per Federal criteria		As per Federal criteria
<i>Model/intensity</i>	Federal standards		Federal standards
Children's Outreach Program			
<i>Families served/year</i>	Not available in this county	12	32
<i>Eligibility/targeting</i>		All newborns	Pregnant or child under 6 with referral
<i>Model/intensity</i>		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			
<i>Families served/year</i>	345 (50% of deliveries)	Not available in this county	Not available in this county
<i>Eligibility/targeting</i>	Families of newborns; requires referral from physician; automatic referral for NICU babies; charges for services impacts acceptance		
<i>Model/intensity</i>	Locally developed; 1-2 visits		

o **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. However, the 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. RWMC also refers babies born in Scottsbluff but from other Panhandle counties back to the home county.

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.

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.

- **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.

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.

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 County 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 has 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 Nebraska stakeholders named Together for Kids and Families (TFKF). 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.

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 the 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.

ECCS staff completed Evidence-Based Practice and Outcome Accountability training provided by CBCAP, and utilizes the FRIENDS Online Learning Community for technical assistance. Similar assessments have been used by other early childhood entities, and the data is interrelated and used by all partners in particular the Early Childhood Systems Team, ECICC, and the Nebraska Early Childhood Data Coalition.

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 were actively involved in preparation of the Updated State Plan, and remain committed to building a continuum of early childhood services, including the ACA home visiting program.

Also described earlier, 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.

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.

During this project period, NE DHHS will initiate planning and systems development activities with up to 10 of the remaining 14 identified at-risk counties. These activities will be in two categories:

1. Contracts with local agencies/organizations to assess a county's existing system of maternal, infant and early childhood services, then to examine whether home visiting would be a viable component of that system, and finally develop a plan for local system development/enhancement. This category would be applicable for those counties with small at-risk populations and/or limited or no existing home visiting services.
2. Contracts with local agencies/organizations to develop a plan for implementing evidence-based home visiting or moving an existing program to an evidence-based model. This category would be applicable for those counties with larger at-risk populations and existing infrastructure to support evidence-based home visiting.

Contractors would be selected through a competitive process. Contract work products will be used to inform state level planning and strategy development. Of particular value to the NE DHHS will be greater understanding of population and service delivery needs in at-risk counties such as Thurston, location of two land-based Native American tribes. Then, more populous counties such as Douglas have complex service delivery systems and multiple existing programs, complicating local consensus building on model selection and delivery structures. A local contractor would be able to provide the intense community engagement necessary to move a plan forward.

The State of Nebraska does not have an extensive history of administering or funding evidence-based home visiting programs. Only one program, located in the Lincoln-Lancaster County Health Department, is currently affiliated with an evidence-based model, Healthy Families America and it is supported through a contract with the Division of Children and Family Services. NE DHHS plans to continue to promote Evidence-Based Home Visiting in the state, and needs to develop our capacity to move additional communities further along on this continuum. Many valuable lessons were learned in the Panhandle region, and NE DHHS plans to establish working relationships with other counties through these contractual relationships.

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.
- ◇ Enhance capacity to build and maintain comprehensive, high quality early childhood systems at both the community and state level.

The program objectives are numerous, iterative, and multidimensional.

In the area of implementation of Healthy Families America:

- ◇ By Oct. 1, 2011, affiliation process is complete.
- ◇ By Nov. 30, 2011, initial HFA training, Growing Great Kids 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 Nov. 30, 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 Dec. 31, 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 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:**

- ◇ Ongoing: State coordinator conducts bi-weekly telephone conference calls with local project team.
- ◇ Ongoing: State coordinator monitors contract deliverables for local and other partners.
- ◇ Ongoing: State coordinator conducts monthly video conference or on-site monitoring visit with local project team.
- ◇ By Nov. 30, 2011, state coordinator participates in HFA implementation training, curriculum, and fidelity standards.
- ◇ By Dec. 31, 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.

In the area of building systems capacity:

- ◇ By November 1, 2011, identify key components for local early childhood systems development, including evidence-based home visiting , and incorporate into a competitive contract process in up to 10 of the 14 remaining at-risk counties.
- ◇ By January 1, 2012, up to 10 contractors begin to implement system building components locally.
- ◇ By August 1, 2012, work products of contractors inform state-level system development strategies.

The logic model for Nebraska's home visiting program is found as Attachment 1.

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 selected Healthy Families America (HFA) as the evidence-based model to be implemented. This model is being implemented through a sole-source contract with the Panhandle Public Health District (PPHD).

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

Healthy Families America was selected 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.

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
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.

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.

NE DHHS staff members 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. 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) includes 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 have been 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 is built on the important collaborative partnerships that the NE DHHS has developed 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 has been working 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

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

When the results of the 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.

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 continued throughout the preparation of the Updated State Plan, and continues through implementation. Commitment to the success of the project was demonstrated through the willingness of community leaders to participate in planning meetings and conference calls throughout the fast-paced initial program planning period. Even between meetings facilitated by NE DHHS staff, we learned that the local community stakeholders group had been networking, developing questions and ideas to bring to the next round of conversations. Local stakeholders were 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 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.

- **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 Great Kids, Inc., Growing Great Kids 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 have been translated into performance standards and incorporated into the contractual agreement with PPHD, and local policies and procedures will be compatible with and support those required by the model and curriculum developers. These standards will also address all relevant statutory requirements, translating them into expectations for the contractor.

- **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 HFA. The Project Coordinator and Regional Director have a good working relationship, and it is anticipated that regular communication will occur with the implementation of HFA in the Panhandle region. 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.

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. Specific technical assistance needs were listed in Nebraska's Updated State Plan. 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 PPHD has 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.**

See Attachment 2.

- **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 curriculum 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 and HFA. 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 is being 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.

The contract agreement with the PPHD has 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. See the PPHD contract description and scope of services in Attachment 6.

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. The PPHD has actively started the recruiting process for a local project coordinator and home visitors as seen in the project timeline (Attachment 2).

- **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.

- **Description of Identifying and Recruiting Participants; Minimizing Attrition Rates; Estimated Number of Families Served; and Timeline.**

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. These tools and associated protocols will be utilized by the service contractor, PPHD.

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.

These communities have had historically high acceptance rates for universally offered newborn visits (as high as 80% prior to visits becoming a charged service). Staff for the three county area will be trained together in the HFA model and curriculum, 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. These community service providers include local Domestic Violence and Education Services (DOVES) Program which provides services to all three targeted counties. DOVES will be the Panhandle provider for domestic violence services as a referral resource both into and from the home visiting program. PPHD will partner with the various area substance abuse programs, and they will also be a referral resource both into and from the home visiting program. Behavioral Health Region I is the major source for substance services in the Panhandle. In addition, the PPHD is an active member and participant in the Panhandle Partnership. As previously described in this Application, 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.

- **Description of How Data Systems will be Utilized to Ensure Data Collection 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 was 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.

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.

The budget for FY2011 formula grant funding includes additional investments to build data collection and analysis capacity.

- **List of Partners**

A list of Panhandle local public and private partners can be found below.

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

- **Explanation of Integration of MIECHV into the Early Childhood System**

Over the years, the Nebraska ECCS project Together for Kids and Families has developed a strategic plan which was updated in 2009-10 by early childhood stakeholders. Subsequently, the plan has been adopted by the ECICC, the Head Start State Collaboration Office, and the Early Childhood Systems Team. The ECST is chartered by the ECICC, and is responsible for advancing the plan in early childhood work in the state. Paula Eurek, Jennifer Severe-Oforah, Lynne Brehm, and Sue Spanhake are members of the ECST. In the plan, the TFKF Parent Education/Family Support work group has a strategy to address home visiting, and both Lynne and Sue participate in these meetings to work on the integration of the Nebraska ACA Home Visiting Program into the Nebraska Early Childhood System.

- **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 as described in Appendix C of the Funding Opportunity Announcement issued June 21, 2011.

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 it complies with the Maintenance of Effort Requirement as defined in Funding Opportunity Announcement HRSA-10-275 as amended July 1, 2010, 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, the Funding Opportunity Announcement issued June 21, 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 were listed on page 19 of the Funding Opportunity Announcement issued on June 21, 2011.

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 FOA. 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*

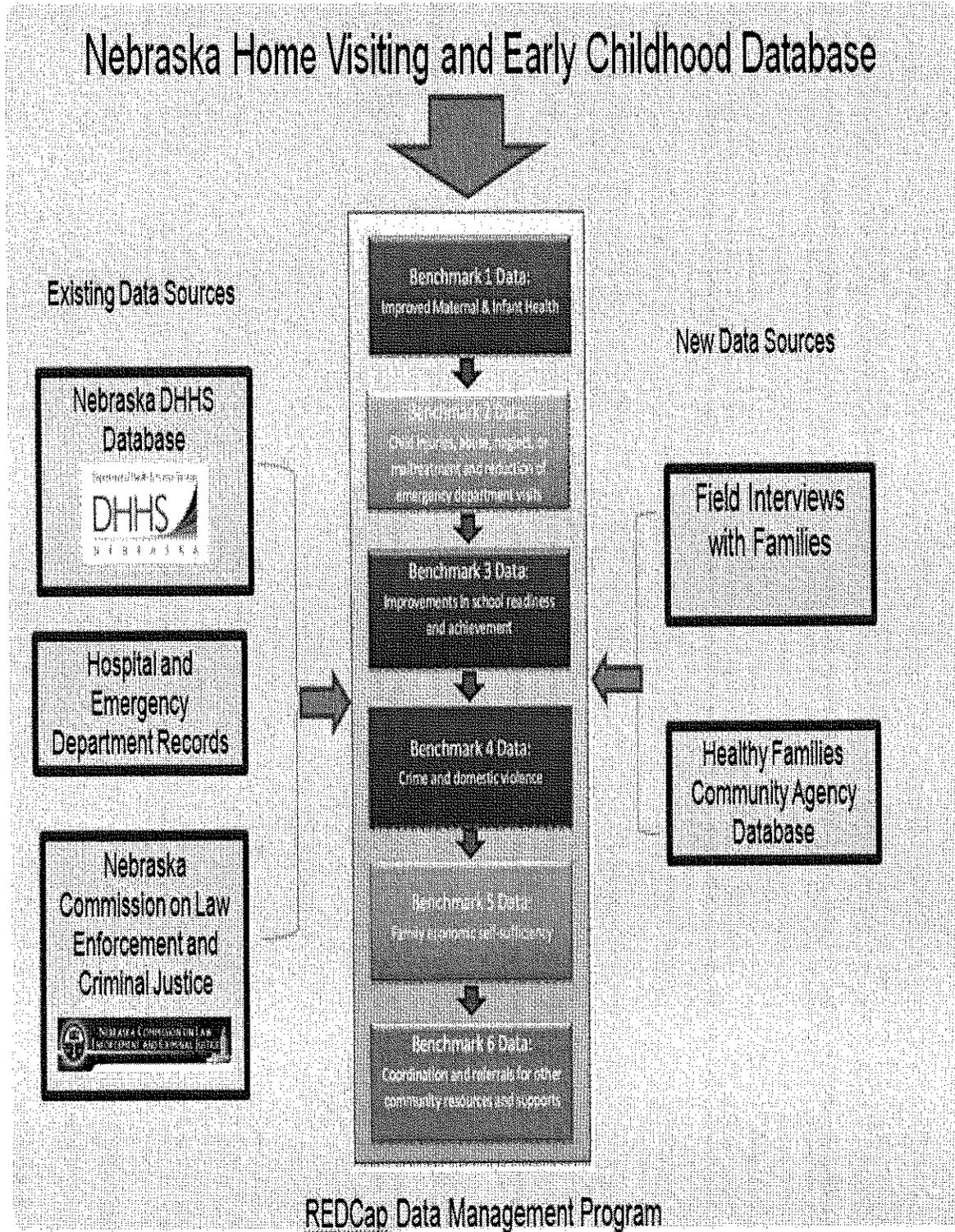
NE DHHS will establish the **Nebraska Home Visiting and Early Childhood Database (NHVECD)**. This comprehensive HIPAA/FERPA-compliant database and management system will be a secure repository of client-level data on those served in the home visiting program. This will be accomplished by using the Research 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 planned data collection and reporting system:



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 of 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.

Descriptions of the benchmarks can be found in Attachment 9.

- **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), and the MCH Epidemiologist (0.10 FTE). A Data Manager Coordinator, 1.0 FTE under contract will be responsible for day to day operations. 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.

o **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

o **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.

○ **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.

○ **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.

• **Anticipated Barriers**

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 Family Services.

- **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 list of key state level partners can be found below.

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)

- **Overall Management Plan**

The Division of Public Health was responsible for the needs assessment and Updated State Plan; 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.

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 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.

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. Jennifer will oversee the work of the new state level Data Manager Coordinator.

Deborah Barnes-Josiah, MSPH, PhD, MCH Epidemiologist - Ms. Barnes-Josiah has both her MSPH and PhD in Epidemiology. She initiated the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), coordinates the Child Death Review Team (CDRT), performs the annual Medicaid: Birth Certificate linkage and outcomes analysis, and provides epidemiologic support to the Division's many maternal and child health programs. Ms. Barnes-Josiah assisted in the needs assessment process, and she will continue to provide technical assistance as DHHS begins collecting benchmark data and implementing the continuous quality improvement plan. See Attachment 4 for 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 include 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 3.

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 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 visitors, 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. An organizational chart of PPHD can be found in Attachment 11.

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 Application, 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.

Structure

The project CQI team will contain representatives from both the state and local levels:

State

- 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

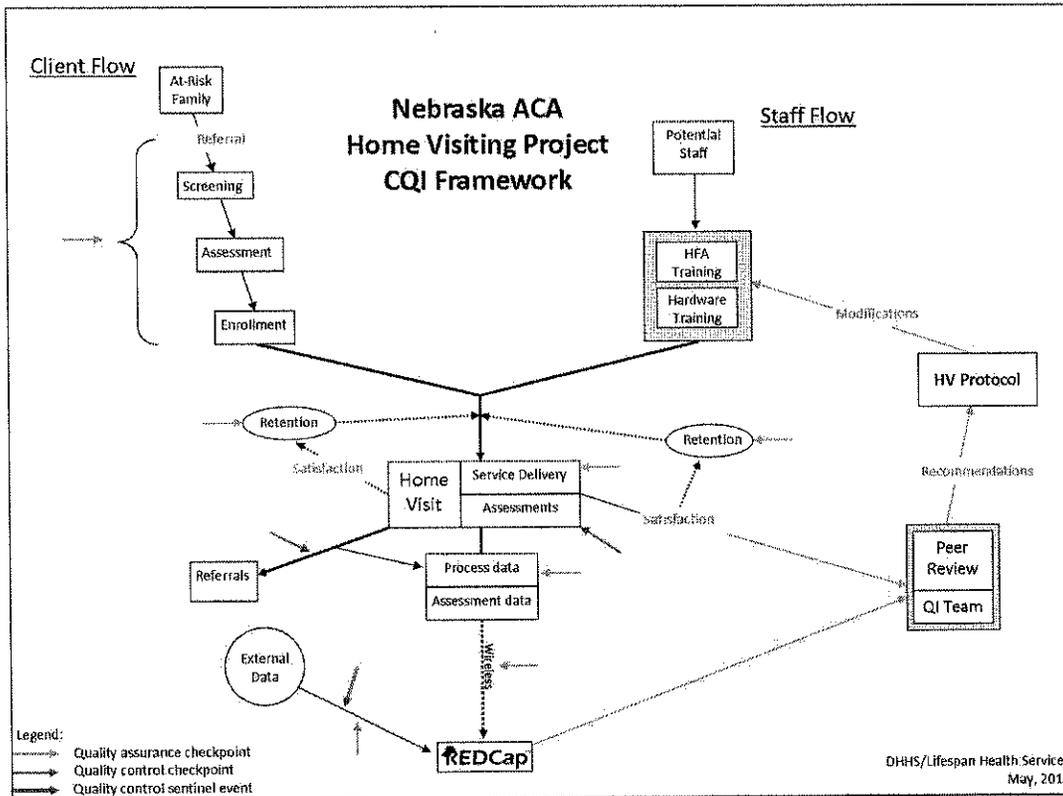
Overall responsibilities of the QI team are to:

- ◇ 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 statewide 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.
- ◇ 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.

As listed on page 2 of this Application, the second highest scoring at-risk county was Thurston county. This location has two land-based Native American Tribes, the Winnebago and Omaha Sioux Tribes. DHHS requests technical assistance to plan for and address the potential for Evidence-based Home Visiting in this county. Suitable models and approaches will need to be identified through the work ACF has completed with other tribes across the nation. ACF may provide useful information in working with these tribes and other partners in Thurston county.

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 are 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.

Budget Narrative

The FY 2011 budget represents a 12-month period, while acknowledging that there is spending authority for the 24-month period ending September 30, 2013. The total FY 2011 anticipated award to Nebraska is **\$1,000,000** which is the projected costs budgeted in Nebraska's FY 2011 Application.

Salaries

Sue Spanhake, DHHS Program Coordinator, provides day-to-day management of the project. This 1.0 FTE position was filled October 2010 and is supported with FY 2010 grant funds through June 2012. FY 2011 grant funds will support this position July – September 2012.

Salary \$55,291 X 0.25 years = \$13,823

Jennifer Severe-Oforah, MCH Epidemiology Surveillance Coordinator. FY 2011 grant funds will be used to fund 25% of her salary beginning October 2011 through September 2012. She will continue to provide technical assistance in implementing the plan for meeting benchmarks and the plan for continuous quality improvement. In addition, she will oversee the work of the new state Data Manager Coordinator. Salary \$56,111 X 25% of one year = \$14,028

Benefits

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

$\$13,823 + \$14,028 = \$27,851 \times 34\% = \underline{\$9,469}$

Travel

FY 2010 funds support travel through June 2012, travel costs projected for July – September 2012 are:

- One trip by 3 state-level staff to the Nebraska Panhandle for a site visit to monitor contract deliverables, be sure the HFA model is being implemented to fidelity, data collection and management are being maintained. (Project Coordinator and data staff) = \$2,250. Assumes travel in a state car which cost is included in the indirect cost pool.

Equipment

None

Supplies

None

Contractual

1. The *Panhandle Public Health District (PPHD)* will continue to deliver local management and oversight for home visiting services and associated costs of curriculum, training materials and travel, assessment tools, HFA annual fee, etc. A projected cost for this 12 month period is \$591,789.
2. The *University of Kansas, Institute for Educational Research and Public Service* for any needed upgrades and modifications to the data collection and management system. A projected cost for this 12 month period is \$20,000.
3. *Data Manager Coordinator* will be responsible to provide state level oversight of the day-to-day operations pertaining to the benchmark data collection and analysis, continuous quality improvement process. Projected total costs for this 12 month period is \$75,000.
4. *Deborah Barnes-Josiah, MCH Epidemiologist*, FY 2011 grant funds will be used to fund 10% of the contract with the University of Nebraska Medical Center which employs Dr. Barnes-Josiah beginning October 2011 through September 2012. She will continue to provide technical assistance as DHHS begins collecting benchmark data and implementing the continuous quality improvement plan. Contract fee \$91,697 X 10% of one year = \$9,169.

5. *Assessment Forms Developers.* Eight different assessment tools were selected for Nebraska's benchmarks. These contracts will bring assessment developers to Nebraska to train administrative staff and local home visiting staff in the Panhandle. Proposed costs = \$10,000.

6. *Community Infrastructure Contracts.* NE DHHS will initiate planning and systems development activities with up to 10 of the remaining 14 identified at-risk counties. Approximately, \$231,620 will be made available for these activities.

Other
None

Construction
None

Total Direct Charges

Salaries:

Project Coordinator	\$13,823
MCH Epidemiology Coordinator	14,028
Benefits :	9,469
Travel:	2,250
Equipment:	- 0-
Supplies:	- 0 -
Contractual:	
PPHD	\$591,789
Kansas University	20,000
Data Manager Coordinator	75,000
MCH Epidemiologist	9,169
Assessment Forms Developers	10,000
Community Infrastructure Contracts	<u>240,664</u>
Total Direct Charges	<u>\$986,192</u>

Indirect Charges

Nebraska's indirect cost rate is 37% of salaries + benefits. The rate agreement is to the Budget Narrative.

$$\$37,320 \times .37 = \underline{\$13,808}$$

TOTAL BUDGET for FY 2011 funds \$1,000,000

PPHD Home Visitation Budget Justification

Personnel Costs

\$446,756

Wages	FTE	Rate	Total
Program Manager:	1	\$23.90	\$49,712
Supervisor	1	\$19.15	\$39,832
Home Visitor 1/FAW	1	\$13.90	\$28,912
Home Visitor 2	1	\$13.90	\$28,912
Home Visitor 3	1	\$13.90	\$28,912
Home Visitor 4	1	\$13.90	\$28,912
Home Visitor	1	\$13.90	\$28,912
Data Entry/Support	0.5	\$10.40	\$10,816
Total Wages			\$244,920

Benefits	FICA	Retire	Health	Un-employment	Total
Program Manager:	\$3,803	\$3,356	\$17,573	\$210	\$24,941
Supervisor	\$3,047	\$2,689	\$17,573	\$210	\$23,519
Home Visitor 1/FAW	\$2,212	\$1,952	\$17,573	\$210	\$21,946
Home Visitor 2	\$2,212	\$1,952	\$17,573	\$210	\$21,946
Home Visitor 3	\$2,212	\$1,952	\$17,573	\$210	\$21,946
Home Visitor 4	\$2,212	\$1,952	\$17,573	\$210	\$21,946
Home Visitor	\$2,212	\$1,952	\$17,573	\$210	\$21,946
Data Entry/Support	\$827	\$730	\$8,786	\$210	\$10,553
Total Benefits	\$18,736	\$16,532	\$131,797	\$1,678	\$168,743

Administration	FTE	
Kim Engel	0.29	
Sara Sulzbach	0.29	
Total Admin	8% of Total Wages and Total Benefits	\$33,093

Non-Personnel Costs

\$115,466

Cost of Meetings	\$5,000
Advisory board bi-monthly meetings \$700/meeting x 6 meetings - mileage and meeting expenses	\$4,200
Family support group meetings \$200/meeting x 4 quarters	\$800
Office Space	\$10,200
Rent and utilities - \$850/month x 12 months	\$10,200
Copies of forms/tools	\$9,000
\$50/family/year x 120 families	\$6,000
Misc copies	\$3,000
Family Support Materials	\$12,000

\$100/family/year x 120 families	\$12,000	
Contracts		\$17,600
Panhandle Partnership for Health & Human Services - wages and mileage for community engagement and collaboration model development	\$17,000	
Training Academy coordination - \$300/training x 2 trainings	\$600	
Advertising and PR		\$500
Advertisements in Box Butte, Morrill and Scottsbluff newspapers	\$500	
Audit		\$3,000
Portion of A-133 audit	\$3,000	
Insurance		\$2,500
Portion of workers comp, office space, and contents insurance	\$2,500	
Legal		\$1,000
Mileage		\$31,626
Travel off site for home visitors training		
13 days @ 120 miles round trip/day x .555	\$866	
13 days @ 90 miles round trip @ .555	\$649	
Monthly staff Meetings		
12 meetings @ 120 miles round trip/meeting x .555	\$799	
12 meetings @ 90 miles round trip/meeting x .555	\$599	
Annual conference - HFA for Coordinator and Supervisor registration, transportation, lodging, and meals - \$2500/person	\$5,000	
Home Visits		
400 miles/month/visitor x 12 months x 5 visitors x .555	\$13,320	
Supervisor travel to off site locations		
52 weekly visits @ 120 miles round trip/visit x .555	\$3,463	
52 weekly visits @ 90 miles round trip/visit x .555	\$2,597	
4 trips to Lincoln for Supervisor and Coordinator	\$4,332	
4 trips - 900 round trip miles x .555 = \$1998		
4 trips - 2 rooms for 2 nights x \$77/room/night = \$1232		
4 trips - 2 people for 3 days @ \$46/person/day = \$1104		
Communication		\$11,040
Internet service for Scottsbluff office @ \$70/month x 12 months	\$840	
Cell phone service for 7 phones @ \$90/month/phone x 12 months	\$7,560	
Telephone service for 3 lines into Scottsbluff office @ \$220/month x 12 months	\$2,640	
Office Supplies		\$4,000
Routine office supplies, including postage		
\$500/person x 8 staff	\$4,000	
Professional Development		\$8,000
\$1000/person x 8 staff	\$8,000	
Services		\$24,567
Healthy Families of America		\$9,206

HFA Annual Fee	\$1,350	
Home Visitor/Supervisor Integrated Strategies Core Training	\$3,800	
Travel for Trainer	\$1,296	
Core Supervisor Training	\$1,200	
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 transportation	\$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 2 BUDGET		\$591,789



DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Service
Division of Cost Allocation
Central States Field Office

July 20, 2008

Mr. Bob Zagozda
Chief Operating Officer
Nebraska Department of Health & Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

1301 Young Street
Room 732
Dallas, TX 75202
(214) 767-3261
(214) 767-3264 FAX

Dear Mr. Zagozda:

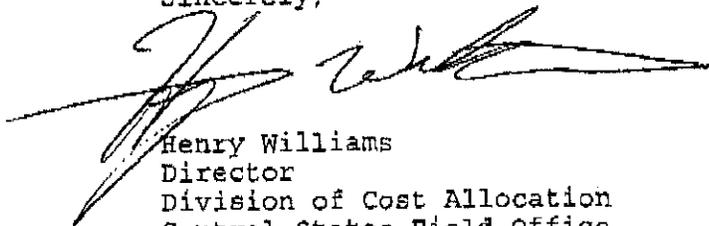
A copy of an indirect cost Rate Agreement is being faxed to you for signature. This Agreement reflects an understanding reached between your organization and a member of my staff concerning the rate(s) that may be used to support your claim for indirect costs on grants and contracts with the Federal Government.

Please have the agreement signed by an authorized representative of your organization and fax it to me, retaining a copy for your files. Our fax number is (214) 767-3264. We will reproduce and distribute the Agreement to the appropriate awarding organizations of the Federal Government for their use.

An indirect cost proposal, together with supporting information, is required each year to substantiate claims made for indirect costs under grants and contracts awarded by the Federal Government. Thus, your next proposal based on actual costs for the fiscal year ending June 30, 2008 is due in our office by December 31, 2008.

Thank you for your cooperation.

Sincerely,



Henry Williams
Director
Division of Cost Allocation
Central States Field Office

Enclosures

STATE AND LOCAL RATE AGREEMENT

EIN #: 1470491233A1

DATE: July 28, 2008

DEPARTMENT/AGENCY:
Nebraska Department of Health & Human Services
P.O. Box 95026
Lincoln NE 68509-5026

FILING REF.: The preceding Agreement was dated November 23, 2004

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES*

RATE TYPES: FIXED	FINAL		PROV. (PROVISIONAL)	PRED. (PREDETERMINED)	
	TYPE	EFFECTIVE PERIOD			
	FROM	TO	RATE (%)	LOCATIONS	APPLICABLE TO
FINAL	07/01/06	06/30/07	40.0	On Site	HHSS - Health Prog.
FINAL	07/01/07	06/30/08	40.0	On Site	HHSS - Health Prog.
PROV.	07/01/08	UNTIL AMENDED	37.0	On Site	HHSS - Health Prog.

*BASE:
Direct salaries and wages including all fringe benefits.

(1)

DEPARTMENT/AGENCY:
Nebraska Department of Health & Human Services

AGREEMENT DATE: July 28, 2008

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

Fringe benefits are specifically identified to each employee and are charged individually as direct costs. The directly claimed fringe benefits are listed below.

TREATMENT OF PAID ABSENCES:

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims for the costs of these paid absences are not made.

Equipment Definition -

Equipment means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit.

FRINGE BENEFITS:

FICA

Retirement

Disability Insurance

Life Insurance

Unemployment Insurance

Health Insurance

Deferred Compensation

(2)

DEPARTMENT/AGENCY:
Nebraska Department of Health & Human Services

AGREEMENT DATE: July 28, 2008

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted; such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the authority in Office of Management and Budget Circular A-87 Circular, and should be applied to grants, contracts and other agreements covered by this Circular, subject to any limitations in A above. The organization may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE DEPARTMENT/AGENCY:
Nebraska Department of Health & Human Services

(DEPARTMENT/AGENCY)

(SIGNATURE)

BOB ZAGOZNA

(NAME)

COO

(TITLE)

8/8/08

(DATE)

ON BEHALF OF THE FEDERAL GOVERNMENT:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(AGENCY)

(SIGNATURE)

Henry Williams

(NAME)

DIRECTOR, DIVISION OF COST ALLOCATION-

(TITLE) CENTRAL STATES FIELD OFFICE

July 28, 2008

(DATE) 7293

HHS REPRESENTATIVE: Rebecca L. Cantu

Telephone: (214) 767-3454

(3)

Project Abstract

Project Title: Nebraska ACA Home Visiting Program
Applicant Name: Nebraska Department of Health and Human Services
Address: 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509
Contact: Paula Eurek, Administrator, Lifespan Health Services
Division of Public Health, NE DHHS
402-471-0196 (voice); 402-471-7049 (fax)
Email: paula.eurek@nebraska.gov

PROBLEM: Through its Statewide Needs Assessment completed in 2010, NE DHHS identified 17 counties with the highest risk for poor outcomes that could potentially be addressed through home visitation. 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.

GOAL(S) 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; and Enhance capacity to build and maintain comprehensive, high quality early childhood systems at both the community and state level.

The program objectives in the area of implementation of Healthy Families America: By Oct. 1, 2011, affiliation process is complete; and, by Nov. 30, 2011, initial HFA training, Growing Great Kids 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. In the area of service delivery to families by trained home visitors: By December 31, 2011 trained home visitors are available for service delivery; and by September 30, 2012 at least 50 local families are enrolled and receiving visits from trained home visitors. In the area of development of local systems for intake/identification of eligible families, and coordinated resource and referral processes: 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; and by September 30, 2012 at least 50 local eligible families are enrolled and receiving visits from trained home visitors.

METHODOLOGY: A three level process was used to identify Scotts Bluff, Box Butte and Morrill counties in the Panhandle as the communities targeted for implementation of the ACA MIECHV Program.

COORDINATION: The ACA MIECHV Program is administered by the NE DHHS, Division of Public Health, in collaboration with the Division of Children and Family Service. Partners include the Early Childhood Interagency Coordinating Council, the Nebraska Children and Families Foundation (Nebraska's Title II of CAPTA entity), and the Head Start State Collaboration Office. Local-level engagement by Panhandle stakeholders was key to selecting Healthy Families America (HFA) and Great Kids, Inc. as the model and curriculum.

ANNOTATION: This program seeks to implement an evidence-based home visiting model, HFA, with fidelity in Scotts Bluff, Box Butte, and Morrill counties in the rural Panhandle area in Nebraska.

EVALUATION: The NE DHHS provides assurances that the state will participate in national evaluation activities, and NE DHHS does not plan on conducting further evaluation at the state level.

NEBRASKA'S ACA HOME VISITING PROGRAM
LOGIC MODEL

INPUTS (Resources)	Processes/Activities	OUTPUTS (Products)	Short-term Outcomes	Intermediate Outcomes	Long-term Impacts
<p>State level epidemiology capacity.</p> <p>Existing state and county-level MCH needs assessments</p> <p>Multi-state discussion forums and listserves</p>	<p>Epidemiological constructs created to structure HV needs assessment, data acquired</p> <p>DHHS Internal workgroup structure formed and functioning</p>	<p>Level 1 and Level 2 Needs Assessments</p> <p>Model comparison matrix</p> <p>Model selection matrix</p> <p>Data plan</p>	<p>State and Local partners have formed a good relationship of mutual trust and respect.</p> <p>Local community has assessed risks and partners with state to address with targeted home visiting.</p> <p>There is a mutual awareness of quality and effectiveness.</p>	<p>Infrastructure improving with measurable change in recruitment, referrals, and retention.</p> <p>Nebraska's ACA Home Visiting Program is operating with fidelity to model requirements.</p> <p>Service recipients: Voluntarily accept home visiting; Participate in or are represented in planning of services (e.g. serving on advisory committee)</p>	<p>Measurable change in 50% of constructs in four of six benchmark areas at the end of three years.</p> <p>Enhanced early childhood systems development at state and local levels.</p> <p>Improved family outcomes as measured in HFA model.</p> <p>Increase community capacity to address needs of high-risk families.</p>
<p>ACA Home Visiting regional advisors and technical assistance; HFA TA</p> <p>Current NE Children and Families Foundation and Early Childhood Systems Development: preventive and collaborative history in the target region.</p> <p>Early Childhood Systems Stakeholders</p>	<p>Consultations with key policymakers</p> <p>Identification and selection of target community</p> <p>Communications with key informants and stakeholders in target community; develop stakeholders for active involvement in home visiting</p>	<p>CQI plan</p> <p>State Plan submitted</p> <p>Contract with model developers</p> <p>Contract for service (service provider is identified and prepared to deliver quality services)</p> <p>Branding and Marketing Plan: Home visiting is seen as an asset of all strong families.</p> <p>Systemic barriers identified and resolved.</p> <p>Selection of assessment instruments.</p>	<p>Contract for service (service provider is identified and prepared to deliver quality services)</p> <p>Branding and Marketing Plan: Home visiting is seen as an asset of all strong families.</p> <p>Systemic barriers identified and resolved.</p> <p>Selection of assessment instruments.</p>	<p>Contract for service (service provider is identified and prepared to deliver quality services)</p> <p>Branding and Marketing Plan: Home visiting is seen as an asset of all strong families.</p> <p>Systemic barriers identified and resolved.</p> <p>Selection of assessment instruments.</p>	<p>Contract for service (service provider is identified and prepared to deliver quality services)</p> <p>Branding and Marketing Plan: Home visiting is seen as an asset of all strong families.</p> <p>Systemic barriers identified and resolved.</p> <p>Selection of assessment instruments.</p>
<p>Existing home visiting and MCH infrastructure in NE:</p> <ul style="list-style-type: none"> • CPS intervention • Home visiting as a TFKF strategy • Knowledge of 	<p>Develop application, coordinate a work plan and manage a time line</p> <p>Identify organizational</p>	<p>Identify organizational</p>	<p>Identify organizational</p>	<p>Identify organizational</p>	<p>Identify organizational</p>

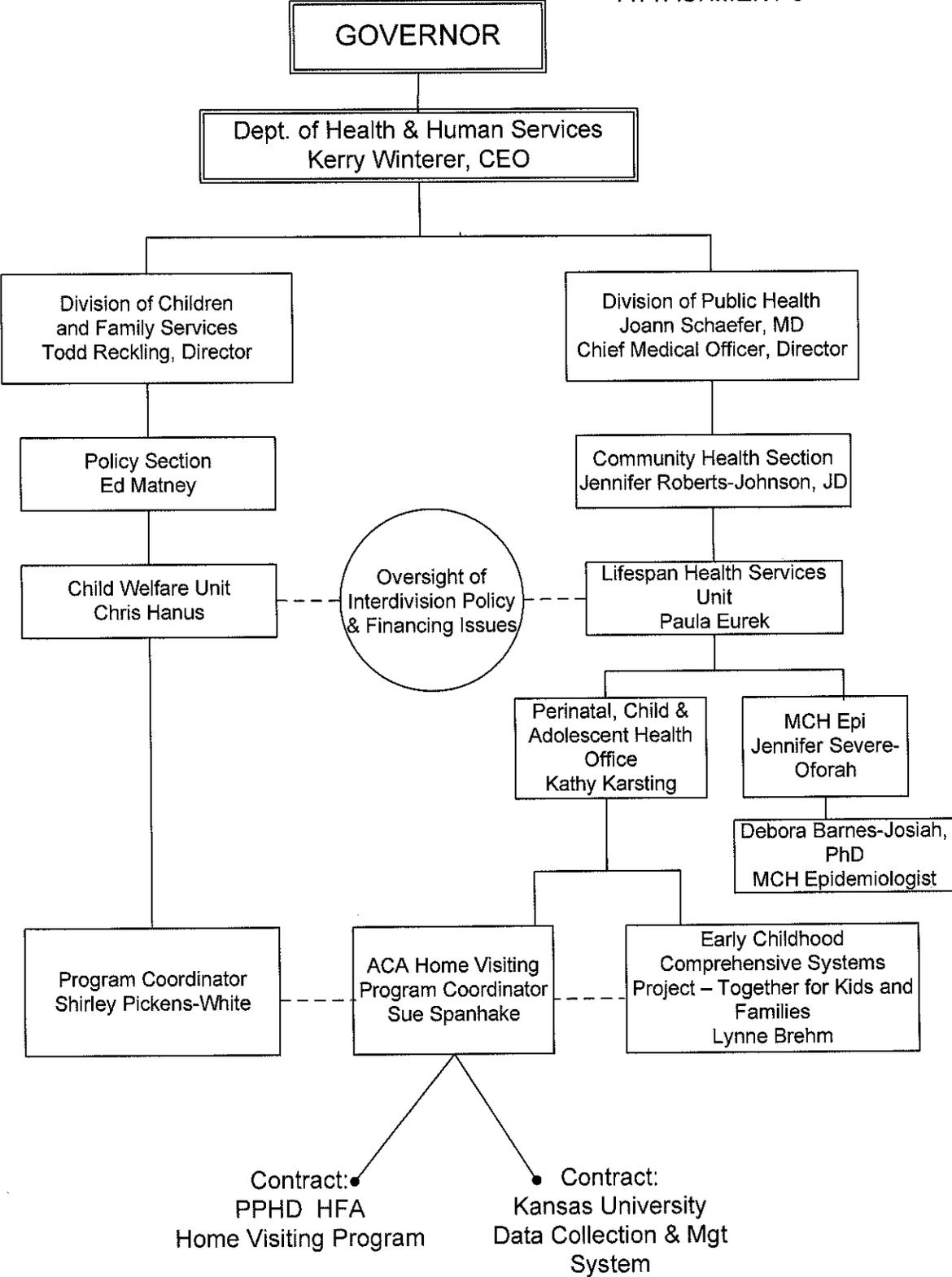
ATTACHMENT 1

<p>existing home visiting programs in NE</p> <p>Existing local capacity for HV in Children's Outreach Program .</p> <p>Home visitors are recruited from the local target community</p> <p>Panhandle Partnership Training Academy</p>	<p>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.</p>	<p>Training of home visitors</p> <p>Additional communities participate in training opportunities, utilization of data plan, CQI plan, and benchmark assessments.</p>			
--	---	--	--	--	--

Nebraska's ACA Home Visiting Program
Project Timeline

Level	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sept 2012
Healthy Families America	By Oct. 1, affiliation process is complete.	By Nov. 30, staff completes HFA training.					By April 10, 20 families are being served by the program.			By July 10, 40 families are being served by the program.		By Sept. 30, 50 families being served by the program.
Growing Great Kids Curriculum		By Nov. 30, staff completes GGJK training.										
Data Collection & CQI	By Oct. 1, data sharing agreements across agencies are completed. By Oct. 31, REDCap database is built & system has been tested with dummy data.	By Nov. 30, outcome reports are generated from REDCap.	By Dec. 31, local HFA personnel trained in data collection & CQI.	By Jan. 31 & ongoing, data collection begins by 100% of active home visitors. Ongoing: Training of administrative staff & technical assistance.								
State Assurance of Compliance & fidelity	Ongoing: State Project Coordinator conducts bi-weekly telephone contacts with local site contractor & monthly video conference or on-site visits. Ongoing: Monitor contract deliverables by local & other partners.	By Nov. 30, State Project Coordinator & Project Team complete HFA, GGJK, & fidelity training with the local project team.	Ongoing: State Coordinator assures reporting per federal & model developer requirements, local project plan.									

Level	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sep 2012
Local Systems Development of Intake/Identification of Resources & Referral Processes	By Oct. 31, begin development of intake/enrollment processes & referral service network for families to other community services & programs. By Oct. 1, HFA staff hired.	By Nov. 30, marketing plan for eligible family recruitment is implemented.	By Dec. 31, intake & referral systems are in place. By Dec. 31, administrative & programmatic tools in place.	Processes are implemented, active enrollment, referrals begin.								
Service Delivery by Trained Home Visitors			By Dec. 31, trained home visitors are available for service delivery.	Families accepting home visits by trained local staff.					By June 30, at least 75% of active home visitors participate in one professional development event.			
Statewide Infrastructure Development	Ongoing: State Project Coordinator participates on the ECJCC Technical Assistance Team, Early Childhood Systems Team, & the TRKF Parent Education/Family Support Work Group. By Oct. 31, electronic newsletter sent to stakeholders.	By Nov. 1, issue RFP for the remaining 14 at-risk counties for early childhood systems development.	By Dec. 31, DHHS Home Visiting web site is updated.	By Jan. 31, electronic newsletter sent to stakeholders. By Jan. 1, 10 contractors begin to implement system building components locally.		By Mar. 31, DHHS Home Visiting web site is updated.	By April 30, electronic newsletter sent to stakeholders.		By June 30, DHHS Home Visiting web site is updated.	By July 31, electronic newsletter sent to stakeholders.	By Aug. 1, contractors deliver work products to DHHS.	By Sept. 30, Home Visiting web site is updated.



PAULA EUREK
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
301 Centennial Mall South, P.O. Box 95026
Lincoln, Nebraska 68509
402-471-0196 Voice
402-471-7049 Fax
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
Nebraska Department of Health and Human Services
1050 N Street, Suite 540
Lincoln, Nebraska 68508
402-471-1384
lynne.brehm@nebraska.gov

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-May 2002

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

Sue Spanhake
Nebraska Department of Health and Human Services
301 Centennial Mall South
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; 1982-1987

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

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 Scholar, 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 Surveillance 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 emerging issues and on-going trends in health status and outcomes. Directs the MCH Epidemiology unit consistings of State Systems Development Initiative, Title V and Needs Assesment data management, Child Death Review Team, and the Pregnancy 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 participating and organizing policy and planning initiatives to reduce health disparities, reduce infant mortality, 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 & AFFILIATIONS

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.

Debra Lynn Barnes-Josiah, Ph.D.
debra.barnesjosiah@nebraska.gov

EDUCATION

UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH

Ph.D. (Epidemiology) 1989, M.S.P.H. (Epidemiology) 1986

MASSACHUSETTS INSTITUTE OF TECHNOLOGY

B.S. (Biology) 1980

EMPLOYMENT

ASSISTANT PROFESSOR, Department of Epidemiology, College of Public Health, University of Nebraska Medical Center. 2008 – present

MCH EVALUATION & ASSESSMENT COORDINATOR, Nebraska Health and Human Services System. 2002-present

ASSISTANT PROFESSOR, Department of Pediatrics, University of Nebraska Medical Center. 1999-2008.

PRINCIPAL RESEARCH SCIENTIST, Division of Family Health Minnesota Department of Health, Minneapolis, Minnesota. 1996-1998

EPIDEMIOLOGIST, Minneapolis Department of Health and Family Support, Minneapolis, Minnesota. 1995-1996

POST-DOCTORAL FELLOW, Division of Epidemiology, School of Public Health, University of Minnesota, Minneapolis, Minnesota. 1992-1995

CHILD SURVIVAL FELLOW, Institute for International Programs, Johns Hopkins University, Baltimore, Maryland. 1989-1991

EPIDEMIOLOGIST, Institut Haitien de l'Enfance, Port au Prince, Haiti. 1989-1991

CERTIFICATIONS

National Board of Public Health Examiners. Certification in Public Health. 2008

SELECTED PUBLICATIONS, REPORTS AND PRESENTATIONS

Nebraska Health and Human Services System. Nebraska Child Death Review Report: 2007-2008 (2011); 2005-2006 (2009); 2004 (2007); 2002-2003 (2006); 1996-2001 (2004). Lincoln, NE.

(Various authors), **Barnes-Josiah D.** PRAMS and... Unintended Pregnancy (2010); ...PostPartum Contraception (2009); ...Breastfeeding (2009) ... Postpartum Depression (2008). Nebraska Department of Health & Human Services. Lincoln, NE.

Barnes-Josiah DL. April, 2009. Eliminating Racial / Ethnic Health Disparities in Nebraska. Presentation at the Nebraska Public Health Conference, Lincoln, NE

Barnes-Josiah DL, Eurek P, Huffman, Heusinkvelt J, Severe-Oforah J, Schwalberg R. 2007. Impact of "This Side Up" t-shirts on infant sleep position. *MCH Journal* 11(1)45-48.

Barnes-Josiah DL. 2005. Medical Enrolled Births, Nebraska 2000-2003. Nebraska Department of Health & Human Services. Lincoln, NE.

Barnes-Josiah DL. 2004. Undoing Racism in Public Health: A Blueprint for Action in Urban MCH. Omaha, NE: CityMatCH at the University of Nebraska Medical Center.

Nebraska Health and Human Services System. 2002. Nebraska Pregnancy Risk Assessment Monitoring System – 1999 Data Book. Lincoln, NE.

Peck MG, **Barnes-Josiah DL.** 2002. Social Policy Reform and America's Cities: Risk and Opportunity for Maternal and Child Health. In: Wallace H et al. (ed.) Health & Welfare for Families in the 21st Century. Boston: Jones and Bartlett Publishers.

Barnes-Josiah DL, Peck MG, Bartee D, Santibanez S, Orloff S. 2001. Expanding the "Cascade": Opportunities for Prevention of Perinatal Transmission of HIV/AIDS. Presentation at the Seventh Annual MCH Epidemiology Conference, Clearwater, FL.

Barnes-Josiah DL, Ansari B, Kress DS. 1996. Minneapolis Youth Homicide Study: Victims and Chargees 1994-1995. Minneapolis Department of Health and Family Support, Minneapolis, MN.

Barnes-Josiah DL, Augustin AA, Coreil J, et al. 1993. Maternal Mortality in Haiti: Report and Evaluation from a National Study. Institut Haitien de l'Enfance, Petionville, Haiti.

July 13, 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:

The following divisions within the Nebraska Department of Health and Human Services have these responsibilities:

- Division of Public Health – Title V/Maternal and Child Health
- Division of Children and Family Services – Child Welfare Agency (Title IV-E and IV-B) and Child Care and Development Fund (CCDF)
- Division of Behavioral Health – State’s Single State Agency for Substance Abuse Services.

As the Directors of these Divisions, we concur with and support the application being submitted by the NE DHHS Division of Public Health in response to the June 21, 2011 Funding Opportunity Announcement for the Application to continue a State Home Visiting Program.

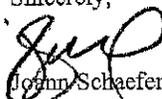
The Nebraska Department of Health and Human Services (NE DHHS) is the designated entity for administering Nebraska’s Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Responsibility for planning and program development was assigned to the Division of Public Health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

We understand that the federal FY2011 funds will be used to enhance infrastructure for home visiting, and continue to support the implementation of evidence-based home visitation in the counties of Scotts Bluff, Morrill, and Box Butte. We also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated.

The Application 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 together as the Division of Public Health implements the evidence-based home visiting services in the three selected counties, and expansion of the statewide home visiting program. 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.

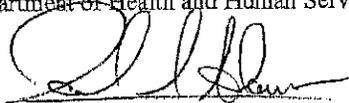
Sincerely,



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



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



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



July 15, 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, I concur with and support the Application being submitted by the NE DHHS Division of Public Health in response to the June 21, 2011 Funding Opportunity Announcement for the Application to continue a State Home Visiting Program.

I understand that the federal FY2011 funds will be used to enhance infrastructure for home visiting, and continue to support the implementation of evidence-based home visitation in the counties of Scotts Bluff, Morrill, and Box Butte. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated.

The Application 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, and expansion of the statewide home visiting program. 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>

July 11, 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.

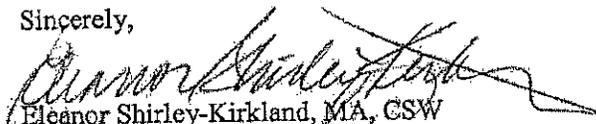
The Nebraska Department of Education, Office of Early Childhood houses the Nebraska Head Start-State Collaboration Office. As the Director of the Collaboration Office, I concur with and support the Application being submitted by the NE DHHS Division of Public Health in response to the June 21, 2011 Funding Opportunity Announcement for the Application to continue a State Home Visiting Program.

I understand that the federal FY2011 funds will be used to enhance infrastructure for home visiting, and continue to support the implementation of evidence-based home visitation in the counties of Scotts Bluff, Morrill, and Box Butte. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated.

The Application 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 and existing early childhood programs, such as Head Start or Early Head Start, to enhance referral systems and service linkages and promote sustainable collaboration.

The Head Start-State Collaboration Office maintains its commitment to the Division of Public Health as it implements evidence-based home visiting services in the 3 selected counties, and expansion of the statewide home visiting program. 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,


Eleanor Shirley-Kirkland, MA, CSW
Head Start Early Childhood Systems Director

Nebraska Department of Education • Office of Early Childhood
"Building and Bridging Systems in Early Care and Education"



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

July 13, 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 by the ECICC Steering Committee. The ECICC concurs with and supports the Updated State Plan being submitted by the NE DHHS Division of Public Health in response to the June 21, 2011 Funding Opportunity Announcement for the Application to continue a State Home Visiting Program.

The Council understands that the federal FY2011 funds will be used to enhance infrastructure for home visiting, and continue to support the implementation of evidence-based home visitation in the counties of Scotts Bluff, Morrill, and Box Butte. The Council also understands that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated.

The Application 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, and expansion of the statewide home visiting program. 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

Heather Gill
ECICC Chairperson
Phone: (308) 284-3164
E-mail: hgill@esu16.org

Terry Rohren
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/



NEBRASKA DEPARTMENT OF EDUCATION



Roger D. Breed, Ed.D., Commissioner
Scott Swisher, Ed.D., Deputy Commissioner

301 Centennial Mall South Tel: (402) 471-2295
PO Box 94987 Fax: (402) 471-0117
Lincoln, NE 68509-4987 Web: www.education.ne.gov

July 13, 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 Office of Early Childhood in the Nebraska Department of Education (NDE) has responsibility for administering pre-kindergarten programs operated by school districts and education service units. As the Co-Administrator of the Office of Early Childhood, I concur with and support the Application being submitted by the NE DHHS Division of Public Health in response to the June 21, 2011 Funding Opportunity Announcement for the Application to continue a State Home Visiting Program.

I understand that the federal FY2011 funds will be used to enhance infrastructure for home visiting, and continue to support the implementation of evidence-based home visitation in the counties of Scotts Bluff, Morrill, and Box Butte. I also understand that Healthy Families America has been chosen as the evidence-based home visiting model to be replicated.

The Application 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 NDE Office of Early Childhood is committed to working with the NE DHHS Division of Public Health as it implements evidence-based home visiting services in the three selected counties, and the expansion of the statewide home visiting program. 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,

A handwritten signature in cursive script that reads "Melody Hobson".

Melody Hobson, Co-Administrator
Office of Early Childhood

Description(s) of Proposed/Existing Contracts (subcontracts)/Itemized subcontracts

EXISTING CONTRACTS:

Panhandle Public Health District (PPHD)

The Healthy Families America (HFA) evidence-based model will be implemented through a sole-source contract with PPHD. 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.

Purpose: The purpose of this contract is to initiate the implementation of evidence-based home visiting services for the maternal, infant, and early childhood populations in Scotts Bluff, Morrill, and Box Butte County, in accordance with the requirements of the Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Program and the DHHS's Updated State Plan.

Term: June 1, 2011 through June 30, 2012

Total Payment: \$510,000

Scope of Services:

1. Design and implement an operational and business plan for the delivery of Healthy Families America as an evidence-based home visiting program in the counties of Scotts Bluff, Morrill, and Box Butte. Plan shall be submitted to DHHS by July 10, 2011 and shall include but not be limited to:
 - a. Organizational structure, including that needed for general oversight, financial management, service delivery, and reporting/accountability for the home visiting program.
 - b. Description of relationships and any needed agreements with Scotts Bluff County Health Department for the delivery of services in Scotts Bluff County.
 - c. Community engagement and collaboration, including anticipated advisory structures.
 - d. Communication strategies to accomplish coordination with key entities, including but not limited to community service providers and referral sources, HFA model developer, and NE DHHS.
 - e. Incremental timeline for meeting eventual target of serving 125 families upon full implementation, first increment to be number of families to be enrolled by June 30, 2012.

- f. Processes or major action steps for completing items 2 – 8 in Section III A within the specified time frames.
2. Acquire sufficient qualified staff to deliver Healthy Families America (HFA) evidence-based home visiting services. Such staffing shall include a project coordinator to manage the project, supervisory and service delivery staff that meet supervisor to visitor and visitor to family ratios as established by HFA, and other staff as needed to implement HFA model with fidelity.
 - a. Selection of staff shall be based on HFA guidelines and be appropriate to meet the cultural, language, and other social needs of targeted at-risk families.
 - b. Project coordinator shall be in place by July 30, 2011. Remaining staff shall be in place by August 30, 2011.
 3. Schedule and make logistical arrangements for all initial training required for HFA affiliation and start up of services. Such training shall be delivered to all supervisors, visitors, and other relevant staff positions by November 30, 2011.
 4. Develop, design, and/or acquire administrative and programmatic tools required for implementation of HFA with fidelity. These tools shall be available for use prior to initiation of HFA home visiting services and shall include but not be limited to:
 - a. Program policy and procedure manual.
 - b. Outreach and screening tools, including algorithm for guiding families to appropriate home visiting services in communities based on needs/risks.
 - c. Evidence-based or evidence-informed curricula that meets recommendations of HFA and also meets community needs and those of targeted families.
 - c. Assessment tools as needed to meet requirements of HFA and that of the DHHS benchmarking plan.
 5. Assist the DHHS in designing data collection and analysis plan that meets both HFA requirements and those of the DHHS plan for benchmarks and continuous quality improvement. Implement local components of plan to include but not be limited to:
 - a. Acquiring needed data collection tools and/or devices.
 - b. Establishing local procedures for data collection and transmission.
 - c. Training staff on data collection and transmission procedures.
 6. Develop intake/enrollment processes for eligible families, including but not limited to targeting strategies, training/technical assistance to referral sources, and

other necessary processes to provide suitable access to HFA program for at-risk families. All services to families are to be voluntary and enrollment processes are to incorporate consent procedures that inform families of the voluntary nature of the services. Such processes shall be established prior to the initiation of HFA home visiting services.

7. Develop processes for referring enrolled families to other community services and programs, including processes for documenting such referrals and family follow-through. Such processes shall be established prior to initiation of HFA home visiting services
8. Initiate screening, assessment, enrollment, and delivery of HFA home visiting services to at-risk families by January, 2012, utilizing work products as described in Section III A 1-7.
9. Maintain regular and ongoing communication with DHHS to monitor progress and to coordinate training, technical assistance, federal reporting requirements, and other key activities needed to assure implementation of HFA program with fidelity and in accordance with federal requirements.

Status: Fully executed.

University of Kansas Institute for Educational Research and Public Service

The NE DHHS will establish the Nebraska Home Visiting Early Childhood Database through a contract with the University of Kansas, who has experience in building such systems in their own state. Request for this sole source contract was approved by NE DHHS and the Nebraska Administrative Services through a standard deviation process for contracts over \$50,000.

Purpose: The purpose of the contract is to provide a secure repository of client-level data on those served in the home visiting program by using the 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 HFA Program Information Management System, and data collected in the field by home visiting staff.

Term: July 1, 2011 through June 30, 2012

Total Payment: \$58,817

Scope of Services:

Tasks	Timeframe
Task 1: Data Mapping and Collection Plan	
1.1 Compile and profile all necessary and existing data sources across state/agencies for agreed upon constructs under each benchmark area	Jul 1 – Aug 1, 2011
1.2 Review existing agency data to identify data elements and gaps	Jul 1 – Aug 1, 2011
1.3 Develop a data collection plan for new instrument administration	Jul 1 – Aug 1, 2011
1.4 Identify appropriate data collection tools/technology	Jul 1 – Aug 1, 2011
1.5 Create complete data map of data sources for all benchmark areas and constructs	Jul 1 – Aug 1, 2011
Task 2: Data Linking Work	
2.1 Work with one agency/program to identify or create data elements and format for exporting data to REDCap	Aug 1 – Sept 30, 2011
2.2 Assist State in creating data sharing agreements across agencies	Sept 1 – Sept 30, 2011
2.3 Develop data linking protocol for existing databases across systems/agencies for client or family-level IDs	Aug 1 – Sept 30, 2011
Task 3: REDCap Development Work	
3.1 Develop and build REDCap Survey Database with existing or new instruments and import data from one program/agency	Sept 1 – Oct 31, 2011
3.2 Test system with dummy data from different data sources	Oct 1 – Oct 31, 2011
Task 4: Data Reporting	
Generate outcome reports from REDCap from existing features with no editing/writing	Nov 1 – Nov 30, 2011
Task 5: Training and Technical Assistance	
5.1 Conduct hands-on training of staff responsible for direct data collection with families using new or existing technology/methodology	Oct 1, 2011 – Jan 31, 2012
5.2 Conduct training of administrative staff on how to use and/or maintain REDCap	Ongoing
5.3 Providing on-going technical assistance on data collection, data linking, data reporting, and/or data analysis	Ongoing

Status: In final stages of approval.

MCH Epidemiologist

Existing contract with the University of Nebraska Medical Center for the ongoing support of

a doctoral prepared epidemiologist.

PROPOSED CONTRACTS:

Data Manager Coordinator

Business Systems Analyst hired through the State of Nebraska temporary employment pool.

Assessment Forms Developers

To be identified and details developed.

Community Infrastructure Contracts

Details to be developed upon approval of the concept and application.



**healthy
families
america**®

a program of Prevent Child Abuse America

July 11, 2011

228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

Paula Eurek
Lifespan Health Services
Division of Public Health
Nebraska Department of Health and Human Services

Re: Documentation of Approval to Utilize the HFA Model

Dear Paula Eurek:

This letter is in response to the requirement of the FY11 Formula grant as part of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding implementation of the Healthy Families America (HFA) model in Nebraska and any intentions to implement adaptations to the HFA model. **This letter outlines the approval from the HFA national office at Prevent Child Abuse America to use the HFA model in Nebraska (herein referred to as "the State")**. Approval to make adaptation to the model has not been granted as adaptations were not proposed.

We understand that given the continuation funding available in the FY11 Formula Grant through the MIECHV program the State will continue with the goals, objectives and activities in the Updated State Plan (USP) and expand the new program in the Panhandle region (Scotts Bluff, Box Butte, and Morrill counties), enhance infrastructure, and continue to support the implementation of evidence-based home visiting in the above three counties.

Should any additional HFA sites be established in Nebraska at a later time through the MIECHV program, those sites will also affiliate with the HFA National Office. The State agrees that it will assure that each HFA site will pay the required annual fees (\$1,350 in 2011) and purchase necessary HFA training for program staff utilizing national certified HFA trainers. The State is interested in considering the Train the Trainers process to develop in-state capacity in the future. The State has indicated its intent to work in partnership with the HFA National Office to obtain model specific technical assistance and support related to site planning, development, implementation, and accreditation. Technical assistance will be made available to you from the HFA National Office's Southeastern /Western Region Director at no cost via phone and email, and at a cost of \$1,250 per day plus travel for on-site technical assistance. Finally, the State will utilize the Growing Great Kids curriculum, and will secure the necessary curriculum training from the curriculum developers to use within the HFA program site(s).



Prevent Child Abuse America

In order to maintain HFA affiliation and the right to use the Healthy Families America name and to insure model fidelity, the State agrees that within the first 3 years of site affiliation, the program will complete the accreditation process. The State also agrees to complete an annual site survey (distributed by PCA America on an annual basis), and to utilize a data management system to better provide information to the National Office. It is PCA America's intention to affiliate individual program sites and multi-site systems and to authorize use of the name "Healthy Families" and use of variations of the name (i.e., Healthy Families Place, County, or City), provided they are committed to the best practice standards identified by PCA America through research. Should there be any instance that would impede the program's ability to implement the critical elements (such as a loss of funding, etc.), it is understood that it is the program's responsibility to notify PCA America immediately. It is also understood that PCA America is the sole grantee of the right to use the HFA name and/or affiliation with the HFA model. PCA America reserves the right to revoke use of the name, and/or affiliation with the Healthy Families model, at any time before, during, or after the community/program enters the HFA Accreditation process. Finally, once entering the HFA Accreditation process, it is understood that the program will be subject to the policies and procedures of that process.

We are pleased to grant approval to the Nebraska Department of Health and Human Services, Division of Public Health to implement the HFA model. If you would like to discuss this further, I can be reached at kwhitaker@preventchildabuse.org or at 520.297.9158. I applaud your commitment to Nebraska's children and families and look forward to working together in partnership with you.

Sincerely,



Kate Whitaker
Director, Southeastern & Central HFA Region

Cc: Sue Spanhake
Project Coordinator
Nebraska Home Visiting Program

Cydney M. Wessel, MSW
HFA National Director
Prevent Child Abuse America



Prevent Child Abuse America

Nebraska ACA Home Visiting Project - Constructs and Measures

Benchmark 1. Improved Maternal and Newborn Health

Construct	Measurement Tool	Measure	Population Assessed	Numerator	Denominator	Direction of Improvement	Data Source	Timing of Collection	Outcome Type	HFA?
1.1: Prenatal care	Life Skills Progression Scale - Health & Medical Care / Prenatal Care	Percent of women with LSP prenatal care score of 3 or higher	All post-partum women	Number of women with PNC score of 3 or higher	Number of post-partum women	Higher scores in subsequent pregnancies	Self-report, OB/GYN records	3 months post-partum	Outcome	<input type="checkbox"/>
1.2: Maternal depression screening	Center for Epidemiological Studies Depression scale (CES-D)	Percent of women screened for depression	All women with children 0-5	Number of women screened for depression	Number of women	Increase	Self-report	Annually	Process	<input checked="" type="checkbox"/>
1.3: Parental use of ATOD	Michigan Alcohol Screening Test (MAST)	Percent of adults screened for alcohol abuse	All adults	Number of adults screened for alcohol use	Number of adults	Increase	Self-report	Annually	Process	<input type="checkbox"/>
1.4: Preconception care	N/A	Percent of women with one or more primary care visits prior to conception	All women who are pregnant or within 6 months post-partum	Women with primary care visit within 12 months prior to conception	Number of women	Increase	Self-report	Enrollment or once per pregnancy	Outcome	<input type="checkbox"/>
1.5: Inter-birth intervals	N/A	Percent of women with at least 18 months between births	All previously parous women with a post-enrollment birth	Number of women with at least 18 months between births	Number of women	Increase	Vital statistics	At delivery	Outcome	<input type="checkbox"/>
1.6: Breastfeeding	Life Skills Progression Scale - Breastfeeding	Percent of women with LSP breastfeeding score of 1.5 or higher	All women who entered the program prenatally, at delivery, or have a subsequent live birth, through 1 year post-partum	Number of women with a breastfeeding score of 3 or higher	Number of women	Increase	Self-report / observation	Every visit through 12 months post-partum or documented termination	Outcome	<input type="checkbox"/>
1.7: Well-child visits	N/A	Percent of children whose immunization status is current at 15 months	All children 12-15 months	Number of children with full 12 month immunization status by 15 months	Number of children	Increase	Immunization cards; Nebraska State Immunization Information System (NESIIS).	Once per child, between 12 and 15 months	Outcome	<input type="checkbox"/>
1.8: Health Insurance	N/A	Percent of mothers and infants with insurance coverage	All infants and women with children 0-5	Number of infants and women with insurance coverage	Number of infants and women	Increase	Self-report; HV administrative records; DHHS Medicaid.	Annually	Outcome	<input type="checkbox"/>

Nebraska ACA Home Visiting Projects - Constructs and Measures

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

Construct	Measurement Tool	Measure	Population Assessed	Numerator	Denominator	Direction of Improvement	Data Source	Timing of Collection	Outcome Type	HFA?
2.2: Maternal emergency department visits	N/A	Rate of maternal emergency department visits	All women with children 0-5	Number of ED visits in past 12 month period	Number of women	Decrease	Hospital records; trauma registry; self-report	Annually	Outcome	<input type="checkbox"/>
2.3: Prevention information	N/A	Percent of families who have received prevention information	All families	Number of families provided information and/or training	Number of families	Increase	Program records	Annually	Process	<input type="checkbox"/>
2.4: Child injuries requiring medical attention	N/A	Rate of child injuries requiring medical attention	All children 0-5	Number of injury incidents requiring medical treatment	Number of children	Decrease	Self-report; pediatric & hospital records	At least quarterly	Outcome	<input type="checkbox"/>
2.5: Screened-in child maltreatment reports	N/A	Rate of assessed maltreatment reports to children 0-5	All children 0-5	Number of children with one or more screened-in maltreatment reports	Number of children	Decrease	DHHS/Child Protective Services	At least quarterly	Outcome	<input type="checkbox"/>
2.6: Substantiated child maltreatment	N/A	Rate of substantiated maltreatment reports to children 0-5	All children 0-5	Number of substantiated maltreatment reports	Number of children	Decrease	DHHS/Child Protective Services	At least quarterly	Outcome	<input type="checkbox"/>
2.7: First-time maltreatment of program children	N/A	Rate of first time screened-in maltreatment reports to children 0-5	All children 0-5	Number of children with a first-time screened-in child maltreatment report	Number of children	Decrease	DHHS/Child Protective Services	Annually	Outcome	<input type="checkbox"/>
2.1: Child emergency department visits	N/A	Rate of emergency department visits by children 0-5	All children 0-5	Number of ED visits in past 12 month period	Number of children	Decrease	Hospital records; trauma registry; self-report	Annually	Outcome	<input type="checkbox"/>
3.1: Parental support for learning & development	Life Skills Progression Scale - Relationships with Children / Support of Development	Mean maternal LSP Support of Development score	All women with children 0-5	Aggregate maternal LSP relationship score	Number of women	Increase	Self-report / observation	Every visit through 12 months post-partum or documented termination.	Outcome	<input checked="" type="checkbox"/>

Nebraska ACA Home Visiting Project - Constructs and Measures

Benchmark 3. Improvement in School Readiness and Achievement

Construct	Measurement Tool	Measure	Population Assessed	Numerator	Denominator	Direction of Improvement	Data Source	Timing of Collection	Outcome Type	Outcome: HFA?
3.2: Parental knowledge of child development and actual progress	Knowledge of Infant Development Inventory (KIDI)	Mean maternal KIDI child development knowledge score	All women with children 0-5	Aggregate maternal KIDI score	Number of women	Increase	Self-report	At least quarterly	Outcome	<input type="checkbox"/>
3.3: Parenting behaviors and parent-child relationship	Family Stress Checklist	Mean maternal FSC parenting score	All families	Aggregate maternal FSC parenting score	Number of women	Decrease	Self-report	Quarterly	Outcome	<input checked="" type="checkbox"/>
3.4: Parental emotional well-being	Family Stress Checklist	Mean maternal FSC stress score	All women with children 0-5	Aggregate maternal FSC stress score	Number of women	Decrease	Self-report	Quarterly	Outcome	<input checked="" type="checkbox"/>
3.5: Child's communication level	Ages & Stages 3	Percent of children 4-60 months screened for communication delays and referred if indicated	All children 4-60 months	Number of children assessed and referred if above cutoff (TBD)	Number of children	Increase	Maternal report/ observation	Quarterly	Process	<input checked="" type="checkbox"/>
3.6: Child's cognitive skills	Ages & Stages 3	Percent of children 4-60 months screened for cognitive delays and referred if indicated	All children 4-60 months	Number of children assessed and referred if above cutoff (TBD)	Number of children	Increase	Maternal report/ observation	Quarterly	Process	<input checked="" type="checkbox"/>
3.7: Child's positive approach to learning	Ages & Stages - Social Emotional	Percent of children 4-60 months screened for learning and referred if indicated	All children 4-60 months	Number of children assessed and referred if above cutoff (TBD)	Number of children	Increase	Self-report/ observation	Quarterly	Process	<input checked="" type="checkbox"/>
3.8: Child's social behavior and emotional well-being	Ages & Stages - Social Emotional	Percent of children 4-60 months screened for emotional well-being and referred if indicated	All children 4-60 months	Number of children assessed and referred if above cutoff (TBD)	Number of children	Increase	Self-report	Quarterly	Process	<input checked="" type="checkbox"/>

Nebraska ACA Home Visiting Project - Constructs and Measures

Benchmark 3: Improvement in School Readiness and Achievement

Construct	Measurement Tool	Measure	Population Assessed	Numerator	Denominator	Direction of Improvement	Data Source	Timing of Collection	Outcome Type	HFA?
3.9: Child's physical health & development	Ages & Stages 3	Percent of children 4-60 months screened for health and development and referred if indicated	All children 4-60 months	Number of children assessed and referred if above cutoff (TBD)	Number of children	Increase	Self-report	Quarterly	Process	<input checked="" type="checkbox"/>
4.1: Screening for domestic violence	N/A	Percent of women screened for domestic violence	All adult women	Number of women screened for domestic violence	Number of women	Increase	PIMS / Administrative screening data; observation	Annually	Process	<input type="checkbox"/>
4.2: Referrals for domestic violence services	N/A	Percent of women who screened positive for domestic violence who are referred for services	All adult women	Number of referrals made for women screening positive for DV	Number of women screening positive for DV	Increase	PIMS / Administrative screening data	Annually	Process	<input type="checkbox"/>
4.3: Domestic violence - Safety Plan	N/A	Percent of women who screened positive for domestic violence who have a completed safety plan	All adult women	Number of women who screened positive for DV with a completed safety plan	Number of women screening positive for DV	Increase	PIMS / Administrative screening data	Annually	Outcome	<input type="checkbox"/>
5.1: Household Income and benefits	Missouri Community Action Family Self-Sufficiency Scale - Income	Mean household MCAFSS income score	All families	Aggregate household income score	Number of households	Stable or improving	Self-report; administrative records	Enrollment and annually	Outcome	<input type="checkbox"/>
5.2a: Employment of adults	Missouri Community Action Family Self-Sufficiency Scale - Employment	Mean household MCAFSS employment score	All families	Aggregate household employment score	Number of households	Increase	Self-report; administrative records	Quarterly	Outcome	<input type="checkbox"/>
5.2b: Education of adults	Missouri Community Action Family Self-Sufficiency Scale - Education	Mean household MCAFSS educational score	All families	Aggregate household education score	Number of households	Stable or increasing	Self-report; administrative records	Enrollment and annually	Outcome	<input type="checkbox"/>

Nebraska ACA Home Visiting Project - Constructs and Measures

Benchmark 5: Improvements in Family Economic Self-Sufficiency

Construct	Measurement Tool	Measure	Population Assessed	Numerator	Denominator	Direction of Improvement	Data Source	Timing of Collection	Outcome Type	Outcome HFA?
5.3: Health insurance	N/A	Percent of household members with insurance coverage	All household members	Number of household members with insurance coverage	Number of household members	Increase	Self-report; HV administrative records; DHHS Medicaid.	Enrollment and annually	Outcome	<input type="checkbox"/>
6.1: Families identified as requiring services	N/A	Percent of families that are positive for need	All families	Number of families needing services	Number of families	Decrease	Program administrative data	Annually	Outcome	<input type="checkbox"/>
6.2: Families receiving referrals	N/A	Percent of families with positive need that receive appropriate referrals	All families	Number of families identified with need and receiving a referral	Number of families identified with need	Increase	Administrative data	Annually	Process	<input type="checkbox"/>
6.3: MOUs with community social services agencies	N/A	Number of MOUs	N/A	Number of active MOUs	-	Increase	Administrative records	Annually	Process	<input type="checkbox"/>
6.4: Agencies sharing information with HV provider	N/A	Number of agencies with documented sharing arrangements	N/A	Number of agencies sharing information	-	Increase	Administrative records	Annually	Process, Outcome	<input type="checkbox"/>
6.5: Completed referrals	N/A	Percent of referrals that are completed	All families	Number of completed referrals	Number of referrals made	Increase	Administrative records	Annually	Process	<input type="checkbox"/>