

**Kansas Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program
Competitive Development Grant Proposal
Project Narrative**

I. INTRODUCTION

Project Purpose: In the 2011 Kansas Updated State Plan for the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program, the established goals are to: (1) Deliver a coordinated, integrated system of evidence-based home visiting programs with high model fidelity and quality to families with pregnant women and children (0-5) in at-risk communities; (2) Effectively engage and retain underserved, hard-to-reach populations in home visiting services; and (3) Utilize a coordinated, integrated system to determine outcomes and quality of home visitation programs. The purpose of the Kansas MIECHV Development Project is to further augment these primary goals with innovative strategies so that high quality home visiting programs are able to better improve the health and well-being of at-risk pregnant women, infants and young children, and their families. This project will develop and evaluate new elements of the programs, coordinated community systems, and state systems that will contribute to successful implementation, expansion, and sustainability of evidence-based home visitation services.

More specifically, this project will seek to further saturate identified high need communities with needed home visiting services by further increasing the number of home visitors and families served in the two currently targeted areas and will expand to two more high risk counties in rural southeast Kansas. To develop additional capacity and improve quality of home visiting services, coordinated and centralized screening and referral systems will be expanded in these areas as well. Innovative approaches will be implemented to improve engagement and retention of vulnerable families in home visiting services including those of diverse cultures and languages, and to enhance practices and interventions for serving families with mental health and/or substance use problems.

Strategies for integrating the system of home visiting services with the early childhood system and to build infrastructure and sustainability at both the state and community levels will be further developed. To promote innovative cross-systems collaboration, the Kansas MIECVH Program will partner with the Missouri MIECHV Program and Children's Mercy Hospital to address challenges to services in the bi-state Kansas City metropolitan area with the objective of creating and piloting a coordinated cross-state metro area network of home visiting programs linked with the medical home setting. A utilization-focused evaluation will be conducted to yield lessons learned about developing an integrated model of home visitation programs, practices that enhance quality services to vulnerable families and improve maternal and child outcomes, and documentation of the steps and criteria to replicate and expand similar systems.

Building a High-Quality Home Visiting Program in Kansas: Kansas has an array of existing maternal, infant and early childhood home visiting programs that support pregnant women and families with young children. The State recognizes that families have needs on a continuum of risk and services should be provided along the continuum to meet their individual needs. Evidence-based home visiting programs that serve multiple locations across Kansas' 105 counties include:

The **Kansas Early Head Start (KEHS)** program began in 1998 and is a national model serving at-risk infants and toddlers through home-based and center-based services. KEHS was implemented using Child Care and Development Block Grant (CCDBG) quality set-aside dollars augmented by the transfer of federal TANF funds. In recent years, state general revenue funds and Children's Initiatives dollars from the state's tobacco settlement have expanded the program. KEHS is administered by the Kansas Department for Children and Families (DCF; previously the Department of Social and Rehabilitation Services) under the Economic and Employment Services Division. This division also administers the State Head Start Collaboration Program. KEHS provides comprehensive services following federal Head Start Program Performance Standards for pregnant women and eligible families with children from birth through age 3. Fourteen Kansas-administered grant-funded EHS programs serve 48 Kansas counties and 1,006 enrolled slots for pregnant women and young children. Some local program agencies also receive federal funds. KEHS also works to increase the number of infant/toddler child care slots in communities and partners with existing community-based child care providers to improve the quality of child care available for infants and toddlers. The KEHS programs are required to partner with existing child care providers to provide center-based services to families who are employed, attending school, or in job training. All KEHS child care partners must meet both Kansas Child Care Licensing and federal Head Start Program Performance Standards.

Healthy Families America (HFA) programs are administered by the Kansas Children's Service League (KCSL). A statewide not-for-profit agency, KCSL has a 119 year history with the mission of strengthening the quality of family life through the provision of prevention, early intervention, treatment, advocacy, and placement services. The agency serves as the Kansas Chapter of Prevent Child Abuse America; has achieved national accreditation from the Council on Accreditation and Healthy Families America; and is a member of the Alliance for Children and 8 United Way agencies across the state. KCSL has demonstrated experience in the area of early childhood services with more than 30 years administering Head Start and Early Head Start services in 13 Kansas counties as well as 15 years administering HFA. Currently, HFA services are provided in 18 counties of Kansas which include the targeted MIECHV Program communities. To ensure model fidelity, KCSL is a HFA Multi-Site System and programs are currently affiliated with the HFA National Office. HFA accreditation is current through March 2013.

Parents as Teachers (PAT) is a program administered since 1990 by the Kansas State Department of Education (KSDE). PAT is in the Early Learning Services Unit which advances the provision of high quality early childhood and family services that result in the ability of all young children to succeed in school and life. KSDE provides grant funding to local school districts, or consortiums of school districts, statewide to implement PAT for families during pregnancy or with children from birth to age 3. Local school districts match \$0.65 for every state \$1.00. PAT programs are in 180 Kansas school districts covering portions of nearly 80 counties. The KSDE PAT State Program Consultant serves as a liaison with both the PAT National Office and local programs. This includes coordinating the implementation of the national model in Kansas and providing leadership, technical assistance and training, model fidelity, continuous quality improvement, reporting and evaluation. Kansas has a state team of certified PAT trainers who, in 2011, provided trainings statewide in accordance with the new PAT Foundational Curriculum, the updated research-based curriculum and approach to working with families. Kansas PAT programs are affiliates of the PAT National model.

Other Home Visiting Programs. The Part C Infant Toddler Services early intervention program to help families whose children have developmental delays or disabilities is provided in all counties and delivers some services via home visits. Many local public health departments offer *Healthy Start Home Visitors*, a program of paraprofessional or lay home visitors providing universal outreach services to pregnant women and women with infants up to age one, with one to a few home visits. A recent addition to Kansas is Save the Children's Early Steps to Success, a literacy-focused program provided by paraprofessional home visitors that has commenced implementation in several southeast Kansas counties and will be in Wyandotte County soon.

Integration with Early Childhood Systems and Funding. Kansas has spent the last decade building and funding a strong early childhood system that is focused on health, mental health, early care and education, parent education, and family supports. From prenatal services through kindergarten transition, Kansas early childhood partners have committed to providing high quality, coordinated services to support young children and their families. Statewide initiatives, including the Kansas Early Childhood Comprehensive Systems (KECCS) Plan and the Child Care Development Fund (CCDF) have provided the framework and infrastructure to support collaboration and coordination among partners. State General Funds are dedicated to providing 4 Year Old At Risk Preschool programs throughout the state. The Kansas Children's Cabinet and Trust Fund is a key State partner and instrumental in distributing funds through Tobacco Settlement monies to early childhood programs across the state, including home visitation. Other initiatives have leveraged federal funds or private foundation support to sustain home visiting in Kansas.

Home visiting partners in the State have a strong history of cooperation and coordination and are generally well connected, sharing training, partnering on grant-writing, and working together on the KECCS Plan; the Kansas Strengthening Families Plan; the development of the Kansas Early Childhood Advisory Council (ECAC); the Kansas School Readiness Framework; as well as the MIECHV Program. Also, these programs are leaders, along with partners in child care, mental health and special needs, in the Kansas Early Learning Collaborative, which is building systems of services at the state and community level for pregnant women and children 0-3, as well as in statewide advocacy efforts and other initiatives.

Kansas has emphasized implementation of **high quality, evidence-based practices**. Partnerships with researchers in higher education assist agencies and communities in addressing fidelity in implementation. Standards for professionals (Core Competencies for Early Care and Education Professionals in Kansas and Missouri and Early Childhood Unified Teacher Licensure) and for child development (Kansas Early Learning Document) guide quality development in early care and education programs. Early childhood program partners adhere to increasingly strict quality standards, including individual program standards and those set by state policy and research including the Kansas Quality Rating System (KQRS) and the National Institute for Early Education Research (NIEER) standards. Research based standards are the foundation for progress toward a statewide system for professional development and continuous quality program improvement.

The KECCS Plan has resulted in significant collaboration and cross-agency initiatives at the state and local level and it is funded through federal HRSA funds. Goals of the KECCS Plan are to: (1) ensure that all Kansas children have health insurance and access to medical providers; (2) fully integrate mental health and social-emotional development into the early childhood system in Kansas; (3) develop a comprehensive and coordinated early childhood care and education system in Kansas birth-5; (4) educate and mentor parents about childhood health,

development, and education; and (5) promote a system that helps families develop and utilize both intellectual and material resources to prepare their children for school and life. The KECCS Plan utilizes school readiness as a bridging framework to create a statewide, unified effort for investing in Kansas through investing in our children.

In 2008, the Kansas Legislature approved \$11 million in funding for an **Early Childhood Block Grant** (ECBG). Administered by the Kansas Children's Cabinet and Trust Fund, the ECBG targets services and programs for at-risk and underserved infants, toddlers and their families. All applicants are required to incorporate the KECCS Plan goals and objectives in the proposed services, ensuring continued coordination of services across the State. This funding is now in its fifth year and supports, among other programs, home visiting services. ECBG funding has been used in the development of an endorsement system for practitioners working with infants and toddlers through the Kansas Association of Infant and Early Childhood Mental Health. Also funded is an Infant Toddler Recruitment Program implemented through the Kansas Child Care Resource & Referral network to recruit and support quality caregivers and slots for the 0-3 population.

In 2012, the School Readiness Data Task Force completed work on the updated Kansas School Readiness Framework emphasizing the broad context in which school readiness occurs from birth to five within communities, educational environments, families and children. These components function as interdependent systems of support that have multi-directional influences. The framework incorporates policy, funding and systems that support school readiness. Indicators and data elements were identified to be used in incorporating early childhood programs including home visiting into the State's Longitudinal Data System to connect with K-12 data and beyond providing for data based decisions to positively impact the early childhood system in Kansas. KSDE has dedicated significant resources to the development of a web-based application incorporating the work of the SR Data Task Force that will collect demographic and outcomes of children, families, service delivery and access to selected community resources to inform future state and local policy and further assist the work in program coordination and collective impact.

Statewide Collaboration on Home Visitation. Regular communication among partners on specific projects, such as home visiting and early childhood mental health, provide an avenue for coordination and information sharing. For KECCS, quarterly Early Childhood Forums are convened and attended by a broad group of individuals in the early childhood field. Additionally, The Home Visitation Training Workgroup guides statewide cross-agency staff training programs (such as the Kansas Basic and Advanced Home Visitation Trainings) through a Department for Children and Families contract administered by the Kansas Head Start Association.

The Workgroup met several times from March 2010 to April 2011 convened by the Kansas Head Start Association. The group grew from the Kansas Home Visitation Training Task Force to include a broader range of state and community stakeholders. The initial meetings focused on the growing interest in home visiting by the federal government and other organizations, anticipation of and preparation for Kansas' needs assessment and application for the federal MIECHV Program funding, and discussion and work on a preliminary framework statement for a system of evidence-based services. The Task Force crafted vision and mission statements as follows:

Vision

Home visiting in Kansas is available to all families with young children through a continuum of evidence-based, integrated services.

Mission

The Kansas Home Visiting Task Force promotes home visiting as an effective method for meeting the needs of families with children prenatally to age 5. The Task Force works to improve the integration and quality of home visiting services through Planning and Policy Development, Professional Development, and Resource Development.

Now, the Kansas MIECHV Program, in partnership with KECCS, is taking steps to re-convene the task force and/or other networking opportunities specific to coordinating the state system of home visiting services. In June and July 2012, a survey was distributed statewide to solicit input on interest, preferences for participation, and topics and purposes for meetings or other types of communication. Responses to the survey were robust and will be used to guide planning over the coming months.

All of the partners believe that the Kansas MIECHV Program will enhance these efforts as well as strengthen and create partnerships between early childhood and prevention professionals to deepen the quality and reach of home visitation services. This coordination informed the development of the MIECHV state plan and the identified need to support and expand home visiting programs as part of the KECCS plan and ultimate goal of a statewide comprehensive, integrated early childhood system. Throughout the planning and implementation process, the Kansas MIECHV Program has established strategies to develop close connection with the local and statewide early childhood programs, plans and initiatives which will facilitate integration of the planned project. The MIECHV partners have been and will continue to be active partners in the development, implementation and coordination of all Kansas early childhood plans and initiatives. State and local partners also saw that there was much more needed to truly transform the home visiting system and further develop high quality services to those most at risk. State and local partners determined that the best approach for a coordinated, comprehensive state plan is to build on the strong foundation of evidence-based home visiting programs already in place given the existing commitment to support these programs and their likelihood to yield more geographical coverage with a higher level of fidelity. These established programs and their experienced, trained staff will facilitate timely and cost-effective implementation for the MIECHV Program as well as future development and expansion.

MIECHV Implementation. Implementation of the Kansas MIECHV Program and State Plan objectives is well underway. The State's MIECHV formula funds are dedicated to constructing coordinated, integrated systems of evidence-based home visiting programs with high model fidelity and quality to families with pregnant women and children (0-3) in two targeted high-need, high-risk areas - Wyandotte County (urban Kansas City, Kansas) and Montgomery County (rural southeast Kansas). Established EHS, HFA, and PAT evidence-based home visiting programs in each of these counties have hired additional home visitors to increase the number of families with identified risks served. Also in Wyandotte County, a promising

approach serving pregnant and postpartum women affected by alcohol or other drugs, the Team for Infants Endangered by Substance Abuse (TIES) Program, is being added to the delivery system and will be rigorously evaluated. Specific attention across all of the home visiting programs is on enhancing the capacity of program staff to effectively address substance abuse and mental health concerns in families they serve. A new coordinated, centralized outreach and referral system has been developed and launched in Montgomery County while the capacity of the current Wyandotte County system is being enhanced. The involved home visiting programs have received training on screening and assessment tools and specific topics such as substance abuse, mental health, and domestic violence. A comprehensive, cross-program data collection and reporting system and common indicators and measures for required benchmarks and continuous quality improvement have been constructed. Procedures for monitoring fidelity and quality assurance are being coordinated across the various program models. Taken in total, Kansas has the beginning of a robust home visiting infrastructure in the highest need communities but additional innovations are required to more effectively identify and meet the needs of at-risk families with children birth to 5.

The Problem: The Kansas Needs Assessment for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program submitted in September 2010 reported that even with the existing programs, Kansas home visiting services are insufficient to meet the needs of pregnant women and families with children from birth to 5 who experience multiple stressors and risks. Most counties in Kansas have at least one home visiting program and not all models are available in every county. This means that some counties must take a ‘one size fits all’ approach to home visiting services with the community families. Lacking a true continuum of services designed to meet different needs of families including at risk families, communities are not able to optimize resources that will best impact outcomes. Due to the lack of access to a continuum of home visiting services, families do not always receive the intensity or frequency of visits that is needed. In addition, most home visiting programs operate at full caseload capacity with waiting lists for services. In those communities with multiple home visiting models, there are inherent challenges. Effectively implementing multiple models and coordinating services between each model and with multiple community partners requires additional resources and effort to develop an efficient and high quality system of home visiting services.

For all home visiting models, the engagement and retention of parents is a significant challenge that can influence how effective home visiting services are in producing optimal outcomes for families and children. Programs in both the Kansas City, Kansas urban area and the very rural areas of southeast Kansas experience difficulty in reaching, enrolling, engaging, and retaining at-risk families in services. Failure to engage families occurs for a variety of reasons including a lack of understanding and trust in agency services, and intermittent phone service, frequent moves and family crises making it difficult to provide regular and consistent home visiting service. Other reasons are distinct to the broader cultures and attitudes present within local communities. Innovative and effective engagement strategies are necessary to better reach those in need and to ensure that families become engaged in services that are designed to improve individualized family goals.

The home visiting programs in the target communities particularly struggle with engaging and retaining families experiencing substance use and/or mental health concerns. The MIECHV programs involved in Wyandotte County and Montgomery County have reported various challenges including limited access to mental health and substance abuse treatment

services or clinicians that serve families with very young children. Access and affordability of, as well as poor parent motivation and the stigma associated with accessing these types of services, make it difficult to have a serious impact on the delivery of home visiting model components including implementation of research-based curriculum and critical relationship building with the family. Addressing crisis issues related to mental health and substance use often consume a home visitor's time, ability, and capacity, and compromise the achievement of their other program activities and objectives.

Evidence-based home visitation programs in Kansas require staff that are responsive to the unique and multiple cultural and linguistic variances of the families they serve. In Wyandotte County, for example, a growing population of Somali refugees has challenged home visiting efforts to build relationships within this new community and to develop effective outreach to those in need of home visiting services. In southeast Kansas, rural poverty often influences issues of trust with outside agencies, making it difficult to build relationships between home visitors and wary families. Programs must work with diverse populations to provide services in a way that represents and respects their culture. Language and cultural barriers have a significant impact on access to health care and social services (Timmons, 2002). Appropriate services are needed including services in native languages and services tailored to immigrants. Diversity of home visitors and continuous staff training and reflection can begin to address this issue and will be goals for home visiting expansion.

Within a large community such as Wyandotte County or within a multi-county region such as southeast Kansas, it is crucial to develop a network of partners and coordinate their efforts to identify, outreach, and refer at risk populations for home visiting services. This helps avoid duplication of services and ensures at risk families do not fall through the referral cracks. Coordinated, centralized outreach and referral processes across home visiting programs and other maternal and early childhood services need to further scale up and refine practices in order to effectively reach and refer vulnerable families to home visiting services that are most likely to positively impact family goals and program outcomes. Furthermore, home visiting programs and other early childhood and health services in Kansas City, Kansas, face long-standing, historical challenges and gaps in coordination across the Missouri state line and multiple county jurisdictions that compose the greater Kansas City metropolitan area. Rural counties such as in southeast Kansas also have substantial challenges with limited services and resources while attempting to reach isolated families and cover substantial geographic areas. This lack of coordination limits the ability to optimize the impact of home visiting programs. Developing and effectively implementing a systems-level approach will address these issues.

Currently, Kansas has multiple training/professional development sub-systems for early childhood service providers that are primarily siloed by type of early childhood program (i.e., child care and special education). These include a statewide home visitation training curriculum for cross-agency basic and advanced home visitor training. Professional development and training is woven throughout the KECCS Plan and a goal of the newly instituted ECAC is to support early childhood professionals in ongoing education, training, and career advancement through a coordinated professional development system. Further planning and actionable steps are needed to develop a coordinated, comprehensive system of professional development resources for home visiting programs that are tied to essential competencies and quality outcomes, and integrated with the state's other early childhood initiatives.

The State of Kansas has made substantial investments in early childhood programs including home visiting services. Early childhood advocates have been very successful in

maintaining funding for programs and services despite the challenges of the nation's and State's economic downturn. These advocacy efforts have demanded a great deal of time and energy from partners across the state. Kansas has strong networks of evidence-based home visiting programs yet still has many challenges to build a strong and enduring statewide system of support. Developing a coordinated vision of home visitation within the early childhood systems can help guide the most effective use of resources and collaborative strengths to meet the increasing demand for services for at risk populations. Strategic planning and collaboration is essential to address current and future infrastructure and sustainability for the statewide system of home visiting services as well as the broader early childhood system.

Taken together, Kansas has demonstrated challenges in fully and effectively implementing multiple home visiting models in the targeted communities with the highest at-risk populations. This development proposal seeks to focus attention and implement innovative enhancements to the existing home visiting system that improve quality of services and outcomes for families and improve engagement and retention of families into evidence-based home visiting programs that meet family goals and MIECHV outcomes.

Proposed Intervention: With substantial consideration and input from state and community partners, the Kansas MIECHV development project will focus on the following proposed interventions and expected benefits. More specific information is contained in the *Methodology* and *Work Plan* sections. The **first activity** of this project is to further develop and improve evidence-based home visiting programs in the targeted at-risk communities. The EHS, HFA, and PAT programs will add home visitors and thus the number of vulnerable families served in Wyandotte County/Kansas City and Montgomery County. In addition, programs will expand in two more high risk counties in rural southeast Kansas (Cherokee and Labette). The promising approach program, TIES, will also expand in Kansas City, Kansas. Coordinated screening and referral systems will be expanded and further refined in the targeted areas as well, with new outreach services in Cherokee and Labette counties. ***Anticipated Benefit.*** This will support each community as they build the home visiting capacity to serve a larger number of high risk families. Communities will further develop coordination as a system of services identifying and implementing effective strategies.

The **second activity** involves developing and implementing innovative approaches to improve engagement and retention of vulnerable families in the MIECHV programs including those of diverse cultures and languages, and to enhance practices and interventions for serving families with mental health and/or substance use problems. Home visiting program staff will receive additional, effective training to increase competencies and skills on identifying, referring, communicating with, and supporting families of various cultures and those experiencing substance use, mental health, trauma and violence. Programs will increase effective incorporation of bilingual staff, interpreters, and effective practices culturally respectful of the families they serve. Consultation and technical assistance to determine and develop social marketing strategies and tools appropriate for the local populations will be utilized. Home visiting staff will receive training in Motivational Interviewing (MI; Miller & Rollnick, 2002) to increase parent engagement and retention, and to improve behavior change and use of home visiting and other services including mental health and substance abuse treatment. In Wyandotte County, participating women screened positive for perinatal depression will be referred to the *Moving Beyond Depression* In-Home Cognitive Behavioral Therapy program (IH-CBT; Ammerman et al., 2007). Also, programs will be provided opportunities to participate in

reflective supervision groups and receive mental health consultation. **Anticipated Benefit.** Implementation drivers associated with staff training and supervision to improve quality and effective practices, and innovative approaches to improve home visiting services that meet the needs of vulnerable families will improve outcomes for families and children.

The **third activity** is the further development and coordination among and between systems of home visiting, early childhood, and ancillary services will occur. Linkages and referrals between home visiting programs and mental health and substance abuse treatment providers will be strengthened. For the bi-state Kansas City metropolitan area, collaboration building and strategic planning processes with Children’s Mercy Hospital and the State of Missouri’s MIECHV Program will be undertaken to create a coordinated system that will support the numerous home visiting services, establish firm linkages to the medical providers, break down barriers across state and county lines, and improve outreach and outcomes to at-risk populations. The MIECHV Program will work with partners to inform and craft a more coordinated professional development system including identifying common standards and resources for cross-program, cross-discipline training in Kansas. Finally, more explicit plans and strategies will be developed and pursued to integrate the system of home visiting services with the state’s early childhood system and to build infrastructure and sustainability at both the state and community levels. **Anticipated Benefit.** Coordinated community and state systems will contribute to successful implementation, expansion, and sustainability of evidence-based home visitation services which will collectively impact improved outcomes for high needs families with pregnant women and young children.

Programmatic emphasis: Seven of the eight programmatic areas of emphasis will be addressed to build on and enhance the Kansas MIECHV Program as follows:

Programmatic Emphasis	Proposed Activities
<i>Emphasis 1: Improvements in maternal, child, and family health</i>	Increase the capacity of programs to screen, support, and link families to maternal and child health, mental health, and substance abuse treatment resources. Add in-home cognitive behavioral therapy intervention to reduce maternal depression and related mental health concerns in Wyandotte County. Facilitate collaboration and planning with Children’s Mercy Hospital toward an integrated delivery network of home visiting programs and primary care medical providers
<i>Emphasis 2: Effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.</i>	Implement and increase capacity of EHS, HFA, and PAT evidence-based home visiting programs, and the TIES promising approach with fidelity to their models. Implement strategies to recruit, engage, and retain participants by reducing barriers and challenges with mental health and substance abuse concerns, hard-to-reach underserved populations, and diverse cultures and languages. Add training and tools, reflective supervision, and consultation to strengthen the programs’ capacity to screen, respond to, and refer high-need families. Cross-model activities, evaluation, and continuous quality improvement to build strong State and local capacity for implementation.

<i>Emphasis 3: Development of statewide or multi-State home visiting programs</i>	Develop, refine, and test innovative approaches in the targeted communities in a cross model and cross system manner to inform strategies and efforts for high quality statewide standards and infrastructure. Collaborate with the Missouri MIECHV Program and Children’s Mercy Hospital to address challenges and needs of the bi-state Kansas City metropolitan area.
<i>Emphasis 4: Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum</i>	Collaborate with other early childhood system partners and initiatives to create and improve the availability of a coordinated, comprehensive system of professional development for cross-program, cross-discipline training. Coordinated strategic planning and development of centralized screening and referral systems in the targeted counties to enhance service delivery and support positive child and family outcomes.
<i>Emphasis 5: Outreach to high-risk and hard-to-engage populations.</i>	Improve outreach to high risk and hard-to-engage populations by developing and enhancing strategies to facilitate outreach, engagement, and retention of the most vulnerable families, particularly mothers experiencing substance use and/or mental health issues and families from diverse cultures and languages.
<i>Emphasis 7: Outreach to families in rural or frontier areas.</i>	Focused outreach and home visiting services to families in rural southeast Kansas including currently targeted Montgomery County and the addition of Cherokee County and Labette County.
<i>Emphasis 8: The development of fiscal leveraging strategies to enhance program sustainability.</i>	Plan and implement strategies for fiscal leveraging with home visiting and early childhood systems partners, such as expanding public/private partnerships, establishing Medicaid reimbursement, maximizing state and federal funding streams, and braiding funding across various sources. Sustainability planning for effective evidence-based home visiting services within a comprehensive system.

II. NEEDS ASSESSMENT

The following section provides extensive background on the issues facing Kansas communities that are implementing home visiting services for families with children birth to age five. To address those issues, the Kansas MIECHV state and local partnership has developed innovative intervention recommendations that will be described in this proposal that the State has the capacity and expertise to carry out in target communities. Given the emphasis on targeting services to those most in need, we provide comprehensive data on the characteristics of the selected high-risk communities. Furthermore, we overlay risk data with a capacity analysis to examine the current depth and breadth to which home visitation services reach our target population of at-risk families. This analysis includes estimates on the number of families that will be served through this development project. Finally, we outline how the proposed emphasis

areas will assist in reaching program outcomes and how the proposed activities that are grounded in current research and supported by evidence. Taken together, this section will demonstrate that the State has chosen the appropriate interventions for these communities based on risk, need, and capacity to achieve positive child, family, and system outcomes.

Selected Communities to Be Served: To assess the characteristics of the target communities, we built upon the State of Kansas Needs Assessment for the MIECHV Program submitted September 2010. The Needs Assessment identified several communities with high concentrations of risk factors for pregnant women, infants, and children. County-level data were used because most Kansas data are collected and reported at the county level. Of these, **Wyandotte County**, which includes urban Kansas City, KS, and **Montgomery County**, one of a cluster of primarily rural high risk counties in southeast Kansas, were chosen for initial implementation of MIECHV programs. While Montgomery County was selected for initial implementation due to current availability of federal funds and to build a foundation of success, the Kansas state plan calls for taking a multi-county approach in southeast Kansas.

In light of the goal to expand existing home visiting services, the State Home Visiting Workgroup recommended that continued and further need in the communities receiving MIECHV program formula funds be examined as well as the readiness of other possible communities in a high need area of southeastern Kansas. To this end, the first step for this updated needs assessment was to identify areas of the State with populations of pregnant women, infants and children with the highest risks for poor maternal and child outcomes. The methodology used to prioritize communities at highest risk involves ranking communities on indicators of (a) the overall health of each community (i.e., behavioral, social and environmental determinants of health and poor health outcomes); and (b) the health and well-being of pregnant women, infants, and children. Data sources for rankings and risk indicators were the same as those used in the September 2010 Needs Assessment and were updated with most recent data available. Data sources for the risk indicators are identified in Attachment 1, Table 1.

Heat Mapping by Risk Factor. Using updated risk data, we created a visual heat map that simultaneously presents risk factor data across the selected communities and the comparative ranking of those risk factors. See Attachment 1, Table 1. Shading of cells indicates increased risk factor levels in comparison to the State average. The darkest shading indicates that the county ranks worse compared to the State average and the other target counties. Lighter or no shading indicates the county ranking is equal to or better than the State level. This heat map 1) provides detailed county-level information regarding risk by factor in comparison to the State levels, and 2) helps us determine which county(s) among several high need counties should be targeted for additional services under this development grant.

The counties that were assessed include Wyandotte County (WY Co) in northeast Kansas and in southeast Kansas, Montgomery County (MG Co), Bourbon County (BB Co), Cherokee County (CK Co), Crawford County (CR Co), and Labette County (LB Co). This heat map shows that Wyandotte County is the highest need county, ranking worse than the State or other counties on 12 of 21 risk factors, continuing to confirm the 2010 Needs Assessment findings. Indeed, Wyandotte and Montgomery counties both were among the worse five counties in health outcomes (i.e., mortality and morbidity) and factors (i.e., health behaviors, clinical care, socio-economic factors, and physical environment).

Capacity and Service Need Assessment. Next, an in-depth county capacity and service need assessment was conducted. In order to estimate the number of families reached by home

visiting programs in the targeted communities we adopted a method by which we 1) determined potential impact of risk factors on children in a given community, and 2) examined coverage/reach of existing home visiting services relative to need. In the initial step, we derived estimates by county of total number of children birth to age four who would be affected one or more maternal or child risk indicator (i.e., product of population age birth to age four multiplied by % affected by a given risk indicator). It should be noted that the data presented in all figures in Attachment 1 assume risk indicators are mutually exclusive; however, we acknowledge the comorbidity between risk indicators is high. Unfortunately, data on overlap between risk indicators are unavailable and thus cannot be represented here. The bar graphs in Attachment 1 (Figures 1-4) show the estimated number of children affected by each of several maternal risk factors in the target communities.

Next, estimates of children affected by risk factors were used along with current home visiting programs' caseload capacity to determine potential number of children reached by home visiting services. Every Child Succeeds, a program of Cincinnati Children's Hospital Medical Center utilizing two home visiting models (*Healthy Families America* and *Nurse-Family Partnership*; Ammerman et al., 2005; 2007), identified four risk factors that are substantially related to adverse parenting. At least one of the four risk factors must be met to be eligible for home visiting services: mothers who are unmarried, have inadequate income, are under 18, and/or have engaged in little to no prenatal care. As such, we use these eligibility risk factors to determine potential at risk population unserved by existing home visiting programs.

We based the number for potential families served on highest number of children affected by any given risk factor. In Wyandotte County and the southeast Kansas counties, about half of children were born to unmarried mothers, making this the most substantial risk factor for these counties. Using this risk indicator, existing home visiting service slots (MIECHV and otherwise) were overlaid with estimates of need to capture potential unmet need in these communities. The pie graphs and tables (Figures 5-8) in Attachment 1 display estimated total families served/unserved in target communities and existing caseload capacity.

The data show that potential unmet need in the four target counties was substantial. It is clear that the need for services in Wyandotte County is very extensive; only about 12% of families in need are expected to receive home visiting services in FY2013 based on current funding. In the predominately rural counties of southeast Kansas, substantial unmet need is also evident. Only 33% of at-risk families in Montgomery County, 23% in Cherokee, and 11% in Labette are expected to receive services in FY 2013. These data illuminate the extreme need for development and expansion of services in these four target counties. Since multiple counties in southeast Kansas continue to show high need, additional local collaborative input was sought to choose where to target development services under this proposal. The Montgomery County MIECHV team, of which most of the home visiting providers also serve other southeast Kansas counties, considered current infrastructure, resources, challenges, and readiness. Based on the unmet needs and capacity to further develop, Cherokee County and Labette County have been selected for expansion and the Kansas development project will dedicate funds to Cherokee and Labette counties to improve collaboration among partners and develop centralized outreach and referral systems to work toward meeting need in these counties. Following are more specific descriptions, needs, and resources in the targeted community areas.

Southeast Kansas Counties. Montgomery County, Cherokee County, and Labette County are in the far southeast corner of Kansas bordering Oklahoma. Cherokee County also shares a border with Missouri. Population data are summarized in Table 2.

Table 2. Southeast Kansas Counties Population

	Montgomery Co	Labette Co.	Cherokee Co.	State
Population 2010	35,471	21,607	21,603	2,853,118
White Non-Hispanic	80.9%	85.3%	88.9%	77.8%
Black Non-Hispanic	5.9%	4.7%	0.8%	6.1%
Hispanic/Latino (any race)	5.3%	4.1%	2.2%	10.8%
American Indian Non-Hispanic	3.4%	2.2%	3.9%	1.2%
Other	0.7%	0.5%	0.7%	2.5%
Two or more races	4.6%	4.0%	3.9%	2.7%
Children under 5 years	6.7%	6.5%	6.1%	7.1%
Live births in 2010	426	277	237	40,439

Sources: KDHE, 2010; U.S. Census Bureau QuickFacts, July 2012

All three counties are highly rural areas. In Montgomery County, population centers include Coffeyville (10,295) and Independence (9,483; U.S. Census, 2010). The largest population center in Labette County is Parsons (10,500) while the largest community in Cherokee County has just over 4,200 residents.

The heat map in Attachment 1 (see Table 1) shows that the southeast counties have some of the worst health outcomes (i.e. mortality, morbidity) and health factors (i.e., health behaviors, care, environmental factors) in the state. Compared to the state average, Cherokee County and Montgomery County have remarkably high rates of families living in poverty. All three targeted counties have very high rates of births to teens and unmarried women, and high child maltreatment. Furthermore, pregnant women have a greater likelihood of preterm births, of having low birth weight babies, and have substantially high rates of smoking and substance abuse. The manufacture and use of methamphetamines in the region is extensive. According to the Kansas Bureau of Investigation, southeast Kansas counties have the highest numbers of meth lab and dump site seizures in the state; for the year 2011 Cherokee had 26 while Labette and Montgomery counties each had 34.

Established evidence-based home visiting services focused on pregnant women and families with young children operating in the targeted southeast Kansas counties are: **Early Head Start - Home-based:** Administered by the Southeast Kansas Community Action Program in all three counties; **Healthy Families America:** Administered by Kansas Children’s Service League (KCSL) in Cherokee and Montgomery counties; however does not currently serve Labette County; **Parents as Teachers:** Unified School District (USD) 445 Coffeyville in Montgomery County serves families within their community’s school district. The Southeast Kansas Education Service Center serves other school districts in Montgomery County as well as in Cherokee and Labette counties.

Additional services include Part C Infant Toddler Services, an early intervention program to help families whose children have developmental delays or disabilities, and *Healthy Start Home Visitor Services*, part of the Maternal and Child Health program of the county health department that offers one or more paraprofessional outreach visits to pregnant women and families with newborns. Also, in Montgomery County the Four County Mental Health Center provides *Project Before* case managers to visit and assist families with children from birth to age 5 who have been identified with mental health, substance use, or other at-risk factors. Just this year, *Early Steps to Success*, a program of Save the Children, has started implementation in a

number of southeast Kansas communities. This program offers paraprofessional home visits focused on early literacy.

Currently, a **coordinated screening and referral system** in the multi-county region is in its infancy. Called *My Family*, this system was a top priority for the Montgomery County MIECHV Program. It quickly developed through strategic planning with community partners and was launched in Montgomery County in March 2012. Four County Mental Health Center employed the *My Family* Coordinator. Forms and protocol for screening and referrals were designed and are being utilized. The *My Family* Coordinator is based at the Community Access Center in Independence where numerous community resources are co-located (e.g., financial assistance, disaster assistance and other social services) and at the Community Health Clinic of Southeast Kansas, the new federally qualified health clinic located in Coffeyville. Initial data indicate that priority populations of families are being reached. In the first four months of operation over 100 families were referred to the home visiting programs. Through this project, the coordinated system will be developed in Cherokee and Labette counties. Also, further development will occur in order to coordinate home visiting intakes and referrals and match at-risk clients with the most appropriate home visiting program among the continuum of services that exist in this area. Data will be collected on referral sources, referral completions and other key elements that will assist the community in tracking progress towards integrated services and coordination in multiple rural at risk counties.

Wyandotte County. Primarily urban, Wyandotte County contains part of the Kansas City metropolitan area which is split along the Kansas and Missouri state line. The county and Kansas City, Kansas, populations are described in Table 3:

Table 3. Wyandotte County Population

	Kansas City, KS	Wyandotte Co.	State
Population 2010	145,786	157,505	2,853,118
White Non-Hispanic	40.2%	43.7%	77.8%
Black Non-Hispanic	26.8%	25.1%	6.1%
Hispanic/Latino (any race)	27.8%	26.7%	10.8%
American Indian Non-Hispanic	0.8%	1.4%	1.2%
Asian	2.7%	2.7%	2.5%
Two or more races	3.8%	3.0%	2.7%
Speaks English less than “very well”	13.2%	12.6%	4.6%
Live births in 2010	2,608	2,754	40,439

Sources: KDHE, 2010; U.S. Census Bureau QuickFacts, July 2012; U.S. Census, 2008-2010 American Community Survey

As shown in the heat map in Attachment 1 (see Table 1), Wyandotte County ranks lowest in the state on health outcomes and health factors. Compared to the state average, the county has high rates of families with children under five living in poverty. Additional risk factors include high rates of births to teens, births to unmarried women, and births to mothers without a high school diploma. Pregnant women and their infants have a greater likelihood of inadequate or no prenatal care, low birth weight, and infant mortality, and substance abuse. Further analysis of county zip codes conducted in 2010 indicated the highest risk populations are particularly concentrated in the Kansas City, KS inner city area (66101-66106).

Existing evidence-based home visiting services currently serving Kansas City, Kansas, in Wyandotte County are: **Early Head Start - Home-based:** Administered by Project EAGLE Community Programs (affiliated with the University of Kansas Medical Center). **Healthy Families America:** Two sites are administered by (1) KCSL, and (2) the Unified Government of Wyandotte County and Kansas City, KS Public Health Department. **Parents as Teachers:** Two separate programs are administered by (1) USD 445 Kansas City, KS, and (2) USD 202 Turner.

Additional services include *Healthy Start Home Visitor Services* by the public health department. The federal *Healthy Start* program, a home-based prenatal education and case management service offered to pregnant women and mothers until their child is 2 years of age, is administered by Project EAGLE in collaboration with the Mother and Child Health Coalition covering the bi-state Kansas City metropolitan area. Additionally, Part C early intervention services are available to children with development or disabilities birth to 36 months and their families. Another Parents as Teachers program covers the far western side of Wyandotte County. Additionally, plans are being made to implement the Save the Children *Early Steps to Success* program.

A **coordinated screening and referral system** is present in Wyandotte County. Since 2003, Project EAGLE Community Programs has offered the *Connections Centralized Screening and Referral System* to families with pregnant women and/or children ages birth to five who reside in Wyandotte County. *Connections* conducts screenings for multiple risks in families with young children to provide timely referrals to address their needs. *Connections* is staffed by Intake Specialists who conduct phone triage and conduct screening visits. During a home or office visit, the Intake Specialist works in partnership with the family to complete a series of brief, formal screening measures with established sensitivity that provide unique information about the parent and child. Based on the results of all of these assessment tools, families receive referrals to agencies that can best meet their individual needs. Referrals are made to more than 60 agencies/programs providing services in the following domains: self-sufficiency, parent health and mental health, parenting, child health and development. Staff follows up with families to collect data on their access to and satisfaction with services. *Connections* provides screening and referral visits to approximately 600 high-risk families annually. On average, per month, over 80 referrals and 100 phone calls are received, and an average of 53 comprehensive screening and referral visits and 25 follow-up phone calls are completed. Families receive an average of six referrals to medical and behavioral health, parenting, early intervention, child care, food, shelter, housing, utilities, job training/adult education, and transportation services. While this system has been established for 9 years, the opportunity to review its current processes and make necessary improvements in coordinated intakes and referrals is now a focus of MIECHV activities.

Summary. In conclusion, the needs assessment along with the capacity analysis shows that these communities are experiencing substantial need and there are insufficient services to meet the needs of high risk families. As such, this project will focus on expansion of existing services in Wyandotte and three southeast Kansas counties. It is expected that deeper service saturation in these communities will mean more at risk families are reached, receive, and continue to engage in high quality home visiting services. Moreover, we anticipate that implementing innovative evidence-based maternal mental health and substance abuse interventions, and culturally relevant practices, will increase engagement in home visiting services as well as maternal, infant, and child outcomes.

Estimated Number of Families Served: One priority of the Kansas MIECHV Program and the development project is to expand the caseload capacity of the EHS, HFA, and PAT evidence-based home visiting programs to serve additional families with high risk factors. The Kansas MIECHV formula funding allowed each of the involved programs in Montgomery County and Wyandotte County to hire an additional home visitor. The TIES promising approach program has hired three new positions in order to serve Wyandotte County. With the development funds, Wyandotte County program sites will each hire another home visitor to serve one additional caseload, while the southeast Kansas programs each will hire between one to three new home visitors to expand services in the three targeted counties.

Table 4 shows that the current caseloads supported by MIECHV formula funds total 183 and the development funds will add potential caseloads of approximately 238 families. These numbers are for full caseloads that can be served at a given time point. Actual numbers may vary based on hiring and training of new staff, individual family needs, and attrition and subsequent enrollment of new families.

Table 4. Estimated number of families to be served

	Model	Caseload MIECHV Formula Funds	New Caseload MIECHV Development Funds	Total MIECHV Caseload
SOUTHEAST KANSAS COUNTIES				
Montgomery, Labette, & Cherokee				
Coffeyville USD 445	PAT	20	20	40
KS Children’s Service League	HFA	15	30	45
SE KS Community Action Program	EHS	12	24	36
SE KS Education Service Center	PAT	20	60	80
Total SE Kansas		67	134	201
WYANDOTTE COUNTY				
KS Children’s Service League	HFA	15	15	30
Project EAGLE	EHS	12	12	24
Public Health Dept.	HFA	15	15	30
Kansas City, KS USD 500	PAT	25	25	50
Turner USD 202	PAT	25	25	50
Children’s Mercy Hospital	TIES	24	12	36
Total Wyandotte County		116	104	220
TOTAL ALL COUNTIES		183	238	421

Early Head Start (EHS); Healthy Families America (HFA); Parents as Teachers (PAT); Team for Infants Endangered by Substance Abuse (TIES; Promising Approach)

Programmatic Area of Emphasis and Outcome Achievement: For each emphasis area that Kansas has selected for innovation, its proposed link to achieving outcomes is outlined below.

Emphasis 1: Improvements in maternal, child, and family health. The targeted communities have high rates of multiple risks to maternal, child, and family health. These outcomes will be impacted by enhancements to reaching and engaging families with such risks in home visiting services and to strengthen the capacity of programs to screen, support, and link families to maternal and child health, mental health, and substance abuse treatment resources.

Emphasis 2: Effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected. Expansion and effective

implementation of the home visiting programs with fidelity to their models increases the likelihood of more vulnerable families receiving quality services that, in turn, result in improvements to outcomes. Specialized training, reflective supervision, and consultation along with focused continuous quality improvement processes will strengthen program capacity and impact.

Emphasis 3: Development of statewide or multi-State home visiting programs.

Developing, refining, and testing innovative approaches in the targeted communities in a cross model, cross system, and even a cross state manner will inform strategies and efforts for high quality community and state level home visiting standards, infrastructure, and systems.

Emphasis 4: Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum. Enhancing the availability of a coordinated, comprehensive system of professional development for cross-program, cross-discipline training, as well as centralized screening and referral systems in the targeted counties that are elementally linked with the comprehensive early childhood systems will enhance quality delivery of services and support positive child and family health, learning, and development outcomes.

Emphasis 5: Outreach to high-risk and hard-to-engage populations. Innovations and enhancements to recruit, engage, and retain participants by reducing barriers and challenges with mental health and substance abuse concerns, hard-to-reach underserved populations, and diverse cultures and languages will contribute to realizing positive outcomes.

Emphasis 7: Outreach to families in rural or frontier areas. Expansion of outreach and home visiting services in rural southeast Kansas will focus on improving outcomes with families experiencing multiple risk factors in small communities and remote areas.

Emphasis 8: The development of fiscal leveraging strategies to enhance program sustainability. Strategic planning for fiscal leveraging in coordination with community and state level home visiting and early childhood systems partners will develop program sustainability and expansion for effective evidence-based home visiting services within a comprehensive system.

III. METHODOLOGY

Evidence-Based Home Visiting Models: Three evidence-based home visitation models will be implemented: (1) Early Head Start (EHS); (2) Healthy Families America (HFA); and (3) Parents as Teachers (PAT). All currently have widespread availability in Kansas and are established in the identified at-risk communities with the exception of HFA in Labette County. Included in the Kansas Updated State Plan, the state's formula funded MIECHV Program, and in the proposed development project, these three models are utilized as a continuum of services in the targeted communities and to address the identified needs. Approval letters from the three national model developers are included as Attachment 8.

State and local partners determined that the best approach for a coordinated, comprehensive state plan is to build on the strong foundation of programs already in place given the existing state and local commitment to support these programs and their likelihood to yield more geographical coverage with a higher level of fidelity. These established programs and their experienced, trained staff will facilitate timely and cost-effective implementation for the MIECHV Program. Furthermore, given the current budgetary constraints in Kansas and the rest of the nation, it is prudent to enhance the quality and coordination of the present infrastructure services rather than adopt an entirely new program that may not be fully implemented or sustained for the long-term. The number of sites for each of these models facilitates expansion

and a greater pool of staff for potential replication of approaches utilized in the MIECHV project.

By including the continuum of three models, this approach reaches families at various risk levels. The community outreach, screening, and referral processes and agreements among the partners will help ensure that families are matched to the appropriate service to meet their needs. Specifically, all of the models meet numerous needs of the targeted communities and align with the proposed project goals. All are voluntary and work with pregnant women and families with children from birth to age three, with some up to age five. Mechanisms for addressing diverse populations are built into the selected home visitation models. EHS, HF, and PAT have been shown to be effective across different racial and ethnic groups, levels of parent education, types of households/family living arrangements, rural and urban settings, and age groups (teen parents, etc.).

Early Head Start particularly serves families who meet federal income guidelines, have an infant or toddler with a disability, or other stressors. At least 55% of those served must be at or below 100% of the federal poverty level (FPL); 35% may be up to 130% FPL; and at least 10% are children with special needs. Per Head Start Program Performance Standards, programs must maintain a priority selection criteria grid which is used to determine the children and families with the highest need or risk factors. Children who are not identified as having the highest risk factors may be placed on a waiting list if all EHS slots are filled at the time of their application. Targeted outcomes include promoting healthy prenatal outcomes for pregnant women, enhancing the development of infants and toddlers, healthy family functioning, and preparing children to enter school ready to learn. The EHS model has demonstrated favorable impacts in the domains of child development and school readiness, positive parenting practices, and family economic self-sufficiency.

Healthy Families America particularly serves families identified with risk factors for child abuse or neglect such as childhood history of abuse, substance use, mental health concerns, lack of social support, family stressors, and lack of parenting and child development knowledge. Targeted outcomes include reducing child maltreatment, increasing utilization of prenatal care, positive parenting and parent-child interactions, healthy child development and school readiness, family self-sufficiency, and access to primary care medical services. The HFA model has demonstrated favorable impacts in the domains of child health, child development and school readiness, reductions in child maltreatment, positive parenting practices, family economic self-sufficiency, reductions in juvenile crime and family violence, and in linkages and referrals.

Parents as Teachers has no income or other eligibility guidelines although priority is given to first time parents, teen parents, and families with at-risk indicators such as low income, single parent and foster or adoptive families. Targeted outcomes include improving parent knowledge of early childhood development and parenting practices, providing early detection of developmental delays and health issues, preventing child abuse and neglect, and increasing children's school readiness and school success. The PAT model has demonstrated favorable impacts in child development and school readiness and positive parenting practices.

Promising Approach. The *Team for Infants Endangered by Substance Abuse* (TIES) Program is included in the Kansas Updated State Plan, the state's formula funded MIECHV Program, and in the proposed development project for implementation and evaluation in Wyandotte County/Kansas City, Kansas, as a promising approach. The TIES Program was selected to specifically address the need to expand effective services for pregnant women and mothers of young children impacted by substance use. Initiated in 1990, TIES is a program of

The Children’s Mercy Hospital in Kansas City, Missouri and has been developed and refined as a project of the Abandoned Infants Assistance program of the Children’s Bureau of the U. S. Department of Health and Human Services. The TIES Program provides intensive, comprehensive home-based services to pregnant and postpartum women, 18 years of age and older, and their families affected by alcohol or other drugs. Referrals are generated from health care, alcohol and other drug treatment, and child protection providers, as well as emergency assistance, shelters, other social service programs, and self-referrals. Referrals are accepted up to six months postpartum, and families are served until the identified child is two years old. The program is entirely voluntary and relative caregivers (e.g., fathers, grandparent) can be served as well with parental consent. All family members, as identified by the pregnant or postpartum woman, will be served including all the children in enrolled families. TIES Program goals are: (1) substance use reduction; (2) improved parenting; (3) accessing appropriate health and mental health needs for the family and child; (4) gaining economic stability; and (5) maintaining adequate housing. Using a community-oriented approach, the TIES Program provides individualized, culturally appropriate services including crisis intervention, support for substance abuse treatment, supportive counseling, child health and development, parenting education, and connection to other community services.

Overarching MIECHV Goals and Objectives: The Kansas MIECHV Program developed a set of goals and objectives in the Updated State Plan submitted in June 2011. This represents the foundation of the MIECHV work currently ongoing in Kansas.

Goals	Objectives
1. Deliver a coordinated, integrated system of evidence-based home visiting programs with high model fidelity and quality to families with pregnant women and children (0-5) in at-risk communities.	<ol style="list-style-type: none"> 1. Increase the number of families with identified risks served in targeted communities by evidence-based home visiting programs (i.e., EHS, HFA, and PAT) and a promising approach (TIES) 2. Ensure program services are aligned with local and individual family needs so that families receive services that best fit their needs. 3. Improve coordination and referrals between home visiting programs and other community resources 4. Build capacity for locally coordinated, centralized outreach, referral and intake processes 5. Ensure accountability, model fidelity, and quality through coordinated cross-program training, technical assistance and monitoring
2. Effectively engage and retain underserved, hard-to-reach populations in home visiting services.	<ol style="list-style-type: none"> 1. Build home visiting programs’ capacity to effectively engage and retain families in services 2. Build home visiting programs’ capacity to involve fathers in services 3. Build home visiting programs’ capacity to appropriately address mental health and substance abuse concerns of referred and enrolled families 4. Implement a promising home visiting approach to serve pregnant women/ mothers with substance use problems and their families
3. Utilize a coordinated, integrated system to determine outcomes and quality of home visitation programs.	<ol style="list-style-type: none"> 1. Select common indicators and measures across home visiting programs 2. Develop and utilize a common data collection and reporting system across home visitation programs 3. Assess program outcomes (i.e., MIECHV Program benchmarks and constructs) and implementation quality

	<ol style="list-style-type: none"> 4. Utilize data for continuous quality improvement 5. Evaluate a promising home visiting approach to serve pregnant women and mothers with substance use problems
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Development MIECHV Goals, Objectives and Activities. Above and beyond the activities with formula funds, the Kansas MIECHV development project will address and build on the specific list of goals and objectives indicated below. For the development project, we have expanded Goal 3 to include a focus on broader state infrastructure development beyond a coordinated data management system. Proposed activities are listed for each objective.

Goal 1: Deliver a coordinated, integrated system of evidence-based home visiting programs with high model fidelity and quality to families with pregnant women and children (0-5) in at-risk communities.

Objective 1: Increase the number of families with identified risks served in targeted communities by evidence-based home visiting programs (i.e., EHS, HFA, and PAT) and a promising approach (TIES).

Activities

1. Local programs will recruit, hire and train new home visitors per model requirements (within first 120 days of year 1; exceptions: HFA in SE Kansas and TIES in Kansas City, KS, - last quarter of Year 1 &/or first quarter of Year 2)
2. New home visitors will enroll new families in targeted communities and attain maximum caseloads (ongoing)
3. PAT sites will continue services to enrolled families after their child reaches age 3 up to age 5 once parent educators complete PAT 3-K curriculum training (ongoing)

Objective 2: Improve coordination and referrals between home visiting programs and other community resources.

Activities

1. Convene regular team meetings of MIECHV service providers/partners in both Wyandotte County and the southeast Kansas counties (every 30-60 days)
2. Refine strategic plans for coordinated cross-program service delivery and referral agreements in each targeted area (Year 1)
3. Coordinate, collaborate, and communicate MIECHV activities with community collaborative groups (e.g., early childhood coalitions, community services partnerships, etc.) in the targeted counties (ongoing)
4. Facilitate and engage in collaboration building and group strategic planning process involving Children’s Mercy Hospital, Wyandotte County MIECHV partners, State of Missouri MIECHV partners, and other Kansas City metro area home visiting partners regarding the creation of a bi-state (KS & MO) coordinated system of home visiting services that also integrates with the medical home setting (Year 1)
5. Collaborate with Children’s Mercy Hospital, Wyandotte County MIECHV partners, State of Missouri MIECHV partners to pilot elements of the Kansas City metro integrated home visitation-medical home collaborative project with programs in Wyandotte County and in Jackson County, Missouri (Year 2)

Objective 3: Build capacity for locally coordinated, centralized outreach, referral and intake processes

Activities

1. Refine strategic plans and protocol for centralized/coordinated outreach, screening and referral systems in Wyandotte County and Montgomery County (Year 1)
2. Prepare and implement centralized/coordinated outreach, screening and referral systems in Cherokee and Labette counties (Year 1)

Objective 4: Ensure accountability, model fidelity, and quality through coordinated cross-program training, technical assistance and monitoring.

Activities

1. Prepare a specialized training plan and schedule for programs in the targeted counties focused on development project priorities (1st quarter of each year)

Goal 2: Effectively engage and retain underserved, hard-to-reach populations in home visiting services.

Objective 1: Build home visiting programs' capacity to effectively engage and retain families in services.

Activities

1. Arrange and provide training and consultation/technical assistance for home visiting and central screening and referral programs, appropriate to the unique needs of the targeted communities, to increase competencies and skills regarding (Year 1):
 - communicating with and supporting families of different cultures (e.g., racial/ethnic, economic, rural/urban)
 - effective strengths-based practices to engage high-risk and hard-to-reach populations
 - social marketing and communication strategies
2. Home visiting and central screening and referral programs will incorporate culturally responsive, qualified language interpretation (i.e., contracted interpreter services, bilingual staff) and other resources to facilitate effective communication and engagement of non-English speaking families (ongoing)
3. Obtain consultation/technical assistance to develop social marketing and public communication strategies and tools appropriate to the unique needs of the targeted communities (Year 1)

Objective 2: Strengthen home visiting programs' capacity to appropriately address mental health and substance abuse concerns of referred and enrolled families.

Activities

1. Arrange and provide specialized training for programs to increase competencies and skills on identifying, referring, communicating with, and supporting families impacted by substance use, mental health, trauma, and violence concerns (Years 1 & 2)
2. Arrange and provide training on Motivational Interviewing for programs (Years 1 & 2)
3. Implement the *Moving Beyond Depression* (MBD) intervention in Wyandotte County (Years 1 & 2)
 - Every Child Succeeds/Cincinnati Children's Hospital will provide training, consultation, and technical support for implementing the intervention program
 - local mental health agency will employ qualified mental health therapist(s) and provide MBD services to referred mothers

- home visiting program staff and mental health therapists will attend required MBD training
 - home visiting programs will refer mothers who screen positive for depression to MBD
4. Increase awareness, referrals, and collaboration between the home visiting programs and substance use treatment and mental health providers (Years 1 & 2)
 5. Contract for professional consultation on mental health, reflective practice, and reflective supervision groups to be provided to programs (Years 1 & 2)

Goal 3: Foster state infrastructure and sustainability of a coordinated, integrated system of quality home visiting services in Kansas.

Objective 1: Integrate the MIECHV Program into other maternal, infant, and early childhood programs to strengthen access for families to systems of home visiting, early childhood development, and family support.

Activities

1. Formally integrate and align the MIECHV Program with the Title V Maternal and Child Health Block Grant program in the KDHE Bureau of Family Health (Year 1)
2. Collaborate with the KECCS, the Early Childhood Interagency Leadership Team, the Kansas Children’s Cabinet and Trust Fund, the Early Childhood Advisory Council, the Kansas Early Learning Collaborative, and other initiatives to coordinate/integrate work on mutual goals and objectives (Years 1 & 2)

Objective 2: Strengthen cross program, cross system professional development and training that supports quality home visiting services

Activities

1. Collaborate with the Kansas Head Start Association (KHSA), KECCS, ECAC, and other key agencies/initiatives to construct plans and implement strategies for a coordinated state training and professional development system (Years 1 & 2)
2. Collaborate with the KHSA, KECCS, ECAC, and other key agencies/initiatives to design and offer quality training opportunities to home visiting programs (Years 1 & 2)

Objective 3: Promote sustainability of a system of quality, evidence-based home visiting services.

Activities

1. In collaboration with KECCS, convene a state Home Visiting Task Force and facilitate communications across the network of home visiting partners (Years 1 & 2)
2. Conduct a strategic planning process with the State Home Visiting Workgroup, the Home Visiting Task Force, and other stakeholders and partners (Years 1 & 2):
 - to develop future needs and objectives for the system of home visiting services; and
 - to craft and implement fiscal leveraging strategies to ensure program sustainability
3. Utilize MIECHV Program evaluation data to inform decision-making on replication and expansion of home visiting services (Year 2)

Proposed Evidence-Based Interventions and Activities. Research has shown that a significant barrier to at-risk mothers engaging in services is maternal depression (Ammerman et al., 2007; 2010). This is because the symptoms of maternal depression adversely affect parenting such that depressed mothers are more likely to disengage from their children, have an inability to regulate affect and behavior during interactions with their children, are insensitive to the psychological, behavior, and physical health needs of their children (see Ammerman, et al.,

2010 for a review; Goodman & Gotlib, 2002). Maternal depression seriously undermines these crucial aspects of parenting and has been linked to a number of poor child health and developmental outcomes including cognitive and language delays (Peterson & Albers, 2001); difficulties in emotional regulation and attachment (Weinberg & Tronick, 1998); early onset of depression (Murray, Woolgar, Cooper, & Hipwell, 2001); and behavioral and educational problems (Black, Papas, & Hussey et al, 2002). Moreover, depression can significantly interfere with the efficacy of home visiting. Detecting and treating depression in prenatal and parenting families will have profound effects on promoting the mental wellness of all family members, especially young children. The need for mental health services is great. Research has demonstrated that depression in postpartum period occurs in about 26% of high risk mothers and in populations served by home visitation, prevalence is up to 50% (Ammerman et al., 2010).

To provide enhanced services to Wyandotte County participants experiencing mild to severe depression, the MIECHV development project will implement the *Moving Beyond Depression In-Home Cognitive Behavioral Therapy (MBD)* intervention (Ammerman et al., 2007). MBD was developed to address these needs through (1) a screening process to identify mothers in need of treatment, and (2) providing an evidence-based treatment for depression that has been adapted for home visitation in order to optimize outcomes. MBD provides mothers enrolled in home visiting, and identified through screening by their home visitor as experiencing depression, with 15 weekly, in-home therapy visits by a trained masters level mental health therapist (e.g., social work, psychology, counseling). These services are provided in addition to, as an enhancement, to their usual home visits. Program evaluation and clinical trial findings indicate that IH-CBT is highly effective at reducing depressive symptoms, facilitating remission of Major Depression (66.7% of mothers receiving home visitation plus IH-CBT vs. 24.3% of mother receiving home visitation alone), increasing social support, reducing overall psychopathology, and increasing functional ability relative to mothers who receive home visitation alone (Ammerman et al., 2011; 2005). Also, mothers who recovered from Major Depression reported improvements in parenting stress, mother-child relationship, and nurturing parenting. Both mothers and home visitors reported high levels of satisfaction with IH-CBT. Mothers receiving the intervention had 44.3% more home visits during the treatment interval than their counterparts who received home visitation alone.

In Wyandotte County, all MIECHV program enrolled women who screen positive for depression will be referred to the MBD program. The clinical staff will be employed by a community mental health agency, the Family Conservancy, who will coordinate the program. The MBD staff will attend an intensive Cognitive Behavior Therapy (CBT) refresher training at the Beck institute in Philadelphia or an equivalent CBT immersion experience prior to providing services, and will also attend intensive two-day IH-CBT training in Cincinnati. Dr. Ammerman and colleagues with Every Child Succeeds, Cincinnati Children's Hospital, will provide the training and ongoing consultation and support including regularly scheduled on-site and telephone consultation for effective implementation over the two years of this project. They will also travel to Kansas City to provide training to the home visitors and program supervisors/administrators in screening and referral procedures. Collaboration between the mental health specialist and the home visitors will be essential to fully meet the needs of the participating mothers. The therapist and the home visitor maintain a working relationship including a co-visit at the end of the therapy cycle.

The potential to implement the MBD program in Montgomery County was also explored. However, the community mental health agency, Four County Mental Health Center, experiences

ongoing difficulty with recruiting and hiring qualified mental health clinicians to serve the rural areas and has a number of chronically vacant positions. Due to these concerns and the impact on successfully implementing the new services, the decision was made to forgo adding MBD to that area at this time. Nevertheless, steps will be taken to improve understanding, increase coordination, and enhance referrals between the home visiting programs and community mental health services. For example, the Four County Mental Health Center has a case management program that includes home visits, *Project Before*, for families with high risk factors such as mental health or substance abuse that have a child birth to age five years of age. They presently can serve up to 60 families. As of July 2012 only about 15 families were being served. *Project Before* can be provided in addition to other home visiting programs and already receives some limited referrals from the EHS and PAT programs. Four County Mental Health Center also provides other early childhood mental health programs that would be beneficial to home visiting families. They are interested in learning and working on ways to enhance coordination of services with the other home visiting programs.

Likewise, substance abuse during pregnancy is related to a whole host of negative developmental outcomes for the child (e.g., deficiencies in motor and cognitive development, language skills, and behavior; Lester et al., 2002). **Motivational Interviewing** (MI) is an intervention that has been shown to increase retention for substance abuse treatment (Carroll et al., 2005). Kansas MIECHV program staff will be provided training by a certified trainer to use MI (Miller & Rollnick, 2002). Adding MI as a tool that home visitors can use with families will help engage and retain families in their programs as well as support change. MI is a client-centered, directive way for enhancing intrinsic motivation to change by exploring and resolving a parent's ambivalence. The home visitor will be trained to respond to resistance in a way that is intended to diminish it. MI focuses on eliciting the parent's intrinsic motivation for change (Miller & Rollnick, 2002). Over twenty clinical trials have been published on MI and meta-analyses have found positive results for a variety of issues (Miller & Rose, 2009). MI has been found to be a brief, cost-effective intervention (Project MATCH Research Group, 1997) with some studies showing increased motivation for change and retention in as little as one session of MI (Brown & Miller, 1993). MI is also being applied in other research settings with home visiting services to investigate whether MI increases engagement and retention in home visiting, and in turn, decreases risk for child abuse and neglect. Results suggest that effect sizes are larger and more enduring when MI is added to another intervention (Hettema et al., 2005). Additionally, some studies have found that the effect size of MI was doubled for participants from minority backgrounds (e.g., Hettema et al., 2005).

Supervision is also a key component of program quality, directly linked to participant outcomes. Home visitors who receive quality supervision have participants who stay engaged in program services longer (McGuigan, Katzev, & Pratt, 2003). Program supervisors and home visitors of the involved MIECHV programs will be provided opportunities to participate in reflective supervision groups and to receive consultation on mental health issues. Program staff will also receive support to pursue training and endorsement from the Kansas Association of Infant Mental Health. This activity is a key implementation driver and will assist in improving quality of services and improved practice.

IV. WORK PLAN

Timeline: The Kansas MIECHV development project Timeline is included as Attachment 6.

Support and Collaboration with Key Partners: Kansas has engaged a *State Home Visiting Workgroup* composed of partners that have provided guidance, support, and been involved with all stages of planning and implementation for the MIECHV Program including this proposal. The Workgroup representatives are from the following state agencies and programs:

- Children’s Cabinet and Trust Fund (administers Title II CBCAP funds; KS Children’s Initiatives Fund; KS Early Childhood Block Grant)
- Department for Aging and Disability Services (Behavioral Health, Addiction & Prevention Services)
- Department for Children and Families (Child Protective Services, Child Care & Early Education - Head Start/Early Head Start)
- Department of Education (Parents as Teachers – Early Learning Services)
- Department of Health and Environment (Bureau of Family Health – MIECHV, Title V MCH, IDEA Part C)
- Institute for Educational Research and Public Service, University of Kansas
- Kansas Head Start Association
- Kansas Children’s Service League (Healthy Families)

The agencies listed above also administer the State’s Medicaid program, pre-kindergarten program, TANF, SNAP, and Injury Prevention and Control programs.

Furthermore, the Kansas MIECHV Program convenes a *Data/Evaluation Workgroup* that has collaborated on planning and implementing all aspects of the benchmarks plan, common cross-program measurement tools, continuous quality improvement (CQI) processes, as well as priorities and strategies for the development project evaluation. The workgroup members include the following representatives:

- Department for Children and Families - Early Head Start state leader
- Department of Education - Parents as Teachers state leader
- Department of Health and Environment – Home Visiting Program Manager
- Kansas Health Institute - analyst
- Kansas Children’s Service League - Healthy Families state leader and Quality Assurance Manager
- Project EAGLE, Wyandotte County - Early Head Start/Home-based Services Manager
- Southeast Kansas Education Service Center - Parents as Teachers Coordinator
- University of Kansas – researchers/evaluators from Institute for Educational Research and Public Service and Juniper Gardens Children’s Project
- University of Missouri-Kansas City Institute for Human Development researchers

Also, the targeted communities have been engaged in all phases of the MIECHV needs assessment, planning and implementation processes including the development project proposal. Throughout the past year, the MIECHV teams in both Wyandotte County and Montgomery County met on a regular basis (approximately 3 hours every 4-6 weeks) and engaged in in-depth strategic planning and other collaborative work with a contracted

facilitator. Several of the service providers in Montgomery County also serve other counties in the southeast region including Cherokee and Labette counties. These various partners are familiar with the cultural, racial, linguistic, and geographic diversity of the populations and communities served.

Implementation plan: The MIECHV activities and interventions are intended to support the home visiting programs' reach, engagement, and retention of the most vulnerable families in their local communities. The MIECHV development project will strengthen provider networks to foster outreach to vulnerable families and to create a seamless system of referral and resource sharing.

Engaging the Communities. The MIECHV teams in each targeted community area will continue to formally meet on a regular basis, finalize their strategic plans, and collaborate on implementation of the MIECHV activities. All of the local MIECHV service partners are well-informed, actively engaged and/or provide leadership with various early childhood system service providers, coalitions, and initiatives. Examples in the targeted southeast Kansas counties include the Montgomery County Early Childhood Coalition, the Coffeyville Early Childhood Action Team, the Partnership for All Cherokee County Children, the Labette County Family Coalition. Examples in Wyandotte County include: the Wyandotte County Early Learning Collaborative, the Mother and Child Coalition of Greater Kansas City, Wyandotte County Smart Start, the Wyandotte County Interagency Coordinating Council for Infant Toddler Services, and the Kansas City, KS Mayor's Healthy Communities Wyandotte Initiative.

Because the TIES Program operates in Kansas City, Missouri and is expanding to Kansas City, Kansas, both parts of a bi-state metropolitan area, a number of agencies in the service area have related to the TIES Program over its long existence. State and local agencies participate on the Kansas City Task Force on Families Affected by Substance Abuse, which is a bi-state group addressing the issues of high-risk families. Wyandotte County Department for Children and Families (DCF; previously Social and Rehabilitation Services) children's services, Wyandotte County Juvenile Court, Kansas City, Kansas Police Department (KCPD), and University of Kansas Medical Center (KUMC) are all represented on the task force. The TIES Program Manager facilitates the Task Force, and the TIES model is well-known in the group. Additionally, there is a subcommittee involving DCF, KCPD, Wyandotte Juvenile Court and their Missouri counterparts addressing child protection, child custody, jurisdiction, transport, and other issues when children are identified in one state and live in the other. Information exchange and policy development are promoting a bi-state approach to these issues, particularly with drug affected families.

Monitoring, Program Assessment, and Technical Assistance. The Kansas MIECHV Program incorporates the quality assurance procedures and support of model fidelity from the selected home visiting program models. The Home Visiting Program Manager will closely collaborate with the EHS, HFA, and PAT state program leaders to ensure all program sites implement the models with fidelity and comply with quality assurance procedures. Joint procedures for coordinated training, technical support, and a system of monitoring will be utilized. Contracts will ensure all state and local partners understand the expectations and procedures (see Attachment 4). As part of their contractual requirement, all MIECHV programs submit semi-annual and annual Program Performance and Progress Reports. Data will be collected from all program sites regarding such factors as staff qualifications, supervision,

provision of program components and services, participant engagement, retention, and attrition, and program adaptations. All programs will also participate in the CQI processes.

Kansas EHS makes an annual site visit with every KEHS program and facilitates a meeting with all KEHS directors/administrators six times per year. In addition, KEHS works with the Administration for Children and Families (ACF) Region VII office which provides technical assistance to the state grantees. Federally-funded staff provide technical assistance in-person or over the phone. They help grantees develop a training plan, write agreements with child care agencies, and perform a community needs assessment. Each grantee must have a training and professional development plan, which is submitted to the TA staff and approved by Region VII ACF Office. Also, Kansas Head Start Association provides training and technical assistance to local programs. In addition to state level monitoring, all KEHS programs that receive federal technical assistance monies are monitored by the Office of Head Start every three years using the federal review process. All programs are required to complete the Program Information Report (PIR) on an annual basis and are monitored by Risk Management Specialists to determine if files and records are complete and up-to-date, referrals are current, children have an individualized learning plan, and parents are working towards self-sufficiency goals. Monitoring is completed monthly and assists the supervisor in addressing concerns. In addition, the program does an annual self-assessment that includes families and communities.

KCSL HFA has a centralized Healthy Families Policy Director, quality assurance manager and technical assistance staff available to ensure appropriate support is available to all sites and all HFA standards and critical elements are met. Also, KCSL maintains three nationally certified HFA trainers and facilitates a centralized training program for Family Support Worker/Specialists, Assessment Coordinators, and Supervisors to ensure all training requirements are met according to HFA standards. KCSL maintains a comprehensive database to collect HFA program data for reporting, evaluation, and quality assurance purposes. KCSL has had 15 years of experience working with national HFA program staff and available technical assistance. KCSL HFA employs four staff credentialed by the national model developer to provide local technical assistance and support to ensure programs meet all national program model standards and expectations. Once every four years, HFA sends a team of at least two external, trained peer reviewers to conduct a site visit. The purpose of this visit is to provide a comprehensive and objective review and validate a program's self-assessment and adherence to the HFA critical elements. Depending on the outcome of the Self-Assessment, the peer reviewer site visit, the program response and the deliberations of the Panel, the evidence will be used to determine whether to grant accreditation.

The KSDE PAT State Office coordinates implementation of the national model in Kansas providing leadership, technical assistance and training on PAT Foundational Curriculum and Model Implementation, program implementation with fidelity, CQI, reporting and evaluation. All PAT programs write an implementation plan that is approved by KSDE and PAT National Office prior to implementing an affiliated program. This plan reflects funding, program service delivery design including personal visits, group connections, developmental screening and resource networking, and staffing. Parent educators and programs sign letters of agreement for family service, use of curriculum and professional development to ensure fidelity to the model. Programs submit required data and affiliate progress reports annually. The KSDE PAT programs are affiliated with the PAT National model and implement Essential Requirements, the PAT Quality Standards and Self-Assessment to demonstrate ongoing fidelity to the PAT national model. Each program develops a Continuous Quality Improvement (CQI) Plan which is

reviewed and revised at least annually and is part of the KSDE PAT Continuation Grant process. The PAT state office reviews and approves affiliate performance reports, data analyses required via the PAT Continuation Grant process including goal setting and reporting on progress with their own CQI. Telephone and email technical assistance is provided. On-site review of model fidelity is conducted every 4 years as part of the Quality Standards process. KSDE partners with the Kansas Parents as Teachers Association (KPATA) to provide ongoing regional professional development opportunities.

For TIES, the program manager will meet with program staff both individually and as a group, accompany staff in home visits, review program documentation, and receive feedback regarding consumer satisfaction from the evaluator. The manager will observe staff regularly interacting with families and will discuss quality improvement efforts on an ongoing basis. This observation and regular supervision coupled with record review will promote model adherence.

Professional Development and Training. For the Kansas MIECHV development project, specific training will be provided to all participating programs addressing the following topics. Some of these trainings may be provided through local and state sources while some will be provided by out-of-state trainers:

- Moving Beyond Depression training
- Motivational Interviewing
- Reflective practice and supervision
- Mental health such as infant mental health, support and communication with families/parents with mental health issues, screening and referrals, trauma-informed care
- Client retention/engagement such as high-risk parents, diverse cultures, culturally relevant practices
- Substance use may include addiction, gender specific issues, screening and identification, referral coordination, assessment and treatment resources
- Domestic violence screening, safety plans, referral resources and coordination
- Evaluation/data collection procedures

Staffing and Subcontracting. Existing and proposed contractual roles and expectations are included in Attachment 4. To implement the project, KDHE plans to establish, or add to currently established contractual agreements, with agencies which will provide local home visiting and coordinated screening and referral services. These agencies along with estimated home visitors to be hired and caseloads are listed in the Needs Assessment section (p. 16) and the agencies are also listed in the Budget Narrative. With the development funds, Wyandotte County program sites (EHS, HFA, PAT, and TIES) will each hire a home visitor to serve one additional caseload, while the southeast Kansas programs each will hire between one to three new home visitors to expand services in the three targeted counties. Program agencies will be responsible for recruiting and hiring staff in accordance with their established program model, agency procedures, the MIECHV development project plans, and contract requirements and approved budgets.

Recruiting and Retaining Participants. The MIECHV programs will recruit and serve eligible participants who are priority populations as identified in the MEICHV Program legislation and funding opportunity announcements. Particular emphasis will be given to pregnant women and families with infants and young children that are impacted by substance use and/or mental health concerns. Families will be recruited from a number of sources. All programs conduct intensive outreach in their respective communities. Referral sources include various social service agencies, hospitals, health clinics, health care providers, shelter providers,

emergency assistance agencies, schools, and other community organizations. Many other forms of outreach are used to personally reach the target populations.

Central screening and referral systems are a critical component of the Kansas MIECHV services at the community levels. In Wyandotte County the Connections Centralized Screening & Referral System, as previously described, will be utilized to recruit, identify and refer families. In Montgomery County, a new central screening and referral system, My Family, was developed and launched in Spring 2012 as an objective of the formula-funded MIECHV Program in order to enhance the coordinated identification and recruitment of participants. Centralized systems will be developed and expanded in Cherokee County and Labette County.

Improving engagement and retention of at-risk and underserved populations is a major objective of this development project. As previously indicated, a number of specific strategies and activities will be utilized to address the engagement and retention of families with multiple risk factors especially those that are experiencing depression or other mental health concerns, substance use and dependence, as well as families of various cultures and languages.

The strategic planning and collaborative process with Children's Mercy Hospital and home visiting services in the bi-state Kansas City metro area will explore, create, and pilot strategies for a system of shared recruitment and scheduling including formalized linkages with primary health care providers.

Continuous Quality Improvement. The MIECHV and local home visiting programs are committed to a CQI plan that is transparent and aimed at identifying program successes in meeting program goals and objectives, as well as informing how home visiting practices can be improved. The Home Visiting Program Manager has worked collectively with the model state leaders of the involved programs and evaluators to formalize specific areas of interest and improvement with associated tracking, monitoring, and communication loops for all levels of program implementation. The Data/Evaluation Workgroup also serves as the state CQI team to provide direction and oversight of the ongoing system for data collection, and how these data are used to drive decision making and programmatic improvements over time.

Measures of program implementation will be examined and compared across programs with the MIECHV teams in both targeted community areas. CQI is being incorporated throughout the benchmark/construct data measurements as well as fidelity, quality, and other implementation components. Priority areas of interest for the CQI plan are: (1) the process of screening, identifying, serving, and referring program participants with mental health and/or substance abuse concerns; (2) centralized screening, referral, and intake procedures and system coordination; and, (3) engagement and retention of high risk populations.

The goal for the CQI process is (1) the development of an efficient system for collecting data on the key program components within each model, the creation of timely reports that are easy to read, interpret and use to inform practice and decision making at the individual program level; and, (2) the development of an infrastructure for responding to these data and implementing programmatic improvements over time that drive program outcomes. This process will provide each program with the ability to examine outcome data in relation to program implementation data, and use what is learned to make informed decisions and implement changes that drive improvements in the quality and impact outcomes

Additional CQI plans are covered under Evaluation and Technical Support Capacity (Section VI). In addition to the contracted researchers/evaluators noted in that section, researchers from the KU Juniper Gardens Children's Project will provide consultation, assistance, and related professional development in conducting CQI processes. This includes the

collection of implementation data and the development and use of reports to inform practice and supervision, the measurement of practices aimed at improving parent engagement, and fidelity of program implementation within and across participating home visiting programs. This includes contributing to CQI plans for the bi-state Kansas City metro area collaborative project with Children's Mercy Hospital and the Missouri MIECHV Program.

Maintaining Program Fidelity. The Kansas MIECHV incorporates the quality assurance procedures and support of model fidelity from the selected home visiting program models. The Home Visiting Program Manager will continue to closely collaborate with the EHS, HFA, and PAT state program leaders to ensure all program sites implement the models with fidelity and comply with quality assurance procedures. The Home Visiting Program Manager will facilitate communication with the EHS, HFA, and PAT national offices to ensure fidelity to the models during implementation and to obtain any necessary technical assistance and support. Given the strong infrastructures and liaisons in Kansas for each of these models, this communication and consultation will be coordinated with the related state program leader. Approval letters specific to this development project from the national model developers are contained as Attachment 7.

The EHS programs are monitored by the state and through the federal Office of Head Start to assure compliance with Head Start Program Performance Standards. KCSL is a HFA Multi-Site System and accreditation is current through March 2013. The PAT Programs are required to submit data and affiliate performance reports to the state and national PAT offices and are required to go through the PAT Standards and Self-Assessment to demonstrate ongoing fidelity to the PAT model. On-site review of model fidelity is conducted every 4 years as part of the PAT Quality Standards process. Fidelity to the TIES model will be accomplished by the TIES manager monitoring and assessing compliance with the practice standards that will be formalized in the implementation development. Furthermore, assessment of implementation and fidelity is a critical feature of the TIES evaluation.

Data Collection on Legislatively-Mandated Benchmarks. In the first full year of program implementation, the State worked collaboratively to develop a shared vision and benchmark plan that would reflect the State's vision for home visiting benchmarks and outcomes. This was done through numerous collaborative meetings with state and local administrators and staff of the three home visiting models selected (HF, PAT, and EHS and the promising practice (TIES) in the two primary communities selected. When discussions began, each program did not collect the same data on existing clients and services. The State worked with each program's staff and data managers to modify their current data collection processes to capture all legislatively-mandated benchmarks at the client-level. The Kansas MIECVH Benchmarks Plan was formally approved by HRSA in January 2012.

Prior to MIECHV, Kansas individual programs did not have a centralized data system or common outcomes across home visiting program which made it difficult to analyze the collective impact of home visitation services on child and family outcomes for at risk populations. For purposes of MIECHV, the State contracted with the University of Kansas Institute for Educational Research and Public Service (KU Institute – Data Systems Team) to build and maintain the new Kansas Maternal Infant and Early Childhood Home Visiting Performance Management System (PMS).

This comprehensive HIPAA/FERPA-compliant database and management system is a robust and secure repository of client-level data on those served by MIECHV. This system was developed using Research Electronic Data Capture (REDCap) to create one cross-program

database that integrates and stores linked client-level data, including existing State databases (e.g., KDHE, DCF, KSDE), the agency-level Management Information System, and any data collected in the field by home visiting program staff. The Kansas MIECHV REDCap database allows the State to collect, monitor, analyze, store, and report on the required MIECHV constructs and benchmark areas.

This system has been beta tested in preparation for federal reporting requirements in October 2012. All agencies have submitted draft exports of data from current clients, that data has been checked for quality and completeness, technical assistance to agencies has been provided, and syntax prepared for calculating each of the legislatively-mandated benchmarks. The data sharing agreement with the state child welfare agencies (DCF) is in place and data matching procedures to obtain maltreatment data are in process.

Finally, the Kansas MIECHV PMS gives the State the capacity, flexibility, and infrastructure to build additional modules into this integrated system to meet further evaluation or CQI needs. Data driven decision making and the effective use of data to improve practice and outcomes is at the core of the State's proposed innovations through this development proposal. The Kansas MIECHV PMS will be further expanded to ensure that the State can effectively evaluate and monitor all MIECHV program activities and outcomes over time, particularly the impact of new innovations within communities. The aforementioned Data/Evaluation Workgroup meets every one to two months to provide consultation and assistance in the necessary data and evaluation activities and will continue throughout the program implementation.

Coordination with Other Entities and Programs. To support the demonstration project objectives and activities, the MIECHV Program will actively coordinate and collaborate with a number of early childhood partners and initiatives. As previously described, coordination will occur with the home visiting program models, workgroup partners, various training and technical assistance providers, and local community partners. Furthermore, the MIECHV Program will work with KHSA, KECCS, ECAC, State agencies and other key agencies/initiatives to construct plans and implement strategies for coordinated state training and professional development. KECCS and MIECHV will also work collaboratively to re-initiate and drive forward a statewide home visiting task force/coalition, and/or communications network. Kansas MIECHV will also coordinate with the Missouri MIECHV Program and Children's Mercy Hospital on the bi-state Kansas City metro collaborative efforts.

State Administrative Structure. The lead agency for the MIECHV Program, as designated by the Governor of Kansas, is the Kansas Department of Health and Environment (KDHE). The MIECHV Program and Home Visiting Program Manager are based in the Bureau of Family Health (BFH). The mission of the BFH is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH administers the Title V Maternal and Child Health (MCH) Services Block Grant Program, IDEA Part C Infant-Toddler Services program, Nutrition and WIC Services, Children and Youth with Special Health Care Needs, Newborn Metabolic Screening Follow-up, and Newborn Early Hearing Detection and Intervention programs, and Child Care Licensing as well as other state and federal funding for maternal and child health, reproductive health, abstinence education, and teen pregnancy case management programs. Plans have just recently been initiated in the KDHE BFH to integrate the MIECHV, MCH, and Part C programs into the same work section which will facilitate further coordination of objectives and activities in the present and future.

Sustainability and Integration into Ongoing Work. Essential to the Kansas MIECHV development project is strategic planning and collaboration at a number of levels to support incorporation of goals, objectives and activities into the ongoing work of KDHE and other partners. This includes the following: integration of the MIECHV Program with the Title V MCH program; the State Home Visiting Work Group and representative agency partners; the statewide home visiting task force/network; the state professional development system; the bi-state Kansas City collaborative; and, of course, the local MIECHV teams. Incorporation and integration into long-term plans of other state and local early childhood, health, mental health and family support systems, strategic plans and initiatives will also be explored. Because the Kansas MIECHV Program builds on existing partnerships, it has a greater likelihood of administrative, public, and community acceptance and commitment. Project activities will emphasize providing a framework for ongoing implementation that can be targeted through programmatic decision-making and identifying and creating the infrastructure and support for systems development that will have impact beyond the project period. The MIECHV project will contribute to efforts in Kansas focusing on optimizing funding for effective services within a comprehensive system. During these turbulent economic times, it is critical to have program outcomes and cost effectiveness data. This project will accomplish both and thus lead to a stronger likelihood of sustainability. Information and findings will be shared across systems, partners, and initiatives, at meetings and conferences, to fully integrate results into ongoing decision-making at the state, local, and program levels.

V. RESOLUTION OF CHALLENGES

Many unique and similar challenges exist for the effective provision of home visiting services in southeast Kansas and Wyandotte County. Challenges unique to the largely rural communities of **Southeast Kansas** often center on limited resources and sparsely populated areas. This presents challenges related to distance between service access points and where families live. Service providers have difficulty recruiting and retaining qualified staff. Enrollment of high needs families in rural areas is especially challenging due to feared “stigma” and this varies from one community to another. For example, not all existing slots for home visiting services are filled in Cherokee County. In Montgomery and Labette counties, however, home visiting programs operate at caseload capacity. Additionally, some programs face language barriers that limit their services to non-English speaking families.

In **Wyandotte County** most of the home visiting programs currently operate at caseload capacity. As a result, many families cannot receive full services immediately upon referral or application and some families are not matched with the home visiting approach that is ideally designed to meet their family’s goals and outcomes. Difficulties with engaging families in services after referrals are made are common. Mechanisms to support follow-up are lacking. There is a lot of mobility across state and county lines in the area which creates many referral, service, and territory challenges. with families are lacking. Additionally, programs have limitations, or are even unable to serve, families who speak languages other than English. While there is indeed a need to be able to communicate with more families in Spanish, there is a large need with numerous other cultures and languages as well. For instance, Connections receives approximately 1-2 referrals each month for families who speak a language other than English or Spanish. They report great difficulties serving them and even more difficulties finding a home visiting program which can, thus these families are often put on indefinite waitlists or even

declined for services. For example, the EHS program currently has 5 families from Malaysia, Burma, and Somalia who have been on their wait list for nearly a year and have not been able to enroll them due to the language barriers. One of the PAT programs also has Somali and Burmese immigrants they want to serve. One of the PAT programs is aware of Somali and Burmese immigrants they would like to serve. Last year, the Part C program provider reported that they were serving up to 12 different languages in their caseload of families.

To effectively address these challenges, we are proposing multiple approaches to improve engagement of at-risk families, additional resources to address substance use and mental health issues, and coordination of services across models to match clients to the home visiting service best designed to meet family goals and outcomes, and address caseload issues. A key emphasis on overcoming implementation challenges is to ensure that the project and partners are focused on supporting implementation drivers known to be key for successful program development. This includes providing ongoing training, technical assistance, resources, and supports for work with culturally diverse populations, and participants experiencing substance use and mental health concerns. Various expert consultants, trainers, and resources will be sought and involved to identify and utilize approaches that will lead to improved knowledge, skills, practices and lead toward positive family and program outcomes. Coordinated efforts involving effective reflective supervision and mentoring practices will be initiated.

This project is dedicated to working across multiple models and agencies to further build a strong system of home visiting services. We will focus our efforts on known strategies that address implementation drivers related to internal management support and cross-systems partnerships. We are committed to continuing regular team meetings in each targeted area and supporting their work in accordance with their strategic plans. Staff across models will attend common trainings to build skills, knowledge and relationships. A related challenge may be how to further coordinate these efforts across models and agencies as an integrated system at the state level. It is expected that this will be a major focus of strategic planning with the various state level groups. Similarly, challenges are expected with building collaboration and trust for the bi-state Kansas City metro area project with Children's Mercy Hospital. Approaches will be employed to engage participation and input from all potential partner organizations and to facilitate collaboration building and strategic planning processes to ensure that the MIECHV home visiting program is a partner within the work of the state's larger early childhood system building efforts.

A third identified challenge will be effective development and expansion of home visiting services as well as coordinated outreach and referral systems in multiple rural counties, where there are large distances and isolated areas, and there is lower trust and higher stigma of involvement in services. Focused work will be needed to involve staff and partners that are trusted in the local areas, identify and utilize appropriate, effective outreach, marketing and communications tools, and determining outreach, screening and referral protocols that fit the unique nature of each county.

A fourth challenge warranting mention is conducting a rigorous evaluation. Some programs may feel threatened or overwhelmed at the prospect of the proposed evaluation and concerned about the effect on families and their staff. The evaluators are committed to securing buy-in and understanding from participants, partner agencies, and staff from the start and throughout the process.

VI. EVALUATION AND TECHNICAL SUPPORT CAPACITY

The Kansas MIECHV development project will use a collaborative *Participatory and Utilization-Focused* Evaluation (Patton, 2008) aligned with State goals of data-driven decision making through CQI and performance monitoring of progress. It is focused on using the evaluation to inform program, policy, and organizational decision making. Evaluators will work with state and local stakeholders to refine the proposed evaluation plan and define success indicators for programs. All evaluation activities will be guided by a set of research questions aligned with the intent of Kansas' proposed development activities. The evaluation team will use multiple methods of data collection to triangulate information across domains using a process evaluation and two impact evaluations for this project. Methods and measures will be linked to the domains and will yield useful information for stakeholders to understand and make meaningful changes to programs and systems based on solid data. The plan includes assessing implementation drivers (Fixsen, Blase, & Naoom, 2009) that support and facilitate successful service delivery and outcomes associated with evidence-based home visiting programs.

Evaluation Plan: Evaluators will focus on assessing the *implementation* and *impact* of the three main development areas for this project: 1) Improved engagement and service delivery of at risk population; 2) Improved screening, referrals, and resources for substance abuse and mental health services; and 3) Improved collaboration and coordination in communities implementing evidence-based home visiting services. This project is developing the State's capacity to provide deeper home visiting service penetration in the communities with highest need. The evaluation is designed to capture factors that facilitate or hinder the implementation of proposed activities and measuring impact of those innovative approaches on child, family, and system outcomes. The evaluation builds on cost efficiencies by seamlessly integrating evaluation data into the existing cross-model MIECHV Performance Management System that supports Kansas' efforts at collecting, analyzing, and reporting benchmark indicators for federal requirements and for continuous quality improvement activities. The State will build upon existing infrastructure to effectively monitor progress and analyze impact of services over time and across programs, providing the evaluation team with a robust tool to support rigorous evaluation and research needs.

The Kansas MIECHV evaluator has developed a comprehensive evaluation and data collection plan to conduct the implementation and impact evaluation components and produce meaningful information and data to support the identified goals of this development project (see Attachment 1, Table 2). The evaluation utilizes a multi-method approach to collect qualitative and quantitative data to assess implementation and impact of MIECHV program activities. Given the complexity of measuring change at multiple levels, evaluators carefully identified data sources and collection methods to appropriately address each research question and triangulate data across domains. Data sources primarily include program records, cross-program management information system (MIS) data, client and staff surveys, fidelity assessments, child and family measures, and program mapping/client tracking systems. Additionally the evaluation team selected time intervals that would best capture the evolution and change over time of implementation and outcome data given the project timeframes.

Research Questions: The following research questions tied to specific development project focus areas will guide the evaluation:

Development Focus	Research Questions
1. Improve Quality of Home Visitation Services	RQ1a. To what extent is staff qualified to effectively implement innovative, evidence based practices? RQ1b. To what extent are data used to inform implementation and practice? RQ1c. To what extent are staff improvement activities implemented as intended across programs and sites?
2. Improve Collaboration and Coordination of HV and Early Childhood Services Within High Need Communities	RQ2a. To what extent are HV referrals and services coordinated within the broader early childhood community? RQ2b. To what extent are HV and EC funds available and shared for continued implementation and sustainability of services?
3. Improve Engagement and Service Delivery to At-Risk Population	RQ3. To what extent are at-risk populations receiving and engaged in home visiting services?
4. Improve Resources to Address Mental Health and Substance Abuse Issues for At-Risk Populations	RQ 4a. To what Extent does MBD reduce postnatal depression and improve social support and parent-child relationships? RQ4b. To what extent does MI improve engagement and retention in HV services and support successful referrals to substance abuse treatment services? RQ4c. To what extent does cross-systems collaboration and mental health consultation with partner agencies improve engagement in services?

Logic Model. The existing MIECHV logic model found in Attachment 8 outlines the theory of change and hypothesized links between program activities and outcomes under the formula grant. Building upon this framework, the MIECHV development project logic model in the same Attachment shows the new proposed implementation and intervention activities and their proposed link with specific outcomes.

Process Evaluation: To address our research questions, the Kansas MIECHV development project will use an *Implementation Evaluation* design which incorporates a program process evaluation and a program monitoring component. This evaluation is perfectly suited for Kansas’ development as it seeks to build the capacity of evidence-based home visiting models and systems in targeted at-risk communities. This design produces quality information about key implementation drivers (Fixsen, Blase, & Naoom, 2009) that enhance fidelity and outcomes associated with evidence-based home visiting programs. Finally, this design allows the evaluator and stakeholders to monitor progress towards goals and provides comprehensive implementation analysis of both service utilization (i.e., coverage, engagement) and organizational functions (i.e., delivery system effectiveness, professional development and training, coordination of services within communities). The complete evaluation plan is found in Attachment 1, Table 2.

Home Visitation Trajectory Study: One key feature of the process evaluation is to evaluate engagement and quality of services with at-risk populations through a *home visitation trajectory study*. The plan includes following a randomly selected sample of 40-50 home visiting clients across programs in Year 1 and Year 2 for an in-depth quantitative and qualitative study of factors that encourage or impede engagement into home visiting services and community supports for these at-risk families. Evaluators will use existing service level data (e.g., number of home visits, length of stay in home visiting services, referral completions) and new data collected by field assessors to assess proposed drivers of engagement with services. Assessors will interview families multiple times over project years and administer measures of home

visitor-client relationship strength, communication style, behavioral checklists of engagement into services, and satisfaction with services. This data will be linked to home visitor data to analyze whether features of home visitor training and practices have an impact on engagement into services and, ultimately, outcomes for these families. Such data will help stakeholders identify how to improve the quality of services delivered and key practices of successful engagement with these at-risk populations.

Cross-systems collaboration and coordination: The process evaluation will examine how and whether development activities improve outreach to at-risk populations, increase intakes and referrals to home visiting programs, and improve collaboration and coordination of services and funding across the early childhood systems in each target community. This includes mapping the process and points in a community via their centralized intake system from outreach to initial contact to intake to referral to home visiting service enrollment. Mapping community partnerships, funding sources, and measuring changes in collaboration and coordination will occur. Additionally, this evaluation will document how effectively two states (Kansas and Missouri) are able to collaborate services in a large metropolitan area serving a large number of at-risk families who cross state borders for services and support. Many of the same methods and data used in the successful *Every Child Succeeds* model (Ammerman and colleagues) in Ohio will be integrated into this evaluation.

Impact Evaluation: Kansas is proposing several innovative approaches to engaging at-risk populations and improving outcomes for families. To measure the efficacy of the proposed interventions on outcomes, the evaluation will include two impact evaluation components. Specifically, the evaluation will test whether adding the Moving Beyond Depression (MBD) program and Motivational Interviewing (MI) to existing home visiting services will improve mental health outcomes and client retention into services. MBD has been shown to decrease depressive symptoms and increase social support and parent-child relations in home visiting clients (Ammerman et al., 2011; Ammerman et al., 2005) while MI has been found to increase retention into services, particularly substance abuse services (Carroll et al., 2008). To test the efficacy of these approaches, evaluators have proposed two rigorous research designs tailored to how each approach is embedded within the service delivery system of home visitation models.

Moving Beyond Depression (MBD): As previously described, MBD is a program that provides In-home-Cognitive Behavioral Therapy (IH-CBT) and will be implemented in one community (Wyandotte County, KS) of this project. IH-CBT is an adapted form of cognitive behavior therapy that is specifically designed to meet the needs of depressed mothers in home visitation. Provided by a trained therapist who provide treatment in the home, IH-CBT helps effectively treat depression, prevent relapse and maximize the impact of home visitation.

Design. To test the efficacy of MBD in conjunction with multiple home visiting models in Kansas, the evaluation team will use a *Regression-Discontinuity* (RD) design. Essentially, this design is a pretest-posttest program-comparison group strategy. Assignment into treatment conditions is based on a cutoff score on an initial screening measure. For this design, evaluators will use the existing maternal depression screening tool, the Edinburgh Postnatal Depression Scale, as the basis for determining cutoff scores and intervention eligibility. This cutoff criterion implies the major advantage of RD designs -- they are appropriate when targeting a program or treatment to those who most need or deserve it. Thus, unlike its randomized or quasi-experimental alternatives, the RD design does not require assigning potentially needy individuals to a no-program comparison group in order to evaluate the effectiveness of a program. This

design is also highly compatible with the implementation plan for the MBD program itself, which requires cut-off scores as its eligibility criterion. Thus, the design is diagrammed below:

Regression-Discontinuity Design			
Cutoff	Outcome	Intervention	Outcome
Cutoff	Outcome		Outcome

Regression analyses will be used to show whether the MBD intervention given at the point of cutoff significantly improves pre-post gains in outcomes relative to no intervention. If MBD has an impact on outcomes, the effect of MDP will have a more amplified effect on those clients who screen positive for maternal depression and receive the intervention than if no intervention had been given. The control group acts as a guide to show the relative pre-post gains in positive mental health we would expect in a ‘normal’ population (e.g., non-positive maternal depression screen). The difference between the two regression lines in terms of relative gains in pre-post scores can be attributed to the MDP intervention at the point of cut-off in the two groups. This robust quasi-experimental design provides the right kind of methodology for the type of program we are implementing and affords the kind of rigor that is necessary to test MDP efficacy.

Target population and Group Assignment: Based on estimates from Ammerman and colleagues (2010), maternal depression prevalence is 26% in the general population and up to 50% among clients in home visitation services. This development grant will expand the capacity in Wyandotte County to serve approximately 104 additional families across programs in that community. All new home visiting clients will be screened for depression using the Edinburgh Postnatal Depression scale and eligible for study participation. Those with a cutoff score of 11 and above will be assigned to the MBD treatment condition (i.e., regular home visiting program enhanced with MBD in-home therapy) and those scoring below will receive treatment as usual (i.e., regular home visiting program). Consents to participate will be obtained on all participants prior to study enrollment.

Sample Size and Power Analysis: A power analysis was conducted using GPower 3.1 for linear multiple regression to estimate sample size to detect a small effect size (.15) with 95% power with one predictor (treatment group). Results showed that a total sample size of 89 would be sufficient to statistically test the model using this design. Adding two additional predictors (e.g., dosage, demographics) to the model would require a total sample size of 107 clients to achieve the same power to detect the same effect size. Prevalence estimates of the eligible caseload of 102-112 would suggest 30-50% screen positive (i.e., above the cutoff score for the Edinburgh) while the other half would score below the cutoff. From the pool of eligible clients, a random sample will be drawn until reaching a total sample size of N= 107 clients who would be served under this program over the course of two years.

Outcomes: MBD has been shown to effectively reduce depressive symptoms, increase social support, and reduce parenting stress and build parent-child attachment (Ammerman et al., 2011). Outcomes for this study include pre-post measurements of: Depressive symptoms using the Center for Epidemiologic Studies Depression Scale (CES-D); Social support and family functioning using the Protective Factors Survey (PFS) Social Support and Family Functioning subscales; and Parent-Child relationship using the HOME Responsivity and Acceptance subscales. All home visiting programs collect data on the PFS and HOME at multiple timepoints.

Evaluators will collect additional data on depressive symptomology using the CES-D, a highly reliable and valid self-report instrument widely used in both general and clinical populations. It is short (20 questions) and easy to administer. Evaluators will use existing data to conduct exploratory analyses of the impact on additional measures such as engagement and child maltreatment and injuries which may be linked to parental neglect as a result of maternal depression. Data from this evaluation component will help demonstrate whether service enhancements to existing home visitation programs improve the efficacy of such programs on adult and family outcomes above and beyond traditional home visitation models.

Motivational Interviewing: To better train and prepare home visitors to effectively engage home visiting clients through collaborative, person-centered guidance to elicit and strengthen motivation for change. This is an evidence-based practice that is particularly focused on helping home visitors engage and prepare clients to seek substance abuse services.

Design. To evaluate the impact of training on MI on engagement into services, evaluators will use a *Cohort Difference-in-Differences* design, a quasi-experimental research design that allows MI training to be staggered over time by home visitor cohorts to compare pre-post client engagement outcomes. This methodology was chosen over random assignment given the nature of the intervention (e.g., expensive training and time commitment for supervision and feedback) embedded within the program milieu of caseloads and staffing. This design allows for more efficient use of data to improve practice and coaching without compromising the integrity of strict design requirements. In other words, program staff can focus on implementation drivers and improving practice around MI within a cohort without worrying about contaminating the evaluation of it. Evaluators will use a difference-in-differences approach to analyze the relative change in outcomes by cohort. The following figure shows this design, with O being outcomes measured over time and X being the MI intervention:

Cohort Difference-in-Differences Design					
	6 Months		12 Months		18 Months
Cohort 1	O ¹	X	O ²		O ³
Cohort 2	O ¹		O ²	X	O ³

Pre-post levels of engagement and service referral completions in participants whose home visitors have received MI training will be compared to those whose home visitors have not. Implementation of the MI training protocol will be staggered over time with *Cohort 1* home visitors in both Wyandotte and Montgomery Counties receiving MI training in the first 6 months of the demonstration project. *Cohort 2* home visitors will receive MI training at 12 months of the project. Within a year, all MIECHV home visitors will have received MI training.

The *Difference-in-Differences* design and analysis is appropriate when it can be demonstrated that the intervention and control groups are well-defined and equivalent. Home visiting clients entering services in the first 6 months with an MI-trained home visitor should not be different than clients entering services in the first 6 months with a home visitor who has not been trained in MI. Additionally, trends in pre-post engagement between the treatment and control group would be the same in the absence of an intervention like MI. An additional comparison will be made on length of stay in home visiting services (dosage) for all home visiting clients to provide longitudinal data on services under conditions where MI was completely absent (pre-development project) and then when it was present (post-development

project). This tests the overall efficacy of MI on client engagement in services over a longer period of time and with additional data and larger sample sizes.

Target Population: All clients served by new and existing home visitors in both Wyandotte County and the southeast counties will be evaluated. Current caseload under the formula funding is 183 and that is expected to double to 421 with this development project.

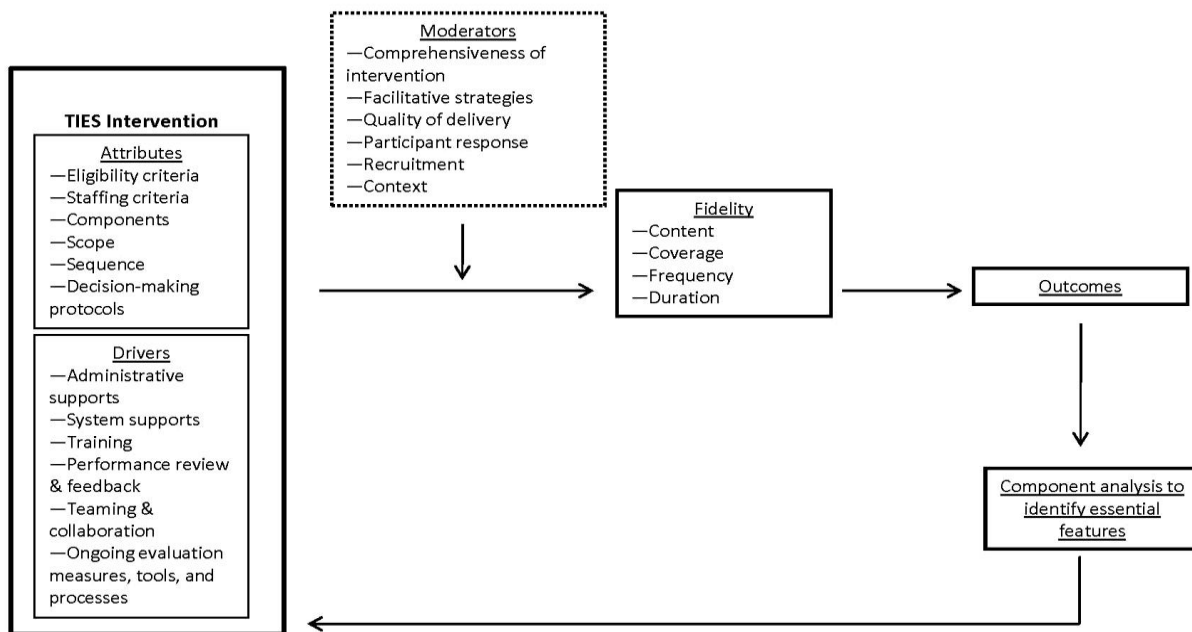
Sample Size and Power Analysis: Using G-Power 3.1, a power analysis to determine an appropriate sample size to detect a moderate effect size (.5) with 95% power showed that a total sample size of 176 is required, or 88 home visiting clients per cohort. Given the development plan to hire approximately 14 new home visitors across programs and communities with a combined caseload of 238 plus existing caseloads, the program would support the sample size requirement.

Outcomes: Existing *service level data* (e.g., number of home visits, length of stay in home visiting services, referral completions) will be used to analyze impact of MI on proxy measures of engagement with home visiting and community services. These measures are collected as part of the existing benchmark data collection for CQI and federal reporting requirements, providing complete historical data on all MIECHV clients. Additionally, evaluators will utilize data collected as part of Home Visitation Trajectory Study (see *Process Evaluation*) to include outcomes related to *home visitor-client relationships and satisfaction* with home visiting services.

Promising Approach Evaluation Plan. The TIES Program is designated by the Kansas MIECHV project as a Promising Approach for families affected by substance abuse. Further refinement of the TIES model for full implementation and replication in Wyandotte County is currently underway with Kansas MIECHV formula funds. This work will also be integrated with the MIECHV development project; it is anticipated that strong structural components proposed and the linkage among the evidence-based models in Kansas will enhance the development of the TIES model. Conversely, it is expected that the implementation study of TIES and the effectiveness study projected for Years 4 and 5 will also strengthen this competitive application by contributing to the enhancement of supports for families affected by substance abuse and mental health challenges, which is one primary objective of the project.

The plan for the implementation study of the TIES model uses a framework adapted from Hasson (2010), Carroll et al. (2007), Fixsen, Naoom, Blase, Friedman, & Wallace (2005) to fit the TIES model. Figure 1 displays this framework.

Figure 1. Implementation Evaluation of the TIES Program Model



Adapted from Hasson (2010).

As a comprehensive decision-making model for women and their drug-exposed infants, TIES is designed with flexibility to address immediate and changing needs of participating women and their children through the infant’s age of 24 months. The TIES model builds upon a foundation of trusting relationships established through home visitation, supplemented by an integrated community network for enhancing family strengths and individualizing support. The TIES evaluation team and TIES program staff are compiling and documenting all aspects of the intervention, including both specific attributes of the interventions that service recipients receive and supports that facilitate and organize the process of providing the intervention (Fixsen et al., 2005). A Blueprint is underway, which will include all instructions, protocols, materials, and measures necessary for implementing the intervention with high fidelity. The additional measures necessary for this comprehensive evaluation of the moderators and fidelity variables are also being piloted. Moderator, fidelity, and outcome data will be analyzed, and the essential features of the program will be identified during Year 3 of the Kansas MIECHV Program. Using a method of collective inquiry, the TIES evaluation team and the TIES program staff will discuss results and modify the attributes and drivers of the TIES intervention accordingly, with a goal of improving the effectiveness of the intervention.

Based on findings of the implementation study, the proposed effectiveness study of the TIES Program Model as a Promising Approach is projected for years 4 and 5 with formula funds. Additional review of the attributes, drivers, and moderators will occur, and the modified version of the intervention will be tested using a rigorous experimental design. A concurrent control group receiving standard care will be selected for comparison with the treatment group. By necessity, the current standard of care would be beyond the control of the researchers, and would produce a wide degree of heterogeneity in the control group; comparison to a broad range of heterogeneous interventions rather than a single narrowly defined intervention provides a more realistic assessment of the overall added value of the TIES Program. Careful matching of subjects in treatment and control groups is projected to occur by zip code, maternal race/ethnicity, maternal age, referral source, drug(s) of choice, and time of referral (prenatal, less

than 15 days postpartum, 15 to 90 days postpartum). An evidence-based evaluation of effectiveness would ideally use randomization, which will be carefully considered. Logistical issues, tendency toward a biased sample, and ethical review of the standard of care for the control group may lead to consideration of a tightly matched cohort of control patients as a viable alternative to randomization. Key variables needed for matching are readily identifiable at baseline and matching will produce a fair and even mix of families in the two groups. Even if randomization is adopted, matching pairs of subjects and randomizing within that pair will be a necessary tool to assurance a balanced and comparable control group, given the wide range of heterogeneity among families. It is anticipated that the following outcome measures will be evaluated for possible inclusion in the effectiveness phase of the research: referral to child protective services, child placement, parental drug use, and housing. For prenatal enrollees, outcomes measures will include infant gestational age and birth weight, as well. If practical, household income and parenting skills, as measured by the AAPI, will be evaluated. Because of the serious concerns of attrition with high-risk populations, all efforts will be made to stay in contact with families in the control and treatment groups, and even if families refuse to cooperate with the research team, some outcomes can still be obtained from public records.

Each of the research questions posed for the development project is well-aligned with the implementation study of TIES as a Promising Approach. Staff qualifications, data-informed practice, and staff improvement (as noted in Research Questions 1a-1c) are currently being studied, and coordination with the Kansas evaluation will enhance this examination of the TIES intervention. Certainly the implementation study of the TIES replication in Wyandotte County will assess the coordination of referrals and services (Research Question 2a), and doing so in partnership with the Kansas network will be advantageous. With TIES' long history of providing home visitation services to high risk populations, it is projected that the addition of the TIES model to the evidence-based models will strengthen Kansas' capacity to achieve the desired outcomes to Research Questions 3a and 4a-4c. The TIES evaluation team is committed to coordinating efforts with the Kansas evaluation team to integrate the evaluation plan for this competitive application into the TIES implementation study (and the effectiveness study during FY 2014).

Reports and Dissemination. To ensure effective use of evaluation data by program staff and State stakeholders, evaluators will prepare an evaluation report annually of progress and findings to date. Evaluators will also share findings with the State and local program staff through monthly meetings and conference calls and aided by community dashboards and other effective data visualization methods.

Evaluation Staff Experience: The evaluation team consists of Ph.D. level researchers and evaluators who have extensive demonstrated experience conducting evaluations on this scale and publishing findings in peer-reviewed journals. A CV of the evaluation PI outlines qualifications, previous evaluation experience and publications.

Teri A. Garstka, Ph.D. is currently an Assistant Director at the University of Kansas Institute for Educational Research and Public Service, serving as PI on multiple federal, State, and foundation funded projects. Dr. Garstka is a researcher and program evaluator in the content areas of child welfare, education, and social services for children, youth, and families. She also is more broadly focused on designing and utilizing data performance management systems for monitoring quality assurance and continuous quality improvement in service systems and agencies. She received her doctorate in Social Psychology in 1997 from the University of Kansas. She will serve as Principal Investigator for this evaluation and lead all aspects of it,

ensuring quality and timely deliverables. Her demonstrated evaluation and related experience can be found on her brief CV in Attachment 3.

Jacklyn W.R. Biggs, Ph.D. currently serves as a project coordinator with the Institute of Educational Research and Public Service and is involved primarily with evaluation of the Kansas child-welfare/education collaboration project and the Center for Restorative Education evaluation. She also assists with the data team of the Kansas MIECHV Program. Dr. Biggs received her doctorate in Social Psychology in 2012 from the University of Kansas, with a specialty in quantitative methodology and statistical analysis. Dr. Biggs will serve as Co-PI for this evaluation and will supervise the day-to-day activities and staff.

Kathryn L. Fuger, Ph.D. is currently the Director of Early Childhood and Youth Programs at the University of Missouri-Kansas City Institute for Human Development, conducts program evaluation, applied research, and assessment addressing such child and family issues as prenatal substance exposure, infant mortality, incarcerated fathers, and school readiness. She directs the DHHS Abandoned Infants Assistance Cross-Site Evaluation and evaluates the Kansas City Healthy Start program, the TIES program, and the Promising Approach being promoted by the Kansas MIECHV Program. Dr. Fuger provides evaluation and technical support for Missouri's early childhood comprehensive system and oversees assessment for numerous program improvement initiatives. Her doctoral degree in Education and Public Affairs and Administration equips her with a broad view of human service sectors that interface with families facing challenges.

Evaluation Costs. The cost of the Development evaluation will represent 10% of the total development request amount or \$300,000 per each year of the grant. The evaluation will be funded through the development award. The evaluation plan calls for multiple designs to effectively evaluate the impact of evidence-based interventions and to document a wide range of implementation process measures across multiple home visiting models and multiple agencies. New data collection and interviews with clients over time necessitate an adequate level of effort from the evaluation staff and related expenses for travel, participant compensation, and research materials. The primary cost of the Promising Approach evaluation is funded through MIECHV formula funds (via a subcontract of Children's Mercy Hospital) and an estimated \$30,000 in development grant funds will be budgeted to support the development evaluation activities over the two-year period

Organizational Experience and Capability: This MIECHV evaluation will be conducted by an independent team from the University of Kansas with demonstrated strength in participatory and utilization focused evaluation and a resume of previous successful evaluation experience in early childhood program evaluation at both the local, state, and national level. Additionally, KDHE and KU have a history of strong collaborative relationships across multiple early childhood programs and evaluation staff existing relationships and experience working with Kansas state agencies and non-profit organizations. Finally, the KU team has experience obtaining Institutional Review Board (IRB) approval for research and evaluation studies across all populations. An evaluator from the University of Missouri-Kansas City will conduct the evaluation of the promising approach, TIES. UMKC, through its Early Childhood and Youth Programs has a long history of conducting evaluations and research through federally and state funded grants or contracts.

VII. ORGANIZATIONAL INFORMATION

KDHE Mission and Structure. The lead agency for the MIECHV Program, as designated by the Governor of Kansas, is the Kansas Department of Health and Environment (KDHE). As the State's public health agency, the KDHE mission is to protect and improve the health and environment of all Kansans. The agency is composed of three divisions: Health, Health Care Finance, and Environment.

The MIECHV Program and Home Visiting Program Manager are based in the Bureau of Family Health (BFH), under the Division of Health. The Home Visiting Program Manager is responsible for day-to-day operations of the MIECHV Program, providing leadership and direction for planning and implementation of the plan, completing activities in support of the program goals and objectives, managing contractual procedures and agreements, providing project oversight, monitoring and preparing program reports and setting priorities. The position description for the Home Visiting Program Manager is included as Attachment 2 and the manager's biographical sketch is Attachment 3.

The mission of the BFH is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities." The BFH has three goals: (1) Improve access to comprehensive health, developmental and nutritional services for women and children including children with special health care needs; (2) Improve the health of women and children in the State through prevention/wellness activities, a focus on social determinants of health, adopting a life-course perspective and addressing health equity; and (3) Strengthen Kansas' maternal and child health infrastructure and systems to eliminate barriers to care and to reduce health disparities. The BFH administers the Title V Maternal and Child Health (MCH) Services Block Grant Program, IDEA Part C Infant-Toddler Services program, Nutrition and WIC Services, Children and Youth with Special Health Care Needs, Newborn Metabolic Screening Follow-up, Newborn Early Hearing Detection and Intervention programs, and Child Care Licensing as well as other state and federal funding for maternal and child health and early childhood development programs. This includes administration of the State Early Childhood Comprehensive Systems (ECCS) grant.

In addition to the MIECHV Program, the BFH administers two programs that are delivered via home visits, Healthy Start Home Visitors (HSHV) and Infant Toddler Services. For HSHV, MCH grants are provided to local health departments to provide outreach visits to pregnant women and families with newborns or infants up to age one. Under public health nurse supervision, trained paraprofessional visitors provide one to a few home visits to offer education, support and referrals to other community services. Objectives are to increase the use of cost-effective preventive health care services such as prenatal care, family planning, immunizations, nutrition and well childcare, promote early entry into and compliance with prenatal care, discourage unhealthy behaviors such as alcohol and tobacco use, identify families at risk and link them with services and supports, and improve and enhance parenting and problem solving skills.

The Part C Kansas Infant Toddler Services provides grants to local networks to assist in maintaining and implementing a statewide system of coordinated, comprehensive, multidisciplinary early intervention services for infants and toddlers with disabilities (birth through 2) and their families. The mission of early intervention in Kansas is to ensure the availability of a collaborative, comprehensive, family-centered service delivery system which meets the developmental needs of all infants and toddlers who have delays or disabilities. Services are provided in the child's natural environment, which allows for the greatest learning

and developmental potential, which often is in the child's home. In addition to home visits, services include family training, counseling, special instruction, speech-language pathology and audiology services, occupational and physical therapy, psychological services, services coordination, medical services as needed for diagnostic or evaluation purposes, early identification, screening, and assessment, social work, health and vision services.

As previously noted, plans are underway to integrate the MIECHV, MCH, and Part C programs into the same work section in the BFH. This will further facilitate coordination across these programs and provide further support to successfully achieve the MIECHV program requirements and objectives.

Organizational Chart. An organization chart for the Kansas MIECHV Program is included in Attachment 5.

Additional Home Visiting Infrastructure and Support: As previously mentioned, there is a need for a state level coordinated professional development system, professional standards and resources for cross-program, cross-discipline training. There are several training systems on which this can build. The Kansas MIECHV development project will collaborate with other partners to provide direction and support about how to best invest professional development resources for home visitors based on core competencies and common training standards models.

The MIECHV Program will partner with KECCS to convene the Kansas Home Visiting Task Force/Coalition and other opportunities for networking, development of common knowledge, best practices across program models, and developing a stronger structure of stakeholders.

A more explicit, actionable plan is needed to further propel effective integration of home visiting and the early childhood system. Home visiting has been a part of the State's early childhood system design since the inception of the KECCS plan framework. More robust discussion among stakeholders about how and where home visiting contributes and integrates into the State early childhood system (e.g., KECCS, ECAC, School Readiness Framework and the Longitudinal Data System) is expected to move forward. The KECCS plan will be updated in 2012-13 and goals and objectives that are specific to home visiting need to be reviewed, aligned and refined. This present opportunity would provide a framework to do so. Systemic planning that can be implemented with shared collective impact will be critical to child, family, community and educational setting outcomes at the state and local level. Development and implementation of a state longitudinal data system that connects early childhood, including home visiting, with the K-12 system and beyond will provide needed data to inform policies. Inclusion of the MIECHV home visiting program into the larger system will further inform and reform State strategic planning. Refining structures such as councils, workgroups, and task forces; interagency collaborative work; public engagement; and work around a policy agenda will be aligned with this larger work. It would be helpful to clarify what the objectives, benefits, and structure of an effective integration might look like as well as consider and identify specific strategies for long-term sustainability of home visiting programs as part of the state's early childhood system.

Support of Culturally and Linguistically Competent and Health Literate Services: The programs involved in Wyandotte County and the southeast Kansas counties are committed to providing culturally and linguistically appropriate services to their target populations. It is due to

the local programs' concern about this issue that it is being addressed as a primary objective of the development project. For this project, training and consultation/technical assistance will be provided for the home visiting and central screening and referral programs, appropriate to the local needs, to increase competencies and skills regarding communicating with and supporting families of different cultures (e.g., racial/ethnic, economic, rural/urban) based on best practices. The programs will incorporate culturally responsive, qualified language interpretation (i.e., contracted interpreter services, staff who are bilingual and share the culture of people they will serve), and other resources to facilitate effective communication and engagement of non-English speaking families. Consultation and training support will be sought from organizations which are experienced, qualified, and familiar with the language, cultural, and immigrant populations in the targeted communities. This includes the KDHE Center for Health Equity which works to meet the health needs of racial, ethnic, tribal and underserved populations. The Center serves as a centralized source of information, advocacy, and training for cultural competency in the Kansas public health system as well as evidence-based, best practice strategies to address reduction of disparities among these populations.

Assessing and Improving Services to Meet Needs of Target Population: Current data from a variety of sources was utilized for assessing the areas in need, population characteristics, service capacity, and constructing plans for this project. The MIECHV programs will continually use data to assess the performance of the project and programs including benchmarks, service utilization, quality and fidelity. CQI processes will utilize data that informs how services are provided and areas for improvement. The evaluation plan for the development project focuses on a number of research questions addressing how services meet the needs of the target population.

Organizational Capacity of Partnering Agencies. Descriptions of proposed and existing contracts are included in Attachment 4. **Local service partners** in Wyandotte County are: Project EAGLE Community Programs (affiliated with the University of Kansas Medical Center) – EHS and Connections Centralized Screening and Referral; Kansas Children's Service League (KCSL) - HFA; Unified Government of Wyandotte County and Kansas City, KS Public Health Department – HFA; USD 445 Kansas City, KS - PAT; USD 202 Turner – PAT; Children's Mercy Hospital - TIES. Southeast Kansas service partners are: Southeast Kansas Community Action Program – EHS; KCSL – HFA; USD 445 Coffeyville – PAT; Southeast Kansas Education Service Center – PAT; and Four County Mental Health Center – My Family Centralized Screening and Referral. Each of the involved local programs and their agencies have an established presence in the targeted service areas. They will have responsibility for managing and supervising day-to-day program operations and delivery of services. Each of the three evidence-based program state leaders for EHS, HFA, and PAT (described in Section I Introduction and Section IV Work Plan) will provide support to respective local programs to coordinate expansion of the evidence-based programs in targeted communities. All have extensive experience working with their home visitation program model and knowledge of the selected communities. These program leaders will work with the Home Visiting Program Manager to provide support to prepare for expansion of services, monitor fidelity issues, finalize common outcome measures, implement the data collection system and CQI plan, identify technical assistance needs related to adherence to the selected models, and coordinate community resources to support the MIECHV.

The **State Home Visiting Workgroup** includes state leadership from each of the home visiting program models and multiple state agencies and organizations. The Data/Evaluation Workgroup is composed of the three evidence-based home visiting model state leaders, program representatives from both Wyandotte County and southeast Kansas, and several researchers and evaluators. Each of these workgroups will meet at least every two months to provide guidance on planning, implementation, and evaluation of the project. Workgroup members are listed in Section IV Work Plan (p. 25). The members of these groups not only meet, but have been and continue to be actively involved with various aspects of the MIECHV Program work.

The **University of Kansas Institute for Educational Research and Public Service** is affiliated with the School of Education at KU and works closely with KU faculty, KSDE, local education agencies and private foundations to further its mission of providing faculty with infrastructure support for its research and providing public service to the State of Kansas. The Institute has expanded its capacity to focus on systems development and research and evaluation. This is particularly evident in the area of early childhood and child welfare where several cross-system collaboration projects demonstrate the abilities and skills of Institute staff to work with multiple agencies serving young children and youth, including key partners Department for Children and Families (DCF) and KSDE. Additionally, research and evaluation staff members at the Institute not only support several of the education-related projects previously mentioned, but also have built a portfolio of research and work in areas such as community-based child abuse prevention, home visitation programs, adolescent and family support programs, training and technical assistance on evidence-based programs and systems evaluation in early childhood programs.

Sustainability, Resources, and Commitment to Continue Services After Grant

Funding: Early childhood and home visiting partners already have coordinated efforts in Kansas focusing on optimizing funding for effective services within a comprehensive system. All of these partners are committed to diligent work on a plan and strategies that will construct long-term sustainable funding for evidence-based, quality home visiting and early childhood program services. State work to develop actionable strategic planning should include a realignment of budgets that support goals that will have collective impact on identified outcomes for children, families, educational settings and communities. Work by various local and state groups to achieve blended and braided funding and cost effective methods to provide accessible service delivery will be identified. A particular step will be to pursue the possibility of leveraging State Medicaid dollars for home visiting services. The Medicaid program is administered in the KDHE Division of Health Care Finance.

As current goals are revised and aligned, it is reasonable to assume that the difficult work of realigning state budgets, including requests for proposals (RFPs) that distribute funding to local programs would occur to support the States' strategic plan for an early childhood comprehensive system. The Kansas Children's Cabinet and Trust Fund is presently undergoing a rigorous assessment and planning process as to how the State Early Childhood Block Grant funds will be targeted to communities most at-risk and evidence-based programs that will substantially impact various child, family, and community outcomes. This process will drive the composition of a new RFP framework to be distributed for 2013 grants. The local MIECHV programs and teams are expected to be well-positioned to respond to the RFP.

The work of the MIECHV project will be a large contributor in the States' work via the successes of its focus on collaborative systems, centralized intake and referral in providing

families greater access to programs, and through its coordination of multiple home visiting programs that can be expanded and replicated. Lessons learned from the MIECHV project will be incorporated into focused work. The planned development and implementation of a state longitudinal data system that incorporates early childhood and home visiting programs with K-12 data and beyond will drive policy decisions and investments in what works. With the charge for professional development system work through ECAC, KECCS, and other initiatives and organizations, the MIECHV project will be an important collaborator and contributor. The resources of ECAC, KECCS, and MIECHV and other agencies will move forward the development of a plan and strategies that will lead to a more sustainable, coordinated professional development system for early childhood including home visiting programs. In addition, more intentional connections will be made with medical, mental health and other systems to integrate and coordinate resources that will support home visiting services.

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