



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

YEAR 2 APPLICATION FOR COLORADO

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SECTION 1: Needs Assessment and Identification of the State's Targeted At-Risk Communities

Colorado's Updated State Plan through the MIECHV program aims to target the state's highest risk counties with expansions of existing evidence-based home visiting programs to improve outcomes for children and families. Two urban counties, ranked 1 and 2 in risk factors, were selected to receive Year 1 formula funding: Adams County and Pueblo County. In Year 2 Colorado proposes to further expand services in Pueblo and Adams counties and to initiate expansion in the communities ranked 3 and 4: the San Luis Valley community, composed of two frontier counties (Costilla and Saguache) and one rural county (Alamosa); and, the community of Otero-Crowley which comprises the rural counties of Otero and Crowley. Table 1, below, illustrates the estimated expansion of services by county and model in Years 1 and 2.

Table 1: State Estimate of Year 2 Program Expansions, by Model and County

	Expansion Capacity (# of families)	Cost per Family Served	Total Cost	Year 1 Funding Awards	Year 1 # to be served	Amount to sustain in Year 2	Additional Families to be Served in Year 2	Cost of Expansion	Year 2 Funding Estimates	Year 2 # to be served
Adams										
NFP	50	4,800	240,000	230,000	50	240,000	0	0	240,000	50
PAT	400	1,300	520,000	220,000	180	224,750	135	175,000	399,750	315
HIPPY	28	2,500	70,000	70,000	28	70,000	0	0	70,000	28
Adams Total	478		830,000	520,000	258	534,750	135	175,000	709,750	393
Pueblo										
NFP	13	5,385	70,000	65,000	13	70,000	0	0	70,000	13
PAT	275	1,500	412,500	151,400	70	155,754	35	77,875	233,629	105
HIPPY	0		0	0	0	0	0	0	0	0
EHS-HB	10	11,340	113,400	0	0	0	2	22,680	22,680	2
Pueblo Total	298		595,900	216,400	83	225,754	37	100,555	326,309	120
San Luis Valley										
NFP	50	4,400	220,000	0	0	0	25	100,000	100,000	25
PAT	60	1,500	90,000	0	0	0	35	68,000	68,000	35
EHS-HB	20	12,500	250,000	0	0	0	2	25,000	25,000	2
SLV Total	130		560,000	0	0	0	62	193,000	193,000	62
Crowley-Otero										
NFP	13	5,769	75,000	0	0	0	13	70,000	70,000	13
PAT	30	2,167	65,000	0	0	0	30	65,000	65,000	30
HIPPY	0		0	0	0	0	0	0	0	0
EHS-HB	5	11,340	56,700	0	0	0	2	22,680	22,680	2
C-O Total	48		196,700	0	0	0	45	157,680	157,680	45
Total	954		2,182,600	736,400	341	760,504	279	626,235	1,386,739	620

Home Visiting Services and the Colorado Early Childhood System

Early childhood leaders and stakeholders across Colorado agree that the early childhood system includes four early childhood service sectors: early learning; family support and parent education; social, emotional and mental health consultation; and physical and oral health.

Colorado has long focused its early childhood system efforts on children from birth to age eight and their families. Early childhood partners are public and private, state and local, and cross the four early childhood service sectors.

The *Early Childhood Colorado Framework (Framework)* was developed by early childhood stakeholders in 2008 as a resource and guide for comprehensive early childhood systems work in Colorado. The *Framework* serves as the Early Childhood Comprehensive Systems grant state plan and guides the work of Colorado’s Early Childhood Leadership Commission. Since its release, state and local early childhood stakeholders use the *Framework* as a resource to identify needs, guide planning and decision making, and build partnerships. The *Early Childhood Colorado Framework*:

- **Recognizes the needs of the whole child and family** by including outcomes that cut across the early learning, family support and parent education, mental health and health sectors.
- **Communicates the vision for comprehensive early childhood work** by helping early childhood partners see how their work, individually and collectively, contributes to the greater picture of all children in Colorado being valued, healthy and thriving.
- **Ties “comprehensive systems building” language to specific strategies for action and measurable outcomes** for children, families and early childhood professionals.
- **Provides a framework to guide and focus the actions** of public and private stakeholders who work with or on behalf of young children.
- **Promotes an outcomes-based approach** to early childhood systems efforts.

Colorado’s Early Childhood Councils (ECCs) are the local governance structure for early childhood services in the state. In 2007, the Colorado General Assembly passed legislation that created a system of local ECCs through HB07-1062. The statute states the role of the councils is to “increase and sustain the availability, accessibility, capacity and quality of early childhood services throughout the State.” Early childhood services include: health, mental health, early care and education and family support. Council work is focused on developing the early childhood system through the six primary strategies identified in the Early Childhood Colorado Framework:

- Build and Support Partnerships
- Fund and Invest
- Change Policy
- Build Public Engagement
- Share Accountability
- Generate Education and Leadership Opportunities

Colorado's council system began with 17 Consolidated Child Care Pilots. Today 30 ECCs operate in 55 of the 64 counties across the state, serving over 98 percent of the state's population. The statewide system of local ECCs provides community-level infrastructure for convening cross-sector partners to identify, plan and address systems change needed to improve outcomes for young children and families. Councils connect multiple systems of care so families can navigate more easily and efficiently to obtain the services they need. Colorado's home visiting plan leverages the existing infrastructure by using the councils in the targeted communities as the hub for convening community partners for planning, decision-making and capacity building in support of home visiting services. The state's plan builds upon lessons learned from The Colorado Trust's Early Childhood Health Integration Initiative, which provided funding for planning and implementation of systems-specific work through the ECCs, to support local planning and systems building activities for the MIECHV program.

Colorado Counties/Communities Targeted for MIECHV Funding to Expand Evidence-based Home Visiting Services

As seen in Table 2, thirteen indicators were used to select the 15 at-risk Colorado counties as described in the MIECHV Needs Assessment. Of the 15 communities, six are classified as urban, five are rural, and four are frontier. Table 3 contains the methodology used to identify the targeted communities as requested in the Updated State Plan. The methodology consisted of assessing community strengths (criteria one and two) and risks (criteria three and four) for each of the 15 at-risk communities identified in the needs assessment. The result of this analysis ranked communities in the following order: 1) Pueblo County; 2) Adams County; 3) San Luis Valley (consisting of Alamosa, Costilla and Saguache Counties); 4) Otero and Crowley Counties; 5) Denver; and, 6) Morgan. Year 1 funding focuses on home visiting programs in the urban communities of Pueblo and Adams Counties. Year 2 focuses on funding programs in the rural and frontier counties in the San Luis Valley and Otero-Crowley communities. Following Table 3 is a description of each of the four communities targeted for formula funding in Years 1 – 5, including a risk profile and the estimated number of families who will be served by each evidence-based home visiting program in Years 1 and 2.

Table 2: At-Risk" Counties, Colorado's 13 Indicators and Metrics, and Number of Flags

INDICATOR	Pre-mature Birth	Low Birth Weight	Infant Mortality	Death Maltmt	3 Mat. Factors	Child Death	Kids in poverty (≤18 years)	Abuse and Neglect Rate (ages 0-17)	Crime arrests juvenile (ages 0-17)	High Schl Drop-outs grade 9-12	Report. Crimes residnt	Unem -plov. rate	Pop. Below Federal Poverty Level	# Flag (in red)
Unit	%	%	per 1,000	per 100,000	%	per 100,000	%	per 1,000	per 1,000	%	per 1,000	%	%	–
COUNTY	9.7	9.0	6.2	10.6	6.7	17.7	14.4	8.6	75.0	5.0	34.6	8.0	11.2	–
BACA	14.4	12.1		0.0	15.0	0.0	27.4	3.6	7.1	17.2	9.2	4.0	17.7	4
COSTILLA	14.7	14.9		0.0	12.9	0.0	37.4	0.0	0.0	0.6	0.0	12.4	24.8	5
SAGUACHE	10.2	9.4	17.8	0.0	13.8	0.0	43.9	15.2	37.8	5.5	12.2	11.6	29.9	5
HUERFANO	12.8	15.7	13.4	0.0	16.3		31.5	24.1	1.5	5.5	2.7	10.3	23.8	8
ALAMOSA	8.7	10.2	3.9	0.0	8.9	32.5	27.8	22.8	77.9	3.7	51.6	7.2	21.4	4
MORGAN	10.3	8.4	8.4	0.0	12.0	44.7	17.5	18.5	64.7	3.3	20.4	6.8	12.7	5
LAKE	12.8	15.3		0.0	17.5	0.0	19.4	6.0	29.7	10.5	16.8	11.2	12.7	5
OTERO	11.3	9.4	8.2	0.0	9.2	15.4	31.5	7.9	63.0	1.8	35.3	8.1	22.2	5
CROWLEY	12.8	10.6	0.0	0.0	10.0	0.0	34.4	15.2	6.1	3.1	1.9	9.9	46.2	6
CLEAR CREEK	11.2	11.2	14.6	0.0	3.5	0.0	11.0	18.4	36.9	1.8	23.3	7.8	7.4	3
DENVER	10.0	9.6	7.1	15.3	8.4	21.4	25.2	8.4	48.4	10.2	44.4	8.7	18.0	5
GILPIN	12.2	14.5	10.1	0.0	5.2	0.0	7.7	4.5	39.5	3.0	53.4	6.9	6.2	4
MESA	8.1	7.6	4.4	37.7	6.8	23.6	13.6	9.8	102.6	5.9	39.3	9.5	10.6	4
ADAMS	9.8	9.1	6.8	18.9	8.5	13.8	16.6	13.2	212.6	8.0	74.7	9.1	12.0	8
PUEBLO	9.2	9.4	6.3	33.5	13.0	24.2	23.9	7.7	9.8	6.3	45.8	9.8	16.8	8

Note: A blank box indicates that data was suppressed so no county rate was available; A zero means that no event occurred in that county during the time frame.

Table 3: Ranking Colorado Communities for the Colorado Home Visiting Program

AT-RISK COUNTIES*	Population Demographics (2009)		Criteria 1: Presence of an Early Childhood Council System (2011)	Criteria 2: Presence of Evidence-based Programs for Children 0 – 5 Years of Age†(2011)					Criteria 3: County Risk # FLAGS*	Criteria 4: Children Poverty (2006 – 2007) Kids (age <18) in poverty	RANK	Cnty. Class.
	Popula-tion (all ages)	Child Popula-tion (ages 0-5)		Early Childhood (EC) Council	NFP (age 0-2)	Early Head Start (age 0-3)	Healthy Steps (age 0-3)	PAT (age 0-5)				
ADAMS	442,971	46,590	EC Partnership	✓			✓	✓	8	16.6%	2	Urban
PUEBLO	158,368	12,512	Pueblo EC Council	✓			✓		8	23.9%	1	Urban
GILPIN	5,608	391	Triad EC Council	✓					4	7.7%	--	Urban
MESA	147,522	11,970	Mesa Partnership	✓		✓			4	13.6%	--	Urban
DENVER	618,656	62,966	Denver EC Council	✓	✓	✓	✓	✓	5	25.2%	5	Urban
C. CREEK	9,143	580	Triad EC Council	✓					3	11.0%	--	Urban
ALAMOSA	15,880	1,458	EC San Luis Valley	✓	✓		✓	✓	4	27.8%	3	Rural
CROWLEY	6,028	264	Judy Rusher				✓		6	34.4%	4	Rural
LAKE	8,299	729	Rural Resort Region EC	✓					5	19.4%	--	Rural
MORGAN	28,491	2,628	Morgan County EC				✓		5	17.5%	6	Rural
OTERO	18,935	1,637	Judy Rusher		✓		✓		5	31.5%	4	Rural
BACA	4,033	226		✓					4	27.4%	--	Front.
COSTILLA	3,361	205	EC San Luis Valley	✓	✓		✓	✓	5	37.4%	3	Front.
HUERFANO	6,914	363	Huerfano-Las Animas EC	✓					8	31.5%	--	Front.
SAGUACHE	7,067	535	EC San Luis Valley	✓	✓		✓	✓	5	43.9%	3	Front.

*At-risk counties were identified as part of the ACA MIECHVP Needs Assessment for CO (page 9);†Evidence-based acronyms

Adams County

Adams County is an urban county located in the Front Range of Colorado in the Denver Metropolitan Statistical Area. More than eight percent of Colorado residents live in Adams County (n=442,971). Among them, 10.5 percent (46,590) are children zero to five years of age. The proportion of children less than 18 years of age living in poverty in Adams County was 16.6 percent in 2009. As illustrated in Table 2, residents of Adams county experience poverty, high rates of crime (for juveniles and adults), with a high school dropout rate that is 1.6 times higher (8.0 percent) than Colorado overall (5.0 percent).

The Early Childhood Partnership of Adams County (ECPAC) works as a member of the Early Childhood Council System to enhance early childhood initiatives in Adams County. Founded in 2004, ECPAC is a coalition of public and private agencies working together to improve coordination and enhance capacity of services for young children and their families. ECPAC's purpose is to:

- Improve school readiness
- Increase the quality of early childhood care and education
- Increase availability and affordability of quality child care
- Provide stronger advocacy at the local, state and federal levels
- Position Adams County to take advantage of federal, state and local funding opportunities

In May 2011 ECPAC led a community planning process (described in Section 4) in which early childhood partners developed a local plan for expanding home visiting services. Partners reviewed county data, identified areas of particular concern, noted the existing community strengths and the areas where improvements are needed, and created a logic model and a home visiting expansion plan to guide expansion activities. A summary of the planning report follows:

- 1) A continuing concern is that 46.75 percent of single mothers with children under age five have household incomes at or below 100 percent of the Federal Poverty Level (FPL). The existing home visiting programs are appropriately targeting this population, but the need exceeds current capacity.
- 2) The high rate of three-risk-factor births and births to teen mothers is also of continuing concern, as these risks further compound the risks inherent to early childhood poverty.
- 3) High rates in Adams County of infant death by maltreatment and general child maltreatment are additional indicators that are positively impacted by effective home visiting programs, but the need for services exceeds current capacity.
- 4) Even though the prevalence of premature and low birth weight births is similar to statewide rates, partners are concerned because of the impact on school readiness and success for these children.
- 5) Partners recognize the continuing importance of providing culturally sensitive and bilingual programming to the high numbers of non-English speaking households.
- 6) Community strengths include the multiple organizations that promote relationships between service agencies and attract system funding at the community level; the local emphasis on evidence-based early childhood programs and evaluation of outcomes across all domains of the Early Childhood Colorado Framework that deeply informs and influences the efforts of early childhood partners; the strong cross sector partnerships and

strategic commitments to children from early childhood service providers, school districts, human services, health and mental health agencies.

- 7) There is significant interest in and demand for home visiting services in the county, as evidenced by lengthy waitlists that develop as a result of parents referring other parents, and strong retention and satisfaction rates among participants.
- 8) Adams County home visiting programs have strong referral networks in place to serve families in a wraparound fashion, and utilize connections both within and between service agencies to assist families in accessing resources.
- 9) The existing evidence-based home visiting programs are embedded in strong community organizations and fit together to create a non-duplicative continuum of services. Partners believe it is essential to maintain the existing continuum of services that address diverse family preferences and deliver the right level of intervention and intensity to meet families' needs.
- 10) Partners agree that the significant concentrations of risk factors, especially poverty, are much bigger problems that home visiting programs alone can address, but that adding capacity to these programs is a step in the right direction.
- 11) Partners identified the following opportunities for improvement: increase awareness of the impact and availability of home visiting services with human services case workers, pediatricians, obstetricians and high school personnel who may see teen parents; recruitment of bilingual Bachelor of Science in Nursing (BSN) nurses for the NFP program; training for home visitors and other early childhood professionals on depression and other mental health issues in adult and child populations; and partnership development with faith-based community organizations that provide parenting resources and other supports for families.

The evidence-based home visiting programs currently in place in Adams County are NFP, PAT and HIPPO. In fiscal year 2009 – 2010, NFP served 180 families through two agencies: Tri-County Health Department and St. Anthony Hospital. PAT served 170 children through the Growing Home program at Tri-county Family Care Center. HIPPO served 106 children through Adams County Head Start. An estimated 393 new families are expected to be served through formula funding in Years 1 and 2: NFP will sustain its Year 1 expansion of services to 50 families; PAT will sustain services to 180 families and expand to serve an additional 135 families in Year 2; and HIPPO will sustain its 28 family expansion in Year 2. Because of its high risk ranking and significant numbers of children living in poverty, additional resources are proposed for Adams County in the recently submitted competitive application for expansion funding.

Pueblo County

Pueblo County is an urban county located in the highly dense Front Range of Colorado. Over three percent of the Colorado population resides in Pueblo County (n=158,368). Among them, approximately 7.9 percent (n=12,512) are children ages zero to five years of age. The proportion of children less than 18 years of age living in poverty in Pueblo County is 23.9 percent, more than 1.5 times higher than the overall state average (14.4 percent). As identified in Table 2, residents of Pueblo experience high rates of poverty, unemployment, and crime compared to the overall state.

Pueblo Early Childhood Council (PECC) works as a member of the council system to enhance early childhood initiatives in Pueblo. As the leader for early childhood information in Southern Colorado, it is the mission of PECC is to:

- Establish partnerships
- Expand collaborative services
- Enrich communities
- Ensure opportunities for early childhood professionals
- Enhance the availability of quality care for young children
- Educate parents and students about the importance of quality child care

In May 2011, PECC led a community planning process to develop a local plan for the expansion of home visiting services. Early childhood partners reviewed county data, identified areas of particular concern and noted the existing community strengths and areas where improvements are needed. A summary of the planning report follows:

- 1) Pueblo's population includes rich and diverse ethnicity.
- 2) Based on a review of the data by community partners, primary concerns are the high rates of child death from abuse or neglect (three times the statewide average), teen pregnancy (over twice the statewide rate), children living in poverty, school dropout rates and high crime rates.
- 3) Community strengths identified by partners include the strong collaborative partnerships among family support agencies, the high percent of children covered by health insurance, and the high quality, dedicated and culturally adept staffs that provide home visiting services in the county.
- 4) Existing home visiting program participants represent all at-risk populations targeted by the MIECHV program with the exception of military families; however, as Fort Carson expands its troops and more families seeking housing move into Pueblo county, programs expect to see increases in this population among those served.
- 5) Partners believe offering a continuum of evidence-based home visiting programs is critical in addressing the needs of families expecting a child or parenting young children, as evidenced by the county's drop in rates of child maltreatment (at the same time that the state's rate has increased) which the county attributes to home visiting and family supports.
- 6) Pueblo has a high level of comfort with the concept of parent education through home visitation and all existing programs consistently have waiting lists.
- 7) Existing programs routinely collaborate with each other and other early childhood partners, sharing resource materials and training, coordinating referrals to engage families in the program that best fits their needs, and offering playgroups and shared trainings for program participants to create the best utilization of resources.
- 8) Partners noted the following areas for improvement: strengthen partnerships with the judicial, government and business communities to raise awareness of the critical importance of parenting education and support in the earliest years and leverage more local support for programs; the PAT program needs to work more intently with the private practice medical community; the NFP program needs to strengthen their partnerships with infant mental health and domestic violence resources; and all programs need to strengthen partnerships with faith-based community organizations.

Pueblo has three existing evidence-based home visiting programs in place: NFP, PAT and Early Head Start-Home Based Program (EHS-HB). In fiscal year 2009 – 2010 the Pueblo Community Health Center’s NFP program served 112 families and the PAT program, operated by Catholic Charities of the Diocese of Pueblo, served 278 children. The EHS-HB program at Otero Junior College served 114 children in the tri-county area of Bent-Crowley-Otero, and currently has a waiting list of 10 Pueblo County children. An estimated 120 new families are expected to be served through formula funding in Years 1 and 2: NFP will expand to serve an additional 13 families in Year 1 and will sustain that expansion in Year 2; and PAT will expand to serve 70 additional families in Year 1, and expand by another 45 in Year 2. The EHS-HB program expects to expand to Pueblo and serve two families. Catholic Charities is also in the process of implementing a HIPPO program in Pueblo to compliment its PAT program and better serve the population of three to five year olds. Upon review of the state’s expansion plan for Year 2, community partners may choose to shift support of 45 additional PAT families to serve an additional 45 families with HIPPO instead.

San Luis Valley (Alamosa, Costilla, and Saguache Counties)

Alamosa, Costilla, and Saguache counties are located in the San Luis Valley of Colorado. Alamosa County is a rural county with a total population of 1,880. Among them, 9.2 percent (1,458) are children zero to five years of age. Costilla County and Saguache County are frontier counties with total populations of 3,361 and 7,067, respectively. About 6.1 percent (205) of the total population in Costilla County and 7.6 percent (535) of the total population in Saguache County are children birth to five years of age. All three counties have high proportions of children less than 18 years of age living in poverty. In Alamosa (27.8 percent) and Costilla (37.4 percent), the proportion of children in poverty is double the proportion of children in poverty in the state (14.4 percent). The proportion of children in poverty in Saguache County (43.9 percent) is triple the proportion of children in poverty in the state (14.4 percent). Alamosa, Costilla, and Saguache counties also have high proportions of the total population in poverty, 21.4 percent, 24.8 percent, and 29.9 percent, respectively, compared to the state (11.2 percent). As seen in Table 2, residents of Alamosa County experience high child maltreatment rates and crime rates. Residents in Costilla County experience elevated infant morbidity and unemployment. Residents of Saguache County experience high infant mortality and unemployment rates. The infant mortality rate in Saguache County is 17.8 per 1,000 live births, more than double the Colorado infant mortality rate (6.2 per 1,000). An estimated 62 new families are expected to be served through formula funding in Year 2 with NFP, PAT and EHS-HB: NFP will expand services to 25 new families; PAT will expand to serve an additional 35 families; and EHS-HB will expand to serve two additional families.

Additional information and local knowledge will be provided to the Colorado Department of Public Health and Environment (CDPHE) following the community planning process, described in Section 4, in the San Luis Valley under the leadership of the regional ECC. Community partners will also have the opportunity to propose changes to the state’s plan based on the outcome of the local planning process.

Crowley and Otero Counties

Crowley and Otero are rural counties located on the Eastern Plains of Colorado. Crowley has a total population of 6,028 with 4.4 percent (264) children birth to five years of age.

Approximately 34 percent of children less than 18 years of age live in poverty in Crowley County. Otero has a total population of 18,935 with 8.6 percent (1,637) children birth to five years of age. Approximately 32 percent of children less than 18 years of age live in poverty in Otero County. Crowley and Otero counties also have high proportions of the total population in poverty, 46.2 percent and 22.2 percent, respectively, compared to the state (11.2 percent). As seen in Table 2, residents of Crowley County experience high rates of premature birth, maternal risk factors, child maltreatment, and unemployment. Residents of Otero County experience elevated rates of premature birth and infant mortality. An estimated 45 new families are expected to be served through formula funding in Year 2 with NFP, PAT and EHS-HB: NFP will expand to serve an additional 13 families; PAT will expand to serve an additional 30 families; and EHS-HB will expand services by two families.

Additional information and local knowledge will be provided to CDPHE following the community planning process, described in Section 4, in the Otero-Crowley community under the leadership of the regional ECC. Community partners will also have the opportunity to propose changes in the state's plan based on the outcome of the local planning process.

At-Risk Communities Identified But Not Selected for Implementation in Years 1 and 2

Colorado's recently submitted application for competitive funding under the MIECHV program proposes an expansion of services in the next highest ranked counties with expansion capacity: Denver County, a large urban area; Morgan County, which is considered rural; and Mesa County, also considered urban. This application also includes a plan to provide funding support for systems building efforts in these and the remaining counties of Gilpin and Clear Creek (urban counties), Lake (rural county), and Baca and Huerfano (frontier counties).

SECTION 2: Home Visiting Program's Goals and Objectives

The Early Childhood Colorado Framework, developed in 2008, recognizes the roles, responsibilities and resources across the health, mental health, family support and early learning system sectors and calls for increased alignment and integration of efforts to ensure all young children are valued, healthy and thriving. The goals of the framework are: to ensure Colorado children have high quality early learning supports and environments and comprehensive care; to ensure families have meaningful community and parenting supports; and, to ensure early childhood professionals have the knowledge, skills, and supports to work effectively with and on behalf of families and children.

Home visiting is a crucial component of the system that works to achieve Colorado's early childhood vision and goals at state and local levels. The following goals of the state's home visiting program align with comprehensive early childhood systems efforts:

- 1) Improve health and developmental outcomes for children; and
- 2) Strengthen parent-child relationships.

Objectives designed to support these goals include an expansion of evidence-based home visiting programs in identified at-risk counties, enhancement of early childhood systems at the

state and local level to support home visiting services, and a Continuous Quality Improvement (CQI) plan that focuses on quality issues for model implementations and state-level support for systems building.

Communities targeted for expansion are those where social, economic and environmental factors contribute to poor health and developmental outcomes for children and persistent inequalities in the health and well-being of families, as identified in the statewide needs assessment and described in the preceding section. The recently submitted Updated State Plan builds upon Colorado's rich history of early childhood home visitation programming that includes five of the evidence-based models approved for MIECHV funding and an additional model funded by the Administration for Children and Families Evidence-Based Home Visiting (EBHV) program.

State partners developing Colorado's home visiting program recognize an effective and sustainable plan for expanding home visiting services in at-risk communities requires leadership and support at the local level. Home visiting partners also recognize the importance of a comprehensive system of supports and services to improve outcomes, and embrace the Early Childhood Colorado Framework. Early Childhood Councils lead local systems-building work by involving partners from each of the four domains (Health; Early Learning; Family Support and Parent Education; and Social, Emotional and Mental Health); engaging in collaborative funding and policy decisions and shared accountability; and impacting availability, accessibility, capacity and quality of services. Using the ZERO TO THREE Community Planning Tool (adapted for Colorado) Colorado will continue to engage at-risk communities, under the leadership of the Early Childhood Councils, to guide the expansion of home visiting programs. This approach affords opportunities for evidence-based home visiting programs to work with Colorado's system of ECCs in a more formalized way than in the past, and promotes further understanding and respect for the multiple domains of early childhood work among community partners.

Colorado's Updated State Plan also seeks to increase coordination and integration of home visiting efforts at the state level. Colorado will be merging the original Home Visitation Coalition (formed in the late 1980's) with the Early Childhood Home Visiting Stakeholder Advisory Group convened by the Governor to develop the state's home visiting plan under the MIECHV program. This action will leverage the multiple early childhood partnerships that already exist to ensure thoughtful decision-making and capable guidance for Colorado's home visiting program.

SECTION 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of the Targeted Community(ies)

In Year 2, Colorado will expand existing evidence-based models serving families in the targeted communities: HIPPI, NFP, PAT and EHS-HB. Model approval letters, included in Attachment 8, have been received from Lia Lent, Interim Executive Director, HIPPI USA; Kammie Monarch, Chief Operating Officer, NFP National Service Office; Cheryle Dyle-Palmer, Interim President/CEO, PAT; and Yvette Sanchez Fuentes, Director of the Office of Head Start.

The HIPPY model is well suited for the following groups: parents with low educational achievement levels who lack the skills or confidence to prepare their children for success in school; teen parents; parents whose first language is not English; rural families; and areas where low school achievement is a major problem. The model's focus on children from age three to five meets a vital need in the continuum of support to families, especially those whose own educational experiences have left them inadequately prepared to support a child's school readiness needs. The model is aptly matched in its evidence-base to impact families affected by poverty and low educational attainment levels. For the Colorado communities expanding HIPPY, the model has been selected as it is the appropriate fit for the school readiness and positive parenting practice needs of those communities, particularly for children ages three, four and five who are from low-income and low educational attainment level families. Parents will gain the knowledge, skills, and confidence to help their children achieve success. HIPPY, as outlined in the HomVEE, is an evidence-based home visitor model with research to support improvements in health and developmental outcomes for children ages three to five years, particularly children living among families in at-risk communities.

The NFP model is designed to give first-time mothers valuable knowledge and support throughout pregnancy and until their babies reach two years of age. The program partners first-time moms with caring nurse home visitors who empower these young mothers to confidently create a better life for their children and themselves. Nurse home visitors support moms to have a healthy pregnancy, to improve the child's health and development and to become more economically self-sufficient. These primary outcomes are associated with preventing child abuse, reducing juvenile crime and increasing school readiness. This program fits well with Colorado's home visitation program goals to improve health and developmental outcomes for children and families and with the risk-factors identified in each of the targeted counties.

The PAT model, which serves pregnant mothers and their children from birth to age five, provides a cohesive package of services with four primary goals:

- Increase parent knowledge of early childhood development and improve parenting practices.
- Provide early detection of developmental delays and health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

PAT, as outlined in the HomVEE, is an evidence-based home visitor model with research to support improvements in health and developmental outcomes for children aged zero to five years, particularly children living among families in at-risk communities. As a model that serves families with a variety of characteristics and risks across the age range from prenatal to age five, PAT is well-positioned to serve families who may not qualify for other models based on factors such as not being first time mothers, being identified for services after the birth of the child or anywhere on the birth to five age range, having the custodial parent not be the birth mother, or not meeting the income requirements of other programs but still having identified risks in other key areas.

PAT is one of three National Affiliate Organizations of Strengthening Families, a framework that early childhood partners aim to embed into existing early childhood programs and services.

Model components are integrated to promote parental resilience, to increase knowledge of parenting and child development, and to encourage social and emotional competence of children—all vital protective factors.

The comprehensive, two-generation Early Head Start program includes intensive services that begin before the child is born and concentrate on enhancing the child's development and supporting the family during the critical first three years of the child's life. The framework of the Early Head Start program includes four cornerstones: Child Development, Family Development, Community Building and Staff Development. For Child Development, programs must support the physical, social, emotional, cognitive, and language development of each child, including parenting education. For Family Development, programs seek to empower families by developing goals for themselves and their children. Outcomes of Early Head Start include improved school readiness, improved family self-sufficiency, and improved home environment and parenting behavior, making the program a good match for the prevalent risk factors in the targeted communities of Pueblo, the San Luis Valley and Otero-Crowley.

The State's Current and Prior Experience with Implementing the Model(s) Selected

CDPHE has extensive experience with three of the four models eligible for MIECHV funding. HIPPY, NFP and PAT have the support of state offices designated by model developers and dedicated to building capacity within local agencies implementing the specific evidence-based model: the Colorado Parent & Child Foundation (CPCF) for HIPPY and PAT; and Invest in Kids (IIK) for NFP. Services provided by the state offices include technical assistance for community planning and implementation, staff training on the evidence-based program, technical assistance, program monitoring, liaison to national program offices and evaluation coordination. CPCF also provides financial administration through subcontracts with several implementing agencies. CDPHE has no prior experience with the Early Head Start program, however the Head Start State Collaboration Director has been an active partner in the development of Colorado's home visiting program and she has agreed to serve as the department's liaison to the regional office for the Head Start Program.

NFP has a long history in the state of Colorado. During the 2000 legislative session, the Colorado State Legislature passed a bill allocating Colorado's share of the proceeds from the Master Settlement Agreement negotiated between the States' Attorneys General and the tobacco industry. This legislation directed three percent (or roughly \$3 million) of the tobacco settlement proceeds in fiscal year 2000-2001 to create the Nurse Home Visitor Program (NHVP). According to the legislation, the NHVP receives an additional one percent (roughly \$1 million) each fiscal year until funding reaches 19 percent (not to exceed \$19 million), with the program slated to receive 19 percent each year in perpetuity. The State Board of Health established rules for the program, and the first grants were awarded in fiscal year 2000-2001 to nine sites. Due to state fiscal constraints, the NHVP appropriation has grown at a much slower pace than planned. In fiscal year 2011-2012 the appropriation is slightly over \$12.7 million for the third consecutive year. These funds were awarded to 19 sites to serve 2,500 families in 50 Colorado counties.

As established in statute, the NHVP is administered by two state agencies: CDPHE manages the fiscal components of the program; and the University of Colorado at Denver oversees the

programmatic aspects of the NFP program through its subcontractor, Invest in Kids. IIK works in partnership with local communities to identify, introduce, implement and ensure the success of research-based programs, and is responsible for the ongoing growth and development of the NFP in Colorado. IIK works closely with the Nurse-Family Partnership National Service Office (NFPNSO) to ensure communities offering NFP have the knowledge, skills and support needed to sustain the program and build strong nursing teams, and that all nurse-home visitors and their supervisors are prepared and supported in delivering NFP to diverse communities and families. IIK also helps local teams interpret client data for quality improvement and protects state funding for NFP through education and advocacy.

The PAT and HIPPY models are supported through a nationally designated state program office created in 1991. The Colorado Parent & Child Foundation is dedicated to the vision that parents are their child's first and most influential teachers, who prepare their children for success in school and life. CPCF promotes and supports high quality early childhood education programs and family initiatives to inspire parent involvement, facilitate school readiness, provide parents with updated information on child development and school readiness, and connect parents to critical services within their community.

Last year, Colorado's HIPPY program served 898 children and their families through six agencies in eight counties; and the PAT program served 2,689 children and their families through 34 agencies in 35 counties. The Tony Grampas Youth Services (TGYS) program at CDPHE, designed to reduce youth crime and violence and to prevent or reduce child abuse and neglect, funds 21 of these programs across Colorado. Eighteen were funded through direct contracts with the Colorado Parent & Child Foundation and three sites were funded independently but were provided model consultation and support by CPCF. Additional PAT and HIPPY programs are being considered for FY2012 funding by the Colorado's Children's Trust Fund (CCTF), also part of the Prevention Services Division (PSD) at CDPHE. The mission of the CCTF is to provide leadership and support to promote the establishment, implementation and expansion of state and local programs that reduce the occurrence of child abuse and neglect in Colorado.

The Head Start State Collaboration Director and the Executive Directors of both CPCF and IIK serve on the Stakeholder Advisory Group and are actively collaborating with CDPHE in the development and implementation of the updated state plan for home visiting. Staff members from CPCF and IIK have also provided leadership for the Colorado Home Visitation Coalition for many years.

Plan for Ensuring Implementation with Fidelity to the Models

CDPHE has collaborated with state offices for HIPPY, NFP and PAT for many years to support program implementation with model fidelity by subcontractors. All three models require an implementation application with a detailed plan approved by an implementation review team prior to granting the right to use proprietary materials. The value of supporting evidence-based models with strong national and state leadership has been effectively demonstrated in CDPHE's administrative relationships with sites using these models. Monitoring activities for CDPHE-funded programs are coordinated with the respective state offices and the national program

offices; progress reports and site visits are designed to assure model fidelity; and technical assistance and consultation from model representatives is readily available.

HIPPY has a strong internal monitoring system to ensure fidelity and Continuous Quality Improvement. The program assessment process requires sites to first engage in a self-assessment to measure the program against HIPPY standards. This rigorous self-assessment process is conducted by a team, including the coordinator, a home visitor, a parent and a representative from the implementing organization. The agency then receives an on-site visit by a national HIPPY trainer to monitor the quality of the program through file reviews, interviews and observations of home visits. Each site demonstrating quality programming by meeting all standards of the HIPPY model earns accreditation status and a two-year certification. Any standards not being met by the program must be addressed in a Continuous Improvement Plan developed by the site. The plan is submitted within 30 days of the site visit and plan compliance is monitored throughout the year by the national trainer.

NFP employs a CQI approach to monitor implementation and identify opportunities for improvement. Implementation of the program must be in accordance with 18 core model elements that increase the likelihood the program will be delivered with fidelity to the model tested in the original randomized controlled trials. A web-based information system generates data on key implementation components and outcomes. Reports made available to sites enumerate the degree to which they meet, exceed or fall short of implementation benchmarks, and guide the development of quality improvement strategies to improve program performance. In those cases where a site is faltering, a Performance Improvement Plan is required of the agency and is monitored by IIK to ensure compliance and correction.

PAT's Quality Assurance Guidelines help programs to plan an expansion of services, operations and, if needed, management. Ongoing compliance with the essential requirements is necessary for continued implementation of the PAT model and compliance with the essential requirements is reported annually via the Affiliate Performance Report. In addition, agencies engage in an expanded program assessment every four years, incorporating additional data, stakeholder input and documentation review to support the findings of their assessment. Both the focused annual compliance assessment and the comprehensive program self-study result in action plans that help ensure high quality services to children and families.

While CDPHE has no previous experience implementing an Early Head Start-Home Based Program, Home Visiting Program staff will have support from the Head Start State Collaboration Director and will work closely with the regional Head Start staff to coordinate implementation support and technical assistance for program expansions in accordance with the Head Start Program Performance Standards.

Annual continuation applications and proposals for further program expansion for all evidence-based programs will be reviewed and approved by both the respective model developers and CDPHE. Continuation funding will be contingent on fidelity of implementation and meeting funded caseload numbers.

Colorado's significant experience funding programs affiliated with HIPPI, NFP and PAT mitigates many of the risks and challenges expected when implementing a model or program for the first time. By dedicating funding to the expansion of existing successful programs in communities with strong early childhood partnerships, implementation risks are minimized, and opportunities for strong outcomes are maximized. Sustaining program expansions funded under the MIECHV program will be the primary challenge for both the state and the local communities. The certainty of this challenge compelled state partners to leverage the MIECHV opportunity to strengthen local counties through systems building grants to the local ECCs, as described in the following section. Advocacy work by IIK and CPCF at the state level will continue, aided by policy work at the state level that will be conducted by the home visiting leadership group. Additional opportunities to increase Medicaid reimbursement for home visiting services are being explored under the leadership of the Colorado Department of Health Care Policy and Financing.

SECTION 4: Implementation Plan for Proposed State Home Visiting Program

A process for engaging the targeted at-risk counties was developed and successfully implemented with two counties as part of Colorado's Updated State Plan. That process will be replicated in Year 2 with the counties/communities newly targeted for expansion, though with modifications necessitated by the very short timeframe within which the application is due. In Year 2, CDPHE will subcontract with the Early Childhood Council of the San Luis Valley community (representing Alamosa, Costilla and Saguache counties) and the Bent, Otero and Crowley Counties Early Childhood Council (representing Crowley and Otero counties) to lead a community planning process using the ZERO TO THREE Community Planning Tool (adapted for Colorado) to review community level data from the statewide needs assessment and apply local knowledge to examine community risks and unmet needs and identify strengths that support effective service delivery to families. Five thousand dollars will be allocated for expenses necessary to support the process, including utilizing a trained facilitator. The completed Tool will include community strengths and risk factors; characteristics and needs of potential program participants, existing home visiting services in the community (number and type of programs and initiatives); the models used by identified home visiting programs; existing mechanisms for screening, identifying and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the local or State level); and referral resources currently available and needed in the future to support families residing in the communities. Completed tools will also describe a plan for coordination among existing programs and resources, and how the expansion of home visiting services will address existing service gaps.

With the support of a facilitator, Council partners will use the information gathered in the planning process to create a logic model to guide the local home visiting program and then review the expansion plan proposed for their community for Year 2. Local approval or proposed changes to the expansion plan will then be provided to CDPHE, along with supporting documentation. If changes to a plan are identified and requested through this community planning process, CDPHE will contact the Region VIII Project Officer regarding the submission of a revision to this proposal.

Further support will be provided to these two Councils through subcontracts for identified systems building and infrastructure development activities known to enhance home visiting programming and improve outcomes for children and families. The Colorado Department of Education, Early Childhood Initiatives program, in partnership with the Colorado Department of Human Services, Child Care Development Fund program, provides funding and technical support to the Early Childhood Councils. As a requirement of the council support grants in the state Fiscal Year 2012, every ECC will complete a strategic planning process based on an assessment of local service-delivery systems serving young children and their families. Through this Local Systems Assessment (LSA), Councils consider community-specific data to identify and prioritize systemic barriers to address. The systems building subcontracts awarded to ECCs by CDPHE will build on the LSA and the results of the planning process for the MIECHV. A primary focus will be coordination and collaboration activities that support identification and enrollment of families into home visiting programs and effective referrals of families to community resources and data tracking at the local level to monitor current activities and guide future program investments. This investment will also elevate community capacity to engage in CQI activities and sustainability planning.

A home visiting advisory body is being established to merge the MIECHV Stakeholder Advisory Group with the Colorado Home Visiting Coalition. The new entity will engage in a facilitated planning process in the fall to complete the ZERO TO THREE “Self-Assessment Tool for States” and further refine Colorado’s home visiting vision and plan for the future. Consideration of policy and standards for home visiting programs will be included in the work of this advisory group.

The true experts on the models are best positioned to provide implementation support and ensure that programs are expanded with fidelity. In Colorado, Invest in Kids has filled this role for the NFP programs operating across the state while CDPHE has provided fiscal monitoring and oversight, including contracting processes, for the overall statewide project. This dual approach to monitoring has been demonstrated to be extremely effective in CDPHE’s management of the Nurse Home Visitor Program since 2000 (currently 19 contracts totaling \$12,700,000), and ensures that program staffs are not burdened with duplicative monitoring activities. CDPHE will replicate this approach with PAT and HIPPY programs through the Colorado Parent & Child Foundation in its role as model representative for the national offices of PAT and HIPPY. Oversight and technical assistance for the Early Head Start – Home Based Programs in Colorado is provided by the Office of Head Start through its regional office utilizing The Head Start Program Performance Standards. The Head Start State Collaboration Director is assisting CDPHE to develop a similar partnership to ensure effective monitoring, program assessment and support, and technical assistance is available to the Early Head Start- Home Based Programs participating in the MIECVH program. Each of the evidence-based programs has developed protocols and instruments to collect data on fidelity of implementation and demographics of participants. These are discussed further in Section 5, which describes how data will be collected to meet the required benchmark measures, and in the implementation plans for each of the models below.

HIPPY Implementation Plan

The HIPPY USA national and state offices work directly with program sites to ensure quality replication, expansion and implementation of the model. HIPPY, in partnership with the CPCF,

provides comprehensive training and technical assistance from program inception throughout the entire continuum of programming. This includes start-up assistance; pre-service training; initial on-site training; annual on-site visits to monitor progress, ensure quality, troubleshoot programmatic challenges and guide continuous quality improvement; biennial national professional development conferences; a web-based resource network; research-based model and curriculum updates; and the Efforts to Outcomes (ETO) data system. CPCF also provides compliance monitoring; a monthly topical webinar series; an annual HIPPY Management Institute and home visitor retreat; state-level evaluation, reporting, and data tracking guidance; and ongoing communication and technical assistance tailored to the needs of individual sites.

Training and Technical Support

HIPPY USA, with the state office, provides the following training and technical assistance, as appropriate, for organizations implementing the HIPPY model:

- HIPPY USA Start Up Manual - This guide assists potential programs through the decision making and program application processes. The content provides information to support actual implementation.
- Pre-Service Training - This week-long session is required for all new coordinators and assistant coordinators. Coordinators learn about job responsibilities and strategies for successful implementation.
- Coordinator Manual - This comprehensive reference covers responsibilities of the HIPPY Coordinator. The manual is distributed during pre-service training.
- HIPPY USA Managing for Excellence - This manual is an essential supplement to the Coordinator Manual. It provides in-depth, step-by-step guidance in the daily operation of a HIPPY program. Flexible time lines and lists of tasks assist coordinators in establishing and maintaining quality programming.
- HIPPY Curriculum - Once approved as a HIPPY program, sites access the HIPPY curriculum through C3PG Publishing. The developmentally appropriate curriculum provides the basis of the weekly visit plans with families.
- HIPPY USA Training for Excellence - These easy-to-use training modules allow coordinators to train and provide orientation for new home visitors using the same materials and techniques used by HIPPY's national trainers.

Initial and Follow-Up (for new programs)

An Initial Site Visit and a follow-up visit approximately mid-year are provided to first year programs. These visits include home visitor training, orientation with agency administrators and collaborators, assistance with public relations events and on-site coordinator training.

Regular Site Visits (for existing programs)

Regular site visits include troubleshooting programmatic issues, training, and an overall assessment of the program to ensure the program is being implemented with fidelity to the HIPPY model. Trainers provide ongoing communication to the sites leading up to the visit and a report including recommendations and action plans for quality improvement. HIPPY USA trains and maintains a cadre of national trainers to provide this comprehensive training and technical assistance.

- HIPPY ETO Information Management System - This web-based data collection system gives programs assistance in organizing, tracking and reporting on data about children, families, staff and group meetings (process data). In addition, programs can generate outcome reports.
- Resource Library - The Resource Library at www.hippyusa.org is a password protected portal for HIPPY coordinators, trainers and state leaders. It houses HIPPY USA guides, forms, training modules, action alerts and other important information. The Resource Library contains toolkits for research, evaluation and advocacy, as well as guides for alignment with early learning goals, bridging literacy from home to school and community, annotated bibliographies of assessment instruments, guides for community resource development and funding and a variety of training modules to assist HIPPY coordinators in training home visitors.
- Biennial Conference - The biennial HIPPY USA conference provides coordinators, home visitors, agency supervisors, HIPPY advisory board members, trainers and state leaders an opportunity to meet and to participate in workshops designed to increase their HIPPY specific knowledge and skills and further their professional growth.
- State Office Support - CPCF, state office for HIPPY USA in Colorado, provides the network of HIPPY programs in Colorado with intensive, ongoing training and technical assistance, fidelity monitoring, state-level evaluation and research, resource development, strategic alliances and advocacy efforts. CPCF is the first line of support for Colorado HIPPY programs. Examples of training and technical assistance include a 2-day HIPPY Management Institute at the start of every program year, a mid-year retreat for HIPPY Home Visitors, on-site compliance and fidelity monitoring, monthly review of home visitor time and activity records, monthly review of data entry into the HIPPY ETO, a monthly topical webinar series, guidance on evaluation instrument implementation, analysis of HIPPY pre/post tools (both site aggregates and statewide aggregates) and ongoing, regular telephone and email technical assistance targeted to the specific needs of individual sites.

Recruiting, Hiring and Retaining Staff

HIPPY requires two primary staff positions: (1) peer home visitors who deliver the curriculum to their assigned parents each week; and (2) coordinators who oversee the day-to-day implementation of the HIPPY program, supervise home visitors and organize group meetings. Local HIPPY program sites recruit, hire and supervise home visitor staff. Home visitors are recruited from the parent population served by this peer-based model, and are generally paraprofessionals. Visitor must be able to read and speak the language of families in their caseload (currently English or Spanish). The peer-based approach means a pool of potential home visitors is always available for recruitment. Workforce development and ongoing training is an essential component of the model, and staff members receive weekly training and support. The model encourages retention of home visitors for two to four years, after which the design and intention is that home visitors are prepared to move from paraprofessional to professional work.

HIPPY Coordinators, who are professionals with at least a bachelor's degree and training in early childhood education, elementary education, family or adult education, social work, or a related field, are also recruited by the local HIPPY program site. HIPPY USA requires coordinators to

complete a week-long HIPPY pre-service training, which provides guidance in recruiting, selecting, hiring and training home visitors.

The HIPPY sites under consideration for expansion are equipped and experienced in recruiting, hiring and retaining appropriate staff.

Ensuring High Quality Clinical Supervision and Reflective Practice

HIPPY coordinators are responsible for ongoing supervision and training of home visitors. Staff development plans include individual reflective supervision sessions and observation of each home visitor during a visit three times a year. Coordinators provide weekly in-service training on curriculum, activities, challenges and problem solving. HIPPY USA recommends coordinators oversee programs with a maximum of 180 children and a staff ranging from 7- 12 home visitors (depending on FTE status). Model standards specify the type of annual training hours required for home visitors and coordinators. In partnership with CPCF, HIPPY provides on-site training, training materials and instruction to support the efforts of the coordinator. While the implementing agency provides direct supervision of the coordinators, the supervision provided to the coordinator and the reflective practice between the coordinator and home visitors is monitored by HIPPY USA through the state office.

Identifying and Recruiting Participants

HIPPY is designed to serve families of preschool-aged children. Services can commence with families at any point along that age spectrum, but the model standard is to provide services for a minimum of two years. Targeted recruitment of participants is influenced by the type of community (major city, small town, urban, rural or suburban) and its associated characteristics such as geographic isolation, lack of accessible resources and community partners. HIPPY programs under consideration for expansion have significant waiting lists. Recruitment in cases where there is no waiting list occurs through a variety of settings: hospitals/health clinics, organizations providing diagnostic and early intervention services, social service organizations, schools, mental health agencies, other early childhood community resources such as libraries, job training centers and faith-based entities. Recruitment methods include print materials, personal outreach, informal meetings and family recruitment events.

Minimizing Attrition Rates

Attrition rates for HIPPY are calculated within a single program year, and are less than 20 percent. Most families cite a move/relocation out of the area for more gainful employment as the reason for non-completion. The program is designed to maintain participant involvement through regular and consistent contact at home visits and group meetings, and referrals to community resources. Strategies to prevent attrition are inherent to the model and are built into training. Individualized technical assistance to minimize attrition is provided by CPCF, in partnership with HIPPY USA.

Estimated Timelines to Reach Maximum Caseload

The HIPPY program site under consideration for funding has significant numbers of identified, eligible families on a community waiting list, making the timeline for achieving maximum caseload short. Upon approval of funding, the expansion site will need to hire additional HIPPY home visitors as current caseloads are at a maximum. New staff will complete the requisite

training and will immediately be equipped to serve families. Orientation and initial training of a home visitor upon hire is approximately two weeks.

Coordination among Home Visiting Programs and Other Resources

HIPPY programs are not designed to meet every need for families. Partnerships with schools, local early childhood councils, government programs, libraries, businesses, community non-profits and faith-based organizations are the foundation for successful referrals to other resources and services a family needs. Each community is unique, and local program sites establish formal relationships and agreements to ensure coordination of services with appropriate community partners.

Continuous Quality Improvement

HIPPY utilizes the ETO web-based performance management system for comprehensive data collection, reporting and outcome measurement at the local, state and national levels. This secure, scalable, customizable, easy-to-use tool meets current program-wide needs to lessen administrative burdens and has the flexibility to adjust to future needs as they evolve. The system can also migrate data to or from other data collection and reporting systems. Individualized assessments of each family, and services and referrals based on those assessments, are currently tracked in ETO. HIPPY USA is working to ensure all benchmarks and constructs required under the MIECHV program can be tracked through this system. CPCF has access to state and local data and is working with CDPHE's evaluator to plan data transfers to the state home visiting database. The HIPPY ETO supports program management and monitoring of fidelity through reports used to inform continuous quality improvement strategies.

Anticipated Challenges

The HIPPY site under consideration for expansion has been assessed for expansion capacity and readiness. It is considered an exemplary program and no major challenges are anticipated in an expansion of this program. CPCF and HIPPY USA have a long history in providing timely and relevant technical assistance and other needed support to ensure successful implementation and expansion of HIPPY programs in Colorado.

Nurse-Family Partnership (NFP) Implementation Plan

The first step to successful NFP program replication is to ensure the implementing agency has a thorough understanding of the intervention and essential elements of successful program operation and good outcomes. NFP National Service Office orients potential public and private sector partners before they apply for funding. This educational process has already occurred in Colorado's targeted communities and includes the following information:

- Core components of NFP, including 18 model elements; randomized controlled trials; and outcomes achieved.
- Infrastructure requirements for successful implementation. These include engagement with community residents, activists, organizers, leaders, businesses and health and social services providers; hiring and training of staff, supervisors and administrators; development of adequate referral systems; and data collection requirements.
- Activities proven to support successful implementation in the community and within the agency.

Commitment to implementing the model elements, with the support of the national office, is a contractual requirement.

Recruiting, Hiring and Retaining Staff

Competency definitions, assessments and professional development resources and consultation for supervisor-directed skill development with NFP teams are provided by NFPNSO. These resources guide the development of a strong team of nurse home visitors with complementary natural talents and abilities and for ongoing professional development of staff.

NFPNSO requires a multi-step orientation and education process for new home visitors and an additional training and consultation process for supervisors. Training resources include a series of topical education and discussion guides for supervisors to use in conducting team meetings to reinforce key aspects of NFP nursing practice and annual ongoing education for supervisors.

The NFP model is founded on nursing practice's ecological framework for human development, which recognizes mothers and families have unique histories, perspectives and values that are intrinsically linked to their culture, ethnicity, language communities, geographical identities and historical experiences. By design and practice the model embraces differences as important factors in service delivery and in relationships developed with the families. Nurse home visitors are trained to provide services that value individuals and to recognize participants are experts in their own lives. NFPNSO provides cultural competency training specific to the model focusing on cultural and ethnic awareness. Ideally, nurses are fluent in the languages spoken by the families they serve and materials used in the program are culturally and socially relevant.

NFP educates nurses and communities about the significant research conducted to demonstrate model effectiveness in culturally and geographically diverse populations. The model has been successfully used with Caucasian families in a rural setting, African American families in an urban setting, and Latino families in a semi-urban setting. Lessons learned from randomized controlled trials are incorporated to ensure program delivery is culturally, ethnically and socially relevant.

Like most new practitioners, new nurse home visitors acquire most of their learning experientially and through on-the-job training. The rate at which nurses acquire competence and confidence in their practice can be hastened by providing scaffolding for learning. New nurse home visitors experience weekly reflective supervision during which the most challenging issues and situations are discussed and nurses are encouraged to discern what is and is not working in their approach. Nurses also participate in case conferencing with their peers and multi-disciplinary consultants to expand learning and foster an exchange of successful practices.

To further scaffold the learning process, the NFPNSO provides detailed and resource-rich home visit guidelines for each phase of the program (pregnancy, infancy and toddlerhood) that make it easier for novice NFP nurses to translate the program's theory and principles into practice with diverse families. Home visit guidelines are revised periodically to ensure consistency with best practice in preventive nursing care for pregnant women and young children.

NFPNSO's web-based program quality information system sets out clear performance thresholds for each element of the NFP model. This gives every nurse and supervisor clear targets for quality assurance in program implementation. Reports can be accessed by programs and at the community or state level and used to steadily improve service delivery and fidelity to the model.

Highly trained and committed nurses and administrators are central to the success of an NFP program. NFPNSO provides implementing entities with clear job descriptions, recruitment and interviewing resources and guidance to assist new supervisors and administrators to attract capable candidates to nursing roles in the program. In addition, NFPNSO strongly encourages programs to recruit and hire racially and culturally diverse nursing staff and supervisors from the communities they serve. To support local recruitment efforts, NFPNSO works with national and regional nursing organizations, universities and community leaders to make bilingual and racially and culturally diverse nurses aware of career opportunities with NFP programs.

In Colorado, the State Nurse Consultant with IIK helps sites assess the local nursing pool and provides guidance for recruiting and hiring the best nurses. IIK tracks nurse retention for Colorado programs and promotes retention through the Colorado NFP Nurse Practice Council. The council's mission is to improve nursing practice in the NFP program by addressing issues related to nurse retention. Regional supervisor meetings, held quarterly and facilitated by IIK, provide peer support opportunities for supervisors to share challenges, successes and to problem solve common implementation issues. IIK's nurse consultant meets monthly with each supervisor to problem solve and provide support through reflective supervision.

IIK also raises money to support an annual state meeting for all Colorado NFP staff. This meeting is an opportunity for continued education, communication, collaboration and support across the state, and is considered an effective retention strategy.

Ensuring High Quality Clinical Supervision and Reflective Practice

NFP's supervisory expectations and practices are reflected in two core model elements. Element 13 stipulates a full-time nurse supervisor can provide supervision to a maximum of 8 nurses. Element 14 requires nurse supervisors to provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings and field supervision. To ensure nurse home visitors are clinically competent and supported, supervisors provide reflective supervision in the following ways:

- 1) One-to-one clinical supervision: Weekly, one-hour sessions support nurses to reflect on practice, caseload management and quality assurance goals. Supervisors use the principles of reflection as outlined in supervisor training.
- 2) Case conferences: Meetings involving all nurses occur twice a month and are dedicated to joint review of cases, data reports and charts and to facilitate problem solving and professional growth. Experts from other disciplines are included as appropriate.
- 3) Team meetings: Twice monthly administrative meetings are used to discuss program implementation issues and promote team building

- 4) Field supervision: Joint home visits with supervisor and nurse are scheduled every four months and as needed. A Visit Implementation Scale is completed and discussed.

Identifying and Recruiting Participants

NFP has successfully recruited participants across the state for 12 years. All NFP sites are placed within agencies that have strong community partners who refer clients. These partners include Medicaid enrollment sites, schools, primary care providers and departments of social services. Many referrals come from Woman, Infants and Children (WIC), family planning programs and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs within implementing agencies. NFP sites under consideration for MIECHV funding have waiting lists.

NFP supervisors and nurse teams at each site also engage in community outreach activities to inform individuals and groups about the program and encourage referrals. Every NFP site has a community-based Advisory Board that provides local support and outreach. The Nurse Practice Council maintains a database of successful outreach and recruitment practices that is shared.

Minimizing Attrition Rates

The Colorado NFP program monitors attrition rates through the NFPNSO database. Each NFP site must submit an annual progress report evaluating performance on the model elements and program outcomes, including client engagement and retention. Sites analyze attrition rates and devise strategies to address the causal factors. Client attrition in Colorado is frequently related to moving. In other cases, nursing interventions are examined and strategies are directed at improving those interventions.

Nurses are encouraged to create a flexible visit schedule with clients, as this was identified as a helpful strategy in recent studies done by Dr. David Olds. The NFPNSO has revised the curriculum used by the nurses to reflect a more client-centered approach to topics in an effort to increase client engagement.

Client attrition is a regular focus of supervisor meetings and Nurse Practice Council meetings. Continuing education, designed to improve competence and confidence in delivering the program with fidelity, also contributes to increased client engagement.

Estimated Timeline to Reach Maximum Caseload

In Adams County, an existing federal grant program (Safe Schools, Healthy Students) supporting an NFP site serving 50 families is ending in September 2011. This program, under consideration for MIECHV funding, would be at or near maximum caseload from the start. Other NFP programs under consideration for expansion in Adams and Pueblo counties will require the typical start-up time of seven to nine months.

Coordination among Home Visiting Programs and Other Resources

The NFP model requires sites to have a community advisory board including representatives from area schools, primary care providers, home visiting program representatives, community members and clients. Advisory boards support implementation through outreach and education about NFP services. Boards also provide opportunities for communication, problem solving, coordination of care and collaboration among resource providers. Nurses develop and maintain

relationships with other service providers to coordinate care for individual clients. This is an essential part of the case management services provided by NFP. Leadership staff from implementing agencies also participates in the local ECC.

Continuous Quality Improvement (CQI)

CQI and evaluation is supported by a robust data collection and reporting system that provides information about program implementation fidelity, client intervention and maternal and child outcomes. NFP collects information on family characteristics, needs, services and progress toward accomplishing program goals. Client level data is collected according to schedule by nurse home visitors during visits. Nurses are trained in standard data collection methods. Regular quality reports are provided to ensure data are complete and accurate. Local, state and national data are provided regularly to local agencies for comparison. Additionally, agencies can run reports of particular use to them.

Anticipated Challenges

NFP has operated successfully in Colorado for over 12 years. In that time, the program has experienced and addressed many challenges. Nurse recruitment has been challenging in rural communities lacking baccalaureate prepared nurses, but the reputations of the model and the implementing agencies have helped attract well-qualified nurses. NFPNSO's marketing department provides exceptional nurse recruitment literature and maintains a nursing career information website.

Nurse retention is also a challenge. When a nurse resigns, about 50 percent of her clients are lost. Colorado has implemented several strategies described in previous pages to address nurse retention.

Client attrition is the number one challenge faced by NFP in Colorado. Sites are required to have transition plans to minimize client attrition. Colorado participated in several studies over the years that looked at various ways to decrease attrition, such as increasing nursing skill, nurse retention, addressing intimate partner violence and developing new assessment tools. NFP nurses have increased their skills through these opportunities and will continue to do so through local, regional and state professional development options.

Parents as Teachers (PAT) Implementation Plan

The Colorado Parent & Child Foundation and the PAT national office work with program sites to ensure quality replication, expansion and implementation of the model. Comprehensive training and technical assistance is provided from program inception throughout the entire continuum of programming. This includes start-up guidance, foundational and model implementation training, an annual national professional development conference, a web-based resource network, research-based model and curriculum updates and the Visit Tracker data system. CPCF also provides on-site fidelity monitoring; a monthly topical webinar series; regional and statewide training and technical assistance meetings; state level evaluation, reporting, and data tracking guidance; and ongoing communication via telephone and email tailored to the needs of individual sites.

Training and Technical Support

The national office in partnership with the CPCF provides the following training and technical assistance, as appropriate, for organizations implementing the PAT model:

- **Start Up Guidance** – The guidance includes Readiness Reflections, Essential Requirements, and Quality Assurance Guidelines, which combine to provide detailed information to complete the Affiliate Plan. The Affiliate Plan, designed as a logic model (linking inputs, activities, outputs and outcomes), guides program sites through start-up, staffing and budgetary plans for implementing a quality program with fidelity. The Affiliate Plan is then approved by the state and national offices, and becomes a working document. Thus, when a program expands, the Affiliate Plan is updated to incorporate changes.
- **Foundational and Model Implementation Training** – The PAT Foundational Training lays the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of PAT with practice. The PAT Model Implementation Training and corresponding Model Implementation Guide incorporates the PAT Quality Assurance Guidelines and offers implementation strategies and evidence-based practices that help organizations fully understand and deliver quality PAT services. The Model Implementation Training explains how to successfully replicate the PAT model with fidelity. Demonstrating accountability, evaluation and outcomes are themes woven throughout PAT. New parent educators hired by a new or existing program must attend the Foundational and Model Implementation Trainings to attain certification in the PAT model. This must be completed prior to delivering services. Upon successful completion, certified parent educators are provided with access to the online PAT curriculum, which forms the basis of the personal visit plans with families.
- **Visit Tracker** – PAT sites in Colorado use the PAT Visit Tracker data management system to track service delivery.
- **Annual Conference** – The annual PAT conference provides program staff with opportunities to meet and participate in workshops designed to increase their knowledge and skills and further their professional growth.
- **Annual Recertification** – PAT parent educators are required to access competency-based professional development and training and recertify with the state and national office annually. For parent educators, 20 hours of professional development are required in Year 1, 15 in Year 2 and 10 in Year 3 and beyond. Recertification is required for continued access to the PAT curriculum and resources.
- **State Office Support** – CPCF, the PAT state office and the first line of support for Colorado programs, under a contractual relationship with the national PAT office, provides Colorado PAT programs with intensive, ongoing training and technical assistance; fidelity monitoring; state-level evaluation and research; resource development; and strategic alliances and advocacy efforts. Examples of training and technical assistance provided by CPCF includes grantee management training; regional and statewide topical training and meetings; on-site fidelity monitoring (including on-site file reviews); monthly review of data entry into the PAT Visit Tracker; a monthly topical webinar series and bi-monthly PAT model fidelity webinar series; guidance on evaluation instrument implementation, analysis of PAT evaluative tools (both site aggregates and

statewide aggregates), and ongoing, regular telephone and email technical assistance targeted to the specific needs of individual sites.

Recruiting, Hiring and Retaining Staff

PAT requires two primary staff positions: (1) professional, certified PAT parent educators who provide the direct services with families; and (2) program supervisors who direct, coordinate, support and evaluate the performance of parent educators.

Local PAT sites recruit, hire and supervise PAT parent educators. It is recommended that parent educators have a Bachelor or four-year degree in early childhood or a related field. However, parent educators may have less than a four-year degree if they have at least two years of supervised work experience with young children and/or parents. Parent educators must be computer literate and those serving Spanish-speaking families must be bilingual (fluent in both English and Spanish). Parent educators must have core competencies in family support and parenting education, child and family development, human diversity within family systems, health, safety and nutrition, and relationships between families and communities. PAT certification is required for parent educators and is granted upon the successful completion of the five-day Foundational and Model Implementation training, conducted by CPCF or by traveling to another state to receive training from PAT. The retention rate for PAT parent educators is similar to that of the overall early childhood field.

PAT program supervisors undergo training in the PAT model and Advanced Supervision Training, designed to support retention through reflective supervision methods. A maximum of 12 parent educators can be assigned to a supervisor.

Additional PAT parent educators will need to be hired in programs under consideration for Year 1 funding, as current caseloads are at maximum levels. However, expansion would occur within existing programs that are well-equipped and experienced in recruiting, hiring and retaining appropriate staff.

Ensuring High Quality Clinical Supervision and Reflective Practice

Supervisory expectations for PAT are captured in the model's Essential Requirements. A maximum of 12 parent educators are assigned to each full time supervisor whether the parent educators being supervised are full-time or part-time employees. Each month parent educators must participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings. CPCF also provides an Advanced Supervision Training for program supervisors, described earlier in this section.

Identifying and Recruiting Participants

PAT is designed to serve families throughout pregnancy until their child(ren) enter kindergarten. Services can commence with families at any point along that age spectrum, but the model standard for service delivery is a minimum of two years. Targeted recruitment of participants is completed by the local program site, and is influenced by the characteristics of the target community. Recruitment of eligible participants will not be a challenge as the existing program sites and communities have significant waiting lists. However, if recruitment is necessary it is conducted through a variety of settings, such as hospitals/health clinics, organizations providing diagnostic and early intervention services, social service agencies, schools, mental health

agencies, libraries, job training centers, faith-based entities, other early childhood programs, family events, informal meetings and personal outreach.

Minimizing Attrition Rates

Attrition rates for PAT are calculated within a single program year, and are less than 20 percent. A move or relocation out of the area for a job is the most common reason families leave the program early. The model is designed to maintain participant engagement through regular and consistent contact at home visits and group meetings, and by providing access to supportive services for the entire family. Strategies to prevent attrition are inherent to the models, and are built into PAT's Foundational and Model Implementation Training. Individualized technical assistance to minimize attrition is provided by CPCF, in partnership with PAT.

Timeline to Reach Maximum Caseload

Given the substantial waiting lists at existing PAT program sites in the two identified counties, maximum caseloads should be achieved soon after parent educators are hired and trained. Trainings are scheduled throughout the fall and new staff will be equipped to deliver the model by December 2011 based on an October 1 contract start date.

Coordination among Home Visiting Programs and Other Resources

The PAT model is not designed to meet every need for families. Rather, sites develop partnerships that support referrals for families and improve coordination with schools. Local early childhood councils, government programs (such as WIC, Supplemental Children's Health Insurance Program and Child Find), libraries, the business sector, and community and faith-based organizations provide a powerful support network for families.

Continuous Quality Improvement (CQI)

PAT uses Visit Tracker data management system, a web-based family contact management, recordkeeping and service delivery tracking system. Visit Tracker maximizes program effectiveness by providing real-time access to reports that support program management, model fidelity monitoring and CQI activities. Parent educators and supervisors can access visit records and plan upcoming visits with families, monitor program quality and track model fidelity. CPCF is working with CDPHE to ensure all of the benchmarks and constructs required under the MIECHV program can be tracked through this system and transferred to the state's database for MIECHV analysis and reporting.

Monitoring, Assessing and Supporting Implementation

PAT has established systems for ensuring model fidelity and providing implementation assistance to maintain quality. CPCF uses model-specific protocols during on-site visits to assess fidelity of local programs and provides consultation to local sites on continuous improvement plans. PAT program sites undergo an annual compliance assessment and an expanded assessment every four years.

Anticipated Challenges

PAT program sites in Colorado's targeted communities were assessed for expansion capacity and readiness in preparation for the community planning process. The PAT sites under consideration are exemplary in their adherence to fidelity and no major challenges are anticipated in expanding and sustaining high quality services. CPCF has an impressive history of providing timely,

relevant and appropriate technical assistance with PAT sites to support quality implementation and model fidelity, and to develop and monitor improvement plans when needed.

Early Head Start – Home Based Program (EHS-HB) Implementation Plan

Implementation of EHS-HB services must be in accordance with Head Start Program Performance Standards.

Training and Technical Support

Early Head Start provides a variety of learning experiences to new staff, including written materials regarding the organization and its mission, policies and procedures, shadowing experienced staff, role-playing challenging situations, case studies of particular families, video observation of actual home visits or group socialization experiences, mentorship or “buddy systems” and interdisciplinary or group staffing meetings. Individual reflective or supportive supervision, which involves a collaborative relationship between supervisors and staff members, provides regular opportunities for staff to reflect on the work of providing high quality services to expectant parents and families with infants and toddlers.

The Office of Head Start (OHS) Training and Technical Assistance (T/TA) system supports program staff in their delivery of quality services to children and families. The system consists of three components: National Centers; State, Migrant and Seasonal Head Start (MSHS) and American Indian/Alaskan Native (AI/AN) Centers; and direct funding to grantees.

Six National Centers function as a team that provides Head Start grantees with consistent information from OHS across all service areas. Centers communicate best practices and provide content-rich, usable, and practical resources and information to grantees. Additionally, they provide training at State, regional and national meetings and institutes; support training/technical assistance center staff and consultants; communicate with local program staff through online discussion boards, conference calls, and other forms of technology; and develop and distribute lists of highly qualified consultants who are available to local programs.

- **Early Head Start National Resource Center (EHSNRC)**
The EHSNRC provides information on best practices to Early Head Start and Migrant and Seasonal Head Start programs through Webinars and Webcasts; conferences; newsletters; an annual Birth to Three Institute; and training and technical assistance.
- **National Center on Quality Teaching and Learning**
This Center’s focus includes ongoing child assessment linked to teaching and learning; curriculum selection and implementation; mentoring and supervision; measurement and use of aggregate child outcome data for program improvement and professional development; and family engagement in children’s education. An important feature of this Center will be the provision of ongoing technical assistance and guidance to State, MSHS, and AI/AN training/technical assistance Early Childhood Specialists and Early Learning Mentor Coaches as they support local grantees in establishing quality teaching and early learning practices.
- **National Center on Cultural and Linguistic Responsiveness**
This Center focuses on increasing the cultural and linguistic competence of programs and staff across service areas; first and second language development for children birth-to-five,

including home language and English language acquisition; strategies for assessing the progress of children who are dual language learners; and strategies and approaches for language revitalization, preservation, and maintenance.

- **National Center on Program Management and Fiscal Operations**

This Center's focus includes risk management; internal controls; ongoing monitoring; human resources management; governance; data collection and analysis; budgeting and cost allocation; managing multiple funding sources; and property acquisition and facilities management. Staff from this Center also provides ongoing technical assistance and guidance to State, MSHS, and AI/AN training/technical assistance Grantee Specialists.

- **National Center on Parent, Family, and Community Engagement**

This Center develops and disseminates strategies related to parent, family, and community engagement practices that are positively associated with the development and learning of children birth-to-five. Strategies focus on family support services; positive parent-child relationships; parents as first and lifelong educators; parent connections to peers and community; intentional transitions; and parent leadership and advocacy, as well as professional development for Head Start staff who work with families.

- **National Center on Health, Oral Health, Mental Health, and Nutrition**

This Center focuses on strategies for promoting children's healthy development so that they are ready for school. It expands ongoing work in the areas of health, nutrition, health promotion, and disease prevention; access to care; mental wellness for staff, children, and families; safe environments; health literacy; emergency preparedness; oral health; and obesity prevention

The State, MSHS, and AI/AN training/technical assistance Centers include two categories of specialists: Early Childhood Education (ECE) Specialists and Grantee Specialists. ECE Specialists support local programs in their work to develop supportive environments for infants, toddlers, and their families and improve school readiness outcomes for Head Start children. A small cadre of Grantee Specialists are assigned to Regional Offices who deploy them to work with grantees with needs identified through monitoring, Program Information Report (PIR) results, Risk Management Meetings, or other data reviewed by OHS. The ECE Specialists focus on four key areas:

1. School Readiness

- Ongoing child assessment developmentally, linguistically and culturally appropriate and inclusive of all domains of the Child Outcomes Framework
- Aggregation, analysis and use of child assessment data for multiple purposes
- Selection and implementation of developmentally, linguistically and culturally appropriate curriculum
- Effective mentoring and coaching
- Other as specific to evolving priorities

2. Professional and Career Development

- Increase the number of education and family engagement staff with appropriate degrees and certificates
- Assist with the development of grantee T/TA plans

3. Parent Family Engagement

- Build relationships with parents & families

- Facilitate home-school/community-school connections with parents & families to reinforce children’s learning and development and strengthen program-family partnerships
- Improve communication and coordination between teaching staff and staff who predominantly work with families to facilitate child development and optimal parent and family development

4. Collaboration

- State, MSHS and AI/AN managers collaborate with HS Collaboration Directors, State Advisory Councils, and other ECE entities in the State to support:
- Planning and implementation of QRIS and State Early Learning Standards
- Addressing areas identified in local community and state needs assessments within scope of work
- Meeting the needs of low-income children (birth-five) and their families

Recruiting, Hiring and Retaining Staff

Recruiting, training, and retaining qualified home visitors requires a comprehensive approach to professional development, including:

- Knowledge of the unique aspects of the home visitors role;
- Clearly articulated needs and resources of the families you are serving, and the staff qualifications to meet those needs;
- Hiring practices to identify the best match for the job;
- Professional development experiences that build on each other, use a variety of adult learning strategies, honor individual needs, and provide links to formal education;
- Evaluation mechanisms to ensure that your training and professional development experiences are having the desired impact on the work you do with children and families; and
- Resources to maintain staff commitment and avoid turnover, such as adequate compensation, career advancement, and mental health needs.

Current and former Early Head Start and Head Start parents must receive preference for employment vacancies for which they are qualified. Home visitors must have knowledge and experience in child development and early childhood education; the principles of child health, safety, and nutrition; adult learning principles; and family dynamics. They must be skilled in communicating with and motivating people. In addition, they must have knowledge of community resources and the skills to link families with appropriate agencies and services. Staff and program consultants must be familiar with the ethnic background and heritage of families in the program and must be able to serve and effectively communicate, to the extent feasible, with children and families with no or limited English proficiency.

Ensuring High Quality Clinical Supervision and Reflective Practice

Home-based supervisors should supervise an average of 10–12 home visitors. Home visiting supervisors are expected to share their clinical knowledge about child development, family support intervention, and *Head Start Program Performance Standards*.

The State's Plan for Recruitment of Subcontractor Organizations

Using the Request for Applications (RFA) process created for the Updated State Plan by model representatives and CDPHE, programs identified for funding under the MIECHV program will submit an implementation plan that addresses all elements for expansion required by the evidence-based models, including an implementation work plan and a line item budget with budget justification. Following review and approval by the model developer representatives, CDPHE will complete a fiscal review and then execute a subcontract with each program for the expansion of services to a specified number of participants. Both the application and the subcontract include required assurances that the agency will meet all program requirements, expand with fidelity to the chosen model, give priority to participants that meet MIECHV program targeted characteristics, provide services to clients on a voluntary basis, conduct individual assessments of all participants and provide services in accordance with those individual assessments, and provide participant level data on all benchmarks and constructs and any additional data required to CDPHE.

In subsequent project years, funded programs will submit a continuation application that includes 1) an annual progress report with a letter of recommendation from the appropriate model developer for continued funding, 2) a CQI progress report, 3) a CQI plan for the next project year, and 4) a line item budget with budget justification. The contracting requirements will be repeated for each project year.

Colorado's Public and Private Partners

In May 2010 former Governor Bill Ritter created a broad Stakeholder Advisory Group under Lorez Meinhold, Health Reform Implementation and Senior Policy Analyst, to ensure collaboration across the public and private sectors for the development of an effective and comprehensive home visiting system. CDPHE was named lead agency, designated to develop and implement the MIECHV program. Following the change in administration in January 2011, Governor John Hickenlooper confirmed his approval and support for the Stakeholder Advisory Group.

In addition to Ms. Meinhold, the Stakeholder Advisory Group includes:

Karen Trierweiler, M.S., C.N.M, Director
Maternal and Child Health (Title V) Program
and Center for Healthy Families and
Communities
Prevention Services Division
Colorado Department of Public Health and
Environment

Jennifer Stedron, Executive Director
Early Childhood Leadership Commission
Office of Lt. Governor Joseph A. Garcia

Heather Tritten
Head Start State Collaboration Director
Office of Lt. Governor Joseph A. Garcia

Jodi Hardin, Director
Early Childhood Systems Initiatives
Office of Lt. Governor Joseph A. Garcia

Sharon Triolo-Moloney, Assistant Director
Early Childhood Initiatives
Department of Education

Joyce Johnson, LCSW, Senior Consultant
Early Childhood Councils Initiative
Department of Education

Steffanie Clothier
National Conference of State Legislators

Mary Martin, LCSW, Director
Home Visiting Programs
Prevention Services Division
Colorado Department of Public Health and
Environment

Don Horton
Family Health Division Manager
Boulder County Public Health

Lisa Waugh, RN, PhD
Quality and Health Improvement Unit
Department of Health Care Policy and
Financing

Lilas Rajae-Moore, Director
Treatment Accountability for Safer
Communities (TASC) and Denver At-Home
Intervention Service Initiative (DAISI)
Colorado Judicial Department
ACF Evidence-based Home Visiting program
grantee

Ayelet Talmi, PhD, Associate Director
Irving Harris Program in Child Development
& Infant Mental Health
Assistant Professor, Departments of
Psychiatry and Pediatrics for University of
Colorado Denver at The Children's Hospital
Early Childhood Councils Advisory Team

Lisa Merlino, Executive Director
Invest in Kids, Nurse-Family Partnership
Nurse-Family Partnership National Service
Office

Chris Habgood
Office of Behavioral Health
Department of Human Services
Single State Agency for Substance Abuse
Services

Melissa Kelley, Executive Director
Colorado Parent & Child Foundation
Parents as Teachers (PAT) and
Home Instruction for Parents of Preschool
Youngsters (HIPPPY)

Members have helped create a state home visiting plan that reflects better coordination among state level partners and expands the continuum of evidence-based home visiting programs to improve outcomes and strengthen parent-child relationships for Colorado's children. This group will unite with the Colorado Home Visiting Coalition to thoughtfully outline an agenda for future policy, coordination and funding support for Colorado's home visiting program.

Assurances Provided By Colorado Regarding the MIECHV Program

The state provides assurances that:

1. The State home visiting program is designed to result in participant outcomes noted in the legislation.
2. Individualized assessments will be conducted of participant families and services will be provided in accordance with those individual assessments.
3. Home visiting services in Colorado will be provided on a voluntary basis.
4. Colorado will comply with the Maintenance of Effort requirement of the Maternal, Infant and Early Childhood Home Visiting program.

5. Priority will be given to serve eligible participants who:
- have low incomes;
 - are pregnant women who have not attained age 21;
 - have a history of child abuse or neglect or have had interactions with child welfare services;
 - have a history of substance abuse or need substance abuse treatment;
 - are users of tobacco products in the home;
 - have, or have children with, low student achievement;
 - have children with developmental delays or disabilities; and/or
 - are in families with individuals who are serving or have formerly served in the armed forces, including families who have members of the armed forces who have had multiple deployments outside of the United States.

SECTION 5: Plan for Meeting Legislatively-Mandated Benchmarks

CDPHE, with state representatives for the models, has developed a detail plan describing how Colorado will meet the legislative requirements related to quantifiable, measurable improvement in the six benchmark areas as outlined in the Funding Opportunity Announcement (FOA). All six benchmarks with their multiple constructs will be measured for all eligible families that have been enrolled to receive services funded with the MIECHV program funds. Using the template being developed by Health and Human Services (HHS), Colorado will report on benchmark progress at the three- and five-year points. The benchmark data collection plan incorporates revisions recommended by HRSA reviewers. The same plan for benchmark data collection will be used for the expansion program proposed in Colorado's competitive funding application submitted on July 1, 2011.

In addition to benchmark reporting requirements, Colorado will collect individual-level demographic and service utilization data on participants in the program. Individual-level demographic and service-utilization data will include, but are not limited, to the following:

- *Family's participation rate:* number of home visiting program sessions / number of possible sessions; duration of sessions; topics covered;
- *Participant demographic data:* gender, age of all participants (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family. Participants are defined as the child(ren), pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services;
- *Language:* participant child's exposure to languages other than English; and
- *Family socioeconomic indicators:* family income; employment status; and education.

The following benchmarks table (Table 4) provides the details on collection of the benchmark data for each of the model programs to be implemented in Colorado. Specifically, it includes information on each construct and related numerator and denominator. Also, the table defines how quantifiable change is demonstrated for the construct. Required constructs will be measured at intake and either one year later, or as appropriate for the measure (e.g. following delivery for perinatal constructs, according to the recommended schedule for well-child visits, every six months for ER/Urgent care visits, etc.). Table 4 lists what is currently collected and the

instruments used. The table indicates that different data sources (*i.e.*, instruments or questions) may be used by each of the model programs. However, CDPHE will continue to work collaboratively with model developers and the state offices for the model programs to establish standard measures for as many constructs as possible across the evidence-based home visiting programs.

Table 4: Legislatively-Mandated Benchmarks

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program						
Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Benchmark 1: Improved Maternal and Newborn Health						
Prenatal Care	Pregnant Women	# pregnant women enrolled in Colorado's EBHV model programs who scored 3.0 or better for Prenatal Care or who began prenatal care in the second or third trimester and whose observed to expected visits ratio is ≥ 0.7	# pregnant women enrolled in Colorado's EBHV model programs	% pregnant women enrolled in Colorado's EBHV model programs who received prenatal care starting in the 2nd or 3rd trimester who kept most prenatal care appointments	Increase the % pregnant women enrolled in Colorado's EBHV model programs who received prenatal care starting in the 2nd or third trimester who kept most prenatal care appointments from intake to delivery	No
Parental use of alcohol, tobacco, or illicit drugs	Parents/ Women	# parents enrolled in Colorado's EBHV model programs who scored 3.0 or better on the LSP for tobacco use, who did not smoke at intake, or who decreased smoking from intake	# parents/ women enrolled in Colorado's EBHV model programs	% of parents enrolled in Colorado's EBHV model programs who did not smoke, quit smoking or decreased smoking from intake	Increase the % of parents enrolled in Colorado's EBHV model programs who did not smoke, quit smoking or decreased smoking from intake to subsequent evaluation	No
Preconception care	Women	# women enrolled in Colorado's EBHV model programs who received preconception care after the birth of the first child through conception of the second child	# women (including postpartum women) enrolled in Colorado's EBHV model programs	% of women enrolled in Colorado's EBHV model programs who received preconception care after the birth of the first child through conception of the second child	Increase the % of women enrolled in Colorado's EBHV model programs who received preconception care between the birth of first child and conception of the second child	No
Inter birth intervals	Postpartum Women	# postpartum women enrolled in Colorado's EBHV model programs who had a subsequent child within 18 months of the previous child	# postpartum women enrolled in Colorado's EBHV model programs	% postpartum women enrolled in Colorado's EBHV model programs who had a subsequent child within 18 months of the previous child	Decrease the % postpartum women enrolled in Colorado's EBHV model programs who had a subsequent child within 18 months of the previous child	No

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program

Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Screening for maternal depressive symptoms	Women	# of women enrolled in Colorado's EBHV model programs who were screened for maternal depressive symptoms at least once	# women enrolled in Colorado's EBHV model programs	% of women enrolled in Colorado's EBHV model programs who were screened for maternal depressive symptoms at least once	Increase the % of women enrolled in Colorado's EBHV model programs who were screened for maternal depressive symptoms at least once from intake to subsequent evaluation	No
Breastfeeding	Infants	# infants enrolled in Colorado's EBHV model programs who scored 1.5 or better on the LSP for breastfeeding or who received breast milk for at least 2 weeks	# infants enrolled in Colorado's EBHV model programs	% infants enrolled in Colorado's EBHV model programs who received breast milk for at least 2 weeks	Increase the % infants enrolled in Colorado's EBHV model programs who received breast milk for at least 2 weeks	No
Well-child visits	Infants/ Children	# children enrolled in Colorado's EBHV model programs who receive the recommended number of well child visits	# children enrolled in Colorado's EBHV model programs	% children enrolled in Colorado's EBHV model programs who receive the recommended number of well child visits	Increase the % children enrolled in Colorado's EBHV model programs who receive the recommended number of well child visits from two months of age to subsequent evaluation	No
Maternal and child insurance status	Infants/ Children	# of children enrolled in Colorado's EBHV model programs who have medical/health insurance coverage	# children enrolled in Colorado's EBHV model programs	% of children enrolled in Colorado's EBHV model programs who have medical/health insurance coverage	Increase the % of children enrolled in Colorado's EBHV model programs who have medical/health insurance coverage from birth to subsequent evaluation	No

EBHV=Evidence-Based Home Visiting; LSP = Life Skills Progression

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

Visits for children to the emergency department from all causes	Infants/ Children	# infants and children enrolled in Colorado's EBHV model programs who scored 2.0 or lower on the LSP for Safety, or who were taken to the ER/Urgent care in the past six months due to injury or ingestion	# infants and children enrolled in Colorado's EBHV model programs	% children enrolled in Colorado's EBHV model programs taken to the ER/Urgent care in the past six months due to injury or ingestion	Decrease the % children enrolled in Colorado's EBHV model programs taken to the ER/Urgent care in the past six months due to injury or ingestion	No
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Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program

Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Visits of mothers to the emergency department from all causes	Mothers	# mothers enrolled in Colorado's EBHV model programs who were taken to the hospital emergency room/urgent care center in the past six months for all causes	# of mothers enrolled in Colorado's EBHV model programs	% of mothers enrolled in Colorado's EBHV model programs who were taken to the hospital emergency room/urgent care center in the past six months for all causes	Decrease the % of mothers enrolled in Colorado's EBHV model programs who were taken to the hospital emergency room/urgent care center in the past six months for all causes	Yes
Information provided or training of participants on prevention of childhood injuries	Parents/ Women	# of parents/women enrolled in Colorado's EBHV model programs who are provided information or training on childhood injury prevention	# of parents/women enrolled in Colorado's EBHV model programs	% of parents/women enrolled in Colorado's EBHV model programs who are provided information or training on childhood injury prevention	Increase the % of parents/women enrolled in Colorado's EBHV model programs who are provided information or training on childhood injury prevention in the past six months	Yes
Incidence of child injuries requiring medical treatment	Infants/ Children	# children enrolled in Colorado's EBHV model programs who had a serious injury in the past year or who were admitted to the hospital in the past six months due to injury or ingestion	# infants and children enrolled in Colorado's EBHV model programs	% children enrolled in Colorado's EBHV model programs who had a serious injury or ingestion in the past year	Decrease the % children enrolled in Colorado's EBHV model programs who had a serious injury or ingestion in the past year <i>CDPHE will work with local & state child welfare system for verification</i>	No
Reported suspected maltreatment for children in the program	Infants/ Children	# infants and children enrolled in Colorado's EBHV model programs whose mothers or fathers were referred to social services for abuse or neglect of the child since his/her birth	# infants and children enrolled in Colorado's EBHV model programs	% of infants and children enrolled in Colorado's EBHV model programs whose mothers or fathers were referred to social services for abuse or neglect of the child since his/her birth	Decrease the % of infants and children enrolled in Colorado's EBHV model programs whose mothers or fathers were referred to social services for abuse or neglect of the child since his/her birth <i>CDPHE will work with local & state child welfare system for verification</i>	No

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program

Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Reported substantiated maltreatment for children in the program	Infants/ Children	# of substantiated maltreatment cases for infants and children in Colorado's EBHV model programs	# infants and children enrolled in Colorado's EBHV model programs	% of substantiated maltreatment cases for infants and children in Colorado's EBHV model programs	Decrease the % of substantiated maltreatment cases for infants and children in Colorado's EBHV model programs from program intake to subsequent evaluation <i>CDPHE will work with local & state child welfare system for verification</i>	Yes
First-time victims of maltreatment for children in the program	Infants/ Children	# of first-time maltreatment of infants and children in Colorado's EBHV model programs	# infants and children enrolled in Colorado's EBHV model programs	% of first-time maltreatment cases of infants and children enrolled in Colorado's EBHV model programs	Decrease the % of first-time maltreatment cases of infants and children enrolled in Colorado's EBHV model programs from intake to subsequent evaluation <i>CDPHE will work with local & state child welfare system for verification</i>	Yes
EBHV=Evidence-Based Home Visiting; LSP = Life Skills Progression						
Benchmark 3: Improvements in School Readiness and Achievement						
Parent support for children's learning and development	Parents	# parents/mothers enrolled in Colorado's EBHV model programs who select a score of 4 or higher on the Parent Survey in knowing how to meet their child's social and emotional needs, or who rank their ability/knowledge of how to meet their child's social and emotional needs above average	# parents enrolled in Colorado's EBHV model programs	% of parents enrolled in Colorado's EBHV model programs who indicate their knowledge/ability of how to meet their child's social and emotional needs is average or above	Increase the % of parents enrolled in Colorado's EBHV model programs who indicate their knowledge/ability of how to meet their child's social and emotional needs is average or above from initial assessment to annual follow-up	Yes

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program

Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Parent knowledge of child development and of their child's developmental progress	Parents	# parents/mothers enrolled in Colorado's EBHV model programs who select a score of 4 or higher on the Parent Survey in understanding their child's development and how it influences their parenting responses, or who understand their child's development and how it influences their parenting responses	# parents enrolled in Colorado's EBHV model programs	% of parents enrolled in Colorado's EBHV model programs who understand their child's development and how it influences their parenting responses	Increase the % of parents enrolled in Colorado's EBHV model programs who understand their child's development and how it influences their parenting responses from birth to subsequent evaluation	Yes
Parenting behaviors and parent-child relationship	Parents	# parents enrolled in Colorado's EBHV model programs who select a score of 4 or higher on the Parent Survey in establishing routines and setting reasonable limits and rules for their child, or who report establishing routines and setting reasonable limits and rules for their child	# parents enrolled in Colorado's EBHV model programs	% of parents enrolled in Colorado's EBHV model programs who report establishing routines and setting reasonable limits and rules for their child	Increase the % of parents enrolled in Colorado's EBHV model programs who report establishing routines and setting reasonable limits and rules for their child from birth to subsequent evaluation	Yes
Parent emotional well-being or parenting stress	Parents	# mothers enrolled in Colorado's EBHV model programs who rank their ability to deal with the stresses of parenting and life in general as average or above, or who select a score of 4 or higher on the Parent Survey for being able to deal with the stresses of parenting and life in general	# parents enrolled in Colorado's EBHV model programs	% of parents enrolled in Colorado's EBHV model programs who are able to deal with the stresses of parenting and life in general as average or above	Increase the % of parents enrolled in Colorado's EBHV model programs who are able to deal with the stresses of parenting and life in general as average or above from birth to subsequent evaluation	Yes
Child's communication, language and emergent literacy	Infants/Children	# children enrolled in Colorado's EBHV model programs who are screened for needed communication services using the communication sections on the LSP or ASQ	# infants and children enrolled in Colorado's EBHV model programs	% of children enrolled in Colorado's EBHV model programs who are screened for needed communication services	Increase the % of children enrolled in Colorado's EBHV model programs who are screened for needed communication services from initial assessment to subsequent evaluation	No

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program						
Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Child's general cognitive skills	Infants/ Children	# children enrolled in Colorado's EBHV model programs who are screened for needed cognitive skills services using the problem solving sections on the LSP or ASQ	# infants and children enrolled in Colorado's EBHV model programs	% of children enrolled in Colorado's EBHV model programs who are screened for needed cognitive skills services	Increase the % of children enrolled in Colorado's EBHV model programs who are screened for needed cognitive skills services from initial assessment to subsequent evaluation	No
Child's positive approaches to learning including attention	Infants/ Children	# children enrolled in Colorado's EBHV model programs who are screened for needed personal-social services using the personal-social sections on the LSP or ASQ	# infants and children enrolled in Colorado's EBHV model programs	% of children enrolled in Colorado's EBHV model programs who are screened for needed personal-social services	Increase the % of children enrolled in Colorado's EBHV model programs who are screened for needed personal-social services from initial assessment to subsequent evaluation	No
Child's social behavior, emotion regulation, and emotional well-being	Infants/ Children	# children enrolled in Colorado's EBHV model programs who are screened for needed services using the social-emotional and/or regulation sections on the LSP or ASQ	# infants and children enrolled in Colorado's EBHV model programs	% of children enrolled in Colorado's EBHV model programs who are screened for needed social-emotional and/or regulation services	Increase the % of children enrolled in Colorado's EBHV model programs who are screened for needed social-emotional and/or regulation services from initial assessment to subsequent evaluation	No
Child's physical health and development	Infants/ Children	# children enrolled in Colorado's EBHV model programs whose physical and developmental health is screened by direct assessment, health records or home visiting documents	# infants and children enrolled in Colorado's EBHV model programs	% of infants and children enrolled in Colorado's EBHV model programs whose physical and developmental health is screened	Increase the % of infants and children enrolled in Colorado's EBHV model programs whose physical and developmental health is screened from initial assessment to subsequent evaluation	No

EBHV=Evidence-Based Home Visiting; LSP = Life Skills Progression; ASQ = Ages and Stage Questionnaire

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program						
Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Benchmark 4: Crime or Domestic Violence*						
Crime <ul style="list-style-type: none"> • Arrests • Convictions 	Caregivers/ Parents	# parents enrolled in Colorado's EBHV model programs (plus caregivers) who report caregiver arrests and convictions	# parents/ women enrolled in Colorado's EBHV model programs (plus caregivers)	% of parents enrolled in Colorado's EBHV model programs (plus caregivers) who report family-level crime (arrest & convictions by reason)	Decrease the % of parents enrolled in Colorado's EBHV model programs (plus caregivers) who report family-level crime (arrest & convictions by reason)	No
Screening for domestic violence	Women/ Parents	# of women/ parents enrolled in Colorado's EBHV model programs receiving a screening for the presence of domestic violence	# parents/ women enrolled in Colorado's EBHV model programs	% of women/parents enrolled in Colorado's EBHV model programs who were screened for the presence of domestic violence	Increase the % of women/ parents enrolled in Colorado's EBHV model programs who were screened for the presence of domestic violence	No
Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services	Women/ Parents	# parents/women enrolled in Colorado's EBHV model programs identified for the presence of domestic violence referred to Intimate Partner Violence Services	# parents/ women enrolled in Colorado's EBHV model programs identified for the presence of domestic violence	% of parents/women enrolled in Colorado's EBHV model programs identified for the presence of domestic violence referred to Intimate Partner Violence Services	Increase the % of parents/women enrolled in Colorado's EBHV model programs identified for the presence of domestic violence referred to Intimate Partner Violence Services from initial assessment to subsequent evaluation	No
Of families identified for the presence of domestic violence, number of families for which a safety plan was completed	Parents	# of families enrolled in Colorado's EBHV model programs identified for the presence of domestic violence with a documented safety plan	# of families enrolled in Colorado's EBHV model programs identified for the presence of domestic violence	% of families enrolled in Colorado's EBHV model programs identified for the presence of domestic violence with a documented safety plan	Increase the % of families enrolled in Colorado's EBHV model programs identified for the presence of domestic violence with a documented safety plan	Yes
*Note: While the SIR only requires measurement of either crime or domestic violence, we recognize communities will need to select their focus. EBHV=Evidence-Based Home Visiting; LSP = Life Skills Progression						

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program						
Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Benchmark 5: Family Economic Self-Sufficiency						
Household income and benefits	Parents/ women	# parents enrolled in Colorado's EBHV model programs with a score of 3.0 or higher on the LSP for Income, or with household income at or above 200% of FPL	# parents/ women enrolled in Colorado's EBHV model programs	% of women/parents enrolled in Colorado's EBHV model programs with a household income \geq 200% of FPL	Increase the % of women/parents enrolled in Colorado's EBHV model programs with a household income \geq 200% of FPL from intake over time	No
Employment of adult members of the household	Parents/ women	NOTE: not ratio # of paid hours worked plus unpaid hours devoted to care of an infant by all adults in households enrolled in Colorado's EBHV model programs over time	NOTE: not ratio	# of paid hours worked plus unpaid hours devoted to care of an infant by all adults in households enrolled in Colorado's EBHV model programs	Increase in the number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in households enrolled in Colorado's EBHV model programs over time	No
Education of adult members of the household	Parents/ women	NOTE: not ratio Level of educational attainment of adults in households enrolled in Colorado's EBHV model programs over time	NOTE: not ratio	Level of educational attainment of adults in households enrolled in Colorado's EBHV model programs	Increase in the educational attainment of adults in households enrolled in Colorado's EBHV model programs over time, including completion of academic degrees and/or training & certification programs	No
Health Insurance status	Parents/ women	# parents/women enrolled in Colorado's EBHV model programs who scored 3.0 or better on the LSP for Medical/Health Insurance, or who have health insurance	# parents/ women enrolled in Colorado's EBHV model programs	% parents/women enrolled in Colorado's EBHV model programs who have medical/ health insurance	Increase % parents enrolled in Colorado's EBHV model programs who have medical/ health insurance from intake to subsequent evaluation	No
EBHV=Evidence-Based Home Visiting; LSP = Life Skills Progression						

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program						
Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Benchmark 6: Coordination and Referrals for Other Community Resources and Supports						
Number of families identified for necessary services	Parents and children	# parents and/or children enrolled in Colorado's EBHV model programs who are screened for needed services	# parents and children enrolled in Colorado's EBHV model programs	% of parents and/or children enrolled in Colorado's EBHV model programs who are screened for needed services	Increase the % of parents and/or children enrolled in Colorado's EBHV model programs who are screened for needed services over time	No
Number of families that required services and received a referral to available community resources	Parents and children	# parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral	# parents and/or children enrolled in Colorado's EBHV model programs identified as needing services	% of parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral	Increase the % of parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral	No
Number of MOUs with other social service agencies in the community	N/A	Number of MOUs Colorado's EBHV model programs have with other social service agencies in the community	N/A	N/A	Increase the number of MOUs Colorado's EBHV model programs have with other social service agencies in the community	No
Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	N/A	Number of agencies with which Colorado's EBHV model program providers have a clear point of contact in collaborating community agency that includes regular sharing of information between agencies	N/A	N/A	Increase the number of agencies with which Colorado's EBHV model program providers have a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	No

Legislatively-Mandated Benchmarks for the Maternal, Infant and Early Childhood Home Visiting Program

Construct	Population Group	Numerator	Denominator	Indicator	Improvement	Measure may change due to changes in NFP data collection
Number of completed referrals	Parents and children	# parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral and received services or are waiting for service	# parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral	% of parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral and received services or are waiting for service	Increase the % of parents and/or children enrolled in Colorado's EBHV model programs identified as needing services who received a referral and received services or are waiting for services over time	No

EBHV=Evidence-Based Home Visiting

Validity and Reliability of Measures

Most proposed measures, whether single questions or psychometric instruments, have been used by the models for many years, with populations similar to those targeted by the MIECHV program. Instruments assessing child development (e.g., the Ages and Stages Questionnaire) have age-specific versions available to align with the population receiving services. The instruments are also available in Spanish. Where programs do not currently assess constructs, established instruments have been proposed (see Table 4).

NFP, HIPPY and PAT use two tools with demonstrated psychometric validity and reliability: the Ages and Stages Questionnaire (ASQ) and the Edinburgh Depression Scale (EPDS). The ASQ, developed by Jane Squires, Diane Bricker, and Elizabeth Twombly, is a 30-item standardized survey to assess child development during the first five years of life. Questions are grouped into five domains: 1) communication, 2) gross motor, 3) fine motor, 4) problem solving, and 5) personal-social. The EPDS is a 10-question instrument designed by J. L. Cox, J.M. Holden, and R. Sagovsky for use in home visiting settings. It has been utilized and tested among numerous populations, including U.S. women and Spanish speaking women in other countries. For some constructs, NFP uses other questions that assess the required constructs. These questions have been formatively tested to assure clarity of interpretation by the client and nurse home visitor. Additional reliability and validity testing of particular data elements is ongoing and targeted to those items for which the risk is greatest for interpretive problems.

PAT programs and HIPPY (for some constructs) use the Life Skills Progression instrument developed by Linda Wollesen and Karen Peifer. This 43-item scale has been tested as a reliable and valid measurement tool for use by home visiting programs working with at-risk families. It assesses family functioning in the following seven areas: 1) relationships with family and friends, 2) relationships with children, 3) physical health care, 4) basic needs, 5) education and employment, 6) mental health and substance abuse, and 7) infant/toddler development and temperament. These areas align with many of the constructs required by the MIECHV Program.

EHS-HB uses the Program Information Report that spans most of the required constructs. These have been standardized and used nationally for a least half a decade, with additional concepts added over time. Measures are under development by EHS-HB for those constructs not previously collected or made optional to implementation sites. In this area, the evaluation stakeholder group (described below) will work with EHS-HB program staff and the national Head Start office to assure that measures are valid and reliable and, as much as possible, in alignment with instruments being used by other evidence-based programs in Colorado.

CDPHE has a battery of questions to assess insurance status, access to health care, visits to healthcare providers in accordance with established recommendations, and health risk behaviors and outcomes. These questions have been tested and validated by the Centers of Disease Control and Prevention (CDC) and are used in national and state surveillance efforts, including the Vital Records Birth Certificate Questionnaire, Pregnancy Risk Assessment Monitoring System, Child Health Survey and Behavioral Risk Factor Surveillance System Survey. Should reliability issues be discovered with Colorado's proposed measures, these instruments provide a bank of alternative questions to assess the required constructs. Staff from the Epidemiology, Planning

and Evaluation (EPE) Branch at CDPHE will identify the need for replacement measures through periodic analyses.

Data Quality

Staff from the Epidemiology, Planning and Evaluation (EPE) branch at CDPHE will provide an additional layer of data quality assurance through the creation of an evaluation stakeholder group (described below). Data quality at the program level is assured through training of home visitors responsible for conducting the assessments, monitoring of entered data and review of quarterly reports from agencies. The following describes the process used by each program to assure and improve data quality.

NFP's online reporting system is a customized version of Social Solutions' Evidence to Outcomes (ETO) platform. NFP implemented ETO in November 2010, replacing the Clinical Information System previously used. Data are collected by nurse home visitors primarily through interviews, observation, self-reporting and self-administered scales such as the Edinburgh Scale that screens for maternal depression. These data are entered directly into the national NFP web-based information system by data entry personnel, nurses and supervisors. To ensure quality, staff is encouraged to enter data daily, with a requirement to complete the entry of the previous month's data by the 5th of the following month.

Training on the reporting system is provided to nurse home visitors, supervisors, data assistants and administrators through online modules, manuals, webinars and in-person nursing education. Technical assistance is continuously available through the NFP Information Technology and Program Quality office. Data quality is maintained by a combination of review and technical problem solving to generate solutions. Data entry personnel at each site review data they have entered. Supervisors, nurses and state nurse consultants review reports at least monthly. NFP Nurse Consultants and Regional Quality Coordinators review data and reports quarterly for quality and to identify measures needing quality improvement. For fields with a finite set of possible answers or characteristics, data validation is performed at the field level by the ETO software. Also, drop-down lists are available to reduce errors. The NSO provides various reports, including exception reports, to assist with data quality monitoring. Outcomes are reported directly to each implementing site and some site-specific data can be generated by individual sites through the ETO system.

HIPPY uses Social Solutions' Evidence to Outcomes platform adapted for the model. Development began in fall 2010, with a roll out in late spring 2011. Data are collected by the home visitors, who are also responsible for data entry. Coordinators also have the ability to enter home visitor information while also being able to grant system access to the home visitors. Coordinators have an access level above home visitors, allowing them to review the progress of those they supervise. Home visitors and coordinators have access to the system any time, with a requirement to complete data entry at least monthly. The national office, HIPPY USA, holds weekly webinars to introduce home visitors and coordinators to the ETO system. Video tutorials are currently being developed. The Colorado Parent & Child Foundation will offer training webinars on the ETO in FY 2011-2012. To ensure data quality, all sites submit a mid and end-year report to CPCF. State-level access allows CPCF to pull reports on individual sites in order to aggregate statewide data.

DataKeeper Technologies developed an online reporting system, Visit Tracker, specifically for Parents as Teachers. The system has been successfully implemented by the state office and participating sites since the beginning of 2010. Parent educators are responsible for data collection at the home visit, entering these results into Visit Tracker. Data entry must be completed monthly. Parent educators receive training in-person at the national conference and can access video tutorials. In FY 2011-2012, Visit Tracker trainings will be offered by CPCF through webinars. CPCF also conducts reviews of mid- and end-year reports for data quality. In addition, reports by site and in aggregate can be generated at the site level for staff review.

Both data systems utilized by HIPPY and PAT program staff allow sites to view individual records or aggregated program data reports. Reports highlighting demographics, home visit completion and retention rates are also available, along with dashboard views that provide a “snapshot” of family enrollment, home visits delivered, and other data. These data elements provide a means to monitor program fidelity along with identifying issues for continuous quality improvement.

Data Safety and Monitoring

Data are collected by home visitors using administration procedures that align with standard data security and privacy procedures. All home visitors, as part of their training in the respective program models, receive instruction regarding data collection, confidentiality, Health Insurance Portability and Accountability Act (HIPAA) and Family Education Rights and Privacy Act (FERPA). Data collection and reporting protocols used by each of the models assure privacy and confidentiality.

NFP utilizes a software platform (ETO) into which only designated, NFP-approved persons may enter data collected about clients and obtain reports for managing and evaluating program implementation and results. The web-based information system stores data in an encrypted format and is secured against unauthorized use by VeriSign® 128-bit Security Encryption, the industry standard in Internet site protection. Data transmissions are encrypted as well. The ETO software is secured against unauthorized eavesdropping and tampering using a Secure Socket Layer (SSL) communication channel that has 128-bit Security Encryption. Authorized access to the database and website can only be provided by NFP through their National Service Office.

NFP complies with the rules and regulations concerning the privacy and security of protected health information (PHI) under HIPAA and the HiTech Act as if it were a Covered Entity, as defined by those regulations. NFP enters into HIPAA Business Associate Agreements to ensure all its implementing agencies, vendors and agents agree to the same restrictions. NFP protects against non-permitted use or disclosure of PHI, promptly reporting and addressing incidents of non-compliance.

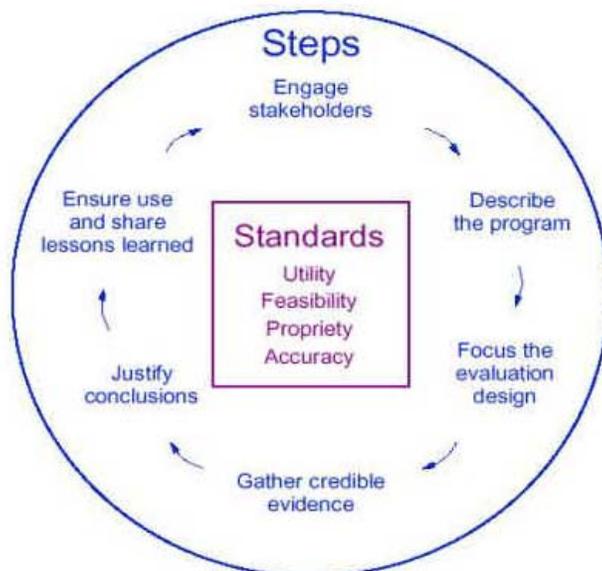
HIPPY and PAT each have their own written protocols on maintaining secure parent files and file retention. These protocols apply to both the paper copies used to gather information from parents and the online systems. For PAT, parent educators and supervisors must complete a five-day training, which includes data collection policies and procedures. Once completed, staff receives an online access code. All PAT programs and individuals must re-certify each year to

continue data access. For HIPPY, each coordinator and home visitor is required to attend a webinar before receiving their login information from HIPPY USA.

Data Analysis Framework

To establish a sound basis for evaluation of the MIECHV program, CDPHE will adopt the Centers for Disease Control and Prevention’s Framework for Evaluation.¹ This ensures that requirements for measuring benchmarks are met while also capturing data that are of interest and actionable at the state, model and local level. Specifically, the MIECHV program will engage in the following six steps, as shown in Figure 1, with key staff involved in each of these steps:

Figure 1: Framework for Evaluation Process



Source: Centers for Disease Control and Prevention. “Framework for Program Evaluation in Public Health.”

- 1) *Engage Stakeholders:* Evaluation stakeholders will include representatives of the state offices for each model; members of CDPHE’s EPE Branch; and staff from sites implementing home visitation programs in the funded counties/regions. Technical assistance or input on specific issues that arise may be requested of HRSA and ACF staff and other state data leads. Similarly structured evaluation stakeholder groups have successfully guided past evaluations and quality improvement efforts.
- 2) *Describe the Program:* Most of the work of describing the program has already been completed because the approved models have extensive evidence demonstrating effectiveness and the overall description of MIECHV program. As this project moves forward, additional program details may be added based on stakeholder input, refinements in the protocols and local implementation. Contextual factors affecting local programs will be documented.
- 3) *Focus the Evaluation Design:* A core evaluation design already exists based on legislative and SIR requirements which define the long-term outcomes. The evaluation

¹ Centers for Disease Control and Prevention. “Framework for Program Evaluation in Public Health.” *MMWR* 1999;48(No. RR-11). <http://www.cdc.gov/eval/framework.htm>. Accessed May 12, 2011.

stakeholders are likely to develop additional evaluation questions that fit the more proximal outcomes expected from the implementation of each model. Improved measurement of these short-term outcomes can better apply to CQI. Short-term outcomes can act as an early warning system on (lack of) progress on the required benchmark constructs, *i.e.*, long-term outcomes.

- 4) *Gather Credible Evidence*: Indicators, protocols, instruments and methods for data collection are well established based on past experience of the models, as well as through the assistance of HRSA, ACF and peers in other states.
- 5) *Justify Conclusions*: Standard methods for analysis and interpretation have been and will continue to be applied. Evaluation stakeholders with direct insight into program implementation will be asked to reflect on results, make interpretations and draw conclusions. EPE staff will review analysis plans and reports for scientific rigor, ensuring that conclusions are appropriate.
- 6) *Ensure Use and Share Lessons Learned*: Results of the evaluation will be shared with program staff, stakeholders, department leadership, grantees and the Early Childhood Councils.

CDC's Framework for Evaluation also includes Four Standards of Effective Evaluation: 1) utility, 2) feasibility, 3) propriety, and 4) accuracy. These four standards will be examined and applied for the duration of the evaluation activities throughout the six steps.

Qualifications of State Data Staff

Staff from the Epidemiology, Planning and Evaluation Branch at CDPHE will work collaboratively with HRSA, ACF, model developers, state offices for the models and local sites to create a rigorous data analysis plan. EPE is responsible for planning, evaluation and data analysis for the Prevention Services Division at CDPHE. Analytical services are provided by a centralized team of statisticians, evaluators and epidemiologists. The branch is composed of 17 statisticians and evaluators who service the full range of prevention programs in the Division. EPE collaborates with PSD programs and other partners to plan and implement effective interventions, promote policy development, and evaluate the outcome of these activities. This is accomplished through systematic collection, analysis and interpretation of population-based and program-specific health and related data to assess the distribution and determinants of the health status and needs of the population.

The EPE Branch also conducts enhanced surveillance and evaluation activities and will bring these skills to the MIECHV program. Staff has extensive experience in Geographic Information Systems (GIS), survey and report creation, design and implementation of web-based data collection systems, and study design that will benefit monitoring of benchmarks and CQI. Evaluators and epidemiologists will work with the state offices and instrument developers to identify scale scores, ratios, or other metrics most appropriate to the measurement proposed. In addition, a plan for analyzing the data at the local and the state level will be developed. At a minimum, this plan will clarify how data will be aggregated and disaggregated to understand progress made within different communities and for different groups of children and families. EPE staff will engage in evaluation and data capacity building with home visiting program staff, grantees and communities.

Anticipated Barriers or Challenges in Benchmark Reporting

Two challenges are anticipated related to benchmark reporting: 1) the data collection burden for home visitors and their clients and 2) potential participant attrition.

While all models have actively engaged in data collection for client assessments and documentation of implementation and participant outcomes, the level of effort needed to meet the legislatively required benchmark reporting represents a significantly greater burden than in the past. In addition, these data collection requirements also impose a change to how services have been delivered. While some constructs may be answered by asking a single question, others require the administration of multi-item instruments (e.g., maternal depression). This requires a significant time commitment during a home visit to establish baselines and collect follow-up data again at the one-year mark. There is a potential for home visitors to resist the increased data collection burden. CDPHE will implement training for home visitors to explain the MIECHV program and its legislative requirements and create buy-in for the importance and usefulness of data collection for CQI and improved service delivery for participants.

Increased data collection also poses a challenge for participants. Some clients may feel uncomfortable answering questions related to constructs like domestic violence and crime. This sensitivity may be more pronounced in some cultures and communities. CDPHE will address this challenge by educating participants about funding requirements and the intention to improve services.

Participant attrition may impact the evaluation since multiple measures must be assessed and re-assessed over time. Losing participants to follow up will pose a challenge to the evaluation design. This issue will be addressed by both program and evaluation staff. Program staff will engage in CQI activities to improve client retention. For measurement, attempts will be made to obtain multiple contact options, so that follow up can be completed even if a participant moves or fails to complete the program.

SECTION 6: Plan for Administration of State Home Visiting Program

Extensive capacity exists within the designated lead agency, the Colorado Department of Public Health and Environment, to collaborate with partners to implement, manage and evaluate the home visiting program. CDPHE is one of 16 cabinet-level departments whose executive directors are appointed by the Governor. The mission of the department is to protect and preserve the health and environment of the people of Colorado. The MIECHV program is administered under the Home Visiting Program which is located in the Center for Healthy Families and Communities (CHFC). CHFC is one of two centers in the Prevention Services Division and has responsibility for Colorado's Maternal and Child Health (MCH) Program. Programs under CHFC include the Nutrition Services Branch which houses the women, Infants and Children (WIC) and Child and Adult Care Food programs, the Child and Youth Branch, and the Women's Health and Injury, Suicide and Violence Prevention Units. Several programs important to the success of a comprehensive home visiting program are co-located in PSD and will continue to support and inform the state's home visiting plan. These include the state's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA), Tony Grampas Youth Services program, and Individuals with Disabilities Education Act (IDEA) Part C and Part B.

The MCH Program has a history of close collaboration with key early childhood partners, in large part due to the MCH Bureau's Early Childhood Comprehensive Systems Grant, the MCH director's appointment to the state's Early Childhood Leadership Commission (ECLC) and her service as co-chair for the Early Childhood Data Collaborative.

Day-to-day administration of Colorado's home visiting program will be under the Director of Home Visiting Programs, who also has administrative responsibility for the existing Nurse Home Visiting Program. Full support for procurement and fiscal management services is available through PSD's centralized Fiscal Services Unit; and data collection and reporting responsibilities will be supported by the Epidemiology, Planning and Evaluation Branch. An organizational chart for the project is provided in Attachment 3, and the job descriptions and resumes for key personnel are provided in Attachment 4. The home visiting director will continue to work closely with the state offices for HIPPY, NFP and PAT and will commence work with the regional office for EHS-HB to ensure that local programs are expanded with fidelity and according to implementation plans proscribed by the respective model, and comply with all requirements of the MIECHV program.

Meeting the Legislative Requirements

Each of the evidence-based models under consideration for expansion has essential requirements or core elements related to the training and competence of staff and the quality of staff supervision. All programs under consideration for MIECHV funding are well established and have been endorsed by the model developers as ready and capable to expand with fidelity. In addition, the state offices that provide model-specific site development, implementation and ongoing programmatic support and technical assistance have long and remarkable histories in the state. CPCF, for PAT and HIPPY programs, was founded in 1991 to promote and support high quality early childhood education programs and family initiatives. IIK, founded in 1999 to improve the health and well-being of vulnerable children and families throughout Colorado, has served as the NFP state office since the organization's inception and has continued to bring NFP and other research-based, proven programs into communities across the state for 12 years. Early Head Start programs in Colorado have technical assistance and support from the Region VIII office.

A monitoring team, led by federal Head Start staff, conducts a thorough review of each grantee every three years to determine its compliance with the Performance Standards and other regulations.

Staff Training and High Quality Supervision

HIPPY Program Coordinators must have a minimum of a bachelor's degree and training in early childhood education, elementary education, family or adult education, social work, or a related field. Coordinators must also have strong training, leadership, communication, organizational and administrative skills, as well as knowledge of the needs and interests of families in underserved communities. It is preferred that the program coordinator is a member of the target community. The HIPPY program eligible for Year 1 funding has an existing coordinator with six years of experience recruiting and supervising staff and managing the program. HIPPY home visitors speak the language of participating families and are members of the target community,

which serves to enhance the development of trusting relationships with families. Home visitors also use the HIPPY materials with their own children, allowing them to identify with the challenges and achievements of parents in the program.

The NFP program requires licensed registered nurses to deliver the intervention. The educational background of nurses supports their ability to provide health care information and to think critically in assessing client needs and skills while delivering individualized care. Supervisors, also licensed registered nurses, receive training in supervision and ongoing support from the NFP nurse consultant to enhance supervisory skills. The NFP programs under consideration for Year 1 funding have been effectively delivering services for seven to twelve years. Current supervisors have been with their programs for five to eleven years.

PAT requires parent educators to have an educational background and experience working with children and parents, followed by model specific training. Expectations for supervisors are outlined in the Essential Requirements, and Advanced Supervision Training is used to support the use of reflective supervision. The PAT programs under consideration for funding have been operating in their respective communities for seven to eleven years and are considered stellar examples of model implementation.

The *Performance Standards* (1304) and *Program Option Regulations* (1306) provide a framework for Early Head Start home visitor qualifications. Within that framework, program developers must decide the specific educational, professional, and personal experiences that are necessary to do the job in the specific community and agency where they will work.

All models require continuing education for both supervisory and direct service staff, and the national offices either directly or through state offices (regional office for EHS-HB), provide consultation, monitoring and technical support. The targeted communities have established resources and referral networks which are connected to the programs targeted for funding. The local implementing agencies have been assessed and approved by the model developers for readiness and capacity to expand with full fidelity to the respective model.

SECTION 7: Plan for Continuous Quality Improvement

Continuous quality improvement is built into the administration of each model under consideration for expansion. CQI processes use demographic variables of participants to ensure alignment between participants and the model, process measurement to track fidelity of implementation of the model and outcome measurement to track progress on the benchmarks for individuals, sites and the state overall.

Each model has established protocols for service delivery and requires standard documentation of the effort by home visitors. This documentation is reviewed at least twice a year by the state-level offices as part of their CQI process to assess implementation fidelity. As discussed previously, fidelity is ensured through training, documentation and observation. Where deviations from the model are observed, corrective measures are implemented.

During the first two years of implementation, Colorado will focus on two potential quality issues: 1) home visitor client case load by site and 2) client retention. Process and demographic information collected by home visitors and entered into the data system will be reviewed by the evaluation stakeholders (described in Section 5) at least quarterly to identify areas for improvement and/or success relative to these two issues. The evaluation stakeholders will share results, successful practices and improvement recommendations with sites and individual home visitors as necessary. Front-line staff will also be consulted to provide insight into potential improvements.

Additionally, state program staff is interested in measuring the quality of state-level support for systems building. For CQI in this area, group functioning will be assessed through quarterly administration of the Wilder Collaboration Factors Inventory.² The Wilder Collaboration Factors Inventory is an assessment tool derived from scholarship conducted by Wilder Research Center to identify the factors that determine successful collaboration. The tool uses 42 questions spread across twenty areas of collaboration to measure the likelihood of a collaborative effort's success. It can be administered before beginning collaborative work or in the midst of such an effort to identify strengths and areas for improvement. This tool is a widely accepted mechanism for improved planning and management of collaborations. Any weaknesses found could be corrected, while strengths could be shared and acknowledged by the group.

SECTION 8: Technical Assistance Needs

Colorado is interested in continuing opportunities to learn with and from colleagues in other states, particularly in the area of data collection and CQI. If grantee meetings are planned, including state leads for data collection and evaluation would be invaluable.

SECTION 9: Reporting Requirements

Colorado will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program.

² Mattessich, P., Monsey, B.; Murray-Close, M., *Collaboration Factors Inventory; A self-guided assessment tool*; Fieldstone Alliance: June 2001.