AFFORDABLE CARE ACT
MATERNAL, INFANT AND EARLY CHILD

Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program

OMB Control No. 9015-0336

Oklahoma State Department of Health

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Section 1: Identification of the State's Targeted At-Risk Communities

INTRODUCTION

In the initial needs assessment that was completed by the state of Oklahoma for the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, "community" was identified as a county. Although a more narrowly-defined area may be desirable, none of the required data was available on a more localized level with the exception of zip codes areas within Oklahoma City and Tulsa. Oklahoma is divided into 77 counties, each with its own local government. For every county, data was compiled for all of the indicators. This data was then used to determine a county level rate for each indicator. To form "risk ratios," the county level rates were divided by the corresponding state level rate for all individual indicators. Risk ratios greater than 1.0 indicated a risk in excess of that statewide standard. These risk ratios were then averaged to determine an overall risk at the county level. Risk indicators held equal weight in computation of the average risk ratio. The average risks were then ranked to reveal the county's relative position among all counties within the state.

Using this method, the Oklahoma needs assessment identified ten counties on which to focus its efforts for the MIECHV Program. The following counties were initially included in the top ten list of counties: Kay, Garfield, Oklahoma, Muskogee, Coal, McCurtain, Carter, Adair, Comanche, and Greer. However, it was decided that due to limited resources, it would be best to concentrate on counties that have a total population greater than 10,000. Neither Coal nor Greer has a population over 7,000. Therefore, a community profile for those two counties was not included. Their removal from the rankings moved McClain and Tulsa Counties into the top ten.

Due to funding limitations, it was determined that the first year of the MIECHV Program would focus on only those counties ranked first and second in the needs assessment. Those counties are Kay and Garfield. If for some unforeseen reason not all of the MIECHV Grant funds can be utilized in Kay and Garfield counties, the monies will be directed towards the county ranked third in the needs assessment, Oklahoma County.

Kay County accounts for 1.2 percent of the population of Oklahoma. Rates for both median household income and per capita income in Kay County are lower than the comparable state rates. For seven of the needs assessment indicators, Kay County has rates higher than the comparable state rates. Those indicators include poverty; juvenile crime rate; high school dropout rate; binge alcohol use; unemployment rate; child maltreatment; and domestic violence.

Along with the needs assessment, meetings were conducted in Kay County to hear directly from local citizens regarding the needs and existing resources in their community. On March 3, 2011,

focus groups were scheduled throughout the day with individual sessions for service providers, families currently participating in home visiting programs, and the public at large. The meeting location for the focus groups was the Pioneer Technology Center in Ponca City. Additional meetings for all community partners with an interest in home visitation were conducted on March 22 and April 14. The location for both of these meetings was the Kay County Health Department in Ponca City.

Meeting participants included home visitors, supervisors, and/or administrators from the existing regional home visitation programs, which are Children First (Nurse-Family Partnership); Northern Oklahoma Youth Services Home Visitation Program (Healthy Families); and Oklahoma Parents as Teachers. Other attendees represented the following agencies or programs: Dearing House Child Advocacy Center; Smart Start Kay County; Court Appointed Special Advocates (CASA) of Kay and Noble Counties; Pioneer Technology Center; Child Protective Services of the Oklahoma Department of Human Services (OKDHS); Oklahoma State University Nutrition Education Program; Kay County Health Department; University of Oklahoma Center on Child Abuse and Neglect; and the Oklahoma State Department of Health.

Families who were currently enrolled or have been enrolled in home visitation programs also shared their ideas and opinions in a special focus group that was designed exclusively for consumers. Participants that attended the meeting included: a single mother that is now economically self-sufficient; a married mother and her pregnant friend who both expressed a strong desire to promote breast-feeding in their community; a mother who asked for help finding childcare for her hours of employment; and a mother with a special needs child. The group repeatedly expressed how valuable home visitation programs are in their community. They agreed that the programs need more marketing and advertising so that other families will be aware of the opportunity to receive home visitation services. Families who were unable to attend the meetings were given the opportunity to write their comments, put them in sealed envelopes and return them to their home visitor.

Garfield County accounts for 1.5 percent of the Oklahoma population. The median household income for Garfield County is less than that of the state average. For eight of the indicators included in the needs assessment, Garfield County has rates higher than the comparable state rates. Those include preterm birth; infant mortality; poverty; overall and juvenile crime rates; binge alcohol and illicit drug use; and domestic violence.

Like Kay County, community meetings were conducted to provide local citizens an opportunity to share their perspectives regarding the needs and existing resources in their community. Focus groups were scheduled throughout the day on April 6, 2011 with separate sessions conducted for service providers, families currently participating in home visitation programs, and the public at large. On April 18, there was an additional meeting for all community partners with an interest

in home visitation. All meetings were held at the Community Development Support Association (CDSA) Branch Office in Enid.

Garfield County meeting participants included: the supervisor and multiple parent educators from Oklahoma Parents as Teachers (OPAT) in the Enid School District; the OPAT parent educator from the Pioneer-Pleasant Vale School District; the Children First supervisor and nurses; a Children First interpreter; Garfield County District Nurse Manager; the state director of Children First; the state director of Smart Start Oklahoma; the executive director of the Community Development Support Association; and the Youth Build Program Coordinator. Additional participants included representatives from Sooner Success; Oklahoma Department of Human Services (OKDHS); Oklahoma State University Cooperative Extension Nutrition Education Program and a business woman with employees that have been served by the Enid OPAT Program.

Families that had been enrolled or are currently enrolled in home visiting programs participated in afternoon and evening meetings conducted in Garfield County. Consumers that attended the meetings included: a disabled grandmother who is raising her grandchildren; a military wife whose husband is in the Air Force; several Spanish-speaking families; and a college student from a small town in a rural area. Families who were unable to attend the meetings were given the opportunity to write their comments, put them in sealed envelopes and return them to their home visitor.

COMMUNITY STRENGTHS

With regard to **Kay County**, community partners agreed that one of the greatest strengths in their community is the experience, longevity, and stability of the staff that serve in local agencies and programs. Stated another way, it was said that there are "seasoned people in agencies" and they "know the community and services." They also stated that there is "great collaboration" of service providers with "many organizations coming together."

Additionally, it was stated that, although the child abuse and neglect statistics reported in the needs assessment are almost double that of the state average, more recent statistics indicate that child maltreatment rates in Kay County have been reduced. However, it was noted that comparisons between the statistics are difficult to make because the Oklahoma Department of Human Services (OKDHS) has undergone a complete system makeover. Participants did generally agree that there is now an "improved response" to child abuse and neglect reports.

Other community strengths that were mentioned included local domestic violence services, Smart Start (school readiness), and Sooner Start (early intervention). Specific disciplines were also named as strengths such as the school-based social workers in both Ponca City and Blackwell and the new child development specialist at the health department.

Finally, existing home visitation programs were recognized as community strengths (Children First, Start Right and Parents as Teachers). Expressions of such appreciation were made by both providers and consumers. Specific comments made by women who had received home visits included:

- It was great;
- Amazing; and
- Loved the program

A major strength that was identified for **Garfield County** was the presence of many community services and organizations available to help families. It was stated that services are typically provided by individuals who have "years of professional expertise and experience."

Community programs that were discussed as being strengths included: Oklahoma Parents as Teachers; Sooner Start (early intervention); the Community Nutrition Education Program through Oklahoma State University Cooperative Extension; the Child Advocacy Center; Park Avenue Thrift Store and Vance Air Force Base Family Services. The Community Development Support Association (CDSA) sponsors a variety of services. Those services include housing assistance; emergency housing; emergency assistance; legal aid; financial assistance for medication; and Youth Build. The county health department also provides several resources including: health screenings; early intervention services; immunizations; Women, Infants and Children (WIC) Program; and a lactation consultant.

Enid, the county seat and largest city in Garfield County, was described as a "hub" for services. Specifically, Enid was identified as being the center of medical and educational services for not only Garfield County, but for all Northwest Oklahoma as well.

The Metropolitan Human Services Commission was also listed as a community strength. It was described as providing representatives from all service agencies "a clearly defined infrastructure to address human services needs within the community." In the past, this group was "utilized to address issues related to early childhood, workforce investment, mental health, and increased public awareness." This has resulted in a mechanism for appropriately addressing issues and "thereby assuring healthy partnerships and reduced duplication of efforts."

It was stated that "the community supports education." This support was recently demonstrated when an almost $100 million school bond issue was passed by local citizens. Support was explained as being from both the public and private sectors. Smart Start, which promotes the investment of resource in the early years of development, was described as having strong support from the business community.

Other strengths that were identified included charitable institutions such as churches. The faith-based community has provided assistance for families and has also sponsored programs like "Mentor Mom" which is a parenting ministry.

Local law enforcement is considered a strength of the community. They were described as being prompt to arrive when help is needed.

Finally, comments from consumers indicated they consider the existing home visitation programs to be strengths of the community. Families that had received home visits consistently described their home visitation program using words like "great" and "wonderful." The following are comments made by participants:

- "I think that all families that can, should have this program."
- "I really think this program is amazing and extremely reassuring especially for first-time single mothers like myself."
- "It's very helpful."
- "I love my home visitor. I can correct anything so that I don't lose my son and I can raise a happy, healthy child."

COMMUNITY RISK FACTORS

In **Kay County**, many of the community risk factors discussed were related to poverty and the economy. Budget and funding cuts at all levels including local, state, and federal were listed as having an impact. It was noted that there are "not enough staff for different programs" and there are "staff limitations;" "declining community services;" and "stretched resources." Comments included concerns about "resources drying up;" "economic hits;" "business and factories closing" and a "federal program discontinued." The result has been increased unemployment and economic hardships for families.

Risk factors that were mentioned included lack of services for preteens and teens especially in regards to substance abuse and prevention of juvenile crime. The school dropout rate was a related concern. Adolescent pregnancies were also listed as a risk factor. It was stated that "teens that have babies who then live with their parents are caught in generational patterns of child rearing." The mindset of parental dysfunction impacts both the teen parents and their children.

Another concern was for the large single parent community. It was stated that this group often has "difficulty with resources," may have "self-esteem" issues, and has a tendency toward participating in risky behaviors. Additionally, it was stated that there are issues with parental disputes over custody, issues with co-parenting and blended families. It was said that there is a need for more family mediation services at low cost.

Other Kay County risk factors that were listed as concerns included: limited mental health services; lack of quality childcare available and no local, public transportation system.

In **Garfield County**, poverty was listed as a major risk factor. Related issues included high rates of obesity and limited access to healthy foods. Another concern was "not enough safe, affordable housing." It was noted that lead-based paint is an issue in some of the older homes in the community. There is no independent living or housing available for teens under the age of 18.

Additional risk factors in the community included abuse of both drugs and alcohol. It was stated that there are many bars as well as liquor stores in the area. Alcoholism has become a concern.

Violence has also become a concern in Garfield County. This would include domestic or intimate partner violence as well as violent criminal activity in general.

Adolescent pregnancy was identified as a risk factor. A lack of free or inexpensive recreational activities for children and teens was also listed. Programs such as Big Brothers/ Big Sisters are not available in Garfield County.

A related community issue was the scarcity of locations that have been designated for physical exercise. Specifically mentioned were public spaces such as walking trails, bike paths, safe parks, and a water park or splash pad.

CHARACTERISTICS OF PARTICIPANTS

In **Kay County**, it was agreed that all participants share the common characteristic of being parents of young children. Often, they are young themselves and may be first-time parents.

Frequently, participants have no true medical home for health care. With no primary care physician, there is often an increase in the use of the hospital emergency rooms for medical care. Another common characteristic of participating families is poverty. They may also have a lack of or limited education. Additionally, some have been identified as experiencing developmental delays.

Frequently, participants have concerns with mental health, substance abuse and/ or domestic violence. Often, these issues are co-occurring and families must deal with simultaneous problems. It was also noted that some family members may have a history of physical and/or sexual abuse. They may also have to contend with past or current incarceration and related issues such as legal fees and court fines.

Participants are often single parents. A number of participants have a blended family. They may have a non-relative in the caregiver role or may even have multiple non-family caregivers for their children.

Program participants in Kay County were described by home visitation program staff as being vulnerable mothers with low self- esteem and low social support. They may also have difficulty with problem solving, decision making, coping skills, and communication. They may have a tendency to develop relationships by “sliding rather than deciding.” For some participants, there is “a lot of drama” and problems with boundary setting in relationships.

Garfield County participants were described as having a desire to improve their parenting skills. Most want to do a better job as parents.

Some participants in Garfield County are pregnant, first-time mothers with low income and social support. The remaining participants were described as very diverse. Descriptors included: married; single; teenagers; military families from Vance Air Force Base; foster families; grandparents raising grandchildren; families with mental health issues; and parents without a high school education or GED. Fathers may or may not be involved. One specific ethnic group that was mentioned was the Marshallese; these families originated in the Marshall Islands, but have relocated in Garfield County.

Characteristically, program participants have an income that is often lower than the state average. They may not have reliable transportation. Even access to healthy food may be a challenge. However, participants were described as being very resourceful. They may have an extended support system with family or friends or both.

NEEDS OF PARTICIPANTS

Kay County community partners said the most significant need they identified for participants was the need to develop family decision making ability or decision-making skills in general. Learning to plan was also listed as a skill families needed.

Other needs of participants include:

- ability to communicate effectively;
- ability to establish boundaries;
- development of self-esteem; and
- an understanding of healthy relationships.

With regard to forming relationships, it was stated that there is a need for education related to relationships. It is important that the parents establish deliberate relationships and not just "slide" into them by happenstance.

Other areas of need identified were literacy and education. Families with developmental delays, whether the adults or children had the delay, were recognized as having unique needs that might require providing additional or expanded services. Children should be referred to Sooner Start, Oklahoma's early intervention services.

Information and assistance with domestic violence, substance abuse, and mental illness were identified as needs for some families in Kay County. Counseling related to all those areas needs to be more accessible. For those that cannot afford services and/or appropriate medications, financial assistance would be useful.

A list of specific educational topics that parents would find useful included: prenatal care; breast-feeding consultation; childbirth; general parenting; nutrition; choosing an appropriate childcare provider; and sexually transmitted disease prevention.

A resource directory would be a useful tool for families. However, families often need assistance with connecting to the actual resources. These thoughts were expressed by both those who provided and those who received home visits.

Advertising or marketing existing home visiting programs was identified by both providers and consumers of home visits as an issue that should be addressed. It was stated that there is a need to share knowledge of community programs and services and to promote programs.

The needs of participants in **Garfield County** seemed to be related to accessing resources - particularly resources for families with limited incomes. Safe, cost-efficient housing, supplemental food and emergency cash assistance for utility bills was mentioned.

Specific behavioral health issues such as access to mental health and substance abuse services were thought to be lacking. In some instances, the service may be in existence, but the professionals in attendance worried that not all services possessed a desired quality of professionalism. Although not strictly viewed as a behavioral issue, additional domestic violence services were thought to be needed also.

On a rarer note, obtaining a driver's license was described as a challenge for some participants. This appeared to be more common for those in the Hispanic population. Following this line of discussion, the fact that some families struggled with the English language was noted.

EXISTING HOME VISITING SERVICES IN THE COMMUNITY

Currently, **Kay County** has three home visiting programs utilizing a model recognized on the MIECHV list as evidence-based: Children First (NFP), Start Right (HFA) and Parents as Teachers (PAT).

Children First is the name given to the Oklahoma's **Nurse-Family Partnership** Program. Children First was created by state statute in 1996 and is primarily funded with state appropriations. Since October 1998, services have been available statewide and until recently in every county. Oklahoma was the first state in the nation to institute the Nurse-Family Partnership on a statewide basis. All Children First programs are implemented through county health departments.

A woman may enroll in Children First if she meets the following criteria:

- is less than 29 weeks pregnant;
- is expecting her first child; and
- has a household income at or below 185% of the Federal Poverty Level.

Services are provided by specially trained public health nurses. Training, consultation, monitoring and evaluation are provided by Children First program staff located at the Oklahoma State Department of Health.

Since 1996, The Northern Oklahoma Youth Services Family Resource Program (NOYS) has been awarded funding to support a **Start Right** Program. Start Right is the collective name used for child abuse prevention programs funded by the Office of Child Abuse Prevention (OCAP) at the Oklahoma State Department of Health. Start Right Programs utilize **Healthy Families America** (HFA) model, although they are not officially affiliated or accredited. All Start Right Programs use the **Parents as Teachers** curriculum and are certified **Parents as Teachers** affiliates.

Expectant parents are eligible to enroll in the Start Right Program

- after the 29th week of pregnancy if the mother is pregnant for the first time;
- anytime during a subsequent pregnancy; or
- after the birth of a child up until the child's first birthday.

Families are assessed for risk factors and must exhibit a minimum number of risk factors in order to be eligible for home visitation services. Services are provided by specially trained paraprofessionals and/or professionals.

Currently, there is only one **Parents As Teachers (PAT)** Program in Kay County. It serves families living in the Newkirk Public School District - a small town with a population of about 2,200. This PAT program is administered through the Osage County Interlocal Education Cooperative and has been in operation since the start of the 2007 school year. Historically, Ponca City had a PAT program for four school years from 2000-2003. Tonkawa, a town of about 3,300, had a program from 1993-1995.

Parents as Teachers (PAT) will accept a family into the program as long as the family has a child under the age of three years. PAT programs are restricted to serving families within the grant funded school district area.

Garfield County has two existing home visitation programs: **Children First** and **Parents as Teachers**. Just as in Kay County, **Children First** is provided through the local county health department and has the same enrollment criteria.

Parents as Teachers is a home visitation program provided by the Enid School District and the Pioneer-Pleasant Vale School District. Funding for Parents as Teachers is provided by the Oklahoma State Department of Education through a grant process to local school districts. Each PAT program provides services in the geographic area served by the sponsoring school district.

PAT Programs are voluntary and offered to families with children under age three years regardless of income. It is an early childhood family education and support program based on the philosophy that parents are their child's first and most influential teachers. PAT workers generally make monthly home visits and provide additional opportunities for parents to gather for sharing, learning and fellowship.

EXISTING MECHANISMS FOR SCREENING, IDENTIFYING, AND REFERRING

There is not an existing mechanism for centralized intake for home visitation services in **Kay County** much less at the state level. Providers reported during their focus groups that they share information about their programs with community partners who then, in turn, refer families to them when appropriate.

Referrals often come from county health department programs like WIC, family planning and the Child Guidance Service. Referrals are also received from other medical providers outside of the health department.

Information about Children First and Start Right has been provided to local hospitals and flyers for the Start Right Program have been placed in packets received by parents of newborns. However, it was stated that a formalized agreement with the hospital might be an effective way to increase referrals for the Start Right Program. [Children First cannot enroll a family after the baby is born.]

Garfield County does not have a centralized intake system either. Children First nurses reported that their referrals typically come from other health department programs like WIC or family planning.

The Pioneer-Pleasant Vale School District PAT Program is limited to receiving referrals from within their small school district. The larger PAT program in Garfield County serves the Enid school district. It is housed at the Community Development Support Association (CDSA) and often receives referrals from other in-house programs. It receives referrals from external partners such as the local domestic violence shelter or Medicaid agency. "Word-of- mouth" and self-referrals are also received.

REFERRAL RESOURCES CURRENTLY AVAILABLE TO SUPPORT FAMILIES RESIDING IN THE COMMUNITIES

During the public meetings, resources recognized as currently available in **Kay County** included:

- Smart Start;
- Sooner Ride (transportation for vital appointments paid by Medicaid);
- churches;
- The Oklahoma Department of Human Services;
- the county health department; and
- the domestic violence shelter.

Faith-based programs were mentioned as good sources for food and nutrition programs as well as coats and other articles of clothing. Specific programs named as currently available were: Kids Café, Friendship Garden, and the Mission. Smart Start was recognized as having discretionary funding for necessary over-the-counter medications and transportation.

Following the community meeting, the Start Right staff sent the following information regarding the referral resources and asked that it be included in the MIECHV Updated Plan:

> "First of all, Kay County has many agencies and organizations that have a basic means of assessing needs of families that seek their services or are in need of other services for their family. Some of these include: Northern Oklahoma Youth Services (Family Resource Program; Workforce Investment Act (WIA); Counseling Services; Parent Assistance Center); Kay County Health Department (Children First, WIC, Family Planning); Department of Human Services (TANF, Food Stamps, Medicaid); Office of Juvenile Affairs; Ponca City Medical Center; Blackwell Integris Hospital; New Emergency Resource Program, Ponca City; Catholic Charities, Blackwell; area OB/GYN and pediatricians; Domestic Violence Program of North Central Oklahoma; Edwin Fair Community Mental Health; Northern Oklahoma College Tonkawa; Living Hope Pregnancy Center, Ponca City; and others. Each of these receives so many fliers, business cards, etc. with information about programs and services that it can be very overwhelming and confusing as to types of services, communities served, intake criteria, etc."

In **Garfield County**, churches were once again recognized as being "food sources." The Salvation Army was identified as having the ability to provide assistance for utility bills. Additional resources also included Hope Outreach; Park Avenue Thrift; the Community Development Support Association (CDSA) and a free medical clinic.

RESIDING IN THE COMMUNITIES

Kay County community service professionals recognize a need for a “centralized referral system that keeps up with changes in programming because funding is added or either taken away.” It was also said there is a need to “talk among programs” and for programs to hold regular meetings in order to staff referrals. Additionally, it was mentioned that all home visitation programs could benefit from marketing in order to reach potential participants.

With regard to the needs of families in Kay County, community professionals stated that families with mental health issues needed mental health services must be available for both adults and children.

Professionals stated that families often needed education and/or counseling regarding health relationships and decision-making skills. Treatment for children with sexual behavior problems was also mentioned.

Assistance for basics such as medical care, baby items such as diapers, transportation and quality childcare are available, but more is needed. Those with special challenges such as development delays may have special needs that could be addressed by community resources and should not be forgotten.

In **Garfield County**, it was noted that more urgent care, minor emergency and free or low-cost clinics are needed in the community. Specific health issues that were mentioned included dental care for adults, free weight loss programs and free smoking cessation programs.

Childcare was an area of concern for some in Garfield County. It was stated that not only was more “quality” childcare needed, but non-traditional childcare such as care provided during evenings, overnight and on weekends should also be available.

Many in the Garfield County community meetings were focused on health and safety issues. It was suggested that Garfield County should make improvements in its public transportation system and parks. The latter specifically referred to “wider” and “lighted walking paths.”

A PLAN FOR COORDINATION AMONG EXISTING PROGRAMS AND RESOURCES

Input for a plan of coordination was collected during meetings with members of both the Kay County and Garfield County communities. Excerpts from their comments are included in the following paragraphs.

With regard to the development of a plan for coordination, one group from **Kay County** wrote that having "a centralized intake and information office/person is so very crucial. We may have great services, but if the referring agencies and entities cannot keep up with what is offered and who needs it, then a lot is being lost." Other community professionals identified a need to have continued group meetings with service professionals in order to strengthen their referral network and assure that all families receive appropriate services.

In **Garfield County**, the need for a centralized intake system was also recognized. It was suggested that perhaps Smart Start in Enid serve as the centralized intake agency.

It was also mentioned that Garfield County might have a need for a home visitation coalition that would mirror the State Home Visitation Leadership Advisory Coalition (HVLAC). The HVLAC is an informal coalition made up of home visitation professionals from a variety of programs. The primary goals are 1) to share information in order to improve services for families; and 2) to identify common problems/concerns and the develop strategies that will address them. It is a member led group and staffed by the OSDH CBCAP Grant Coordinator.

During community discussions, one provider suggested using the plan for centralized intake developed by The Early Childhood Resource Center, Inc. in Washington County. M'Liss Jenkins of the Early Childhood Resource Center gladly provided their intake process – a system that they have had in place since 1997.

The Washington County central intake system is loosely described below and was used as an example for both Kay and Garfield Counties to consider when developing their intake process. Neither county has a concrete plan in place, but is exploring the possibilities of adopting or adapting Washington County's model.

Each county will develop a home visitation coalition. It would be acceptable for an existing community coalition, task force or committee to serve in this capacity instead of creating a new entity. All members of the coalition should have a common interest in home visitation services for families with young children and early childhood programs/initiatives.

The purposes of the coalition would be threefold:

1) Ensure that families are connected to home visitation services that best meet their individual needs;
2) Have home visiting programs avoid competing for the same families and/or duplicating services;
3) Have home visiting programs share information about community resources, best practices, funding opportunities, etc. so that the overall early childhood system, particularly the home visitation component, is being constantly improved.

All members of the coalition will agree to develop and then utilize the following documents:

- <u>Memorandum of Agreement or Understanding</u> – a simple document stating the purpose of the coalition and agency members.

- <u>Release of Information/Referral Form</u> – this document will require that potential home visiting participants sign a release so that their contact information may be provided to the members of the home visitation coalition. This form could be utilized by community services wishing to connect families to a home visitation program or between home visitation programs so that families are provided home visitation services that best suit their needs.

In addition to forming a coalition and drafting documents, a staff person to coordinate these and other related efforts is needed.

LOCAL AND STATE CAPACITY TO INTEGRATE THE PROPOSED HOME VISITING SERVICES

Local capacity to integrate the proposed home visiting services was indicated by the nature and strength of the agencies and organizations represented at the community meetings conducted for the MIECHV Program. Meeting participants in both Kay and Garfield Counties included home visitors, supervisors and agency administrators.

Agencies and organizations represented at the **Kay County** community meetings included:

- Children First (Nurse-Family Partnership);
- Start Right of Northern Oklahoma Youth Services Home Visitation Program (Healthy Families and Parents as Teachers);
- Parents as Teachers;
- Dearing House Child Advocacy Center;
- Smart Start Kay County;
- School Social Workers
- Court Appointed Special Advocates (CASA) of Kay and Noble Counties;
- Pioneer Technology Center Coordinator;
- Child Protective Services of the Oklahoma Department of Human Services (DHS);
- Oklahoma State University Extension Nutrition Education Program;
- Kay County Health Department;
- Oklahoma University Health Sciences Center on Child Abuse and Neglect; and
- Oklahoma State Department of Health.

Kay County participants verbalized the need for a core group to continue meeting on a regular basis. It was suggested that an existing advisory group may be used as the MIECHV Program continues to develop.

At the **Garfield County** community meetings, the agencies and organizations represented included:

- Children First (Nurse-Family Partnership);
- Oklahoma Parents as Teachers;
- Smart Start Garfield County;
- Smart Start Oklahoma;
- Oklahoma Department of Human Services (DHS);
- Oklahoma State University Nutrition Education Program;
- Garfield County Health Department; and
- Oklahoma State Department of Health.

In Garfield County, there were bilingual participants that provide services in both Spanish and English. There was also a Garfield County business owner who has seen the value of home visitation because her employees are active participants.

The **State's** capacity to integrate the proposed home visiting services has been demonstrated by the participation of many state agencies including the departments of health and education. Both agencies have over a decade of experience with developing, implementing, and administrating evidence-based home visiting models.

The Oklahoma State Department of Health has demonstrated a commitment to home visitation services by sponsoring the Home Visitation Leadership Advisory Council (HVLAC). Established in 2003, HVLAC was formed to build collaboration between a variety of home visiting programs.

HVLAC has served as a conduit between those administering the MIECHV Grant and those providing home visitation services – and possibly receiving funds from the MIECHV Grant. Throughout this past year, HVLAC has extended invitations to numerous home visitation programs as to keep all updated about the Oklahoma MIECHV Grant plan. Leaders/professionals from the following programs have regularly attended:

- Smart Start Oklahoma
- Oklahoma Early Head Start
- Healthy Start
- The Federal Evidence-Based Home Visitation Grant at the University of Oklahoma
- Oklahoma Parents as Teachers
- Children First of the Oklahoma State Department of Health
- Start Right/Office of Child Abuse Prevention of the Oklahoma State Department of Health
- Community Action Project of Tulsa County

In addition, The Interagency Child Abuse Prevention Task Force (ITF) is ready and willing to assist in implementing the MIECHV Grant. This body, established by state statute in 1984, is mandated to develop the State Plan for the Prevention of Child Abuse and Neglect and assist in the awarding of Child Abuse Prevention Grants to community-based organization for direct services to children and families. The ITF has a statutorily mandated membership of representatives from various public and private agencies as well as parents. The 17 specific representatives include persons from: the OSDH Child Guidance Service; the OSDH Maternal and Child Health Service; the Oklahoma Commission on Children and Youth's Community Partnership Board; the Judiciary, legal profession or law enforcement; the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Mental Health Division; the ODMHSAS Substance Abuse Division; the Office of Attorney General, Victims Services Unit; the Oklahoma Chapter of the American Academy of Pediatrics; the Oklahoma

Department of Human Services, Child Welfare Services; the Oklahoma Partnership for School Readiness; the Oklahoma Department of Education; the Office of the Faith-Based and Community Initiatives as well as two persons with expertise in the identification and treatment of families at risk of child maltreatment and three parents participating in a child abuse prevention program. The ITF has been involved in the development of Oklahoma's MIECHV Program and will continue to serve in an advisory capacity.

Annette Jacobi, Family Support and Prevention Services Chief, recently provided a presentation to Smart Start Oklahoma's Board of Directors regarding the MIECHV Program. This Board serves as Oklahoma Early Childhood Advisory Council and is comprised of leaders from the public and private sectors. At the conclusion of the presentation, board member expressed a strong desire to support the MIECHV Grant Program.

COMMUNITIES NOT SELECTED FOR IMPLEMENTATION DUE TO FUNDING LIMITATIONS

"Community" was defined as a "county" in the initial needs assessment completed by the state of Oklahoma for the MIECHV Program. There are a total of 77 counties in Oklahoma. Data were compiled for all of the indicators from each county. A county level rate was computed for each indicator. The county level rates were divided by the corresponding state level rate for all individual indicators in order to form risk ratios. If a county had a risk ratio that was greater than 1.0, it meant that the county had a risk for that indicator that was in excess of the statewide standard. The average of these risk ratios was computed for each county to determine the overall risk at the county level. When calculating the average risk ratio, the indicators held equal weight. The average risks were then ranked. Each county was listed in its relative position among all the counties within the state.

The list of rankings was used in the Oklahoma needs assessment for the MIECHV Program to identify ten "at risk" counties on which to focus. The following counties were initially included in the list of counties: Kay, Garfield, Oklahoma, Muskogee, Coal, McCurtain, Carter, Adair, Comanche, and Greer. However, it was decided that due to limited resources, it would be best to concentrate on counties that have a total population greater than 10,000. Since neither Coal nor Greer has a population over 7,000, a community profile for those two counties was not included. When Coal and Greer Counties were removed from the rankings, McClain and Tulsa Counties moved up the list into the top ten.

Due to funding limitations, it was determined that MIECHV funding would be dedicated to the top two counties: Kay and Garfield. Should it not be possible to spend all of the funds in these two counties, funds will be utilized in the third ranked county, Oklahoma.

Section 2: State Home Visiting Program Goals and Objectives

STATE HOME VISITING PROGRAM GOALS AND OBJECTIVES

1. **Develop a sustainable, MIECHV home visitation program infrastructure of selected, multiple models matching consumer needs to program model goals.**

    a. Utilizing the completed Needs Assessment, choose home visitation models for implementation in Oklahoma's at-risk communities. The models chosen must be included on the MIECHV Grant list as having been deemed evidence-based.
    b. Develop home visitation coalitions in each at-risk community to assist with coordinating home visitation services and to assure that families are connected with the home visiting program that best serves their needs.
    c. Establish a central intake system in each at-risk community so that potential program participants and other community service organizations can easily connect with home visitation programs.
    d. Market the home visitation programs so that families, community service organization and others in the communities will know about their availability to serve parents and young children.

2. **Scale-up State evidence-based home visitation program activities by adding more home visitors, maintaining fidelity to model specific protocols, and ultimately providing a higher quality and more stable home visitation service.**

    a. Recruit and hire qualified home visitors to serve in the at-risk communities.
    b. Provide model specific training and technical assistance to home visitors as well as individual topical trainings.
    c. Conduct routine site visits, record audits and shadow visits in order to assure that high quality services are being delivered, staff are competent and satisfied in their as home visitor and best practice standards as utilized.

3. **Improve outcomes in required MIECHV Grant benchmark/indicators and their corresponding constructs: maternal and child health; child injuries, abuse, neglect, maltreatment, emergency room visits; school readiness and achievement; crime or domestic violence reduction; increased family economic self-sufficiency; and coordination and referrals for other community resources and supports.**

    a. Develop or purchase a data collection that will support the program evaluation needs of all implemented models.

b. Develop and or select data collection tools that can be incorporated in the practice and evaluation of all implemented program models.
c. Routinely analyze and report data findings related to the MIECHV Grant benchmarks/constructs as required by the MIECVH Grant.
d. Utilize the data findings related to the MIECHV benchmarks/constructs for continuous quality improvement.

4. Develop or enhance implementation of existing statewide and county level collaborations and partnerships to effectively implement and sustain MIECHV Program.

a. Establish a home visitation coalition in each at-risk community for better coordination of services, ease in making referrals and increased sharing of information.
b. Continue to utilize the state Home Visitation Leadership Advisory Coalition, the Interagency Child Abuse Prevention Task Force and the Smart Start Board of Directors (aka Early Childhood Advisory Council) as partners, collaborators and advisors.
c. Assure that each at-risk community has a coordinator dedicated to marketing to the home visitation programs throughout the community, connects potential participants to the most appropriate home visiting program and facilitates opportunities for home visitation professionals to meet together and with other community service providers.

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STATE HOME VISITING PROGRAM CONTRIBUTION TO DEVELOPMENT OF A COMPREHENSIVE EARLY CHILDHOOD SYSTEM

The process of completing the required elements of the Oklahoma MIECHV Program has resulted in public discussion and interagency dialogue that served to focus statewide resources on maternal, infant, and early childhood issues. The entire process has provided a focal point for collaborative efforts in home visitation at the state and community levels.

Key partners and players, at both the state and local levels, have made contributions to the development of the MIECHV Program Plan. Community meetings were scheduled in the counties identified for services. Meeting participants included professionals, home visitation families/consumers, and the general public with a shared purpose of discussing concerns, risks, and needs of families and young children in their respective communities.

At the state level, special evaluation and planning committee meetings were convened to discuss all aspects of the MIECHV Program Plan. Agencies and organizations that had representation included: Smart Start Oklahoma; Oklahoma State Department of Education; The OU Center on Child Abuse and Neglect, Oklahoma Head Start; Oklahoma State Department of Health (OSDH) Maternal and Child Health Service; OSDH Child Guidance Service; OSDH Family Support and Prevention Service. Other partners who provided input in the development of the MIECHV Program Plan were members of the Interagency Child Abuse Prevention Task Force and the Home Visitation Leadership Advisory Coalition. The result has been an ongoing collaborative effort with multiple partners that is focused on enhancing home visitation for pregnant women and families with infants or young children in Oklahoma.

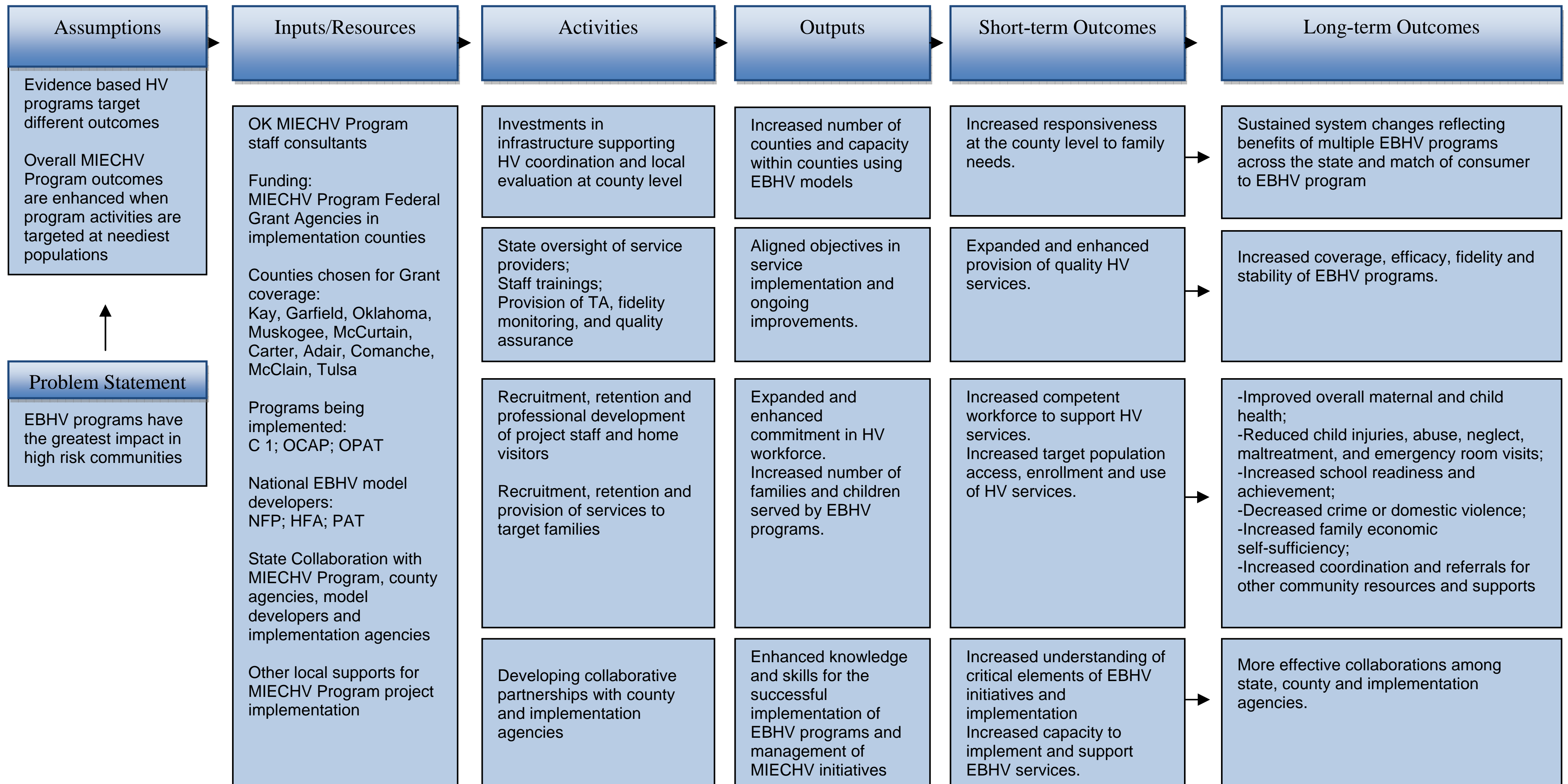
Three nationally recognized, evidence-based models have been chosen for the implementation of Oklahoma's plan for the MIECHV Program. All three have been used in some form, for some time in Oklahoma, but will be expanded and/or enhanced with federal funding. Each of the three has a unique process and system for data collection. Among the three programs, there is wide variation in the proficiency and capacity of evaluation capabilities.

Oklahoma's home visiting plan necessitates the development of a mutual, coordinated system of data collection, data reporting, and evaluation. This system must include agreements to allow data sharing among a variety of programs, agencies, and organizations. As the system is put in place and implemented, it will result in a more comprehensive analysis of home visiting efforts for young children that can, in turn, be utilized to identify existing needs as well as possible strategies for the development of the state's early childhood system.

Implementation, evaluation, and improvement are critical elements of any comprehensive plan. The data collection proposed in the MIECHV plan for Oklahoma will be an important component in facilitating the ongoing development of a statewide comprehensive plan for early childhood.

STATE HOME VISITING PROGRAM LOGIC MODELTHAT IDENTIFIES INPUTS, OUTPUTS, SHORT-TERM AND LONG-TERM OUTCOMES

Oklahoma ACA MIECHV Program Logic Model



Section 3: Selection of Proposed Home Visiting Models and Explanation of How the Models Meet the Needs of Targeted Communities

IDENTIFICATION OF THE EVIDENCE-BASED HOME VISITING MODELS TO BE IMPLEMENTED

The three evidence-based home visiting models selected for either implementation or expansion in Oklahoma with MIECHV funds were Nurse-Family Partnership, Healthy Families America and Parents as Teachers. All three models are currently being used within Kay and/or Garfield counties. Overviews of each of these models were presented during the community meetings. When possible, presentations of the model were made by a seasoned home visitor with experience in a particular model.

The national developers of the selected models have identified program goals as well as outcomes. A brief summary of that information is provided in the following paragraphs.

Nurse-Family Partnership[1] known in Oklahoma as Children First, is a voluntary program that serves low-income, first-time mothers and their children by providing nurse home visiting services during early pregnancy and continuing through the child's first two years of life. The NFP Logic Model lists three program goals. Those goals are:

- To improve maternal health and pregnancy outcomes;
- To improve children's health and guide parents to competent care giving; and
- To improve economic self-sufficiency of families.

Healthy Families America[2] is a voluntary program that initiates services prenatally or before a newborn turns three months. The model is designed for over-burdened families with risk factors for child maltreatment. HFA program goals include:

- To systematically reach out to parents to offer resources and support;
- To cultivate the growth of nurturing, responsive, parent-child relationships;
- To promote healthy childhood growth and development; and
- To build the foundations for strong family functioning.

Parents as Teachers[3] is a voluntary home visiting program with no set income or risk-factor eligibility requirements. Eligibility is based only on the age of the child. Typically, home visits and group meetings are provide once a month. The PAT model has four primary goals:

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[1] *Nurse-Family Partnership.* Accessed on May 25, 2011 from http://www.nursefamilypartnership.org/

[2] *Healthy Families America.* Accessed on May 25, 2011 from http://www.healthyfamiliesamerica.org/about_us/index.shtml

[3] *Parents As Teachers Logic Model.* Accessed on May 25, 2011 from http://www.parentsasteachers.org/images/stories/documents/LogicModel_Web.pdf.

- To increase parent knowledge of early childhood development and improve parenting practices;
- To provide early detection of developmental delays and health issues;
- To prevent child abuse and neglect; and
- To increase children's school readiness and school success.

Choosing only these models does not mean that additional models and services are not needed. Oklahoma has a proud history of implementing evidence-based home visitation programs and appreciates the need for a multitude of programs. With variety of programs, families can more often participate in a program that meets their needs, schedules and perhaps even style.

For Kay and Garfield Counties, the following two particular models were discussed at great length:

> **Early Head Start** (EHS): There are existing Early Head Start Centers in Kay County and Head Start Centers in Garfield County. The Head Start State Collaboration Office has been very involved in the development of the Oklahoma MIECHV Program and the local Early Head Start grantee has been invited to community meetings. However, there are no home-based-option EHS services provided in either county at this time. All have agreed, for the time being, that the three models chosen for the MIECHV Grant should be able to provide services for the EHS or Head Start center-based population. In fact, it has been suggested that the home visitation services give priority to those families receiving no services and are on EHS or Head Start center-based waiting lists – when appropriate. This suggestion may be incorporated into the Requests for Proposals.
>
> **Safe Care+**: Although Safe Care+ was not on the Federal list of approved models, Oklahoma did consider implementing it in at least one of our at-risk communities as a "promising approach." Dr. Lana Beasley from OU's Center on Child Abuse and Neglect presented an overview of the Safe Care+ model at a Kay County community meeting. After careful consideration, it was decided that the funding limitations on "promising approaches" would not support such a new endeavor. Safe Care+, though, is still "on the radar" and will continue to be explored – particularly if Oklahoma receives additional MIECHV funding. The fact that the Safe Care+ model is designed to serve families with the highest of risk factors is very intriguing to those in the existing home visiting programs and those in the community. The existing programs have seen the acuity levels of their clients rise over the years. Even with additional training, staff still worry that perhaps they do not always have the in-house expertise to appropriately address all families' needs.

Continuum of Home Visitation Services in Oklahoma

	Plan to increase with MIECHV Funds			Plan to fund if/when MIECHV funds are available	
	Children First	**OCAP – Start Right**	**Oklahoma Parents as Teachers**	Early Head Start Home-Based	Safe Care
Model:	Nurse-Family Partnership	Healthy Families America and Parents as Teachers	Parents as Teachers	Early head Start Home-based	Safe Care (OU Health Sciences Center Pilot Project
Home Visiting Staff:	Nurses	Paraprofessionals with special training	Paraprofessionals with special training	Paraprofessionals with special training	Paraprofessionals with special training
Enrollment Criteria:	The new mother must: • be less than 29 weeks pregnant; • be expecting her first child; • meet the same income eligibility criteria as WIC and Medicaid	The community-based services program: • enrolls expectant parents after the 29th week of the first pregnancy or • at any time during pregnancy for subsequent births; • enrolls families with a child 1 year or younger; • allows participation up to the child's 6th birthday	Families with a child from birth up to as old as 36 months	Families who are pregnant or have at least one child who is 2 years-old or younger. Families living in poverty.	Families must: • have at least one child 5 years old or younger; • not have a current Child Welfare investigation with DHS; • have risk factors like substance abuse, domestic violence, or mental health issues.
Frequency of Visits:	Every other week	Weekly, then less frequently as needed	Monthly	Weekly	Weekly

DESCRIPTION OF HOW EACH MODEL MEETS THE NEEDS OF KAY COUNTY

As identified by Oklahoma's needs assessment, **Kay County** has seven indicators with rates higher than comparable rates: juvenile crime; high school dropout rate; child maltreatment; domestic violence; unemployment; poverty and substance abuse: binge alcohol use. This means that, when compared to state rates, these Kay County indicator rates are worse or more severe.

The indicator rates used in the Oklahoma needs assessment were not identical to the required MIECHV benchmarks. The following table aligns the highest Kay County indicators, the appropriate MIECHV Benchmark(s), and the stated goals or outcomes of the models that have been selected for implementation or expansion in Oklahoma.

KAY COUNTY INDICATORS RANKED HIGHER THAN STATE INDICATORS	ACA MIECHV BENCHMARKS	STATED GOALS AND OUTCOMES OF EBHV MODELS TO ADDRESS BENCHMARKS
juvenile crime	Crime or Domestic Violence	NFP: goal to improve parental life-course by helping parents develop vision for future & plan PAT: short-term outcome is improved family health & functioning; DOVE tool HFA: program goal is to build the foundations for strong family functioning
high school dropout rate	Family Economic Self-Sufficiency	NFP: goal to improve parental life-course by helping parents complete education PAT: short-term outcome is improved family health & functioning HFA: outcome is increased level of maternal education
child maltreatment	Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	NFP: goal to improve child health & development by helping parents provide sensitive & competent caregiving; PIPE; NCAST PAT: intermediate outcome is the prevention of child abuse & neglect HFA: outcome is child maltreatment prevention
domestic violence	Crime or Domestic Violence	NFP: goal to improve parental life-course by helping parents develop vision for future & plan PAT: short-term outcome is improved family health & functioning; DOVE screening tool HFA: outcome is reduction in intimate partner violence

unemployment	Family Economic Self-Sufficiency	NFP: goal to improve parental life-course by helping parents complete education, find work & refer to all available resources PAT: short-term outcome is improved family health & functioning HFA: goal to build the foundations for strong family functioning
poverty	Family Economic Self-Sufficiency	NFP: goal to improve parental life-course by helping parents complete education & refer to all available resources PAT: short-term outcome is improved family health & functioning HFA: program goal is to build the foundations for strong family functioning
substance abuse: binge alcohol	Improved Maternal and Newborn Health	NFP: goal to improve outcomes of pregnancy by helping women improve prenatal health PAT: short-term outcome is improved family health & functioning HFA: goal to build the foundations for strong family functioning

In Kay County, all three evidence-based home visiting models are currently utilized in some form. A brief history and description of each is summarized below.

Children First (Oklahoma's **Nurse-Family Partnership**) has been operating in Kay County since January 1998. It is offered through the Kay County Health Department with services provided by specially trained public health nurses. A woman may enroll in Children First if:

1) She is less than 29 weeks pregnant;
2) Expecting her first child; and
3) Does not have a household income more than 185% of the Federal Poverty Level.

Services are provided at varying intervals, but most often on a bi-weekly basis. Children First nurses provide visits to families within all of Kay County.

The **Healthy Families America** model is used as the framework for the Start Right Program housed at the Northern Oklahoma Youth Services Center and Shelter, Inc. (NOYS). NOYS has contracted for more than fifteen years with the Office of Child Abuse Prevention at the Oklahoma State Department of Health to provide child abuse prevention services. Start Right Programs utilize the Healthy Families America framework and have trained HFA family support/assessment workers. However, they are also trained in Parents as Teachers and utilize the PAT curriculum. Enrollment criteria for the Start Right Program include:

- A woman be beyond her 29th week of pregnancy if she is pregnant with her first child (no longer eligible for Children First); or
- A woman is pregnant with a child subsequent to her first child; the stage of her pregnancy is irrelevant; or
- A parent or caregiver has a child less than twelve months of age. (Note: HFA model developers require enrollment to be within the infant's first three months.)

Families that are eligible for the program are assessed for risk factors to determine if home visitation services would be beneficial. Initially, the weekly home visits are provided for each family, but the frequency of visits may be reduced over time. Start Right home visitors are allowed to provide services throughout Kay County.

Currently, there is only one **Parents As Teachers (PAT)** Program in Kay County. It serves families living in the Newkirk Public School District - a small town with a population of about 2,200. This PAT program is administered through the Osage County Interlocal Education Cooperative and has been in operation since the start of the 2007 school year. Historically, Ponca City had an OPAT program for four school years from 2000-2003. Tonkawa, a town of about 3,300, had a program from 1993-1995.

Parents as Teachers (PAT) will accept a family into the program as long as the family has a child under the age of three years. PAT programs are restricted to serving families within the grant funded school district area.

Continuum of Services Offered to Address Multiple Family Needs

Under the administration of the Department of Health and Human Services, the Home Visiting Evidence of Effectiveness Project[4] was a thorough review of the research literature on home visiting models that target families with pregnant women and children from birth to age five. The HomVEE Review, which was conducted by Mathematica Policy Research, provides information about home visiting program models as well as evidence of effectiveness as required by legislation. The HomVEE results will be used to describe how the selected models meet the needs of Kay County.

Kay County indicators that ranked higher than state averages in the statewide needs assessment included: poverty; juvenile crime rate; high school dropout rate; binge alcohol use; unemployment rate; child maltreatment; and domestic violence.

Both juvenile crime and domestic violence are included in the MIECHV Program benchmark of Crime or Domestic Violence. The HomVEE research review found that reductions in juvenile delinquency, family violence, and crime were outcomes associated with the Nurse-Family Partnership model.

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[4] *Home Visiting Evidence of Effectiveness.* United States Department of Health and Human Services. Accessed on May 20, 2011 from HomVEE - http://homvee.acf.hhs.gov/

The elevated Kay County indicators of high school dropout rate, unemployment, and poverty are associated with the MIECHV Program benchmark of Family Economic Self-Sufficiency. The HomVEE research revealed that both Healthy Families America and Nurse-Family Partnership have favorable outcomes related to Family Economic Self-Sufficiency. The HomVEE also found that Parents as Teachers has an impact on school readiness.

Child Maltreatment in Kay County is also higher than the state rate. This Oklahoma indicator is matched with the MIECHV Program benchmark of Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits. Again, the HomVEE research review found that outcomes for Healthy Families America and Nurse-Family Partnership included reductions in Child Maltreatment. The HomVEE also found that Parents as Teachers showed improvements in positive parenting practices.

Kay County ranked higher than the state norm in a specific type of substance abuse, binge alcohol use. Binge alcohol use is included in the MIECHV Program benchmark of Improved Maternal and Child Health under the construct of Parental Use of Alcohol, Tobacco, or Illicit Drugs. The HomVEE review of literature for the Nurse-Family Partnership model found outcomes that included improved maternal health.

With three evidence-based home visitation (EBHV) models available in the Kay County community, a broad spectrum of families can be served with home visitation services. If a family does not meet the eligibility requirements of the Nurse-Family Partnership program, they can be referred to Healthy Families America program. If a family does not meet the eligibility requirements of the Healthy Families America program, they can be referred to the Parents as Teacher program. This results in a continuum of service for parents who are pregnant or parenting young children.

During SFY 2010, there were 68 referrals made to the Kay County Children First Program. Twenty of those families enrolled. A total of 33 families received services (new enrollees and carry-overs from previous years). These families were served by one Children First nurse. Approximately, 134 pregnant women were eligible for Children First services in Kay County during SFY 2010. [During SFY 2008, there were 268 first-time births in Kay County. At least half of these births occurred in families with households at or below the 185% of the Federal Poverty Level.]

During the same year, there were 60 referrals made to the NOYS Start Right Program. Forty-eight of those families enrolled. A total of 104 families received services that year (new enrollees and carry-overs from previous years). These families were served by one supervisor and two Family Support Workers equaling 1.6 full-time employee home visitors.

During the 2010 school year, the Parents as Teachers program in Kay County was limited to one parent educator providing services only in the Newkirk school district. This Parent Educator served 32 families during 2010.

In 2008, there were a total of 704 live births in Kay County. Assuming that the 268 first-time births were not eligible for Start Right or PAT, there were 436 families to potentially screen for services other than Children First. Generally, at least 50% of Oklahoma's births are paid for by Medicaid. Using Medicaid as a proxy for poverty, it can be deduced that approximately 218 of these families would be living in poor households. Considering that the MIECHV Grant requires that Grantees target low income families for services, it would appear that Kay County had more families eligible for services than could be served.

Conclusion: Kay County is in need of more home visitation services. However, technical assistance and/or consultation regarding the marketing of the services AND converting referrals into participating clients would be beneficial.

DESCRIPTION OF HOW EACH MODEL MEETS THE NEEDS OF GARFIELD COUNTY

Garfield County ranked second on Oklahoma's MIECHV Program needs assessment. For eight of the indicators included in the needs assessment, Garfield County has rates higher than the comparable state rates. These include preterm birth; infant mortality; poverty; overall and juvenile crime; binge alcohol and illicit drug use; and domestic violence. When compared to state rates, these Garfield County indicator rates are less favorable or of greater severity.

The required ACA MIECHV benchmarks and the indicator rates used in the Oklahoma needs assessment were not consistently the same, although they capture similar information. The following table is an alignment of the highest Garfield County indicators, the corresponding MIECHV Benchmarks and the stated goals or outcomes of the models that have been selected for implementation in Oklahoma.

GARFIELD COUNTY INDICATORS RANKED HIGHER THAN STATE INDICATORS	ACA MIECHV BENCHMARKS	STATED GOALS AND OUTCOMES OF EBHV MODELS TO ADDRESS BENCHMARKS
overall and juvenile crime rates	Crime or Domestic Violence	NFP: goal to improved parental life-course by helping parents develop vision for future & plan PAT: short-term outcome is improved family health & functioning HFA: program goal to build the foundations for strong family functioning
domestic violence	Crime or Domestic Violence	NFP: goal to improved parental life-course by helping parents develop vision for future & plan PAT: short-term outcome is improved family health & functioning; DOVE tool HFA: achieved outcome was reduction in intimated partner violence

infant mortality	Improved Maternal and Child Health	NFP: program goals to improve outcomes of pregnancy by helping women improve prenatal health PAT: short-term outcome is increase in healthy pregnancies & improved birth outcomes (when services are delivered prenatally) HFA: achieved outcome was improved birth outcomes & birth weight (when enrolled prenatally)
preterm birth	Improved Maternal and Newborn Health	NFP: program goals to improve outcomes of pregnancy by helping women improve prenatal health PAT: short-term outcome is increase in healthy pregnancies & improved birth outcomes (when services are delivered prenatally) HFA: achieved outcome was improved birth outcomes & birth weight (when enrolled prenatally)
poverty	Family Economic Self-Sufficiency	NFP: goal to improve parental life-course by helping parents complete education PAT: short-term outcome is improved family health & functioning HFA: program goal is to build the foundations for strong family functioning

substance abuse binge alcohol	Improved Maternal and Newborn Health	NFP: goal to improve outcomes of pregnancy by helping women improve prenatal health PAT: short-term outcome is improved family health & functioning HFA: goal to build the foundations for strong family functioning
substance abuse illicit drug use	Improved Maternal and Newborn Health	NFP: goal to improve outcomes of pregnancy by helping women improve prenatal health PAT: short-term outcome is improved family health & functioning HFA: goal to build the foundations for strong family functioning

Nurse-Family Partnership and Parents as Teachers are the two evidence-based home visiting models currently being implemented in Garfield County. At this time, there is no Start Right Program providing services in Garfield County.

Children First (Oklahoma's **Nurse-Family Partnership**) has been operating in Garfield County since February 1997. The Garfield County Health Department was one of four county health departments to pilot the NFP model. The enrollment criteria are the same as in Kay County. Services are offered throughout Garfield County.

Garfield County has a **Parents as Teachers** Program that serves families living in the Enid Public School District throughout Garfield County including several rural communities. The Community Development Support Association (CDSA) is the parent agency for the program which is staffed by one supervisor and four parent educators. One of the parent educators is bilingual and able to provide visits in Spanish. The program is described as a PAT program "with modifications to meet needs of individual families."

The second PAT program in Garfield County is associated with the Pioneer-Pleasant Vale School District - a small school district on the edge of Enid. This program has one parent educator. The eligibility requirement for OPAT is to have a child less than three years of age.

Continuum of Services Offered to Address Multiple Family Needs

Under the administration of the Department of Health and Human Services, the Home Visiting Evidence of Effectiveness (HomVEE) Project initiated a thorough review of the research literature on home visiting models that target families with pregnant women and children from

birth to age five. The HomVEE review, which was conducted by Mathematica Policy Research, provides information about home visiting program models as well as evidence of effectiveness as required by legislation. The HomVEE results will be used to describe how the selected models meet the needs of Garfield County.

Garfield County indicators that ranked higher than state averages in the needs assessment included: preterm birth; infant mortality; poverty; overall and juvenile crime rates; binge alcohol and illicit drug use; and domestic violence.

Both juvenile crime and domestic violence are addressed in the MIECHV Program benchmark of Crime or Domestic Violence. The HomVEE research review found that reductions in juvenile delinquency, family violence, and crime outcomes were associated with the Nurse-Family Partnership model.

The statewide needs assessment identified a higher infant mortality and preterm birth rate for Garfield County than the state average. Maternal and Child Health is the MIECHV Program benchmark associated with infant mortality and preterm birth. The HomVEE review of research for Nurse-Family Partnership revealed favorable outcomes for both maternal health and child health.

The elevated Garfield County indicator of poverty is associated with the MIECHV Program benchmark of Family Economic Self-Sufficiency. The HomVEE research review indicated that Nurse-Family Partnership has favorable outcomes related to Family Economic Self-Sufficiency.

Garfield County ranked higher than the state norm in two specific types of substance abuse, binge alcohol use and illicit drug use. These indicators are included in the MIECHV Program benchmark of Improved Maternal and Newborn Health under the construct of Parental use of alcohol, tobacco or illicit drugs. The HomVEE review of literature for the Nurse-Family Partnership model found outcomes that included improved maternal health.

In the needs assessment, the domestic violence ranking for Garfield County was higher than the state overall ranking. Reduction in family violence is an outcome identified in the HomVEE review of literature for Nurse-Family Partnership.

With only two of the selected models available in the Garfield County, the services are perhaps not as broad as in Kay County. However, Children First does serve a particular population as does the PAT Program. They do refer families to each other's programs. Garfield County might benefit from implementing a Start Right Program as well.

During SFY 2010, there were 139 referrals made to the Garfield County Children First Program. Fifty-two of those families enrolled. A total of 121 families received services (new enrollees and carry-overs from previous year). These families were served by three Children First nurses. Approximately, 154 pregnant women were eligible for Children First services in Garfield County during SFY 2010. [During SFY 2008, there were 308 first-time births in Garfield County. At least half of these births occurred in families with households at or below the 185% of the Federal Poverty Level.]

During the same year, the Enid PAT Program had 144 families participate in home visitation services. These families were served by one supervisor and four Parent Educators.

During the 2010 school year, the Pioneer-Pleasant PAT Program served 24 families. Services were provided by one Parent Educator.

In 2008, there were a total of 999 live births in Garfield County. Assuming that the 309 first-time births were not eligible for Start Right or PAT, there were 691 families to potentially screen for services other than Children First. Generally, at least 50% of Oklahoma's births are paid for by Medicaid. Using Medicaid as a proxy for poverty, it can be deducted that approximately 346 of these families would be living in poor households. In addition to poverty, Garfield County provides the opportunity to serve military families – another MIECHV priority population. The Vance Air Force Based is located in Garfield County. Considering that the MIECHV Grant requires that Grantees target low income and military families for services, it would appear that Garfield County had more families eligible for services than could be served – especially families with more than one child.

Conclusion: Garfield County is in need of more home visitation services. However, which models to initiate or expand have not been determined. Responses to Requests for Proposals specific to the PAT and HFA models may best determine if community-based organizations are willing to enhance or implement one or both models. At least one Children First nurse should be added to the Garfield team at the local county health department. Like Kay County, it is believed that technical assistance and/or consultation regarding the marketing of the services AND converting referrals into participating clients would be beneficial in Garfield County.

DESCRIPTION OF THE STATE'S CURRENT AND PRIOR EXPERIENCE WITH IMPLEMENTING MODELS

The Office of Child Abuse Prevention was created in 1984 as authorized by the Oklahoma State Legislature in the Oklahoma Child Abuse Prevention Act. Prior to 1984, the focus of child abuse and neglect efforts was an "after-the- fact" intervention, preventing the recurrence of child abuse and neglect. The Act declared that the prevention of child abuse and neglect was a priority in Oklahoma. In accordance with the Act, the Office of Child Abuse Prevention (OCAP) was created and placed within the Oklahoma State Department of Health to emphasize the focus on prevention.

Since its inception, OCAP has received State funds. Through a competitive bid process, OCAP distributes those funds to community-based service agencies across the state for the purpose of providing home visitation services to overburdened families. Collectively, these home visitation programs are known as Start Right Programs. For more than a decade, Start Right Programs have been required to use the Healthy Families America® (HFA) model as their foundational framework. Due to funding limitations, none of the Start Right Programs have become official HFA affiliates. However, with approval from the national model developer, all program staff received HFA training and implemented the HFA manual in their daily practice. In conjunction with the HFA model, all Start Right Programs implement the Parents as Teachers® curriculum. Programs are also affiliated with National Parents as Teachers and Start Right Program staff are trained as PAT Parent Educators. OCAP/Start Right staff is responsible for ongoing training, consultation, monitoring and evaluation of the Start Right Programs.

Children First, Oklahoma's Nurse-Family Partnership, is administered through the Oklahoma State Department of Health. Children First was created by state statute in 1996 and funded with state appropriations. In February 1997, four pilot sites with 19 nurses were based in the local health departments of Garfield, Garvin, Muskogee and Tulsa Counties. By October 1998, services were available in all 77 counties making Oklahoma the first state in the nation to institute the Nurse-Family Partnership statewide. At its peak (2001), Children First had 270 full-time public health nurses dedicated to home visiting. Unfortunately, the program has been reduced in size over the years due to budget constraints. Today, approximately 150 public health nurses provide Children First home visits in most counties. Training, consultation, monitoring and evaluation are provided by Children First Nurse Consultants from the OSDH central office.

As a result of the 1990's Education Reform and Funding Act, Oklahoma Parents as Teachers began in 1992 with 13 pilot projects. The PAT model has been implemented in Oklahoma since that time. Local school districts apply each year to the Oklahoma State Department of Education to receive PAT grants. Funding for OPAT is dependent on annual appropriation. Program staff receives official PAT training to become Parent Educators. Oversight for the OPAT program is provided by the Early Childhood Education Coordinator at the Oklahoma State Department of Education.

PLAN FOR ENSURING THE IMPLEMENTATION WITH FIDELITY TO THE MODEL

Permission has been received from model developers to implement three evidence-based home visiting models in Oklahoma utilizing the MIECHV Program Grant monies. Those models are Nurse-Family Partnership,Healthy Families America, and Parents as Teachers. To assure fidelity to all models, implementation as recommended by the model developer of each is addressed.

Healthy Families America: The plan for implementation of the Healthy Families America (HFA) model begins with the completion of the application process for formal affiliation with the HFA initiative and payment of the required annual fee ($1,350 in 2011). Once affiliation is granted, a program site is considered to have provisional status. Within the first three years of HFA affiliation, programs are required to move from affiliation to accreditation and complete HFA accreditation process.

HFA affiliates go through a two-part process to become accredited. The first step is completion of the Self-Assessment. The purpose of the Self-Assessment is to provide each program with an opportunity to critically review its organizational structure and service delivery and compare its results against professionally accepted, research-based national standards. The Self-Assessment forms the basis for the second step required to become accredited which is peer review.

Once the Self-Assessment has been completed and submitted, a team of at least two external, trained peer reviewers conduct a site visit. The purpose of this visit is to provide a comprehensive and objective review and validate a program's self-assessment and adherence to the critical elements.

Based on their findings, the peer review team prepares a Site Visit Report which is sent first to Prevent Child Abuse America and then to the applicant program. The program has 45 days to respond to the report in writing. This response is then discussed by the HFA Advisory Panel and a decision is made. Depending on the outcome of the Self-Assessment, the peer reviewer site visit, the program response and the deliberations of the Panel, the evidence will be used to determine whether to grant accreditation or if a delay is necessary.

It will be a contractual requirement that any Oklahoma provider of the HFA model funded with MIECHV funds become accredited by HFA. This could mean that an existing Start Right Program might have to alter their enrollment criteria to some extent. Oklahoma has applied for an exemption from the model standard “that no more than 20% of the enrollees have a child over the age of three months.” This exemption has been granted by HFA. Oklahoma HFA Programs can have up to 33% of their new enrollees with children older than three months and still become accredited. It is Oklahoma’s intent though, to attempt to maintain the 20% threshold. Oklahoma has agreed that the maximum age of the youngest child at enrollment still must not be over one year of age.

With regard to HFA training, Oklahoma is fortunate to have HFA certified trainers in state. They are allowed to conduct the required HFA trainings according to their licensure agreements. Because HFA has made recent changes, Start Right Family Support Workers will be required to complete the updated Integrated Strategies for Home Visiting Programs. Purchase of the updated HFA manuals will also be required. Technical assistance will be available from the HFA national office and the Southeastern/Western Regional Director.

Nurse-Family Partnership: Children First will continue to implement NFP using the Model Elements. As described by the national model developer, the Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons, and/or theoretical rationales. The 18 Model Elements are divided into the following categories: clients, intervention context, expectations of the nurses and supervisors, application of the intervention, reflection and clinical supervision, program monitoring and use of data, and agency. The elements, as listed below, will be used for implementation of the model.

Clients:

- Element 1: Client participates voluntarily in the Nurse-Family Partnership program.
- Element 2: Client is a first-time mother.
- Element 3: Client meets low-income criteria at intake.
- Element 4: Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy.
  Intervention context:
- Element 5: Client is visited one-to-one, one nurse home visitor to one first-time mother or family.
- Element 6: Client is visited in her home.
- Element 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership guidelines.

Expectations of the nurses and supervisors:

- Element 8: Nurse home visitors and nurse supervisors are registered professional nurses. Although the national developer recommends nurse home visitors have a minimum of a baccalaureate degree in nursing, nurses who deliver the program in Oklahoma must meet the minimum requirements for a Registered Nurse II as outlined by the Oklahoma Office of Personnel Management. According to these requirements, the nurse must possess a valid permanent Oklahoma license as a registered nurse and one year of professional nursing experience or show completion of the requirements for a bachelor’s degree in nursing which substitutes for the required one year of experience.
- Element 9: Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the Nurse-Family Partnership model.

Application of the intervention:

- Element 10: Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.
- Element 11: Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods.
- Element 12: A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Reflection and clinical supervision:

- Element 13: A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors.
- Element 14: Nurse supervisors 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.

Program monitoring and use of data:

- Element 15: Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use Nurse-Family Partnership reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Agency:

- Element 16: A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.
- Element 17: A Nurse-Family Partnership Implementing Agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.
- Element 18: Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

Parents as Teachers: To implement Parents as Teachers (PAT), programs must affiliate with the Parents as Teachers National Office and report annually on service delivery, program implementation and compliance with the model replication requirements through an Affiliate Performance Report.

New PAT programs must complete a three-step process for affiliation. That process is outlined below:

1. Review the Readiness Reflection and Essential Requirements. The purpose of these documents is to help communities assess their ability to fully implement the Parents as Teachers model with fidelity.

2. Complete an Affiliate Plan. An Affiliate Plan guides organizations through planning to build a strong foundation for high quality program. Designed as a logic model, it links inputs, activities, outputs and outcomes for families. It also helps determine appropriate staff and budget. Keeping the end in mind as a new program is developed leads to strong programs and maximized positive outcomes for families.
3. Send home visitors to training. Once an Affiliate Plan is approved, the organization's home visitors complete the PAT Foundational Training and the Model Implementation Training. The Foundational Training is designed to lay the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of PAT with practice. Model implementation Training incorporates the PAT Quality Assurance (QA) Guidelines and offers implementation strategies and evidence-based practices that help organizations fully understand and bring to life quality PAT services. The training explains how to successfully replicate the Parents as Teachers model with fidelity. Demonstrating accountability, evaluation and outcomes are themes throughout.

Existing Parents as Teachers programs should already be affiliated. If so, they will proceed through the implementation process by sending Parent Educators to newly revised training. PAT has revised their training and curriculum with an increased emphasis on evidence-based practices for working with vulnerable populations and a strengthened home visiting model with a heightened focus on quality and model fidelity.

DESCRIPTION OF THE STATE'S OVERALL APPROACH TO HOME VISITING QUALITY ASSURANCE/ASSESSMENT/SUPPORT

Quality Assurance, assessment and support of home visitation programs have primarily been the responsibility of state agencies. For each program, specific policies and procedures have been developed. In general, the Oklahoma State Department of Health and the Oklahoma Department of Education have program staff responsible for the following models and related activities:

Nurse Family Partnership: The Nurse-Family Partnership has drafted objectives to help implementing agencies track their fidelity to the model and monitor program outcomes related to common indicators of maternal, child and family functioning. The objectives have been taken from the program's research trials, early dissemination experiences and current national health statistics (e.g., National Center for Health Statistics, Centers for Disease Control and Prevention; Healthy People 2010). The objectives are intended to provide guidance for quality improvement efforts and are long-term targets for implementing agencies to achieve over time. Over the years, data analysis by Nurse-Family Partnership indicated that Children First has performed well against the national averages and NFP benchmarks.

Children First (NFP) is administered through the Oklahoma State Department of Health with services provided by county health departments. In order to ensure fidelity to the NFP model as well as adherence to agency standards, Children First Nurse Consultants from the OSDH central office work with Children First teams.

Relationship to the NFP: OSDH first brought Dr. David Olds, developer and researcher for the NFP model to Oklahoma in 1996. He presented his research to members of the Oklahoma Legislature'. At that time, Dr. Olds was not replicating his work outside of the clinical trial settings. However, the legislators were quite impressed with his findings particularly in regards to the reductions in child abuse and neglect. They requested that the model be piloted in Oklahoma. Oklahoma's association with NFP has continued since then.

Implementing the NFP model with fidelity has been one of the main goals for Children First. Oklahoma has partnered with Dr. Olds on several quality improvement projects. Our partnership has allowed Children First an opportunity to participate in developing new visit guidelines, revising data collection tools and refining training materials. Children First participated in a preliminary project to help design a domestic violence research study and participated in a research study designed to address client retention. In January 2011, Children First partnered with Dr. Olds and submitted a grant proposal through the Affordable Care Act Nurse, Education, Practice, Quality and Retention Program to continue work to address client retention. The work proposed by this application will be conducted by a consortium of state health departments implementing the NFP model led by the State of Oklahoma and supported by the University of Colorado, College of Nursing. In addition, as members of the NFP State Nurse Consultant Workgroup, our Nurse consultants assist NFP with development of model/program practice standards utilized by all sites.

Training: The nineteen pilot nurses flew to Denver multiple times their first year to receive training from NFP staff. Subsequently, Oklahoma discovered that the nurses needed more training. It was not enough to simply train the nurses about the model, data collection forms, etc. They needed to learn about a myriad of topics - substance abuse, domestic violence, adoption - to name a few. Additional trainings were organized and continue to this day. These subject specific trainings are now open to all home visitors regardless of model, free of charge.

Within six months of implementing the NFP model in Oklahoma, the legislature appropriated monies for statewide expansion. Within a year's time span, OSDH was charged with hiring 250 new nurse home visitors. Hiring and training that number of nurses in that amount of time was overwhelming. Because Oklahoma could not afford to send all nurses to Denver for days at a time, an agreement was reached between NFP and OSDH. NFP would come to Oklahoma and train nurses in the model. Eventually, Children First Nurse Consultants were allowed to provide this training because NFP could not keep up with the training demand. Until the past couple of years, this arrangement continued. Now, because many fewer nurses are hired each year, all new nurses do attend model trainings in Denver. In addition, NFP has transformed some training into online trainings.

NFP and Children First continue to partner and create new trainings that benefit all nurses working in NFP. Just recently, Children First requested that NFP provide in-depth training in Motivational Interviewing. The training was provided and well received. Now, this same training is being provided to other NFP sites across the country.

Technical Assistance/Consultation: A Program Director and two full-time Children First Nurse Consultants, along with staff from the OSDH Nursing Service, provide technical assistance and consultation immediately upon request. Conference calls, emails and in-services are routine ways in which the Nurse Consultants support the nurses out in the field.

Quality Assurance/Oversight: A thorough site visit is conducted with each Children First team every other year. Because of the contractual relationship and the size of their teams, Tulsa City-County and Oklahoma City-County Health Departments receive site visits every year. During the site visits, data is utilized to assess caseload management, outcome measures and more. Record audits are conducted on 10% of the Children First records to assure that the families' needs are identified, referrals for services are made and documentation is adequate. Site visit reports are written and provided to the team, as well as the County Health Department Administrator and District Nurse Manager. Should there be any issues identified that need correction, a plan will be put into place and a site visit will be conducted the immediate following year.

Evaluation: Unlike most NFP sites, Children First enters all of its data into a database owned and maintained by OSDH before sending on to NFP. Children First is rich with more than a decade's worth of home visiting data.

Children First is required by law to provide an annual university-based program evaluation to the Governor, Speaker of the House and Senate President Pro Tempore. Over the years, though,

multiple reports have been developed and distributed. In-house Children First evaluators, typically epidemiologists, analyze data and develop an annual report for wide distribution. A contractual relationship with the University of Oklahoma, College of Public Health has produced outcome reports often focusing on just a few narrow topics. One such report by Dr. Helene Carabin, "*Does Participation in a Nurse Visitation Programme Reduce the Frequency of Adverse Perinantal Outcomes in First-time Mothers?*" was published in the Journal of Pediatric and Perinatal Epidemiology in 2005. [And, the answer is "YES!"] Lastly, the NFP National Service Office provides routine management reports that assist the Nurse Consultants gage how well Oklahoma is doing relative to NFP benchmarks and other measures such as Healthy People 2020. Reports can be found in the publications sections of the Children First website at http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/Children_First_Program/index.html.

Healthy Families America: Healthy Families America (HFA) is an evidence-based, nationally recognized home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is the primary home visiting model designed to work with families who may have histories of trauma, intimate partner violence, mental health and/or substance abuse issues. HFA services are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby).

The HFA model is based upon Critical Elements derived from more than 30 years of research to ensure programs are effective in working with families. These Critical Elements are put into operation through a series of best practice standards that provide a solid structure for quality, yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities.

HFA has a research base which includes randomized control trials and well designed quasi-experimental research. In 2006, HFA was named a "proven program" by the RAND Corporation based on research conducted on the Healthy Families New York programs. Additionally, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has rated HFA as Effective. To date, research and evaluation indicates impressive outcomes. Reviews of more than 15 evaluation studies of HFA programs in 12 states produced the following outcomes:

- Reduced child maltreatment;
- Increased utilization of prenatal care and decreased pre-term, low weight babies;
- Improved parent-child interaction and school readiness;
- Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services;
- Increased access to primary care medical services; and
- Increased immunization rates.

The HFA model is utilized by Start Right Programs funded by the OSDH Office of Child Abuse Prevention. While not currently affiliated with HFA, Start Right Programs provided with MIECHV funding will be required by contract to become formally affiliated.

Relationship to HFA: Start Right OCAP programs have implemented HFA with the national model developer's permission for years. The Start Right programs utilize the guidance available in the HFA manual. All Start Right staff are required to complete HFA training specific to their assigned role. Compliance with the HFA Critical Elements is foundational for Start Right contracts. Even though the programs are not officially accredited or affiliated with HFA, the HFA Critical Elements serve as the bedrock for the Start Right programs. The Critical Elements, which are divided into three categories, are listed below:

Service Initiation

- Initiate services prenatally or at birth.
- Use a standardized (i.e. in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e. social isolation, substance abuse, parental history of abuse in childhood).
- Offer services voluntarily and use positive outreach efforts to build family trust.

Service Content

- Offer services intensively (i.e. at least once a week) with well-defined criteria for increasing or decreasing frequency of service and over the long-term (i.e. three to five years).
- Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.
- Services should focus on supporting the parent as well as supporting parent-child interaction and child development.
- At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g. timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.
- Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for many communities no more than 15 families per home visitor on the most intense service level. And, for some communities the number may need to be significantly lower, e.g. less than 10).

Staff Characteristics

- Service providers should be selected because of their personal characteristics (i.e. non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.
- Service providers should have a framework, based on education or experience, for handling the variety of situations they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.
- Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e. identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).
- Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.

Training: OCAP Start Right staff are required to complete HFA role-specific, core training within six months of hire. Core training is made available to Start Right staff on a quarterly basis or more frequently, if needed. Core training includes training for Family Assessment Workers, Family Support Workers and Supervisors.

Family Assessment Worker (FAW) Core Training*:* The Assessment Core Training is an in-depth, formalized training designed for staff whose primary role is to conduct initial assessments. FAW Training is four full days for the family assessment specialist, plus supervisors and program managers. Topics include but are not limited to: identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, and communication skills. The OCAP has an experienced HFA certified FAW trainer.

Family Support Worker (FSW) Core Training: Home Visitors Core Training is an in-depth, formalized training intended for home visitors and supervisors/program managers of a Healthy Families America program. The four days of training outlines the specific duties of home

visitors in their roles. Topics include but are not limited to: establishing and maintaining trust with families, goal setting, completing necessary paperwork/documentation, the role of the home visitor, communication skills, and intervention strategies. The OCAP has an experienced HFA certified FSW trainer.

HFA home visitor training has been updated and renamed Integrated Strategies for Home Visiting Programs. This training has not yet been implemented in Oklahoma, but the OCAP FSW trainer has completed the new train-the-trainer training and has received certification.

Supervisor Training: This is a day of training specifically for HFA supervisors and program managers. It is in-depth, formalized training which outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of family assessment and home visitation, effective supervision, quality management techniques, crisis management, understanding the program's policies and procedures; and case management. The OCAP has two experienced HFA trainers certified to provide training for supervisors.

Wraparound Training**:** Wraparound training complements core training and covers the additional training topics necessary to support home visitation staff in their duties. All program staff are required to continue their training and professional development by completing training on important topics such as:

- Keeping babies healthy and safe;
- Fostering infant and child development;
- Addressing domestic violence;
- Preventing child abuse;
- Recognizing substance abuse;
- Responding to relationship issues; and
- Promoting mental health.

Great Beginnings Start Before Birth: This is a home visitor curriculum training that supplies service providers with strategies for supporting families during the prenatal period. Based on best practice standards, with a special emphasis on the psycho-social issues facing expectant parents, home visitors learn how to help parents enhance prenatal bonding, stimulate brain development and reduce stress, thereby increasing healthy mother/baby birth outcomes. The OCAP has an experienced HFA certified Great Beginnings trainer.

Additional Required Supplemental Training: In addition to HFA training, OCAP Start Right staff are required to complete supplemental training provided to Children First nurses. Required training topics include the following:

- grief;
- attachment;
- breastfeeding and nutrition;

- paternity, legal, Medicaid;
- substance abuse;
- child abuse, medical examiner, documentation;
- postpartum depression and mental health;
- adoption;
- car seat safety;
- tobacco cessation;
- lead poisoning safety;
- home visitor safety;
- home safety;
- domestic violence; and
- family planning.

Parents As Teachers (PAT) training: Start Right Programs use the PAT curriculum during home visits. Programs are required to be affiliated with the Parents as Teachers National Center and are required to keep their status current each year. All program staff are required to complete the Parents As Teachers Training necessary for program educators. Certification must be renewed annually.

Ages and Stages Questionnaires (ASQ) and Ages and Stages Questionnaires: Social-Emotional training (ASQ:SE): OCAP Start Right Programs provide child development screenings using the ASQ and ASQ:SE. Program staff are required to have received training if their duties include conducting screenings. Two OCAP staff are available to provide training. Start Right has not yet implemented the third edition of the ASQ but plans to do so in the near future.

Technical Assistance/Consultation: The Office of Child Abuse Prevention has two full-time Program Consultants that assist the community-based agencies and ensure fidelity to the HFA and PAT models as well as adherence to agency standards. Consultants are available on an as needed basis to provide support and assistance. Consultation is available in the form of emails, conference calls, onsite visits, and training.

Quality Assurance/Oversight: Annual site visits are conducted with each Start Right program. Family file folder reviews are completed on 10% of the programs records to assure that the families' needs are identified, referrals for services are made and documentation is adequate. The Program Consultant accompanies a home visitor on a visit with an enrolled family providing an opportunity for direct observation of program services. The monitoring process includes a review of documentation that demonstrates compliance with the program's approved contract or memorandum of understanding and compliance with the HFA Critical Elements. Fiscal monitoring for the site visit includes invoice validation and completion of the financial screening tool. Site visit reports are written and reviewed with the program staff and agency administration. If any issues are identified that need correction, immediate technical assistance is provided. When necessary, a plan of correction is developed and additional monitoring is provided.

Evaluation: Start Right staff enters data at each individual program site into a database owned and maintained by OSDH. OSDH evaluators provide staff at both the state and local levels with periodic numerical reports. An annual report is generated as well.

Parents as Teachers: All Oklahoma Parents as Teachers programs are required to follow the program guidelines established by the Oklahoma State Department of Education. Those guidelines are listed below.

School districts must have an enrollment of at least 500 students for the development and operation of a Parent As Teachers (PAT) program. If a district does not have a minimum enrollment of 500 students, the district may partner with other districts to form a consortium whose total combined enrollment is at least 500 students. Districts who receive PAT funds through the State Board of Education, in support of the parent education program legislation 70 O.S. § 10.105.3, shall meet the following program requirements:

1. Provide a 25 percent match of cash or in-kind services.

2. Be operated by the district; or, the district may contract with private, nonprofit corporations or associations or with any public or private agency or institution.

3. Include the following:
   a. Employ parent educator(s). Each parent educator shall complete training and certification through the Parents as Teachers National Center in the *Born to Learn*™ curriculum. It is recommended that each part-time parent educator, working 20 hours per week, serve a maximum of 30 children or each full-time parent educator, working 40 hours per work, serve a maximum of 50 children.
   b. Employ a coordinator if more than one parent educator is required. The coordinator must possess an Oklahoma teaching certificate in early childhood education, elementary education or related field, or a bachelor's degree in early childhood development, nursing, vocational home economics or related field. The coordinator shall complete training and certification through the Parents as Teachers National Center. The coordinator shall serve a minimum of five families if certification is desired; or
   c. Designate a program administrator who is a certified employee of the district and will be responsible for the implementation of the program if a program coordinator is not employed (this applies to programs with only one parent educator who does not function as the program coordinator). The program administrator should attend the informational meeting at the beginning of each program year and participate in the supervisor's training provided through the Parents As Teachers National Center. A maximum of 10 percent (10%) of the grant amount may be used for administrative costs which include salary and fixed charges.

4. Serve families with children under age three (birth to 36 months).

5. Implement the curriculum provided by the Parents as Teachers National Center.

6. Provide services a minimum of 10 months of the year.

7. Services must be voluntary and free to families.

8. Conduct monthly personal visits to each parent/family group involved in the program, scheduled at the convenience of the parent/family group (daytime, evening, or weekend).

9. Conduct, at minimum, monthly parent group meetings. Cooperative programs may find it necessary to schedule monthly meetings in more than one location each month.

10. Designate a room or space in an existing room for parenting and child growth and developmental materials for use by parents and children participating in the program.

11. Establish an Advisory Committee.

12. Provide evidence of coordination of services with other community programs that have similar purposes.

13. Be open to all parents in the community with a demonstrated effort to balance participation among various groups through active encouragement of the involvement of first-time parents, teen parents, and at-risk families. [Note: For the MIECHV Grant, priority will be given to the target populations listed in the Grant Guidance.]

14. Conduct developmental screening using the designated instrument, *Ages and Stages Questionnaires* (ASQ), with each child, each year. Screening should occur sometime during the first two visits for age-eligible children.

15. Submit, by established deadlines, monthly statistical reports indicating information about families and children served and other reports or program information as deemed necessary by the Oklahoma State Department of Education to the Child Services Demonstration Center.

16. Provide a detailed midyear expenditure report in February 2012 and a detailed final expenditure report in September 2012.

17. Require at least one representative from the district's program to participate in each of the following:
    a. Informational Meeting
    b. Fall Regional Meeting
    c. Spring Regional Meeting
    d. Family Matters Conference held in conjunction with the Spring Regional Meeting.

One purpose of the Community Advisory Committee is to facilitate collaboration for the coordination of PAT programs and services between the community and the school.
The advisory group is a local school district committee whose membership includes interested citizens representing a variety of community organizations. Members of the committee could include: the Oklahoma Parents As Teachers coordinator; representatives of the local board of education, mental health agencies, social services agencies, Smart Start community representatives, individual and/or agency health care providers, church/ministerial alliances, civic service groups, and PTA/PTO; parents of infants and toddlers, senior adults, higher education personnel, private and public preschool and/or child care directors, and library personnel. If a cooperative of districts is providing the program, the Community Advisory Committee should fairly represent all of the communities to be served.

Additional responsibilities for the Community Advisory Committee include recruiting prospective participants for the program; gathering information from available community resources and serving as a resource to the local program administrator and the Internal Coordinating Committee.

The Internal Coordinating Committee is responsible for PAT program planning, implementation, and evaluation. The committee members develop the steps needed to implement a district wide plan as well as timetables for implementation. Other responsibilities include identifying resources available in the district and community; generating community awareness and a publicity plan; and creating plans for recruiting families with young children.

The Internal Coordinating Committee is a committee comprised of local school district personnel whose membership shares with the parent education program administrator the ongoing responsibility for successful implementation of the program. If a cooperative of districts provides the program, the Internal Coordinating Committee should be composed of representatives of all involved districts. Members of the committee could include: the Oklahoma Parents As Teachers coordinator, an elementary principal(s), pre-kindergarten, kindergarten and/or primary teacher(s), child development and/or adult education teacher(s), guidance counselor(s), school psychologist(s), school nurse, community advocates, parent educators, and teacher(s) of programs for children with developmental delays.

CHALLENGES AND RISKS OF SELECTED RPOGRAM MODELS AND ANTICIPATED TECHNICAL ASSISTANCE NEEDS

Healthy Families America: Although the Start Right Programs use the Healthy Families America model, the HFA affiliation/accreditation process has never been completed because of funding limitations. Affiliation is a requirement of the national model developer for the MIECHV Grant. Technical assistance for the affiliation application and completion will be provided by the HFA regional consultant.

Historically, the Start Right Programs were permitted to enroll infants as old as one year. However, the national model developer requires infants to be no more than three months of age at enrollment. HFA does allow twenty-five percent of enrollees to be between three and twelve months of age. The national model developer has approved an adaptation for the Oklahoma MIECHV Program that will allow up to thirty-three percent of enrollees to be between the ages of 3 months and one year.

Parents as Teachers: The only enrollment requirement for PAT programs is the age of the child. In other words, PAT enrollment is based on universal access. Mechanisms will be put in place to assure that priority is given to eligible participants as described in the MIECHV Supplemental Information Request. Priority will be given to eligible participants who: have low incomes; are pregnant women who have not attained age twenty-one; 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 children with low student achievement; have children with developmental delays or disabilities; are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States. Because the targeted population may have more challenges than traditional PAT families, PAT staff will have to receive additional training and support.

Nurse-Family Partnership: A question that has plagued many a home visitation program is how to engage and retain participants for as long as possible so that the participant can maximize the most benefits from their participation. While any length of participation in a home visitation program may be beneficial to some extent, certain "dose/response rate" issues do arise. Most literature shows that the longer a participate remains engaged in a home visitation program, the more positive impact can been quantified. This issue is of keeping the participant enthused about the program is a common one among a variety of models. For this reason, the OSDH anticipates that technical assistance regarding this issue, particularly for Children First, may be necessary.

Data and information systems: The OSDH has a good deal of experience with data collection and information systems relating to Children First and Start Right Programs. Since 1997, both programs have been collecting and reporting process data and programmatic outcomes. For the MIECHV Program, the Parents as Teachers Program will have to be incorporated into ODSH's data collection system. With three models, a new system for collecting and analyzing data will have to be developed. Common data collection elements and tools will need to be devised. Additionally, the OSDH has limited capacity (limited by the number of staff, not skill) to

develop computer programming capable of sophisticated analysis. For this reason, the OSDH anticipates that technical assistance will be necessary.

<u>Communication and marketing</u>: A most definite need for the home visitation models associated with the MIECHV Program will be a smart, relevant communication and marketing strategy. Because of limited funding and expertise, the OSDH has struggled to promote its own home visitation programs over the years to the potential program participants and communities at large. The OSDH would appreciate technical assistance regarding the best practices for marketing home visitation services.

<u>Outreach to potential program participants</u>: Over the years, the OSDH home visitation programs (Children First and Start Right) have noticed a decline in the percentage of referred persons that are willing to enroll in the programs. It is possible that the Oklahoma Parents as Teachers home visitation programs may be dealing with this issue as well. Different strategies have been put in place to discover the causes and attempt to reverse the trend. However, technical assistance would be useful.

Section 4: Implementation Plan for Proposed State Home Visiting Program

A DESCRIPTION FOR ENGAGING THE AT-RISK COMMUNITIES

Kay County: Meetings were conducted in Kay County to hear directly from local citizens regarding the needs and existing resources in their community. On March 3, 2011 focus groups were scheduled throughout the day with individual sessions for community professionals, participating families (consumers), and the public. The meeting location for the focus groups was the Pioneer Technology Center in Ponca City. Additional meetings for all community partners with an interest in home visitation were conducted on March 22 and April 14. The location for both of these meetings was the Kay County Health Department in Ponca City. If individuals were not able to attend the meetings, they were allowed to submit comments in writing. Twenty families and/or professionals submitted comments in this manner.

Meeting participants included home visitors, supervisors, and/or administrators from the existing regional home visitation programs which are Children First (Nurse Family Partnership); Northern Oklahoma Youth Services Home Visitation Program (Healthy Families and Parents as Teachers); Oklahoma Parents as Teachers. Other attendees represented the following agencies or programs: Dearing House Child Advocacy Center; Smart Start Kay County; Court Appointed Special Advocates (CASA) of Kay and Noble Counties; Pioneer Technology Center; Child Protective Services of the Oklahoma Department of Human Services (DHS); Oklahoma State University Nutrition Education Program; Kay County Health Department; Oklahoma University Health Sciences Center; Oklahoma State Department of Health. Families who were currently enrolled or have been enrolled in home visitation programs also shared their ideas and opinions in a special focus group that was designed exclusively for consumers.

Attached please find the following:

- *Press Release Announcing Community Meetings*
- *Meeting Agendas*
- *Form for Communities Strengths and Weaknesses*

HEALTHNEWS
Oklahoma State Department of Health · 1000 NE Tenth, Oklahoma City, OK 73117-1299 · www.health.ok.gov · Terry L. Cline, PhD, Commissioner of Health

For Release: Feb. 22, 2011 – Pamela Williams, Office of Communications – (405) 271-5601

Community Input Requested for Home Visitation Grant

The Federal Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program recently announced federal funding available for states to expand and improve existing home visitation services. As part of its grant application, the Oklahoma State Department of Health (OSDH) has conducted a statewide needs assessment and identified Kay County as the county most in need of enhanced and expanded home visitation services for young children and families.

Home visitation programs are defined as services offered on a voluntary basis to pregnant women, expectant fathers, parents and caregivers of children from birth to age 5. The services focus on improving parenting skills through better understanding of early childhood development.

The OSDH is seeking input from Kay County citizens to find the best ways to reach young children and families through improved home visitation programs in Kay County. Information from the community will be collected using focus groups that include program participants, community professionals, and the general public. Focus group sessions will be held on Thursday, March 3, at the Pioneer Technology Center (east side) at 2101 N. Ash, Ponca City. The public is invited to participate in these sessions that will begin at 5:30 p.m. Information collected from public input will be used in the OSDH grant application.

The complete needs assessment can accessed at the Oklahoma Department of Health Web site at the following address:
http://www.ok.gov/health/documents/Needs%20Assessment%20entire%20document.pdf .

Additional information specific to Kay County can be found at the Kids Count Data Center website:
http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OK&group=All&loc=5301&dt=1%2c3%2c2%2c4 .

To learn how you can participate in the focus groups, please contact Lily Freeman at uwsuccessby6@cableone.net or (580) 765-9015; Maggi Hutchason at dearinghouse@sbcglobal.net or (580) 762-5266, or OSDH Family Support and Prevention Service Grant Coordinator Kathie Burnett at kathieb@health.ok.gov or (405) 271-7611.

###

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program

Federal Grant

Kay County Community Focus Group on Home Visitation for Professionals

March 3, 2011 at 10:00 a.m. at Pioneer Technology Center in Ponca City, OK

AGENDA

I. Welcome and Introduction - Maggi Hutchason

II. Grant Information

A. Home visiting services currently in the community - possible additional services
B. Coordination of home visiting services and other community resources (referral/intake)
C. Ongoing input from the community (recognize/utilize community strengths)

III. Outcomes Required for the Grant

A. Improved maternal and child health;
B. Prevention of child injuries, maltreatment or child abuse, and reduction of emergency department visits;
C. Improvement in school readiness and achievement;
D. Reduction in crime or domestic violence;
E. Improvements in family economic self-sufficiency;
F. Improvements in the coordination and referrals for other community resources and supports;
G. Improvements in parenting skills related to child development.

IV. Needs Assessment Results

V. Evidence-based Models for Home Visiting

A. Children First---Nurse Family Partnership
(presented by - **Lisa Hall**, Lead Nurse, Kay Co. Health Department)
B. OCAP - Start Right---Healthy Families - Parents as Teachers
(presented by - **Jan Justice**, Supervisor, Northern Oklahoma Youth Services)
C. Safe Care
(presented by - **Lana Beasley**)
D. Early_Head Start – Home Visiting Option
E. Parents as Teachers

VI. Continuum of Home Visiting Services

VII. Input from Community Participants

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program

Federal Grant

Kay County Community Focus Group on Home Visitation for Families

March 3, 2011 at 2:00 p.m.
Pioneer Technology Center in Ponca City, OK

AGENDA

I. Welcome and Introduction - Maggi Hutchason

II. Family Introductions

III. Specific Home Visiting Programs That Served Families

IV. Discussion of Home Visiting Services

A. Impact on children
B. Impact on parents – primary caregivers

V. What Do Families Need from Home Visiting Programs?

VI. Additional Comments

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program

Federal Grant

Kay County Community Focus Group on Home Visitation for the Public

March 3, 2011 at 5:30 p.m. at Pioneer Technology Center in Ponca City, OK

AGENDA

I. Welcome and Introduction - Maggi Hutchason

II. Grant Information

A. Home visiting services currently in the community - possible additional services
B. Coordination of home visiting services and other community resources (referral/intake)
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V. Improvements in family economic self-sufficiency;
VI. Improvements in the coordination and referrals for other community resources and supports;
VII. Improvements in parenting skills related to child development.

IV. Needs Assessment Results

V. Evidence-based Models for Home Visiting

A. Children First---Nurse Family Partnership
B. OCAP - Start Right---Healthy Families-Parents as Teachers
C. Safe Care
D. Early Head Start – Home Visiting Option
E. Parents as Teachers

VI. Continuum of Home Visiting Services

VII. Input from Community Participants

Family Health Services
Family Support and Prevention Service

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) Federal Grant

Kay County

March 22, 2011 at 9:00 p.m. at Kay County Health Department in Ponca City, OK

AGENDA

Discussion with Community Partners

NARRATIVE REQUIREMENTS
Section 1: Identification of the State's Targeted At-Risk Community(ies)
[Page 9 of the Supplemental Information Request (SIR)]

The Updated State Plan should justify the selection of the at-risk community(ies), from among the communities identified as being at risk I the State's initial needs assessment. For each targeted community proposed, please provide the following information.

A detailed assessment of needs and existing resources, including:

- **Community strengths**
- **Community risk factors**
- **Characteristics of participants**
- **Needs of participants**
- **Any existing home visiting services in the community, currently operating or discontinued since March 23, 2010, including:**
  - ➢ **The number and types of home visiting programs and initiatives in the community:(contact person and contact information)**
  - ➢ **The models that are 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)**
- **Referral resources . . . to support families residing in the community.**
  - ➢ **Currently available**
  - ➢ **Needed in the future**
- **A plan for coordination -**
  - ➢ **among existing programs and resources in those communities (including how the program will address existing service gaps);**
- **Local and State capacity to integrate the proposed home visiting services**
  - ➢ **Into an early childhood system,**
  - ➢ **Including existing efforts or resources to develop a coordinated early childhood system at the community level,**
    -such as governance structure or coordinated system of planning;

Family Health Services

Family Support and Prevention Service

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) Federal Grant

Kay County

April 14, 2011 at 9:00 p.m. at Kay County Health Department in Ponca City, OK

AGENDA

Discussion with Community Partners

Review of Required Benchmarks and Constructs

Maternal and Child Health	• Prenatal care • Parental use of alcohol, tobacco, or illicit drugs • Preconception care • Inter-birth intervals • Screening for maternal depressive symptoms • Breastfeeding • Well-child visits • Maternal and child health insurance status
Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits	• Visits for children to the emergency department from all causes • Visits of mothers to the emergency department from all causes • Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety • Incidence of child injuries requiring medical treatment. • Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated) • Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program • First-time victims of maltreatment for children in the program
School Readiness and Achievement	• Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child) • Parent knowledge of child development and of their child's developmental progress • Parenting behaviors and parent-child relationship

	(e.g., discipline strategies, play interactions) • Parent emotional well-being or parenting stress • Child's communication, language and emergent literacy • Child's general cognitive skills • Child's positive approaches to learning including attention • Child's social behavior, emotion regulation, and emotional well-being • Child's physical health and development

Crime or Domestic Violence	• Crime
	  o Arrests
	  o Convictions
	• Domestic Violence
	  o Screening for domestic violence
	  o Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries):
	  o Of families identified for the presence of domestic violence, number of families for which a safety plan was completed

Family Economic Self-Sufficiency	• Household income and benefits • Employment or education of adult members of the household • Health insurance status
Coordination and Referrals for Other Community Resources and Supports	• Number of families identified for necessary services • Number of families that required services and received a referral to available community resources • MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community • Information sharing: 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 • Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided.)

Adapted from the HRSA Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program, available at:
http://www.ok.gov/health/documents/3rd%20Phase%20of%20HV%20Guidance.pdf

04/01/11

Kay County Home Visitation Advisory Group

for the

ACA MIECHV Federal Grant Program

Spring 2011

Agency/Program: _______________ Date: ________________

NARRATIVE REQUIREMENTS

Section 1: Identification of the State's Targeted At-Risk Community(ies) (page 9)

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- **A detailed assessment of needs and existing resources, including:**

Community strengths:	Community risk factors:

- **A detailed assessment of needs and existing resources, including:**

Characteristics of participants:	Needs of participants:

- **A detailed assessment of needs and existing resources, including:**

Any existing home visiting services in the community, currently operating or discontinued since March 23, 2010, including:	
• **The number and types of home visiting programs and initiatives in the community:** **(contact person and contact information)**	• **The models that are 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)**

- **A detailed assessment of needs and existing resources, including:**

Referral resources: **. . . to support families residing in the community.**
• **Currently available:**
• **Needed in the future:**

A plan for coordination -
among existing programs and resources in those communities
(including how the program will address existing service gaps);

Local and State capacity to integrate the proposed home visiting services
Into an early childhood system,

- **-Including existing efforts or resources to develop a coordinated early childhood system at the community level,**
- **-such as governance structure or coordinated system of planning;**

Garfield County: Community meetings were also conducted in Garfield County to provide local citizens an opportunity to share their perspectives regarding the needs and existing resources of their community. Focus groups were scheduled throughout the day on April 6, 2011 with separate sessions conducted for community professionals, participating families (consumers), and the public. On April 18, there was an additional meeting for all community partners with an interest in home visitation. The location for all meetings was the Community Development Support Association (CDSA) Branch Office in Enid, Oklahoma. If individuals were not able to attend the meetings, they were allowed to submit comments in writing. Twenty-two families and/or professional submitted comments in this manner.

Garfield County meeting participants included: the supervisor and multiple parent educators from Oklahoma Parents as Teachers (OPAT) in the Enid School District; the OPAT parent educator from the Pioneer-Pleasant Vale School District; the Children First supervisor and home visitor nurses; a Children First interpreter; OSDH district nurse manager; the state director of Children First; the state director of Smart Start Oklahoma; the executive director of the Community Development Support Association; and the Youth Build Program Coordinator. Additional participants included representatives from Sooner Success; Oklahoma Department of Human Services (DHS); Oklahoma State University Cooperative Extension Nutrition Education Program and a business woman with employees that have been served by the Enid OPAT Program.

Families that had been enrolled or are currently enrolled in home visiting programs participated in afternoon and evening meetings conducted in Garfield County. Consumers that attended the meetings included: a disabled grandmother who is raising grandchildren; a military wife whose husband is in the Air Force; several Spanish-speaking families; and a college student from a small town in the county. Families who were unable to attend the meetings were given the opportunity to write their comments, put them in sealed envelopes and return them to their home visitor.

Attached please find the following:

- *Press Release Announcing Community Meetings*
- *Meeting Agendas*
- *Form for Communities Strengths and Weaknesses (same as Kay County)*

HEALTHNEWS
Oklahoma State Department of Health · 1000 NE Tenth, Oklahoma City, OK 73117-1299 · www.health.ok.gov · Terry L. Cline, PhD, Commissioner of Health

For Release: March 24, 2011 - Pamela Williams, Office of Communications – (405) 271-5601

Community Input Requested for Home Visitation Grant

The Federal Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program recently announced federal funding available for states to expand and improve existing home visitation services. As part of its grant application, the Oklahoma State Department of Health (OSDH) has conducted a statewide needs assessment and identified Garfield County as a county in need of enhanced and expanded home visitation services for young children and families.

Home visitation programs are defined as services offered on a voluntary basis to pregnant women, expectant fathers, parents and caregivers of children from birth to age 5. The services focus on improving parenting skills through better understanding of early childhood development.

The OSDH is seeking input from Garfield County citizens to find the best ways to reach young children and families through improved home visitation programs in Garfield County. Information from the community will be collected using focus groups that include program participants, community professionals, and the general public. Focus group sessions will be held on Wednesday, April 6, at the Community Development Support Association (CDSA) Branch Office located at 129 North University in Enid. The public is invited to participate in these sessions that will begin at 5:30 p.m. Information collected from public input will be used in the OSDH grant application.

The complete needs assessment can accessed at the Oklahoma Department of Health Web site at the following address:
http://www.ok.gov/health/documents/Needs%20Assessment%20entire%20document.pdf .

Additional information specific to Garfield County can be found at the Kids Count Data Center website:

http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OK&loc=5289

You are invited to participate in the focus group on April 6 at 5:30 p.m. at CDSA. To learn more about the focus groups, please contact OSDH Family Support and Prevention Service Grant Coordinator Kathie Burnett at kathieb@health.ok.gov or call (405) 271-7611.

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Affordable Care Act Maternal, Infant, and Early Childhood
Home Visiting Program (ACA MIECHV) Federal Grant

Garfield County Community Focus Group on Home Visitation for Professionals

April 6, 2011 at 10:00 a.m. at CDSA Branch Office in Enid, OK

AGENDA

I. Welcome and Introduction

II. ACA MIECHV Grant Basic Information

A. Home visitation services
B. Coordination of home visiting services and other community resources (referral/intake)
C. Ongoing input from the community (recognize/utilize community strengths)

III. Benchmarks Required by the Grant

A. Improved maternal and child health;
B. Prevention of child injuries, maltreatment or child abuse, and reduction of emergency department visits;
C. Improvement in school readiness and achievement;
D. Reduction in crime or domestic violence;
E. Improvements in family economic self-sufficiency;
F. Improvements in the coordination and referrals for other community resources and supports.

IV. Needs Assessment Results

Focus on Garfield County

V. Oklahoma Evidence-based Home Visitation Models

A. Children First---Nurse Family Partnership
B. Oklahoma Parents as Teachers
C. OCAP - Start Right---Healthy Families America- Parents as Teachers
D. Early Head Start – Home Visiting Option
E. Safe Care

VI. Continuum of Home Visiting Services

VII. Discussion (Comments, Ideas, Concerns) as Directed by Community Professionals and Leaders

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) Federal Grant

Garfield County Community Focus Group on Home Visitation for Families

April 6, 2011 at 2:00 p.m. at CDSA Branch Office in Enid, OK

AGENDA

I. Welcome and Introduction

II. Family Introductions

III. Specific Home Visiting Programs That Served Families

IV. Discussion of Home Visiting Services

A. Impact on children
B. Impact on parents or primary caregivers

V. What Do Families Need from Home Visiting Programs?

VI. Additional Comments

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) Federal Grant

Garfield County Community Focus Group on Home Visitation for the Public

April 6, 2011 at 5:30 p.m. at CDSA Branch Office in Enid, OK

AGENDA

I. Welcome and Introduction

II. ACA MIECHV Grant Basic Information

A. Home visitation services
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IV. Needs Assessment Results

Focus on Garfield County

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D. Early Head Start – Home Visiting Option
E. Safe Care

VI. Continuum of Home Visiting Services

VII. Discussion (Comments, Ideas, Concerns) as Directed by Community Participants

Family Health Services

Family Support and Prevention Service

Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) Federal Grant

Garfield County

April 18, 2011 at 2:00 p.m. at CDSA Branch Office in Enid, OK

AGENDA

Discussion with Community Partners

NARRATIVE REQUIREMENTS
Section 1: Identification of the State's Targeted At-Risk Community(ies)
[Page 9 of the Supplemental Information Request (SIR)]

The Updated State Plan should justify the selection of the at-risk community(ies), from among the communities identified as being at risk I the State's initial needs assessment. For each targeted community proposed, please provide the following information.

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- **Characteristics of participants**
- **Needs of participants**
- **Any existing home visiting services in the community, currently operating or discontinued since March 23, 2010, including:**
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    - **The models that are 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)**
- **Referral resources . . . to support families residing in the community.**
    - **Currently available**
    - **Needed in the future**
- **A plan for coordination -**
    - **among existing programs and resources in those communities (including how the program will address existing service gaps);**
- **Local and State capacity to integrate the proposed home visiting services**
    - **Into an early childhood system,**
    - **Including existing efforts or resources to develop a coordinated early childhood system at the community level,**
      -such as governance structure or coordinated system of planning;

Garfield County Home Visitation Advisory Group

for the

ACA MIECHV Federal Grant Program

Spring 2011

Agency/Program: _______________ Date: _________________

NARRATIVE REQUIREMENTS

Section 1: Identification of the State's Targeted At-Risk Community(ies) (page 9)

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Characteristics of participants:	Needs of participants:

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• **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)**

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Referral resources: **. . . to support families residing in the community.**
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Local and State capacity to integrate the proposed home visiting services
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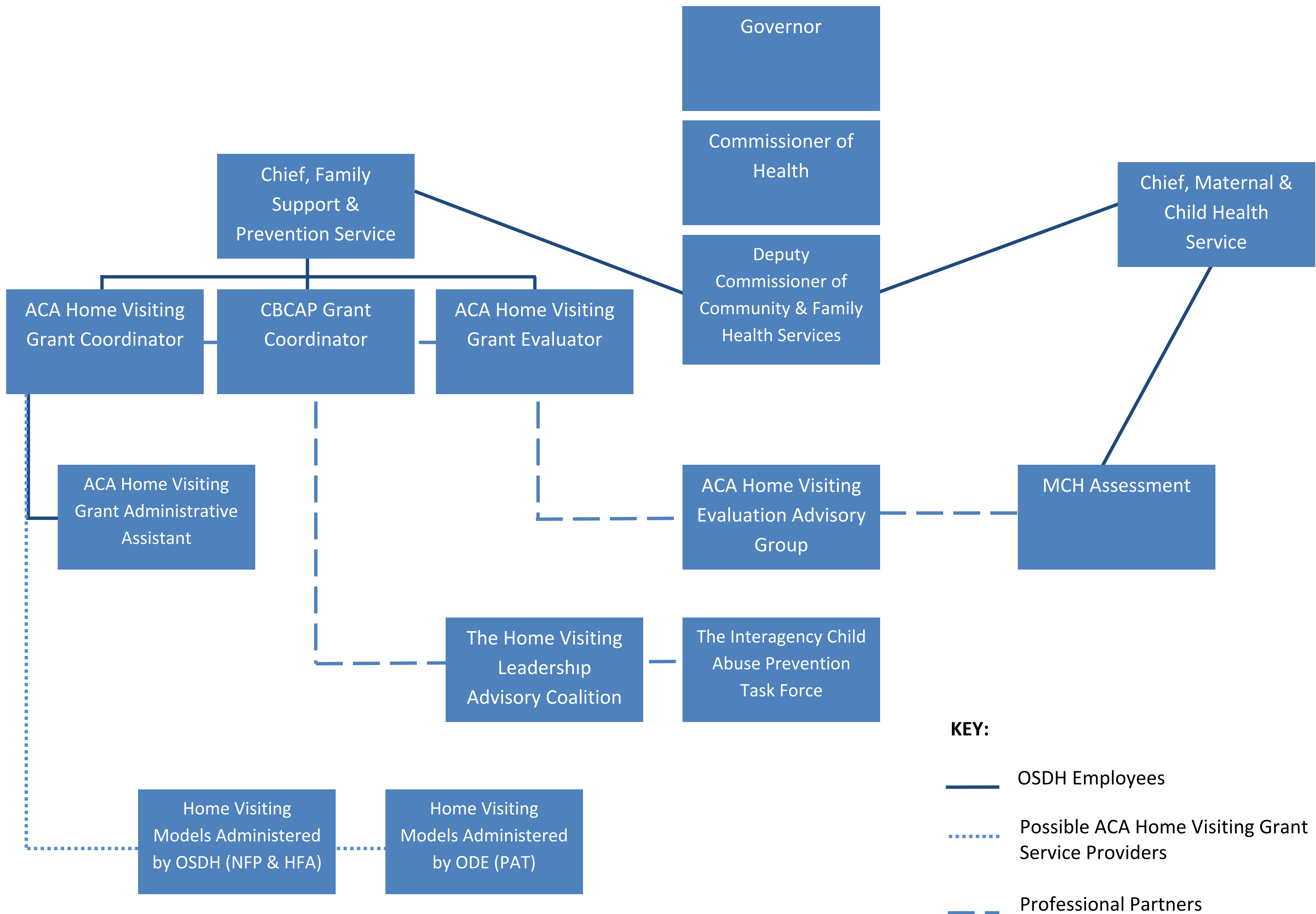
- **-such as governance structure or coordinated system of planning;**

APPROACH TO DEVELOPMENT OF POLICY AND TO SETTING STANDARDS

While the Oklahoma State Department of Health and the Oklahoma State Department of Education will continue in their role as lead agency over their respective home visitation programs, input will continue to be gathered from key partners and stakeholders. The model developers, HRSA/ACF and the state agencies will require that certain policies and standards be put into place.

A system has been devised so that a multitude of partners can participate in the development of policies and standards. As in the development of Oklahoma's MIECHV Grant application, three entities at the state level have been heavily involved. They include the MIECHV Evaluation Advisory Group, the Home Visitation Leadership Advisory Coalition and the Interagency Child Abuse Prevention Task Force.

Oklahoma ACA Home Visiting Program Grant Project Organizational Chart



A PLAN FOR WORKING WITH THENATIONAL MODEL DEVELOPER AND A DESCRIPTION OF THE TECHNICAL ASSISTANCE AND SUPPORT PROVIDED THROUGH THE MODEL DEVELOPER

NURSE-FAMILY PARTNERSHIP: The contractual relationship between OSDH and NFP has been renewed for the next State Fiscal Year. This contract includes training, technical assistance and evaluation. Below is the substantive portion of the contract:

Duties of the NFP:

1. **Professional Development and Nursing Practice.** The Contractor shall provide ongoing NFP Education provided to NFP nurses nationwide, including at least the following professional development:
    - Updated Home Visit Guidelines (to be distributed to all nurse home visitors, with reinforcement/support by Lead Nurses)
    - Continued use of online and on-demand education modules
2. **New Nurse Education.** The Contractor shall provide model-specific training from the NFP National Service Office Nurse Educators to nurses hired after the effective date of this contract. The education consists of the following courses:

- **Supervisor Education**. Each lead nurse, supervisor, and/or state nurse consultant:
    - Completes a pre-class distance education session;
    - Attends an initial ¾ day (Monday) face-to-face education session held in Denver, Colorado;
    - Completes a post-class distance education session;
    - Attends an additional three-day face-to-face education session held in Denver, Colorado, approximately four months after the first face-to-face session.
    - The total fee paid for Supervisor Education shall include education materials.
    - Supervisors are to attend the annual supervisor and nurse consultant education session in Denver.

- **Nurse Home Visitor Education**. Each nurse home visitor, lead nurse, supervisor, and/or state nurse consultant:
    - Completes a pre-class distance education session
    - Attends a four day (Monday evening through mid-day Friday) face-to-face education session held in Denver, Colorado.
    - Completes post-class distance education sessions.
    - The total fee paid for Nurse Home Visitor Education shall include education materials.

3. **Monthly Data Integration.** The Contractor shall integrate Oklahoma data with other NFP national data monthly.

4. **State Report.** The Contractor shall provide a standard annual evaluation report of the Children First Program activity and results across all Oklahoma sites, in accordance with the Nurse-Family Partnership routine reporting. The annual report is due to OSDH by December 31, 2011.
5. **Technical Assistance.** The Contractor shall provide technical assistance and consultation regarding model-specific implementation issues, provided through on-site meetings, monthly calls, and other support as mutually agreed is needed, plus quarterly implementation reports, using state-level data.

Duties of the OSDH:

1. Gather CMIS data as specified by NFP from each program site and enter it into a database that can be electronically transferred at least monthly to the Contractor's Project Manager;
2. Be responsible for gathering complete and accurate data from each site. The OSDH will provide their own intensive technical assistance to local data entry and data management personnel;
3. Use the Contractor's proprietary computer source code only for development, maintenance, and documentation of the OSDH Clinical/Management Information System:
4. Use the Contractor's Clinical Guidelines for Children First operational activities only. The Guidelines will not be released to other entities, except to OSDH contract providers specifically for Children First services.
5. Submit names of newly hired nurses to Contractor and enroll nurses in appropriate educational units.
6. Be responsible for travel, lodging and per diem for newly hired nurses to attend the face-to-face education session held in Denver, Colorado.
7. Promote and publicize the program as "Children First, Oklahoma's Nurse-Family Partnership".

HEALTHY FAMILIES AMERICA: Although OSDH has had a relationship with Healthy Families America, we anticipate that the partnership will be strengthened as we move Kay and possible Garfield sites through the accreditation process. The HFA Approval letter outlined our agreement. The following are excerpts from the letter:

"The State has projected that any new HFA sites will become operational July 2011, and once staff are hired, the State agrees to complete the application process to affiliate new programs. Should any additional HFA sites be established in Oklahoma at a later time through the MIECHV program, those sites will also affiliate with the HFA National Office. The State has also agreed to pay the required annual fees ($1,350 in 2011). Oklahoma currently has HFA certified trainers and agrees to conduct the required HFA training according to trainer licensure agreements. The State has indicated its intent to work in partnership with the HFA National Office to obtain model specific technical assistance and support related to site planning,

development, implementation, and accreditation as needed. Technical assistance will be made available to you from the HFA National Office's Southeastern/Western Region Director at no cost via phone and email, and at a cost of $1,250 per day plus travel for on-site technical assistance, as needed. Finally, the State will utilize the Parents Teachers *Born to Learn* curriculum and will secure the necessary curriculum training from the curriculum developers to use within the HFA program site.

In order to maintain HFA affiliation and the right to use the Healthy Families America name and to insure model fidelity, the State agrees that within the first 3 years of site affiliation, the program will complete the accreditation process. The State also agrees to complete an annual site survey (distributed by PCA America on an annual basis), and to utilize a data management system to better provide information to the National Office. It is PCA America's intention to affiliate individual program sites and multi-site systems and to authorize use of the name "Healthy Families" and use of variations of the name provided they are committed to the best practice standards identified by PCA America through research."

PARENTS AS TEACHERS:

Initial Parents as Teachers Affiliate Plan

1. **Review the Readiness Reflection and Essential Requirements.** This helps communities assess their ability to fully implement the Parents as Teachers model with fidelity.

2. **Complete an Affiliate Plan.** An **Affiliate Plan** guides organizations through planning to build a strong foundation for a high quality program. Designed as a logic model, it links inputs, activities, outputs and outcomes for families. It also helps determine appropriate staffing and budget. Keeping the end in mind as a new program is developed leads to strong programs and maximizes positive outcomes for families.

3. **Send home visitors to training.** Once an Affiliate Plan is approved, the organization's home visitors complete the Parents as Teachers Foundational Training and the Model Implementation Training. The Foundational Training lays the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of Parents as Teachers with practice. Model Implementation Training incorporates the Parents as Teachers **Quality Assurance (QA) Guidelines** and offers implementation strategies and evidence-based practices that help organizations fully understand and bring to life quality Parents as Teachers services. The training explains how to successfully replicate the Parents as Teachers model with fidelity. Demonstrating accountability, evaluation and outcomes are themes woven throughout.

Description of the technical assistance and support to be provided through the national model:
It is widely recognized that model fidelity and program quality provide the foundation for demonstrating outcomes for children and families. Parents as Teachers offers several key resources that provide comprehensive guidance for those implementing the model, including:

Essential Requirements:
The Essential Requirements have been identified as best practices to ensure model fidelity. The requirements cover parent educator background and experience, duration of services, assessment and goal setting, the four core components, supervision, professional development, advisory committee, evaluation, training, materials and funding requirements.

The Quality Assurance Guidelines provide detailed guidance to support the completion of the program plan. These Guidelines establish a blueprint for quality implementation of the Parents as Teachers model. Parents as Teachers expects all who implement its model, including existing Parents as Teachers affiliates, to adhere to these QA Guidelines.

Initially, the QA Guidelines help organizations effectively plan their services, operations, and management. After affiliation, ongoing adherence to the QA Guidelines helps to ensure successful replication, model fidelity and application of evidence-based practice.

Ongoing compliance with the essential requirements is necessary for continued implementation of the Parents as Teachers model. Affiliates report on compliance with the essential requirements annually, via the Affiliate Performance Report. In addition, affiliates 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.

Ongoing affiliation with Parents as Teachers requires regular program self-assessment. To assist with this, Parents as Teachers has developed a quality self-assessment process and tools.

The Model Implementation Guide incorporates the QA Quality Guidelines while providing additional implementation strategies and evidence-based practices that help each organization fully understand and bring to life a quality Parents as Teachers affiliate.

Parents as Teachers recommends use of Visit Tracker software to track service delivery data. This tool will assist with regular reporting on implementation of the Home Visiting Program.

Parents as Teachers Technical Assistance:
Through the national office as well as through its network of state offices, Parents as Teachers provides the following kinds of technical assistance:

- Technical Assistance supporting initial implementation, including development and approval of the initial Affiliate Plan.
- Technical Assistance regarding meeting the essential requirements.
- Ongoing Professional Development: Certified parent educators must complete in-service professional development hours annually to maintain their certification. Parents as Teachers offers a variety of professional development trainings as well as an annual conference to help parent educators meet this requirement.
- Technical Assistance provided to state level agencies around monitoring, assessing and supporting implementation with fidelity to the model and maintaining quality assurance.

A TIMELINE FOR OBTAINING CURRICULUM AND OTHER TRAINING MATERIALS

Nurse-Family Partnership

NFP Training materials are received after the nurses enroll in the training. Trainings are typically held once a month.

Healthy Families America

New HFA training materials will be ordered shortly after July, 1 2011.

Parents as Teachers

New PAT training materials will be order short after July 1, 2011.

DESCRIPTION OF HOW AND WHAT TYPES OF TRAINING AND PROFESSIONAL DEVELOPMENT WILL BE OFFERED

Please see the following charts.

Nurse-Family Partnership Supervisor Core Education Units

Supervisor Unit One	Unit Two	Supervisor Unit Three	Supervisor Unit Four
All new, expansion and replacement supervisors are required to complete the five distance education lessons in this course prior to attending Supervisor Unit Two. Each lesson takes approximately 20 to 30 minutes to complete. The lessons are designed to orient a supervisor to her/his role and responsibilities in the Nurse-Family Partnership program and concentrate on program logistics, including agency setup, documentation, referrals, and hiring nursing staff. Supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker.	This face-to-face session takes place from Monday afternoon through Friday, and is required for all new, expansion, and replacement Nurse-Family Partnership Nurse Home Visitors and Supervisors. The goal of Unit Two is to build on the foundation provided in Unit One and prepare new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Unit Two provides interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. NFP Model diagram	This distance education session focuses on Nurse-Family Partnership implementation issues, provides the supervisor with support in assessing the quality of nursing practice and implementation, and supports the professional development of nurse home visitors. A lesson is included to help supervisors learn how to connect with their community to sustain and grow their program. Supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker.	This face-to-face three-day session occurs approximately 4-6 months after completion of Unit Two. The session again focuses on the Nurse-Family Partnership model to promote supervisor skills around teambuilding and job stress and burnout. It also builds on reflection and motivational interviewing skills learned in earlier sessions. All new, expansion, and replacement supervisors are required to attend.

Nurse-Family Partnership Core Education Units

Unit One	Unit Two	Supervisor Unit Three
The goal of Unit One is to equip newly hired nurses and supervisors with foundational knowledge of Nurse-Family Partnership and the home visiting intervention. This distance education session is completed prior to Unit Two. Unit One is comprised of three components: completion of the Unit One workbook and online self-assessment; completion of the Partners in Parenting Education (PIPE) self-study workbook and online assessment; submission of the PIPE lesson plan; and completion of the online lesson *Using the NFP Visit-to-Visit Guidelines*. Nurse home visitors and supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker. **Unit One workbook:** Completion of Unit One and the PIPE assessments and submission of the PIPE lesson plan are prerequisites to attending the face-to-face Unit Two session. All new, expansion, and replacement nurse home visitors and supervisors are required to complete the Unit One workbook and corresponding assessment. Anticipate spending approximately 25 hours on this self-study module. To view the Unit 1 workbook online, click here. **PIPE self-study workbook:** Additionally, those nurses and supervisors attending Unit Two are required to complete the Partners in Parenting Education (PIPE) Self-Study Workbook and corresponding assignments, which focus on PIPE curriculum. This workbook is designed to provide you with a foundation for understanding and using the PIPE instructional model and curriculum with clients. Anticipate spending approximately five hours on this workbook. After completion of the workbook, you will take the online assessment and submit your PIPE lesson. Your supervisor is responsible for purchasing all necessary PIPE materials for you to complete the workbook.	This face-to-face session takes place from Monday afternoon through Friday, and is required for all new, expansion, and replacement Nurse-Family Partnership Nurse Home Visitors and Supervisors. The goal of Unit Two is to build on the foundation provided in Unit One and prepare new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Unit Two provides interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. NFP Model diagram	Building on Units One and Two, the goal of Unit Three is to provide nurses an opportunity to deepen their understanding of the Nurse-Family Partnership model, specifically in regards to infant temperament, motivational interviewing, and fidelity to the Nurse-Family Partnership Model Elements. Following Unit Two, you will consult with your supervisor regarding the best time to start the Unit Three distance lessons. The distance lessons will take approximately one to two hours per month over a six-month time frame. Nurse home visitors and supervisors access this course by logging in to the online Tracker system.

Healthy Families America Core Training

Core Training is required training for all direct service staff and their supervisors/program managers within six months of hire, core training instructs staff in their specific roles.			
Assessment Core Training	**Integrated Strategies for Home Visiting Programs Training**	**Supervisor Training**	**Orientation**
The Assessment Core Training is an in-depth, formalized training designed for staff whose primary role is to conduct initial assessments. It is also ideal for home visitors, who want to advance their communication skills to more confidently address difficult situations with families. Four full days for the family assessment specialist, plus an additional fifth day for supervisors and program managers include topics such as, but not limited to: identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, communication skills, etc. The trainer is certified and has been trained to train others.	*(formerly known as Family Support Worker Core Training)* Home Visitors Core Training is an in-depth, formalized training intended for home visitors of a Healthy Families America program. In-depth, formalized training which outlines the specific duties of the home visitor's role within Health Families and covers topics including, but not limited to: establishing and maintaining trust with families, completing necessary paperwork/documentation, the role of the home visitor, communication skills, and crisis intervention, etc. The trainer is certified and has been trained to train others.	A day of training for supervisors and program managers of HFA direct service staff positions (Family Assessment Specialists and Home Visitors). In-depth, formalized training which outlines the specific duties of the supervisor's role within Health Families and covers topics including, but not limited to: the role of family assessment and home visitation, effective supervision, quality management techniques, crisis management, understanding the program's policies and procedures; and case management, etc. The trainer is certified and has been trained to train others.	Familiarize staff with site-specific operating policies and procedures. Include information on the services provided, work hours, supervision requirements, emergency procedures, confidentiality issues, etc. (3 hours)

Healthy Families America Additional Training for Assessment Workers, Home Visitors, and Supervisors

Additional Training within 6-months of Hire	Additional Training within 12-months of Hire	Ongoing Training
Infant Care • Sleeping; • Feeding/breastfeeding; • Physical care of the baby; and • Crying and comforting the baby Child Healthy an Safety • Home safety; • Shaken baby syndrome; • SIDS; • Seeking medical care; • Well-child visits/immunizations; • Seeking appropriate child care; • Care seat safety; and • Failure to thrive Maternal and Family Health • Family planning; • Nutrition; • Pre-natal/post-natal healthcare; and • Pre-natal/post-partum depression Infant and Child Development • Language and literacy development; • Physical and emotional development; • Identifying developmental delays; and • Brain development Role of Culture in Parenting • Working with diverse cultures/populations • Culture of poverty; and • Values clarification Parent-Child Interaction • Supporting attachment; • Positive parenting strategies; • Discipline; • Parent-child interactions; • Observing parent-child interactions; and • Strategies for working with difficult relationships	Child Abuse and Neglect • Etiology of child abuse and neglect; and • Working with survivors of abuse Family Violence • Indicators of family violence; • Dynamics of domestic violence; • Intervention protocols; • Strategies for working with families with family violence issues; • Referral resource for domestic violence; • Effects on children; and • Gangs Substance Abuse • Etiology of substance abuse; • Culture of drug use; • Strategies for working with families with substance abuse issues; • Smoking cessation; • Alcohol use/abuse; • Fetal alcohol syndrome; • Street drugs; and • Referral resources for substance abuse Staff Related Issues • Stress and time management; • Burnout prevention; • Personal safety or staff; • Ethics; • Crisis intervention; and • Emergency protocols Family Issues • Life skills management; • Engaging fathers' multi-generational families; • Teen parents; • Relationship; and • HIV and AIDS Mental Health • Promotion of positive mental health; • Behavioral signs of mental health issues; • Depression; • Strategies for working with families with mental health issues; and • Referral resources for mental health	The program ensures that program staff receive ongoing training which takes into account the worker's knowledge and skill base.

Parents As Teachers Training Requirements

<table>
<tr><th>Program Tracks</th><th>Foundational Curriculum</th><th>Model Implementation Guide</th><th>Professional Development</th></tr>
<tr>
<td>Beginning January 2011, there will be two pathways or tracks:

<u>Model Implementation</u>
Requirements include:
• Parents as Teachers Foundational Training (which includes Parents as Teachers Foundational Curriculum)
• Completion of an Affiliate Plan
• Model Implementation Training after (which includes the Guide)

<u>Approved User</u>
Requirements include:
• Parents as Teachers Foundational Training (which includes the Curriculum)</td>
<td>The Foundational Curriculum will cover:

• Core competencies and educator self-assessment
• Protective factors
• Reflective practice
• Family systems/culture
• Family needs assessment
• Role of PE/resourcing
• Foundational personal visit plans and guided planning tool
• Dove DV Intervention
• Edinburgh Depression Screen
• Parent Educator Tool Kit

Online resources include all of the above plus:
• Parent/child activities pages
• Parent educator resources
• Parent handouts
• Family support</td>
<td>Model implementation for those wishing to implement an evidence-based model with fidelity:

• Parents as Teachers logic model
• Quality assurance guidelines and essential requirements
• Reflective practice
• Family systems/culture
• Family needs assessment
• Role of PE/resourcing
• Evaluation and quality</td>
<td>It is essential that parent educators access competency-based professional development and training and recertify with the national office annually.

Professional Development for Parent Educators:
• Year 1: 20 clock hours
• Year 2: 15 clock hours
• Year 3 and beyond: 10 clock hours</td>
</tr>
</table>

Supplemental Training For Children First (NFP) and MIECHV HFA & PAT Funded Programs

Grief	Attachment	Breastfeeding and Nutrition	Paternity Legal Medicaid	Substance Abuse
3.5 hours	3.5 hours	2 hours	3.5 hours	3.5 hours

Child Abuse Medical Examiner Documentation	Postpartum and Mental Health	Adoption	Car Seat Safety	Tobacco Cessation
12 hours	1 hour	3.5 hours	1 hour	1 hour

Lead Poisoning Prevention	Home Visitor Safety	Home Safety	Domestic Violence	Family Planning
1 hour	2 hours	1 hour	4 hours	1 hour

Ages and Stages Questionnaires Third Edition (ASQ)	Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)

A PLAN FOR RECRUITING, HIRING, AND RETAINING STAFF

All Children First Nurse positions will be directly hired by the local county administrator and/or an interview team. They will be "State" employees in "classified" Registered Nurse positions. These positions fall under the laws, rules and regulations of the Oklahoma Merit System of Personnel Administration under the management of the Office of Personnel Management (OPM). At the Oklahoma State Department of Health, all activities related to recruiting and hiring, with the exception of interviewing, are conducted by the OSDH Office of Personnel in compliance with OPM policy.

Most state jobs are classified, i.e., subject to the Merit System of Personnel Administration. Classified jobs are filled on the basis of ability, as demonstrated in competitive examinations and/or experience.

The Merit System also includes a variety of outreach recruitment programs designed to help state agencies meet the challenges of cultural diversity and the modern workforce. Merit System testing is not required for individuals with severe disabilities hired through the Optional Program for Hiring Applicants with Disabilities. Veterans with disabilities may also be considered directly by Merit System agencies through the Special Disabled Veterans Employment Act.

OPM's Targeted Minority Recruitment Program provides technical assistance and recruitment expertise to agencies seeking to achieve targeted hiring goals. The Fair Employment Practices Act is an optional hiring procedure used by state agencies to employ females, blacks, Hispanics, Asian/Pacific Islanders, and American Indians/Alaskan natives who are legal residents of the state in an effort to satisfy Affirmative Action hiring goals.

Classified jobs that are considered "hard-to-fill" require special recruitment efforts. Other classified job openings are considered internal promotional opportunities and are available only to current permanent classified employees of the state of Oklahoma or former employees who are eligible for reinstatement to Oklahoma's classified service.

State jobs that are not subject to the Merit System are unclassified. There are no universal procedures for the recruitment and appointment of unclassified officers and employees, or for the terms and conditions of their employment, except for performance appraisals; practices vary from one agency to another. However, the OSDH Office of Personnel recruits and posts the positions in generally the same manner.

The MIECHV Grant Coordinator, Evaluator and possible Administrative Assistant will be filled with "unclassified" positions. These positions are unclassified because they are directly tied to a grant. Should the grant not be funded, the positions would be terminated.

One of the outstanding programs administered by the Oklahoma Office of Personnel Management is the Carl Albert Public Internship Program, which consists of paid internships for both graduate and undergraduate students. Undergraduates are employed as unclassified temporaries for one or two academic semesters or 999 hours. Executive Fellows (graduate) Interns may be employed in unclassified positions for up to two years, and those who

successfully complete a two-year internship are eligible for appointment to a position in the classified or unclassified state service.

In addition, state agencies may hire participants in the Temporary Assistance to Needy Families (TANF) program as unclassified employees through the State Work Incentive Program. These employees may also be converted to permanent classified status after two years of continuous participation in the Program.

A PLAN FOR RECRUITING SUBCONTRACTORS AND HOW THEY WILL RECRUIT, HIRE AND RETAIN STAFF

Existing home visitation programs in Kay and Garfield counties have participated in local community meetings regarding the MIECHV Grant. They, along with other potential new vendors, are aware that Invitations to Bid will be let and that all will have an opportunity to submit bids.

Without knowing who will be awarded the contracts, we cannot provide specifics regarding the subcontractors practices related to recruiting, hiring and retaining. However, OSDH has always required in the Invitations to Bid that the contractors abide by certain staff qualifications and that contractors do adhere to state and federal laws related to hiring. Such items will included in the MIECHV Invitations to Bid.

A PLAN TO ENSURE HIGH QUALITY CLINICAL SUPERVISION AND REFLECTIVE PRACTICE FOR HOME VISITORS

Children First Supervision (NFP):

Children First developed a Lead Nurse Manual several years ago. This manual is the basis for the NFP version used across the country. Subject matters addressed in the Lead Nurse Manual include:

- Roles and Responsibilities
- Orientation
- Reflective Consultation
- Case Conferences/Staff Meetings
- Audits
- Nurse-Family Partnership Supervisory Forms
- Critical Incidents (how to report)
- The Public Health Oklahoma Client Information System (database)
- Training
- Supplies

Children First Roles and Responsibilities:

The *Children First* (C-1) Lead Nurse (LN) provides leadership, supervision and day-today coordination for home visit services in a designated county or counties. The Lead Nurse is the bridge of communication for the nurse home visitors on the team as well as the nurse home visitors direct link to the Nurse Manager (NM)/Supervisor.

1. The Lead Nurse must meet all the requirements for the Registered Nurse III job classification from the Oklahoma State Office of Personnel Management.

2. The Lead Nurse must complete all required Public Health Nurse Orientation Modules as required by the Oklahoma State Department of Health, Nursing Service or City-County Health Departments.

3. The Lead Nurse must complete all required *Children First* Training including those specified for Lead Nurses.

4. The Lead Nurse must comply with the requirements for supervisory education hours as set forth by the Oklahoma State Department of Health, Human Resources Service or City-County Health Departments.

5. The Lead Nurse must supervise no more than eight (8) nurse home visitors. The nurse home visitors she/he supervises may be headquartered in multiple counties.

6. The Lead Nurse serves as a role model for the nurse home visitors in professional conduct and professional dress.

7. The Lead Nurse, NM/Supervisor and County Health Department Administrator (Administrator) will determine how many clients, if any, a Lead Nurse may carry. The Lead Nurse may carry no caseload or as many as a few depending on the number of nurses she/he has to supervise, the distance she/he must travel to supervise staff. A Lead Nurse's caseload must not be so great as to interfere with her/his supervisory duties. The rationale of having a Lead Nurse carry a caseload is to maintain credibility as a competent Home Visitor.

8. The Lead Nurse is responsible for coordinating home visit services for the *Children First* clients. In the absence of a nurse home visitor the Lead Nurse may serve as a substitute or assign an alternate nurse to the client.

9. The Lead Nurse receives referrals to *Children First* and assigns the referrals to the nurse home visitors. This process may be delegated if needed such as when a Lead Nurse travels between multiple sites.

10. The Lead Nurse consults with the NM/Supervisor and Administrator regarding technical nursing issues, training needs, legal matters or any issue that is pertinent, including but not limited to audit results, DHS reports, and Critical Incidents. The NM, in turn, contacts Nursing Service and the *Children First* Program Staff when assistance from the central office is needed.

11. When a critical incident occurs, the Lead Nurse should immediately notify the NM/Supervisor and Administrator and in turn, Nursing Service and the *Children First* Program Staff. A critical incident may be defined as but is not limited to:
    a. Severe injury to a *Children First* client or the child of a *Children First* client;
    b. Severe illness of a *Children First* client or the child of a *Children First* client;
    c. Death of a *Children First* client or the child of a *Children First* client;
    d. Any harm that has come to a nurse home visitor or Lead Nurse by a client or someone connected to the client.
    e. Any other significant event that may occur

12. The Lead Nurse schedules and facilitates the following:
    a. Reflective Consultation: The Lead Nurse is to meet weekly with each Individual nurse home visitor. The purpose of reflective consultation is to provide support to the nurse home visitor.
    b. Reflective Consultation: The Lead Nurse should meet weekly with the NM/Supervisor for her/his reflective consultation. The purpose of this meeting is to provide support to the Lead Nurse. (See the Reflective Consultation section of the Lead Nurse Manual for more specific information.)
    c. Monthly Staff Meetings: The Lead Nurse is to include all nurse home visitors in her/his area in these meetings. The purposes of staff meetings are to ensure the flow of communication and promote team building and staff development.
    d. Monthly Case Conferences: The Lead Nurse is to include all nurse home visitors in her/his area in these meetings. The purposes of the case conferences are to provide an

opportunity to share expertise, seek support and present successful resolutions for challenging client situations.

13. The Lead nurse should maintain good communication with the Administrator, NM/Supervisor and Coordinating Nurse in each county he/she serves. Periodic meetings are recommended to discuss particular issues or other health department matters.

14. The Lead Nurse assists the nurse home visitors to identify community resources for clients. The Lead Nurse should maintain a resource directory at the county level, which should be periodically updated and utilized during case conferences.

15. The Lead Nurse completes the Supervision Progress Report (SPR) Form #443 for each nurse. Instructions for completing this form are located in the MIS Forms Manual.

16. The Lead Nurse completes the Visit Implementation Scale (VIS) Form #442 for each nurse. Instructions for completing this form are located in the MIS Forms Manual.

17. The Lead Nurse will observe each nurse at least one full workday a minimum of twice per year. The objectives during this observation should include but are not limited to the following:

    Observing/Assessing the nurses

    a. Nursing Practice
    b. Time Management
    c. Adherence to program guidelines and Nursing G & O's
    d. Utilization of tools/resources

    The observation time should not be scheduled on a day the nurse has leave or meetings. These visits may be utilized to complete the SPR and VIS forms.

18. The Lead Nurse and/or the designee conduct in-home assessments in accordance with the *Children First* Program requirements, utilizing the Nursing Child Assessment Satellite Training (NCAST) screening tool.

19. The Lead Nurse conducts quarterly chart audits to ensure adherence to the *Children First* Guidelines, NFP model, Agency Guidelines and Nurse Practice Act. Chart audits are performed utilizing the schedule and tools identified in the *Audits* section of this manual. Additional audits may be performed at the discretion of the NM/Supervisor and/or Program Staff. Audit results are to be shared with NM/Supervisor and the *Children First* Program Staff.

20. The Lead Nurse is responsible for ordering, distributing and maintaining C-1 supplies. This task may be delegated at the discretion of the Lead or NM/Supervisor.

21. The Lead Nurse promotes public awareness and utilization of *Children First* in the community. It is important for the Lead Nurse to maintain relationships with referral sources and to periodically analyze referral resource data to ensure that *Children First* clients are being recruited from all possible venues. It is recommended the Lead Nurse participate in at

least one community outreach activity per year. This should be documented on the county outreach log.

22. The Lead Nurse collaborates effectively with other disciplines and informs staff of all available services from those disciplines.

23. The Lead Nurse routinely meets with other home visitation program staff in order to exchange referrals, share information, collaborate on special projects and ensure that home visitation efforts are not duplicated.

24. The Lead Nurse monitors data entry to be certain that it occurs in a timely manner.

25. The Lead Nurse monitors home visitor's productivity and provides strategies for improvement if necessary.

26. The Lead Nurse notifies NM/Supervisor when a staff member is not adhering to guidelines, policies or procedures. The Lead Nurse proceeds with disciplinary

Start Right Supervision (HFA):

Supervisor Qualifications
At a minimum the program supervisor will have a masters or bachelors degree in early childhood development, family relations, social work, human relations, psychology, adult education or other closely related field and a minimum of two years experience supervising home visitors.

Hardship Clause: If a Start Right Program can provide written documentation that there are no applicants for the Supervisor position that meet the minimum requirements, the Program may petition in writing the Chief of the Family Support & Prevention Service. The petition may request that the position be filled provisionally or temporarily with a person that does not meet the requirements.

Supervisor Activities
The Start Right Programs agree to provide program staff with a minimum of one hour of individual supervision per week to include both professional and administrative aspects of supervision according to the definitions of the OCAP/Start Right Program Manual.

The Start Right Programs agree to provide program staff with a minimum of four hours of group supervision per month to include both professional and administrative aspects of supervision according to the definitions outlines in the OCAP/Start Right Program Manual.

The Start Right Programs agree to keep written documentation of supervision. Written documentation will include:

- Dates and times of supervisory sessions
- Amount of time for each supervisory session
- Names of program staff present during the supervisory session

- Dates and times of supervisory "shadow visits"
- Specific topics and issues discussed
- Notation of decisions made
- Notation of family file folders reviewed
- Recommendations for follow-up action needed
- Notation regarding who is responsible for follow-up
- A services management record
- Weighted caseload assignments for each staff person as defined in the Healthy Families America Training Manual
- Staff training plans and staff training records

In addition, the Supervisor shall:

- Facilitate ongoing collaborations with local community partners
- Assure that program data is being collected and entered into the OCAP database and transmitted to OCAP as required
- Prepare for and participate in OCAP site visits
- Prepare and submit bi-annual and annual program performance narrative reports as required
- Attend all required Start Right Program meetings
- Organize and complete all required Start Right paperwork as required
- Maintain confidentiality
- Complete all pre-service training and required supplemental training

Parents as Teachers

Qualifications:
Master's Degree preferred**.** Demonstrated ability for working with young children and their parents, and possession of an Oklahoma teaching certificate in one of the following:

- Early Childhood Education
- Elementary Education
- Related Field

OR
Possession of a Bachelor's Degree in one of the following:

- Child Development
- Nursing
- Family and Consumer Sciences
- Related Field

Upon employment, completion of the Oklahoma State Department of Education approved professional development training regardless of previous training and experience is required:

Initial employment with PAT

-A minimum of 30 hours preservice training from the Parents as Teachers National Center *Birth to Three Institute* of 12 hours if serving as a Coordinator only.

Continued Education During Employment

-First year: a minimum of 20 hours professional development
-Second year: a minimum of 15 hours professional development
-Third year and every year after: a minimum of 10 hours professional development

Responsibilities:

1. Plan and implement the PAT Program in accordance with the guidelines of the Parents as Teachers National Center and the Oklahoma State Department of Education.
2. Assure all legal, financial and organizational requirements are met during all phases of program development and implementation.
3. Achieve high visibility for PAT by promoting and developing relationships with community and governmental agencies.
4. Develop an annual implementation plan, including measurable objectives, activities and action timetable.
5. Recruit and supervise staff.
6. Recruit program participants and monitor provision of services.
7. Refer children and families with special needs to appropriate services in the community.
8. Develop and maintain an information management system.
9. Monitor program progress and assist in the evaluation of outcomes.
10. Prepare and submit reports to the Oklahoma State Department of Education, as needed, on services provided to children and families.
11. Provide staff support services to the Community Advisory Committee and/or the Internal Coordinating Committee.
12. Attend the annual program orientation meeting and participate in local, statewide and national networking efforts.
13. Maintain confidentiality.
14. Provide education to the community on PAT and its services
15. Assist in the development and implementation of fund-raising projects.
16. Successfully complete the supervisor training and certification through the Parents as Teachers National Center.
17. Serve a minimum of five families each program year if parent educator recertification is desired.
18. Ensure monthly statistical reports are submitted to the Child Services Demonstration Center.
19. Ensure at least one staff member attends the informational meeting, regional meetings and the Family Matters Conference.
20. Facilitate and host the program site visits made by the PAT State Leader from the Oklahoma State Department of Education.

ESTIMATED NUMBER OF FAMILIES TO BE SERVED

Kay County

Children First (NFP):	25 Families
Start Right (HFA)	20 Families
Parents as Teachers	50 Families

Garfield County

Children First (NFP)	25 Families
Start Right (HFA) and/or Parents as Teachers	75 Families

A PLAN FOR IDENTIFYING AND RECRUITING FAMILIES

"Connector" Position

In both Kay and Garfield Counties, there is more than one existing home visitation program. Both counties are also rich in community services. The feature that seems to be lacking though and that the community focus group has highlighted as a need is a "connector" of sorts.

For this reason, MIECHV funds will be used to contract with a community agency for a part-time employee that can serve as that "connector" in each county. This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources
- Collect referrals for home visitation programs and distribute them to the appropriate home visitation program
- Organize opportunities for the home visitation programs to meet on a routine basis so that the program can staff referrals if necessary and share programmatic information
- Organize opportunities for the home visitation programs and other community services to meet on a routine basis so that all can learn from each other

Because of the dollar amount involved, it may be that the contract for such a position will have to go out to bid. This issue is being researched at this time. It should be noted though that while there are several community organizations that are involved in community development, Smart Start Oklahoma appears to be uniquely positioned to partner with the home visitation programs in this manner. Smart Start Garfield County and Smart Start Kay County not only are strongly connected to community services, they also have expertise in and a focus on early childhood.

Period of Purple Crying Project: Almost simultaneously, House Bill 2920 was passed in 2010 requiring the establishment of the Shaken Baby Prevention Education Initiative Task Force. The purpose of the task force was to identify evidence-models for reducing the incidence of abusive head trauma in infants in Oklahoma. Prior to this legislation being passed, the Injury Prevention Workgroup of the Preparing for lifetime Initiative identified this as a priority to be addressed, creating a plan to work with all birthing hospitals in Oklahoma to implement the "Period of Purple Crying." Collaborating closely with the Oklahoma Hospital Association, the University of Oklahoma Health Sciences Center, the Office of Perinatal Quality Improvement and the Medical Services Trauma Unit, the two groups combined efforts and chose to support the implementation of the Period of Purple Crying. Materials were purchased to assure that for one full year, all parents of newborns could receive a Period of Purple Crying DVD and educational brochure. A total of 60,000 DVDs were purchased at $2.00 each. The total cost was split between CBCAP and funds the OSDH Maternal and Child Health Service.

Those hospitals that agreed to participate in the project received the following:

- Program Description and Protocol – a step-by-step implementation guide;
- Online training on how to implement the "Purple" program in the hospitals with patients;
- Period of Purple Crying DVDs – for new parents to view in the hospital and take home;

- Educational brochures for parents about infant crying and possible ways to soothe a baby;
- Parent Acknowledgement Statements – a form acknowledging that the parent has watched the DVD and received the DVD in the hospital take home packet;
- Client Release Forms – a form that provides contact information to a home visitation program if the family is interested in services; and
- Copies of the Oklahoma Home Visitation Directory – a county-by-county listing of all home visitation programs for young children for families with young children

A PLAN FOR MINIMIZING THE ATTRITION RATES OF PARTICIPATING FAMILIES

In January 2011, Children First partnered with Dr. Olds and submitted a grant proposal through the ACA Nurse, Education, Practice, Quality and Retention Program to continue work to address client retention period. The work proposed by this application will be conducted by a consortium of state health departments implementing the NFP model led by the State of Oklahoma and supported by the University of Colorado, College of Nursing.

Once appropriate to share, it is the intention of OSDH to disseminate the "lessons learned" from the above grant experience with all home visitation programs within Oklahoma. Generally, all home visitation programs have struggled with retaining parents – especially parents with multiple risk factors and challenges.

AN ESTIMATED TIMELINE TO REACH MAXIMUM CASELOAD IN EACH LOCATION

Kay County

Children First (NFP):	9 months from hiring
Start Right (HFA)	6 months from hiring
Parents as Teachers	6 months from hiring

Garfield County

Children First (NFP)	9 months from hiring
Start Right (HFA) and/or Parents as Teachers	6 months from hiring

AN OPERATIONAL PLAN FOR THE COORDINATION BETWEEN HOME VISITING PROGRAMS AND COMMUNITY SERVICES

In both Kay and Garfield Counties, there is more than one existing home visitation program. Both counties are also rich in community services. The feature that seems to be lacking and that the community focus group has highlighted is a "connector" of sorts.

For this reason, MIECHV funds will be used to contract with a community agency for a part-time employee that can serve as that "connector" in each county. This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources
- Collect referrals for home visitation programs and distribute them to the appropriate home visitation program
- Organize opportunities for the home visitation programs to meet on a routine basis so that the program can staff referrals if necessary and share programmatic information
- Organize opportunities for the home visitation programs and other community services to meet on a routine basis so that all can learn from each other

Because of the dollar amount involved, it may be that the contract for such a position will have to go out to bid. This issue is being researched at this time. It should be noted though that while there are several community organizations that have expertise in community development, Smart Start Oklahoma appears to be uniquely positioned to partner with the home visitation programs in this manner. Smart Start Garfield County and Smart Start Kay County not only are strongly connected to community services, they also have expertise and a focus on early childhood.

A PLAN FOR OBTAINING OR MODIFYING DATA SYSTEMS FOR CQI

The State of Oklahoma has been investing in home visiting services for families with young children since 1996. Fortunately, those implementing the programs appreciated the need for evaluating such services. However, there was not much knowledge about evaluating home visitation in the mid 1990's.

Evaluating home visitation has certainly evolved over the years. Home visitors soon found that they were not only to work with families, but they were also to collect data – lots of data, lots of paper. The Oklahoma State Department of Health had databases developed to store the data and epidemiologists were then tasked with analyzing it.

There is now a critical need to overhaul both the Children First and Start Right databases. While the Children First database still works, many updates and edits need to be made. The Start Right database has major technical problems and for that reason, it appears impossible to pull accurate and meaningful data. The data for Start Right is so inconsistent that for the first time in years, no annual report was completed for the program.

In addition to the basic need to "fix" or reconstruct the existing Children First and Start Right databases, the MIECHV Grant requires the collection of data for all federally funded home visitation programs. With OSDH potentially funding Parents as Teachers programs as well as Children First and Start Right in the identified at-risk communities of Kay and Garfield counties, there will be the need to develop a system that collects data from all of the programs and measures the required benchmarks and constructs.

Oklahoma will be utilizing some CBCAP funds to make improvements or redesign if necessary the home visitation databases so that ongoing evaluation can occur. The idea of collecting data electronically, as opposed to the pencil and paper process now being utilized, is also being explored. Should home visitors be able to use either tablets or laptops for collecting data, less paper would be used, the home visitor's time entering data would be reduced and perhaps the risk of errors would be reduced as well.

AN EXPLANATION OF THE STATE'S APPROACH TO MONITORING, ASSESSING AND SUPPORTING IMPLEMENTATION WITH FIDELTIY TO THE MODEL AND MAINTAINING QUALITY ASSURANCE

Quality Assurance/Assessment and/Support of home visitation programs have primarily been the responsibility of state agencies. For each program specific policies and procedures have been developed. In general, the Oklahoma State Department of Health and the Oklahoma Department of Education have program staff that is responsible for the following models and related activities:

Nurse Family Partnership: The Nurse-Family Partnership has drafted objectives to help implementing agencies track their fidelity to the model and monitor program outcomes related to common indicators of maternal, child and family functioning. The objectives have been taken from the program's research trials, early dissemination experiences and current national health statistics (e.g., National Center for Health Statistics, Centers for Disease Control and Prevention; Healthy People 2010). The objectives are intended to provide guidance for quality improvement efforts and are long-term targets for implementing agencies to achieve over time. Over the years, data analysis by Nurse-Family Partnership indicated that Children First has performed well against the national averages and NFP benchmarks.

Children First (NFP) is administered through the Oklahoma State Department of Health with services provided by county health departments. In order to ensure fidelity to the NFP model as well as adherence to agency standards, Children First Nurse Consultants from the OSDH central office work with Children First teams.

Relationship to the NFP: OSDH first brought Dr. David Olds, developer and researcher for the NFP model, to Oklahoma in 1996. He presented his research to members of the Oklahoma Legislature. At that time, Dr. Olds was not replicating his work outside of the clinical trial settings. However, the legislators were quite impressed with his findings, particularly in regards the reductions in child abuse and neglect. They requested that the model be piloted in Oklahoma. Oklahoma's association with NFP has continued since then.

Implementing the NFP model with fidelity has been one of the main goals for Children First. Oklahoma has partnered with Dr. Olds on several quality improvement projects. Our partnership has allowed Children First an opportunity to participate in developing new visit guidelines, revising data collection tools and refining training materials. Children First participated in a preliminary project to help design a domestic violence research study and participated in a research study designed to address client retention. In January 2011, Children First partnered with Dr. Olds and submitted a grant proposal through the ACA Nurse, Education, Practice, Quality and Retention Program to continue work to address client retention period. The work proposed by this application will be conducted by a consortium of state health departments implementing the NFP model led by the State of Oklahoma and supported by the University of Colorado, College of Nursing. In addition, as members of the NFP State Nurse Consultant Workgroup, our Nurse consultants assist NFP with development of model/program practice standards utilized by all sites.

Training: The nineteen pilot nurses flew to Denver multiple times their first year to receive training from NFP staff. Quickly, though, Oklahoma discovered that the nurses needed more training. It was not enough to simply train the nurses about the model, data collection forms, etc. They needed to learn about a myriad of topics - substance abuse, domestic violence, adoption - to name a few. Additional trainings were organized and continue to this day. These subject specific trainings are now open to all home visitors regardless of model, free of charge.

Within six months of implementing the NFP model in Oklahoma, the legislature appropriated monies for statewide expansion. Within a year's time span, OSDH was charged with hiring 250 new nurse home visitors. Hiring and training that number of nurses in that amount of time was overwhelming. Because of limited resources not all nurses could be sent to Denver for days at a time for training. An agreement was reached between NFP and OSDH, NFP would come to Oklahoma and train nurses in the model. Eventually, Children First Nurse Consultants were allowed to provide this training because NFP could not keep up with the training demand. Until the past couple of years, this arrangement continued. Because many fewer nurses are hired each year, all new nurses do attend model trainings in Denver. In addition, NFP has created some online trainings.

NFP and Children First continue to partner and create new trainings that benefit all nurses working in NFP. Just recently, Children First requested that NFP provide in-depth training in Motivational Interviewing. The training was provided and well received. Now, this same training is being provided to other NFP sites across the country.

Technical Assistance/Consultation: Two full-time Children First Nurse Consultants, along with staff from the OSDH Nursing Service, provide technical assistance and consultation at a moment's notice. Conference calls, emails and in-services are routine ways in which the Nurse Consultants support the nurses out in the field.

Quality Assurance/Oversight: A thorough site visit is conducted with each Children First team every other year. Because of the contractual relationship and the size of their teams, Tulsa City-County and Oklahoma City-County Health Departments receive site visits every year. During the site visits, data is utilized to assess caseload management, outcome measures and more. Record audits are conducted on 10% of the Children First records to assure that the families' needs are identified, referrals for services are made and documentation is adequate. Site visit reports are written and provided to the team as well as the County Health Department Administrator and District Nurse Manager. Should there be any issues identified that need correction, a plan will be put into place and a site visit will be conducted the immediate following year.

Evaluation: Unlike most NFP sites, Children First enters all of its data into a database owned and maintained by OSDH before sending on to NFP because of agency policy. Children First data is accessible to OSDH evaluators. It is rich with more than a decade's worth of home visiting data.

Children First is required by law to provide an annual university-based program evaluation to the Governor, Speaker of the House and Senate President Pro Tempore. Over the years, though, multiple reports have been developed and distributed. In-house Children First evaluators,

typically epidemiologists, analyze data and develop an annual report for wide distribution. A contractual relationship with the University of Oklahoma, College of Public Health has produced outcome reports often focusing on just a few narrow topics. One such report by Dr. Helene Carabin, "*Does Participation in a Nurse Visitation Programme Reduce the Frequency of Adverse Perinantal Outcomes in First-time Mothers?*" was published in the Journal of Pediatric and Perinatal Epidemiology in 2005. [And, the answer is "YES!"] Lastly, the NFP National Service Office provides routine management reports that assist the Nurse Consultants gage how well Oklahoma is doing relative to NFP benchmarks and other measures such as Healthy People 2020. All reports can be found in the publications sections of the Children First website at

http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/Children_First_Program/Publications/index.html.

Healthy Families America:

The HFA model is utilized by Start Right Programs funded by the OSDH Office of Child Abuse Prevention. While not currently affiliated with HFA, any Start Right Programs provided with MIECHV funding will be required by contract to become formally affiliated.

Training:
Although Start Right programs are not officially affiliated with HFA, compliance with the HFA Critical Elements is included in the monitoring process. All staff is required to complete HFA training that is specific to their position as family support worker, family assessment worker, or supervisor. Additionally, all program staff must complete Parents as Teachers (PAT) training. Programs are required to be affiliated with Parents as Teachers National Center, Inc. and are required to keep their status current each year.

Technical Assistance/Consultation: The Office of Child Abuse Prevention has two full-time Program Consultants that assist the Start Right Programs and ensure fidelity to the HFA and PAT model as well as adherence to agency standards.

Quality Assurance/Oversight: OCAP Program Consultants monitor contracts in three ways:

1. Review of the quarterly Program Performance Numerical Reports and the bi-annual and annual Program Performance Narrative Reports required of each contractor or county health department during each contract or memorandum of understanding period.
2. An on-site visit conducted by the OCAP program staff to review the contractor's or county health department's documentation demonstrating: a) compliance with the program's approved contract or memorandum of understanding; b) compliance with the "essential features" of a community-based family resource and support program as detailed in the Oklahoma plan for the prevention of child abuse and neglect; and, c) compliance with the Healthy Families America (HFA) Critical Elements.
3. Technical assistance provided by an OCAP program consultant, who will provide resources and expertise in the implementation of quality services as set forth in the program's approved contract or memorandum of understanding.

Evaluation: The Office of Child Abuse Prevention, which oversees the Start Right Programs, is legislatively required to submit an annual report each year to the Governor, Speaker of the House and Senate President Pro Tempore. Specific indicators are mandated to be reported and most are simple process measures such as number of referrals to a given agency, number of families served, etc. Over the years, though, the report has evolved and included more outcome information and highlights success stories. Annual reports can be found on the website at

http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/Office_of_Child_Abuse_Prevention/Publications/index.html

Parents as Teachers: All Oklahoma Parents as Teachers programs are required to follow the program guidelines established by the Oklahoma State Department of Education. Those guidelines are listed below.

School districts must have an enrollment of at least 500 students for the development and operation of a Parent As Teachers (PAT) program. If a district does not have a minimum enrollment of 500 students, the district may partner with other districts to form a consortium whose total combined enrollment are at least 500 students. Districts who receive PAT funds through the State Board of Education, in support of the parent education program legislation 70 O.S. § 10.105.3, shall meet the following program requirements:

21. Provide a 25 percent match of cash or in-kind services.

22. Be operated by the district; or, the district may contract with private, nonprofit corporations or associations or with any public or private agency or institution.

23. Include the following:
    a. Employ parent educator(s). Each parent educator shall complete training and certification through the Parents as Teachers National Center in the *Born to Learn*™ curriculum. It is recommended that each part-time parent educator, working 20 hours per week, serve a maximum of 30 children or each full-time parent educator, working 40 hours per work, serve a maximum of 50 children.
    b. Employ a coordinator if more than one parent educator is required. The coordinator must possess an Oklahoma teaching certificate in early childhood education, elementary education or related field, or a bachelor's degree in early childhood development, nursing, vocational home economics or related field. The coordinator shall complete training and certification through the Parents as Teachers National Center. The coordinator shall serve a minimum of five families if certification is desired; or
    c. Designate a program administrator who is a certified employee of the district and will be responsible for the implementation of the program if a program coordinator is not employed (this applies to programs with only one parent educator who does not function as the program coordinator). The program administrator should attend the informational meeting at the beginning of each program year and participate in the supervisor's training provided through the Parents As Teachers National Center. A maximum of 10 percent (10%) of the grant amount may be used for administrative costs which include salary and fixed charges.

24. Serve families with children under age three (birth to 36 months).

25. Implement the curriculum provided by the Parents as Teachers National Center.

26. Be conducted a minimum of 10 months of the year.

27. Be voluntary and free to families.

28. Conduct monthly personal visits to each parent/family group involved in the program, scheduled at the convenience of the parent/family group (daytime, evening, or weekend).

29. Conduct, at minimum, monthly parent group meetings. Cooperative programs may find it necessary to schedule monthly meetings in more than one location each month.

30. Designate a room or space in an existing room for parenting and child growth and developmental materials for use by parents and children participating in the program.

31. Establish an Advisory Committee.

32. Provide evidence of coordination of services with other community programs that have similar purposes.

33. Be open to all parents in the community with a demonstrated effort to balance participation among various groups through active encouragement of the involvement of first-time parents, teen parents, and at-risk families. [Note: For the MIECHV Grant, priority will be given to the target populations listed in the Grant Guidance.]

34. Conduct developmental screening using the designated instrument, *Ages and Stages Questionnaires* (ASQ), with each child, each year. Screening should occur sometime during the first two visits for age-eligible children.

35. Submit, by established deadlines, monthly statistical reports indicating information about families and children served and other reports or program information as deemed necessary by the Oklahoma State Department of Education to the Child Services Demonstration Center.

36. Provide a detailed midyear expenditure report by February 2012, and a detailed final expenditure report by September 2012.

37. Require at least one representative from the district's program to participate in each of the following:
    a. Informational Meeting
    b. Fall Regional Meeting
    c. Spring Regional Meeting
    d. Family Matters Conference held in conjunction with the Spring Regional Meeting.

One purpose of the Community Advisory Committee is to facilitate collaboration for the coordination of PAT programs and services between the community and the school.
The advisory group is a local school district committee whose membership includes interested citizens representing a variety of community organizations. Members of the committee could include: the Oklahoma Parents As Teachers coordinator; representatives of the local board of education, mental health agencies, social services agencies, Smart Start community representatives, individual and/or agency health care providers, church/ministerial alliances, civic service groups, and PTA/PTO; parents of infants and toddlers, senior adults, higher education personnel, private and public preschool and/or child care directors, and library personnel. If a cooperative of districts is providing the program, the Community Advisory Committee should fairly represent all of the communities to be served.

Additional responsibilities for the Community Advisory Committee include recruiting prospective participants for the program; gathering information from available community resources and serving as a resource to the local program administrator and the Internal Coordinating Committee.

The Internal Coordinating Committee is responsible for PAT program planning, implementation, and evaluation. The committee members develop the steps needed to implement a district wide plan as well as timetables for implementation. Other responsibilities include identifying resources available in the district and community; generating community awareness and a publicity plan; and creating plans for recruiting families with young children.

The Internal Coordinating Committee is a committee comprised of local school district personnel whose membership shares with the parent education program administrator the ongoing responsibility for successful implementation of the program. If a cooperative of districts provides the program, the Internal Coordinating Committee should be composed of representatives of all involved districts. Members of the committee could include: the Oklahoma Parents As Teachers coordinator, an elementary principal(s), pre-kindergarten, kindergarten and/or primary teacher(s), child development and/or adult education teacher(s), guidance counselor(s), school psychologist(s), school nurse, community advocates, parent educators, and teacher(s) of programs for children with developmental delays.

A DISCUSSION OF ANTICIPATED CHALLENGES TO MAINTAINING QUALITY AND FIDELITY AND PROPOSED RESPONSES

Nurse-Family Partnership: A question that has plagued many a home visitation program is how to engage and retain participants for as long as possible so that the participant can maximize the most benefits from their participation. While any length of participation in a home visitation program may be beneficial to some extent, certain "dose/response rate" issues do arise. Most literature shows that the longer a participate remains engaged in a home visitation program, the more positive impact can been quantified. This issue is of keeping the participant enthused about the program is a common one among a variety of models. For this reason, the OSDH anticipates that technical assistance regarding this issue, particularly for Children First, may be necessary.

In January 2011, Children First partnered with Dr. Olds and submitted a grant proposal through the ACA Nurse, Education, Practice, Quality and Retention Program to continue work to address client retention period. The work proposed by this application will be conducted by a consortium of state health departments implementing the NFP model led by the State of Oklahoma and supported by the University of Colorado, College of Nursing.

Healthy Families America: Although the Start Right Programs use the Healthy Families America model, the HFA affiliation/accreditation process has never been completed because of funding limitations. Affiliation is a requirement of the national model developer for the MIECHV Grant. Technical assistance for the affiliation application and completion will be provided by the HFA regional consultant.

Historically, the Start Right Programs were permitted to enroll infants as old as one year. However, the national model developer requires infants to be no more than three months of age at enrollment. HFA does allow twenty-five percent of enrollees to be between three and twelve months of age. The national model developer has approved an adaptation for the Oklahoma MIECHV Program that will allow up to thirty-three percent of enrollees to be between the ages of 3 months and one year.

Parents as Teachers: The only enrollment requirement for PAT programs is the age of the child. In other words, PAT enrollment is based on universal access. Mechanisms will be put in place to assure that priority is given to eligible participants as described in the Supplemental Information Request (SIR). Priority will be given to eligible participants who: have low incomes; are pregnant women who have not attained age twenty-one; 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; are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

<u>Data and information systems</u>: The OSDH has a good deal of experience with data collection and information systems relating to Children First and Start Right Programs. Since 1997, both programs have been collecting and reporting process data and programmatic outcomes. For the MIECHV Program, the Parents as Teachers Program will have to be incorporated into ODSH's data collection system. With three models, a new system for collecting and analyzing data will have to be developed. Common data collection elements and tools will need to be devised. Additionally, the OSDH has limited capacity (limited by the number of staff, not skill) to develop computer programming capable of sophisticated analysis.

<u>Communication and marketing</u>: A most definite need for the home visitation models associated with the MIECHV Program will be a smart, relevant communication and marketing strategy. Because of limited funding and expertise, the OSDH has struggled to promote its own home visitation programs over the years to the potential program participants and communities at large. The OSDH would appreciate technical assistance regarding the best practices for marketing home visitation services.

<u>Outreach to potential program participants</u>: Over the years, the OSDH home visitation programs (Children First and Start Right) have noticed a decline in the percentage of referred persons that are willing to enroll in the programs. It is possible that the Oklahoma Parents as Teachers home visitation programs may be dealing with this issue as well. Different strategies have been put in place to discover the causes and attempt to reverse the trend. However, technical assistance would be useful.

A LIST OF COLLABORATIVE PUBLIC AND PRIVATE PARTNERS

MEMORANDUM OF CONCURRENCE: Signors

The Oklahoma State Department of Health
The Oklahoma State Department of Education
Smart Start Oklahoma: Oklahoma's Partnership for School Readiness
The Oklahoma Department of Human Services
The Oklahoma Department of Mental Health and Substance Abuse Services
The Oklahoma Health Care Authority
Oklahoma Head Start Collaborative
University of Oklahoma Center on Child Abuse and Neglect
Oklahoma Coalition Against Domestic Violence and Sexual Assault
Oklahoma's Child Care and Development Fund
The Oklahoma Advisory Council on Early Childhood Education and Care

ADDITIONAL PARTNERS

Enid Parents as Teachers
Garfield County Health Department
Smart Start Garfield County
Kay County Health Department
Northern Oklahoma Youth Services
Smart Start Kay County
Oklahoma Parents as Teachers: Osage County Interlocal Cooperative
Enid Parents as Teachers
Community Development Support Association
Pioneer- Pleasant Vale parents as Teachers
The Interagency Child Abuse Prevention Task Force
The Home Visitation Leadership Advisory Coalition
Smart Start Oklahoma Board of Directors

ASSURANCES

The Oklahoma State Department of Health assures the following:

- That the State home visiting program is designed to result in participant outcomes noted in the legislation;

- That individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments;

- That the State will comply with the Maintenance of Effort Requirement; and

- That 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;
    - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

IMPROVED MATERNAL AND NEWBORN HEALTH

A. Prenatal care

Proposed Measure: The percent of women who receive adequate prenatal visits.

Definition of Improvement: In Year 1, a process to determine the definition of adequate prenatal visits and to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined the completion of a plan to collect standardized prenatal care data. For subsequent years, improvement will be defined as the relative increase from baseline in the percent of pregnant women receiving adequate prenatal care.

Data Collection and Analysis Plan: Data will be collected at the initial home visit with program participants. Data will be self-reported through personal interviews with pregnant women and will not be confirmed by review of medical or prenatal care records. Information will be collected on Start Right Primary Caregiver Intake Form and Children First (C1) Maternal Health Assessment Form. For the PAT model, a similar collection form will be developed and used to collect this information.

From the C1 Maternal Health Assessment Form, the timing of entry into prenatal care can be determined by the following question (HA7), "How many weeks pregnant were you when you began getting prenatal care for this pregnancy?" The number of weeks and the number of prenatal care visits are captured in the response to the question. The same question is used in the Start Right Primary Caregiver Intake Form (PC22). Data collected on these forms can then be transformed into information reporting the percentage of pregnant women receiving adequate prenatal care. Baseline and ongoing, tracking data can be maintained to monitor progress.

Anticipated Barriers and Challenges: For C1 and Start Right, there are no anticipated barriers and/or challenges to data collection for this construct beyond those routinely evident in the process of collecting program data. For PAT, a new collection process must be implemented. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

B. Parental use of alcohol, tobacco, or illicit drugs

Proposed Measure: The percent of parents participating in the MIECHV program who report any use of alcohol, cigarette, or illicit drugs is the measure. Any use to be defined as current

substance use between home visiting encounters. (1) The percent of clients who report current alcohol use at the time of a home visit encounter. (2) The percent of clients who report current cigarette use at the time of a home visit encounter. (3) The percent of clients who report current illegal drug use at the time of a home visit encounter.

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized substance use data. For subsequent years, improvement will be defined as the relative decrease from baseline in the percent of program clients reporting any use for alcohol, cigarette, or illicit drugs.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. A data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Data from Year 1 will be used to determine baseline measure values for the reduction of substance abuse. The percent of program participants reporting substance use will be computed by enumerating the number of clients with alcohol, cigarette, or illicit drug use and dividing by the total number of clients enrolled in the program. A decrease in the percent of program participants with substance use will be considered improvement. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges include honest reporting of MIECHV program clients. For substance use questions, survey respondents are known to give socially desirable responses. When this occurs, estimates for the rate of substance use are underestimated and biased away from the true rate of usage. Standardized data collection tools must be created to ensure uniform reporting across home visiting programs. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

C. <u>Preconception care</u>

Proposed Measure: The percent of women participating in the MIECHV program who receive preconception training and education based upon the recommendations of the American College of Obstetricians and Gynecologists (ACOG).

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized preconception health data. For subsequent years, improvement will be defined as the relative increase from baseline in the percent of women participating in the program who receive preconception training and education based upon the recommendations of the ACOG quality preconception care.

Data Collection and Analysis Plan: The MIECHV program will develop a series of questions addressing the components of ACOG quality preconception care to include on the C1 Maternal Assessment Form. Likewise, program staff will incorporate developed preconception questions into the Start Right Primary Caregiver Intake Form. Similar form development will be undertaken for the PAT program. These forms will be used to collect data at home visiting encounters that can then be used as an index of quality preconception care. Data will be self-reported through personal interviews.

The derived questions will be framed in such a way that information is gathered on the period of time prior to becoming pregnant in which a health care provider discussed preconception health issues. Subsequent questions will be developed to determine if participants received preconception training and education based upon the recommendations of the ACOG quality preconception care while participating in the home visiting program. Content items to be included in the education and training will be use of folic acid; smoking; alcohol use; body weight; chronic health conditions; immunizations; medication use; sexually transmitted infections; illicit drug use; congenital anomalies or hereditary diseases; mental health; pregnancy history; environmental exposures of toxic substances; family planning and birth control; and nutrition.

Data from Year 1 will be used to determine baseline measure values for the assessment of preconception health. The percent of program participants reporting that they have received preconception care will be computed by enumerating the number of women who received preconception care (education and training) based on ACOG recommendations and dividing by the total number of women enrolled in the program. An increase in the percent of women who have received preconception care (education and training) will be considered improvement. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the revision to existing home visitation data collection forms and structural alteration to databases that serve as repositories for program data. It will be necessary

for MIECHV program staff to consult and work with Information Technology (IT) Services to identify steps to address potential changes.

D. Inter-birth intervals

Proposed Measure: The percent of women participating in the MIECHV program having birth-to-pregnancy interval less than 2 years

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized birth-to-pregnancy interval data. For subsequent years, improvement will be defined as the relative decrease from baseline in the percent of women having a birth-to-pregnancy interval less than 2 years.

Data Collection and Analysis Plan: Data will be collected from MIECHV program participants by using the Children First Demographics Update Forms which enable program staff to identify whether a client has had a pregnancy since the birth of an index child. Similar data will be collected from Start Right Primary Caregiver Intake Form and Primary Caregiver Update Form. Data will be self-reported through personal interviews with women participating in the MIECHV program.

C1, Start Right, and PAT form questions will be used to collect the information needed to determine if women in the program have become pregnant since the birth of the index child. The index child will be determined by the enrollment date. For participating women who have become pregnant since the birth of the index child, using the index child's date of birth and the estimated date of subsequent pregnancy the MIECHV program will derive an estimate for the length of time spanning the birth-to-pregnancy interval. Research indicates that an interval of less than 2 years may be harmful to maternal and infant health. Among those women with a subsequent pregnancy, the percent of women with a short birth interval (i.e., less than 2 years) will be calculated.

Data from Year 1 will be used to determine baseline measure values for the assessment of birth-to-pregnancy interval. The percent of women with short birth-to-pregnancy interval will be computed by enumerating the number of women with a pregnancy within 2 years since the birth of the index child and dividing by the total number of women with a pregnancy enrolled in the program. A decrease in the percent of women having a birth-to-pregnancy interval less than 2 years will be considered improvement with preconception care. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the ambiguity (or bias) related to identifying the conception date for a subsequent pregnancy. Women may not be able to report exactly when conception occurred. As a result, the calculated birth-to-pregnancy intervals may be biased by recall error. Standardization of data collection must be implemented across the home visitation programs.

E. <u>Screening for maternal depressive symptoms</u>

Proposed Measures: The number of women participating in the MIECHV program who are screened for depressive symptoms

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of data for women screened for depressive symptoms. For subsequent years, improvement will be defined as the relative increase from baseline in the number of women who are screened for depressive symptoms.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. A data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Data from Year 1 will be used to determine baseline measure values for the assessment of the number of women screened for depression. An increase in the number of women screened for depressive symptoms will be an indicator for improvement. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the revision of existing home visitation data collection forms and structural alteration to databases that serve as repositories for program data. It will be necessary for MIECHV program staff to consult and work with Information Technology (IT) Services to identify steps to address potential changes.

F. <u>Breastfeeding</u>

Proposed Measures: The percent of women in the MIECHV program who initiate breastfeeding

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized prenatal care data. For subsequent years, improvement will be defined as the relative increase from baseline in the percent of women who initiate breastfeeding of their infants.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. Information will be collected on the Children First Demographics Form #401 at first home visit and the Children First Demographics Update Forms which updates client information at 6, 12, 18, and 24 months post-enrollment. On the Start Right Child Health Form which is completed at 2nd visit after enrollment or birth of child and at 6-month intervals, respectively. Forms for the PAT model will be adapted such that there is standardization collection across the home visitation models.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the standardization of program forms. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

G. Well-child visits

Proposed Measures: The percent of children receiving well-child visits according to the schedule as recommended by American Academy of Pediatrics

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized well-child visits data. For subsequent years, improvement will be defined as the relative increase from baseline in the percent of children receiving well-child visits as recommended by AAP well-child visit schedule.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. Information will be collected on the Children First Demographics Form at first home visit and the Children First Demographics Update Forms which updates client information at 6, 12, 18, and 24 months

post-enrollment. On the Start Right Child Health Form which is completed at 2nd visit after enrollment or birth of child and at 6-month intervals, respectively. As needed, PAT program forms will be adapted to conform to a standardized data collection procedure.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the revision to existing home visitation data collection forms and structural alteration to databases that serve as repositories for program data. It will be necessary for MIECHV program staff to consult and work with Information Technology (IT) Services to identify steps to address potential changes.

H. Maternal and child health insurance status

Proposed Measures: (1) The percent of women participating in the MIECHV program who have health insurance (2) The percent of children participating in the MIECHV program who have health insurance

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized health insurance data. For subsequent years, improvement will be defined as the relative increase from baseline in the percent of pregnant women and children having health insurance.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. Insurance information for mothers will be collected on the Children First Demographics Form at first home visit and the Children First Demographics Update Forms which updates client information at 6, 12, 18, and 24 months post-enrollment. On the Start Right Primary Caregiver Health Form and the Start Right Primary Caregiver Update Form which are completed at enrollment and at 6-month intervals, respectively. For children, health insurance status will be collected by way of Children First Demographics Update Form and Start Right Child Health Form. As needed, PAT program forms will be adapted to conform to a standardized data collection procedure.

Form questions from C1 Demographics Forms and Start Right Primary Caregiver Forms will be used to collect the information needed to determine if women in the MIECHV program have health insurance. For participating women, they will report health insurance status by responding to the question, “Do you have health care insurance that covers your health expenses?” A binary response is recorded as “Yes/No”. Changes in health insurance status can

be monitored over time with repeated completion of C1 Demographics Update Forms and Start Right Primary Caregiver Update Forms. In C1, on the Demographics Update Form – 24 Months, clients report current health insurance status of children at age 24 months by responding to the question, “Does your child currently have health insurance?” Response options are “Yes/No”. The same question is used in Start Right with the Child Health Form, which is completed at the 2nd home visit from birth/enrollment and at 6-month intervals in accordance with child’s age.

Data from Year 1 will be used to determine baseline measure values for the assessment of health insurance of program participants. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for this construct include the revision to existing home visitation data collection forms and structural alteration to databases that serve as repositories for program data. It will be necessary for MIECHV program staff to consult and work with Information Technology (IT) Services to identify steps to address potential changes.

CHILD INJURIES, CHILD ABUSE, NEGLECT, OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT VISITS

A. Visits for children to the emergency department from all causes

Proposed Measure: The change in ratio of ER visits for children participating in the MIECHV program between 6 months and 12 months of enrollment/birth

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America program), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. For Year 1, improvement is defined as having an increase in the collection of Emergency Room data for participating children. After Year 1, improvement shall be defined as a decrease in the ratio of ER visits to children in program.

Data Collection and Analysis Plan: Data will be collected at 6 months (baseline) and 12 months of enrollment/birth. Data are collected by personal interview with parent or guardian of child during home visit sessions. Data are not confirmed by medical records but are a self-report measure. Information is collected on the Infant Health Care forms for C1 (6 and 12 months and the Child Health Form for Start Right) based on self-reports. PAT will be using the same form as Start Right. All home visitors will be trained on the collection of this form Year 1 information will be used to determine benchmark measures for the reduction of emergency room visits for all causes for participating children. A total number of ER visits and children will be calculated and ratios determined for each time period. Changes in the ratio of ER visits to children will be calculated by subtracting the ratio at 6 months from the ratio at 12 months. A negative change would be considered improvement. All information will be aggregated at a state-level and analyzed with demographic covariates collected from enrollment forms. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1 or Start Right. This will be a new data collection process for PAT. Additional training may be required to ensure proper collection of this measure.

B. Visits for mothers to the emergency department from all causes

Proposed Measure: The percent of mothers with emergency room visits for all causes as indicated by the completion of a designated form
Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. This will be a new data collection process for all programs. For Year 1, improvement is defined as having an increase in the collection of data regarding emergency room visits among participating mothers. After Year 1, improvement shall be defined as a decrease in the ratio of ER visits to mothers in program.

Data Collection and Analysis Plan: Data will be collected at enrollment, birth of child (if applicable), 6 months of enrollment/birth, and 12 months of enrollment/birth. Data are collected by personal interview with participating mother or primary caregiver during home visit sessions. Data are not confirmed by medical records but are a self-report measure. Information is collected on the designated form with emergency room visit information. Year 1 information will be used to determine benchmark measures for the reduction of emergency room visits for all causes for participating mothers. A total number of ER visits and mothers will be calculated and ratios determined for each time period. Changes in the ratio of ER visits to mothers will be calculated by subtracting the ratio at 6 months from the ration at 12 months. A negative change would be considered improvement. All information will be aggregated at a state-level and analyzed with demographic covariates collected from enrollment forms. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark, however, this will be a new data collection process for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

C. Information provided or training of participants on prevention of child injuries

Proposed Measure: The percent of participants who receive education and training on topics related to preventing child injuries (Family Safety Topics)

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. For Year 1, improvement is defined as having an

increase in the collection of data regarding participants who receive education and training on topics related to preventing child injuries (Family Safety Topics). After Year 1, improvement shall be defined as an increase in the percentage of participants who receive education and training on topics related to preventing child injuries.

Data Collection and Analysis Plan: Information is collected at home visits with program home visitation staff. The measure is based on topics that are covered during home visits. Information the family has on the specified topic (family safety) will be determined by 1 month post-enrollment (baseline), and 6 months and 12 months post-enrollment/birth. An increase in percentage will be calculated between these time points by program and at the state-level and analyzed with demographic covariates collected from enrollment forms. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1 or Start Right. This will be a new data collection process for PAT. Additional training may be required to ensure proper collection of this measure.

D. Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)

Proposed Measure: The rate of suspected maltreatment for children participating in the program

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. For Year 1, improvement is defined as having an increase in the timely reporting of enrollment and/or child birth forms. After Year 1, improvement shall be defined as a decrease in the rate of suspected maltreatment for children participating in the program.

Data Collection and Analysis Plan: Program participant identifying information will be matched with Oklahoma Department of Human Services data. Data will be linked at the end of each State Fiscal Year. Program participant information is based on program enrollment forms. DHS data is collected based on maltreatment, abuse and neglect reports. A total number of maltreatment reports will be calculated for each state fiscal year and then divided by the number of children in the program. All information will be aggregated at a state-level and analyzed with

demographic covariates. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark as a MOU is already in the process of being renewed with OKDHS for the data linkage.

E. Reported substantiated maltreatment (substantiated/ indicated/ alternative response victim) for children in program

Proposed Measure: The rate of substantiated maltreatment for children participating in the program

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. For Year 1, improvement is defined as having an increase in the timely reporting of enrollment and/or child birth forms. After Year 1, improvement shall be defined as a decrease in the rate of substantiated maltreatment for children participating in the program.

Data Collection and Analysis Plan: Program participant identifying information will be matched with Oklahoma Department of Human Services data. Data will be linked at the end of each State Fiscal Year. Program participant information is based on program enrollment forms. DHS data is collected based on maltreatment, abuse and neglect reports. A total number of maltreatment reports will be calculated for each state fiscal year and then divided by the number of children in the program. All information will be aggregated at a state-level and analyzed with demographic covariates. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark as a MOU is already in the process of being renewed with OKDHS for the data linkage.

F. First-time victims of maltreatment for children in the program

Proposed Measure: The rate of first-time victims of maltreatment among program participants

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. For Year 1, improvement is defined as having an increase in the in the timely reporting of enrollment and/or child birth forms. After Year 1, improvement shall be defined as a decrease in the rate of first-time victims of maltreatment among program participants.

Data Collection and Analysis Plan: Program participant identifying information will be matched with Oklahoma Department of Human Services maltreatment, abuse and neglect data. Data will be linked at the end of each State Fiscal Year. Program participant information is based on program enrollment forms. DHS data is collected based on maltreatment, abuse and neglect reports. First-time victim shall be defined as a child who: 1) had a maltreatment disposition of "victim" and 2) never had a prior disposition of victim. A total number of first-time victims will be calculated for each state fiscal year and then divided by the number of children in the program. All information will be aggregated at a state-level and analyzed with demographic covariates. T-tests will be performed to discover differences between program settings.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark as a MOU is already in the process of being renewed with OKDHS for the data linkage.

See Data Sharing Agreement DRAFT at the end this section.

SCHOOL READINESS AND ACHIEVEMENT

A. Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)

Proposed Measure: Program participant scores on the Developmental and Educational Care Question (Question H) from the Child Well Being Scale

Definition of Improvement: This will be a new data collection process for all three program models. Year 1 definition of improvement is the completion of a plan to collect data on the Child Well Being Scale in support of achieving baseline data. After Year 1, definition of improvement will be defined as a decrease in scores on the Developmental and Educational Question (Question H) from the Child Well Being Scale.

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as one month post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected during home visits using self-report. Information will be used to determine benchmark measures for condition of home environment and parental support.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training will be required to ensure proper collection of this measure.

B. Parent knowledge of child development and of their child's developmental progress

Proposed Measure: Program participant scores on the Parental Expectations of Children Question (Question O) from the Child Well Being Scale

Definition of Improvement: This will be a new data collection process for all three program models. Year 1 definition of improvement is the completion of a plan to collect data on the Child Well Being Scale in support of achieving baseline data. After Year 1, definition of improvement will be defined as a decrease in scores on the Parental Expectations of Children Question (Question O) from the Child Well Being Scale.

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at

baseline and 1 year post-enrollment/birth. Baseline is defined as one month post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected during home visits using self-report. Information will be used to determine benchmark measures for condition of home environment and parental support.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

C. Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)

Proposed Measure: Program participant scores on the Parental Positive Interactions with Child Question (Question L), Parental Discipline (Question M), Parental Use of Clear Rules and Limit Setting (Question N), and Parental Consistency of Discipline (Question P) from the Child Well Being Scale

Definition of Improvement: This will be a new data collection process for all three program models. Year 1 definition of improvement is the completion of a plan to collect data on the Child Well Being Scale in support of achieving baseline data. After Year 1, definition of improvement will be defined as a decrease in summary scores from the Child Well Being Scale subscales.

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as one month post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected during home visits using self-report. Information will be used to determine benchmark measures for condition of home environment and parental support.

Anticipated Barriers and Challenges: This will be a new data collection process for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

D. Parent emotional well-being or parenting stress

Proposed Measure: Program participant scores on the Parental Distress Question (Question S), Caregiver-Partner Conflict (Question T), and Caregiver-Partner Control Issues (Question U) from the Child Well Being Scale

Definition of Improvement: This will be a new data collection process for all three program models. Year 1 definition of improvement is the completion of a plan to collect data on the Child Well Being Scale in support of achieving baseline data. After Year 1, definition of improvement will be defined as a decrease in summary scores from the Child Well Being Scale subscales.

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as one month post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected during home visits using self-report. Information will be used to determine benchmark measures for condition of home environment and parental support.

Anticipated Barriers and Challenges: This will be a new data collection process for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

E. <u>Child's communication, language and emergent literacy</u>

Proposed Measure: Program participant scores on communication area

Definition of Improvement: Develop a process to collect data using the Ages and Stages Questionnaire (ASQ-3)

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as one to three months (the age range for appropriate administration of the 2 month ASQ-3) post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected as appropriate for the administration of the ASQ-3 during home visits using self-report. Information will be used to determine benchmark measures for child communication, language and emergent literacy.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

F. Child's general cognitive skills

Proposed Measure: Program participant scores on problem solving area

Definition of Improvement: Develop a process to collect data using the Ages and Stages Questionnaire (ASQ-3)

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as one to three months (the age range for appropriate administration of the 2 month ASQ-3) post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected as appropriate for the administration of the ASQ-3 during home visits using self-report. Information will be used to determine benchmark measures for child problem solving and general cognitive skills.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

G. Child's positive approaches to learning including attention

Proposed Measure: Program participant scores on self-regulation and compliance areas

Definition of Improvement: Develop a process to collect data using the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as 3-8 months post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected as appropriate for the administration of the ASQ:SE during home visits using self-report. Information will be used to determine benchmark measures for child attention and approaches to learning.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

H. Child's social behavior, emotion regulation, and emotional well-being

Proposed Measure: Program participant scores on adaptive behaviors, autonomy, affect, and interaction with people subscales

Definition of Improvement: Develop a process to collect data using the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and 1 year post-enrollment/birth. Baseline is defined as 3-8 months post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected as appropriate for the administration of the ASQ:SE during home visits using self-report. Information will be used to determine benchmark measures for child attention and approaches to learning.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

I. Child's physical health and development

Proposed Measure: Program participant scores on gross motor and fine motor areas

Definition of Improvement: Develop a process to collect data using the Ages and Stages Questionnaire (ASQ-3)

Data Collection and Analysis Plan: Subscale scores will be combined for each participant and analyzed with demographic covariates by program and statewide. Data will be collected at baseline and one year post-enrollment/birth. Baseline is defined as one to three months (the age range for appropriate administration of the 2 month ASQ-3) post-birth for clients with pre-natal enrollment or one-month post-enrollment for clients with children enrolling in the program after the child is one-month of age. Data are collected as appropriate for the administration of the ASQ-3 during home visits using self-report. Information will be used to determine benchmark measures for child attention and approaches to learning.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

Other Data Related Items

Reliability and Validity:
Child Well Being Scale – The Child Well Being Scale is a modified scale based on the Magura and Moses Child Well Being Scale. The original scale showed good internal consistency (correlations ranging from .70-.88) and concurrent validity (canonical correlation = .72)[1]. Additional subscales were included to cover caregiver conflict with partner issues, caregiver communication and family involvement.

ASQ-3 - The Ages and Stages Questionnaire-3 has undergone reliability and validity testing[2]. Test-retest reliability correlations ranged from .75 to .82 showing good retest among parents. Inter-observer reliability correlations ranged from .43 to .69 showing agreement between parents and examiners. The ASQ-3 has tested to be internally consistent across the developmental scores with Cronbach alphas ranging from .51 to .87. Comparison of the ASQ-3 and a standardized test showed the ASQ-3 to have 86.1% sensitivity and 85.6% specificity indicating the ASQ-3 will appropriately indicate children with developmental delays.

ASQ:SE - The Ages and Stages Questionnaire: Social-Emotional has undergone reliability and validity testing[3]. The ASQ:SE has tested to be internally consistent across the developmental scores with Cronbach alphas ranging from .67 to .91. Comparison of the ASQ:SE and a standardized test showed the ASQ:SE to have an overall sensitivity of 78.0% (70.8%-84.6%) and overall specificity of 94.5% (89.5%-98.2%) indicating the ASQ:SE will appropriately indicate children with social-emotional developmental delays.

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[1] Gaudin, J.M., Polansky, N.A., and Kilpatrick, A.C. (1992). The child well-being scales: A field trial. *Child Welfare,LXXI,*319-328.
[2] Squires, J., Twombly, E., Bricker, D., Potter, L. (2009). *Psychometric Studies of ASQ, Third Edition: Excerpt from ASQ-3 Users Guide.* Paul H. Brookes Publishing Co. Inc. Accessed on May 19, 2011 from http://www.brookespublishing.com/store/books/squires-asq/asq3-technical.pdf.
[3] *Technical Report on ASQ:SE.* Paul H. Brookes Publishing Co. Inc. Accessed on May 19, 2011 from http://www.brookespublishing.com/store/books/squires-asqse/ASQ-SE_TechnicalReport.pdf.

CRIME OR DOMESTIC VIOLENCE

A. Screening for domestic violence

Proposed Measure: The number of participants completing the relationship assessment form at intake

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. Improvement shall be defined as an increase in the percentage of participants completing the relationship assessment form per program protocol.

Data Collection and Analysis Plan: Data will be collected at enrollment and 12 months post-enrollment/birth. Data are collected by personal interview with mother during home visit sessions. Data are not confirmed by medical records but are a self-report measure. Information is collected on the Relationship Assessment Form. A total number of relationship assessment forms will be calculated at each time point and divided by the number of program participants to obtain the percentage of participants screened for domestic violence.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark for C1 or Start Right. This will be a new data collection process for PAT. Additional training may be required to ensure proper collection of this measure.

B. Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries, etc.)

Proposed Measure: The rate of referrals made to relevant domestic violence services within one year

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as Teachers (PAT). The collection process must be established with the PAT model to ensure common data across all three programs. Year 1 Improvement shall be defined as an increase in the percentage of program staff completing the service utilization form per program protocol.

After Year 1, improvement shall be defined as an increase in the rate of referrals made to relevant domestic violence services.

Data Collection and Analysis Plan: Data will be collected at every home visit based on the Service Utilization Form. Data are collected by personal interview with participating mother during home visit sessions. A total number of referrals will be calculated for each client identified for the presence of domestic violence on a yearly basis. A rate will be calculated based on the number of total participants identified with the need for domestic violence services.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark. This will be a new data collection process for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

C. Of families identified for the presence of domestic violence, number of families for which a safety plan was completed

Proposed Measure: The rate of safety plans created within one year

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. This is a new process for Children First (NFP) program, Start Right (Healthy Families America), and Parents as Teachers (PAT). The collection process must be established to ensure common data across all three programs. Year 1 Improvement shall be defined as an increase in the percentage of participants completing a safety plan. After Year 1, improvement shall be defined as an increase in the rate of safety plans created.

Data Collection and Analysis Plan: Data will be collected at every home visit based on the safety plan. Data are collected by personal interview with participating mother during home visit sessions. A total number of created safety plans will be calculated for each client identified for the presence of domestic violence on a yearly basis. A rate will be calculated based on the number of total participants identified with the need for domestic violence services.

Anticipated Barriers and Challenges: No anticipated barriers or challenges are foreseen with this benchmark. This will be a new data collection process for C1, Start Right, and PAT. Additional training may be required to ensure proper collection of this measure.

FAMILY ECONOMIC SELF-SUFFICIENCY

A. Household income and benefits

Proposed Measures: The aggregated value of household income and benefits recorded for MIECHV program participants

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized household income and benefits data. For subsequent years, improvement will be defined as an increase from baseline in the amount of household income and benefits, documented for each adult household member.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. A data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Data from Year 1 will be used to determine baseline measure values for the assessment of household income and benefits for adults living in the home. The aggregated value of household income and benefits will be computed by totaling each household member's contribution and its source. An absolute increase in the aggregated value of household income and benefits will be considered improvement. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for these constructs include the development of new form items that query program participants about the income and benefits and their associated sources for each adult member of the household. Revision of forms and changes in the structure of databases will be necessary to accommodate these data elements. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

B. Employment or education of adult members of the household

Proposed Measures: (1) The number of adult household members employed during the month prior to the home visit. (2) The average number of hours per month worked by each adult

household member. (3) The number of adult household members enrolled in an educational program. (4) The number of adult household members who have completed a high school degree

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized employment and education data. For subsequent years, improvement will be defined as an increase from baseline in the (1) number of adult household members employed during the month prior to the home visit; (2) average number of hours per month worked by each adult household member; (3) number of adult household members enrolled in an educational program; (4) number of adult household member having completed a high school degree.

Data Collection and Analysis Plan: For mothers enrolled in the MIECHV program, education data will be collected on the Children First Demographics Form and on the Start Right Primary Caregiver Intake Form. Plans will be developed to collect this education information for adults residing in the household. For employment data, plans will be developed to gather this information from participants in the MIECHV program.

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for these constructs include the development of new form items that query program participants about the employment and education activities for adult household members. Revision of forms and changes in the structure of databases will be necessary to accommodate these data elements. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

C. <u>Health insurance status</u>

Measures and data collection and analysis procedures for health insurance status under Family Economic Self-Sufficiency are identical to those reported for maternal and child health status under Maternal and Child Health.

Proposed Measures: (1) The percent of women participating in the MIECHV program who have health insurance (2) The percent of children participating in the MIECHV program who have health insurance

Definition of Improvement: In Year 1, a process to collect data for this measure will be implemented. These data will serve as baseline information from which improvement in subsequent years can be assessed. Steps will be taken to ensure that the Children First (NFP) program, the Start Right (Healthy Families America) program, and the Parents as Teachers (PAT) program collect these data in a uniform manner. In Year 1, improvement will be defined as an increase across program models in the collection of standardized health insurance data. For subsequent years, improvement will be defined as the relative increase from baseline in percent of adults enrolled in the MIECHV program who have health insurance.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. Insurance information for mothers will be collected on the Children First Demographics Form #401 at first home visit and the Children First Demographics Update Forms #448 and #463 which updates client information at 6, 12, 18, and 24 months post-enrollment. On the Start Right Primary Caregiver Health Form #131 and the Start Right Primary Caregiver Update Form #353N which are completed at enrollment and at 6-month intervals, respectively. For children, health insurance status will be collected by way of Children First Demographics Update Form #463 and Start Right Child Health Form #353J. As needed, PAT program forms will be adapted to conform to a standardized data collection procedure.

Form questions from C1 Demographics Forms and Start Right Primary Caregiver Forms will be used to collect the information needed to determine if women in the MIECHV program have health insurance. For participating women, they will report health insurance status by responding to the question, "Do you have health care insurance that covers your health expenses?" A binary response is record as "Yes/No". Changes in health insurance status can be monitored over time with repeated completion of C1 Demographics Update Forms and Start Right Primary Caregiver Update Forms. In C1, on the Demographics Update Form – 24 Months, clients report current health insurance status of children at age 24 months by responding to the question (DM36), "Does your child currently have health insurance?" Response options are "Yes/No". The same question is used in Start Right with the Child Health Form #353J, which is completed at the 2nd home visit from birth/enrollment and at 6-month intervals in accordance with child's age.

Data from Year 1 will be used to determine baseline measure values for the assessment of health insurance of program participants. Data will be aggregated at the state-level and analyzed by demographic characteristics and for changes over time.

Anticipated Barriers and Challenges: There are no anticipated barriers and/or challenges to data collection for this construct beyond those routinely evident in the process of collecting

program data. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

A. Number of families identified for necessary services

Proposed Measure: The percent of families participating in the MIECHV program screened for identification of a need for necessary services

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years as a comparison for improvement. Although some data on referrals has been collected, C1, Start Right, and PAT have not collected data on number of families screened for necessary services. Since this is new, the collection process must be established to ensure common data collection across all three programs. Year 1 improvement shall be defined as an increase across program models in the collection of screening data to identify families that have a need for necessary services. After Year 1, improvement shall be defined as an increase in the percentage of participants that are screened for identification of necessary services.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. A data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for these constructs include the development of new form items that query program participants about their needs for necessary services. Revision of forms and changes in the structure of databases will be necessary to accommodate these data elements. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

B. Number of families that required services and received a referral to available community resources

Proposed Measure: The percent of families participating in the MIECHV program that required services and received a referral to available community resources

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years to be compared to for improvement. While this is not a new data collection process for Children First (NFP) program or Start Right (Healthy Families America), it is a new process for Parents as

Teachers (PAT). The collection process must be established to ensure common data common data across the three programs. For Year 1, improvement is defined as having an increase across program models in the collection of data on the number of families that received a referral to available community resources. After Year 1, improvement shall be defined as an increase in the numbers of families that required services and received a referral to available community resources.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. Information will be collected on Children First and Start Right Service Utilization Forms. The data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for these constructs include the development and/or revision of form items regarding the number of families that required services and received a referral to available community resources. Revision of forms and changes in the structure of databases will be necessary to accommodate these data elements. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

C. MOU's: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community

Proposed Measure: An increase in the number of formal agreements with other social service agencies at the state level or in the communities chosen for implementation of the MIECHV Program

Definition of Improvement: There has been a Memorandum of Understanding between the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (DHS). This agreement has expired and will need to be renewed. This single agreement will be considered to be a baseline of one that will be used for comparison to indicate improvement. Improvement for Year 1, and subsequent years, shall be defined as an increase in the number of Memoranda of Understanding or other formal agreements with other social service agencies at the state level or in the communities chosen for implementation of the MIECHV Program.

Data Collection and Analysis Plan: The total number of Memoranda of Understanding or other formal agreements with other social service agencies at the state level or in the communities chosen for implementation of the MIECHV Program will be reported.

Anticipated Barriers and Challenges: Anticipated Barriers and Challenges include the complexity and variation in procedures required by different agencies to formalize agreements or generate Memoranda of Understanding. As a result, this is often a lengthy, time-consuming process.

D. Information sharing: 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

Proposed Measure: An increase in the number of social services agencies that engage in regular sharing of information with the home visiting provider

Definition of Improvement: None of the existing community programs has a system for regular sharing of information between the home visiting providers and other social services agencies. For Year 1, improvement is defined as developing a clear point of contact among home visiting providers and other social services agencies that includes regular sharing of information. For subsequent years, improvement will be defined as increasing the number of social services agencies that engage in regular sharing of information with the home visiting provider.

Data Collection and Analysis Plan: Establishment of a clear point of contact among home visiting providers and other social services agencies that includes regular sharing of information will be reported. Data will be collected on the total number of social services agencies that engage in regular sharing of information with the home visiting provider.

Anticipated Barriers and Challenges: Overcoming individual concerns about territorial issues, personality conflicts, confidentiality, and/or trust issues are possible barriers and challenges. Time limitations and time-management for home visitors may also be a barrier and challenge.

E. Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided)

Proposed Measure: An increase in the percentage of families with completed referrals

Definition of Improvement: The process to obtain data on this indicator will be put into place during Year 1. This data will then be used as baseline information for future years as a comparison for improvement. Although some data on referrals has been collected for C1, Start Right, and PAT have not collected data on the percentage of families with referrals for which receipt of services can be confirmed. Since this is new, the collection process must be established to ensure common data collection across all three programs. Year 1 improvement

shall be defined as an increase across program models in the collection of data on the percentage of families with referrals for which receipt of services can be confirmed. After Year 1, improvement shall be defined as an increase in the data on the percentage of families with referrals for which receipt of services can be confirmed.

Data Collection and Analysis Plan: Program staff will collect data at home visiting encounters with program participants. Data will be self-reported through personal interviews. A data collection plan will be developed in Year 1 to assure that standardized, uniform data will be collected across home visiting models (NFP, HFA, and PAT).

Anticipated Barriers and Challenges: Anticipated barriers and/or challenges to data collection for these constructs include the development and/or revision of form items regarding the number of completed referrals. Revision of forms and changes in the structure of databases will be necessary to accommodate these data elements. Review of data collection procedures and data entry process will be conducted to assure high standard for data quality.

OTHER ADDITIONAL DATA-RELATED ITEMS

Confidentiality: To ensure confidentiality, the program and OSDH protocols will be followed. All instruments with identifying information will be kept in a secure environment within the program office. All report forms and computer equipment will be kept in a locked cabinet/office with limited access. All data will be aggregated to the program or state-level and will not be released at an individual level.

Participation in Program: Program participants will be protected on multiple levels. Participation in the program is voluntary. All participants are advised (via informed consent and verbal exchange) that participation is voluntary; they may refuse to participate in program activities, skip questions they are uncomfortable answering and/or quit the program at any time. Any data collected on participants prior to removal from the program may be used for evaluation purposes, but will not be reported on an individual basis. Program staff will immediately complete the form to update the status of any client that has withdrawn from the program.

Data Analysis Staff: Data will be analyzed by the Community Development Service (CDS) Epidemiologist and the Maternal and Child Health Assessment statistics staff. The CDS Epidemiologist has a PhD in Educational Psychology with a focus on Educational Statistics. MCH Assessment staff are Masters-trained bio-statisticians and epidemiologists.

Data Security: All information will be entered into a secure web-based or secure networked system. Both systems require a unique user ID and password for entry. All information is stored on a secured server within the Oklahoma State Department of Health and backed up in a secure off-site location.

Continuous Quality Improvement: Data collected by the Oklahoma MIECHV staff will be examined on a continuous to ensure high quality data collection and entry. Staff will also ensure timely reporting is taking place and benchmark measures are being addressed. Analytics staff will work with program staff to address issues as they arise and provide potential training topics for improving data collection and entry. For additional quality improvement processes and information, please see section 7.

Oklahoma Department of Human Services
Service Agreement

THIS AGREEMENT, which shall be interpreted pursuant to the laws of the State of Oklahoma, is made and entered into by the Oklahoma Department of Human Services (hereinafter OKDHS), and **the Oklahoma State Department of Health, Family Support & Prevention Services, 1000 NE 10th Street, Oklahoma City, OK 73104** (hereinafter OSDH).

WHEREAS, the OKDHS, finds that access to information from the OKDHS Children and Family Services Division (hereinafter Division) would assist in obtaining data regarding the trauma suffered by victims of child abuse and neglect.

WHEREAS, the OKDHS, pursuant to Title 10 of the Oklahoma Statues, is empowered to investigate child abuse and neglect and to provide for the care and custody of children adjudicated deprived.

NOW, THEREFORE, IT IS AGREED BY AND BETWEEN THE PARTIES:

A. PROVISION OF INFORMATION BY THE OKDHS

As the Children First program and the Office of Child Abuse Prevention at the Oklahoma State Department of Health maintain a goal to prevent child abuse, the process of sharing data on child abuse and neglect records with OKDHS is vital to the continued effective implementation of these programs. This agreement to share data between OSDH and OKDHS for the purpose of examining child abuse occurrence among participating program clients is a high priority. Thus, the two herein establish a standing agreement to collaborate on sharing of data on an annual basis.

1. The OKDHS shall provide select information on children who have participated in the Children First Program, a nurse home visiting service following the Nurse-Family Partnership model for first-time parents. The information will be based on data that is matched from a file provided to OKDHS by OSDH with specific elements to be specified in #3 below. (Attachment 1)

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2. The OKDHS shall provide select information on children involved in The Office of Child Abuse Prevention (OCAP) that are funded by the Child Abuse Prevention (CAP) Fund. The OCAP programs utilize the Prevent Child Abuse America's Healthy Families America (HFA) approach to voluntary home visitation using the Parents As Teacher curriculum combined with center-based services. The information will be based on data that is matched from a file provided to OKDHS by OSDH with specific elements to be specified in #3 below. (Attachment 2)

3. In consideration of the OSDH duties and obligations herein, the OKDHS agrees to complete a data match on client information provided by OSDH regarding the above cited children (#1 and #2 above) for the time frame beginning July 1, 2009 and ending June 30, 2010 with the provision for two additional years of data, collected during state fiscal years 2011 and 2012. Children will considered to be matched if they have the same first three letters of their first name, the same first three letters of their last name, and the same date of birth. Where possible, matches can be verified using address and/or mother's identity (first name, last name, and date of birth).

4. OKDHS will return the following information on matching clients:
   a. Number of reports of abuse and neglect, dates and reporting sources
   b. The child's age at the time of the report
   c. The child's gender and race/ethnicity
   d. Child's county of residence
   e. Information on the perpetrator, including relationship to the child, race/ethnicity, gender and age
   f. Category of maltreatment, (neglect, emotional or physical abuse, sexual abuse) and type of maltreatment (type of neglect, type of physical abuse, type of injury, and type of sexual abuse)
   g. Result of the report (disposition of investigation and investigation results, assessment, confirmation, removals, and other pertinent findings or results – for example: court intervention)

Information will be provided in the following 5 comma delimited files unless modified after further discussion. Parentheses are used below to indicate which of the above is addressed by each file:

1. CHRFLINK.CSV – This file is a cross reference file that will link an input row id to 1 or more matching referrals. (**Doing a count of referral id by row id should provide data for 4a above).** This file contains:
   a. Original Row Id
   b. Referral Id.

2. CHREFER.CSV – This file contains all the matching referrals. Each matching referral is listed once. This file contains:

   a. Referral Id
   b. Case Id
   c. Referral Date
   d. Completion Date
   e. Referral Type (Screen Out, Investigation, Assessment)
   f. Type of Person that Reported the Referral
   g. County of Investigation **(4d above)**

3. CHALLEG.CSV – This file contains a summary of the allegations associated with the Referrals in CHREFER.CSV. If one perp was alleged to have 3 abuse, 1 neglect and 2 sexual abuse allegations, a row in this table would show the highest ranked finding for each category. This file contains:

   a. Referral Id
   b. Victim Id
   c. Perp Id
   d. Relationship
   e. Abuse Flag **(4f above)**
   f. Abuse Finding **(4g above)**
   g. Neglect Flag **(4f above)**
   h. Neglect Finding **(4g above)**
   i. Sexual Abuse Flag **(4f above)**
   j. Sexual Abuse Finding **(4g above)**

4. CHVCTM.CSV – This file contains identifying information about Victims **(4c above)**.

   a. Victim Id
   b. Victim DOB **(using this and the referral date, one can compute 4b above)**
   c. Victim Gender
   d. Victim Race (primary or all, what about Hispanic?)
   e. Victim SSN
   f. Victim Name

5. CHPERP.CSV – This file contains identifying information about Perpetrators **(4e above)**.

   a. Perpetrator Id
   b. Perpetrator DOB
   c. Perpetrator Gender
   d. Perpetrator Race/Ethnicity
   e. Perpetrator SSN
   f. Perpetrator Name

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B. SERVICES PROVIDED BY OSDH

In consideration of the OSDH duties and obligations herein, the OSDH agrees to:

a. Provide OKDHS with two electronic files (one for Children First and one for OCAP) regarding clients discussed in Section A (1 & 2) with information such as name, date of birth, gender, etc. in order for OKDHS to complete a match and return agreed upon data. OSDH will provide the lists of children served in the Start Right and Children's First programs by August 1 of each year for the previous fiscal year.

b. Provide copies of all reports resulting from the information provided through this agreement.

C. CONFIDENTIAL INFORMATION

The OSDH personnel shall have access to above specified private data maintained by the OKDHS to the extent necessary to carry out its responsibilities under this agreement. OSDH personnel are the responsible authority in charge of all data collected, used, or disseminated by the OSDH in connection with the performance of this agreement. OSDH agrees that its employees will not at any time or in any manner, either directly or indirectly, use any information for the benefit of the OSHD or divulge, disclose, or communicate in any manner any information to any third party except as aggregate data. The OSDH accepts responsibility for providing adequate supervision and training to ensure compliance with the Privacy Act of 1974 (Public Law 93-579), (5 U.S.C. 552a). No private or confidential data collected, maintained or used in the course or performance of this contract shall be disseminated other than for the specified research purposes, either during the period of this agreement or thereafter. Only summary data will be used in any reports. Identifying information is not included in any document generated for research and all information in any format, including originals and copies, shall be completely, permanently, and irretrievably destroyed upon completion of the research.

The OSDH agrees to maintain the data in a secure manner compatible with their content and use. The OSDH will control access to the data. Computer terminals will be in secured areas and only authorized staff will have access to the information.

Under no circumstances will data provided by OKDHS or OSDH be used for any purpose not specified in this agreement.

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D. PROVIDER AGREEMENT

For the purposes of the programs' study, the data set will initially include identifying information in order to be able to match records as the two systems (OSDH and OKDHS) do not use the same numbering system to identify unique individuals. However, once the matching process is completed, numbers will be used to match different pieces of information from the same individual. Information will only be reported in aggregate form; no individual will ever be identified or identifiable in study reports.

E. EFFECTIVE DATE, RENEWAL AND CANCELLATION

This agreement shall become effective **July 1, 2011** and continue until **June 30, 2012,** and will be automatically renewed up to two additional years. It is agreed by both parties that this agreement may be terminated by notice in writing by either party thirty (30) days before effective date of termination. Either party may terminate agreement immediately upon written notice in the event of a material breach of agreement.

OSDH will provide the data sets to OKDHS by October 1st of the given year, and OKDHS will return the matched dataset to OSDH by December 31st of the given year. The obligations of the OSDH with respect to privacy of the Division case data shall not be abrogated by cancellation of the contract. The obligations of the OKDHS with respect to the privacy of OSDH Children First and Office of Child Abuse Prevention client data shall not be abrogated by cancellation of the service agreement.

F. Modifications

Any modifications or amendments to the service agreement shall be in writing and agreed to by both the OSDH and the OKDHS.

G. OKDHS'S AUTHORIZED AGENT

The OKDHS's authorized Division agent(s) for the purposes of administration of this contract are Children & Family's Services, Protection, Services & Training Administrator, and Family-Centered Services Programs Manager.

H. ASSIGNMENT

A party shall neither assign nor transfer any rights or obligations under this agreement without the prior written consent of the other party.

I. OKDHS AUDITS

The books, records, documents, procedures and practices of the OSDH relevant to this contract shall be subject to reasonable examination by the OKDHS.

J. RELEASE AND PUBLICATION OF DATA INFORMATION

The OSDH's personnel shall have access to private data maintained by the OKDHS to the extent necessary to carry out its responsibilities under this agreement. The personnel are the responsible authority in charge of all data collected, used, or disseminated by the OSDH in connection with the performance of this agreement. The OSDH accepts responsibility for providing adequate supervision and training to ensure compliance with relevant confidentiality/ privacy law, regulations and contractual provisions. No private or confidential data collected, maintained or used in the course or performance of this contract shall be disseminated except as authorized by statute, either during the period of this agreement or thereafter. Except as required by law, the OSDH may not release any confidential case information accessed through the OKDHS; however, the OSDH shall otherwise have the right to publish the results of any research or study obtained pursuant to this agreement. Except as required by law, the OKDHS may not release any confidential OSDH client information provided by OSDH.

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K. ENTIRE AGREEMENT

This written agreement constitutes the entire agreement between parties, and no additional representations, writing or documents are a part hereof, unless specifically referred to herein above. This agreement may be amended by written agreement of the parties hereto.

L. EQUAL OPPORTUNITY AND DISCRIMINATION

The State is an Equal Opportunity Employer, a provider of services and/or assistance, and is in compliance with the 1964 Civil Rights Act, Title IX of the Education Amendment of 1972, Section 504 of the Rehabilitation Act of 1973, as amended and Executive orders 11246 and 11375. In addition, the State assures compliance with the Americans with Disabilities Act of 1990 (Public Law 101-336), all amendments to, and all requirements imposed by the regulations issued pursuant to this act.

To the extent applicable, the provisions of Executive Order (EO) 11246, as amended by EO 11375 and EO 11141 and as supplemented in Department of Labor regulations (41 CFR Part 60 et. seq.) are incorporated into this agreement and must be included in any subcontracts awarded involving this agreement. The parties represent that all services are provided without discrimination on the basis of race, color, religion, national origin, disability, political beliefs, sex, or veteran's status; they do not maintain nor provide for their employees any segregated facilities, nor will the parties permit their employees to perform their services at any location where segregated facilities are maintained. To the extent applicable, the parties agree to comply with the applicable provisions of Section 504 of the Rehabilitation Act and the Vietnam era Veteran's Assistance Act of 1974, 38 U.S.C. Section 4212.

M. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

The OSDH shall agree to use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The definitions set forth in the Privacy Rule are incorporated by reference into this agreement (45 CFR §§ 160.103 and 164.501).

DRAFT

N. INFORMATION SECURITY

The OSDH will perform an annual audit of information security risk assessment and provide its findings to the OKDHS Information Security Office by the last day of January of each year. The final information security risk assessment report shall identify, prioritize, and document information security vulnerabilities. The OSDH will have 60 working days after final report submission to respond with a mitigation plan for the identified security vulnerabilities. The OSDH may use either the standard security risk assessment created by the Office of State Finance or a third party risk assessment meeting the ISO/IEC 17799 standards and using the National Institute of Standards and Technology Special Publication 800-30 (NIST SP800-30) process and approved by the Office of State Finance.

The OSDH will disclose any breach of the security of the system following discovery or notification of the breach in the security of the data to any resident of Oklahoma whose encrypted or unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person. The disclosure shall be made in the most expedient time possible and without unreasonable delay to the OKDHS Information Security Office. The OSDH must deliver a final report of the breach post-mortem, citing the reason, sources, affected records, and mitigation plans or actions within ten business days of breach discovery.

The OSDH will comply with Federal Information Processing Standards – FIPS 200 which promotes the development, implementation, and operations secure information systems within governmental agencies by establishing minimum levels of due diligence for information security and facilitating a more consistent, comparable, and repeatable approach for selecting and specifying security controls for information systems that meet minimum security requirements.

DRAFT

CONTRACTOR

Oklahoma State Department of Health

Family Support and Prevention Services

1000 NE 10th Street Oklahoma City, OK 73104

SIGNATURES

Oklahoma State Department of Health

______________________________ _______________

Annette Jacobi, JD **Date**

Chief, Family Support and Prevention Service

Subscribed and sworn before me this _______ day of ___________, 2008. My commission expires ____________________.

____

Notary Public

DRAFT

Oklahoma Department of Human Services

________________________________ _______________

Marq Youngblood, Chief Operating Officer **Date**

Attachment 1

Children First

Children First provides nurse home visiting services following the Nurse-Family Partnership model for first-time parents who meet the eligibility requirements. A woman is considered eligible to participate in Children First if she is fewer than 29 weeks pregnant, a first-time mother and at or below 185% of the federal poverty level.
The mission of Children First is to empower first-time eligible families to care for themselves and their babies by providing information and education, assessing health, safety and development, and providing linkages to community resources, thereby promoting the well being of families through public health nurse home visitation, ultimately benefiting multiple generations.
Children First's vision is to promote a continuum of healthy pregnancies, healthy babies, healthy families and healthy communities.
The objectives of the Children First program include:

. Increase clients' self-sufficiency and ability to problem solve
. Improve clients' parenting skills
. Improve access to community resources for clients
. Improve pregnancy outcomes
. Improve child health and development
. Strengthen bond between parent and child
. Help clients achieve personal goals

DRAFT

Office of Child Abuse Prevention Programs

The Office of Child Abuse Prevention evaluates and monitors statewide OCAP Programs that are funded by the Child Abuse Prevention (CAP) Fund. OCAP also provides training and technical assistance to these programs.
The OCAP programs utilize the Prevent Child Abuse America's Healthy Families America (HFA) approach to voluntary home visitation using the Parents As Teacher curriculum combined with center-based services. HFA is a national effort to establish a voluntary home visitor system for all new parents to help give their children a healthy start. HFA promotes positive parenting and child health and development, thus preventing child abuse and other poor childhood outcomes.

An OCAP program enrolls first-time mothers after the 28th week of pregnancy, pregnant women expecting a subsequent child, and parents who have a baby less than 6 months of age. Services continue until the child is five years of age, if necessary. Key components of OCAP programs include:
-Screening and assessing families for enrollment eligibility.
-Identifying families at risk for child maltreatment and recruiting them into the program
-Referring high risk families to extensive services needed in areas such as mental health, domestic violence, or substance abuse
-Providing home visits and center-based parent education and support groups to moderate and low risk families
-Assisting families to fully utilize existing parenting skills and acquiring new parenting skills
-Promoting positive parent-child interaction
-Promoting child health through developmental screenings and assessments and linking families with healthcare providers
-Ensuring on-time immunizations
-Assisting families in accessing community resources
-Providing additional support services such as respite care, childcare, and transportation
-Holding family events such as health fairs and public awareness activities

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Section 6: Plan for Administration of State Home Visiting Program

THE LEAD AGENCY

OKLAHOMA STATE DEPARTMENT OF HEALTH

The Oklahoma State Department of Health (OSDH), a public entity, is comprised of local county health departments and one central office. It is responsible for protecting, maintaining and improving the public's health status. In addition to the MIECHV Grant, it is the lead agency responsible for administering the State's two largest home visitation programs as well as the Federal Community-Based Child Abuse Prevention Funds. Because of its size and diverse programming, OSDH is in a unique position to seek innovative approaches to coordinating funding streams and other resources to enhance services for families with young children.

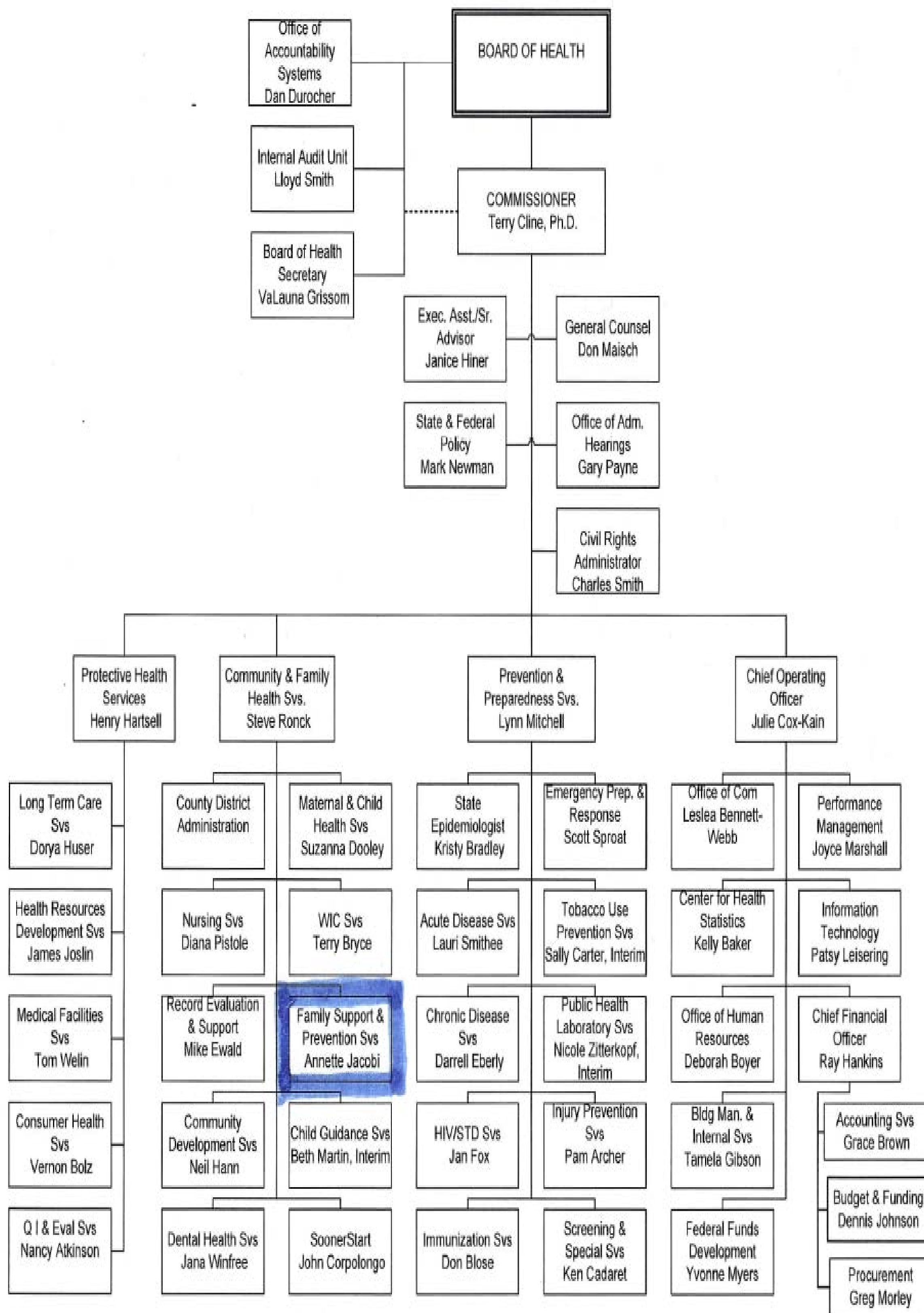
COMMUNITY AND FAMILY HEALTH SERVICES

Community and Family Health Services (CFHS) is one of the primary service areas within the OSDH. The mission is to protect and promote the health of the citizens of Oklahoma by assessing health status, establishing evidence-based priorities and providing leadership to assure the availability of individual and population-based health services. Oklahoma currently has 68 county health departments and two independent city-county health departments serving all 77 counties. Each county health department offers a variety of services such as immunizations, family planning, maternity education, well-baby clinics, adolescent health clinics, hearing & speech services, child developmental services, environmental health, the early intervention program and community development activities.

Located within Community and Family Health Services are the following distinct Services:

1) Child Guidance Service - programs designed to promote optimal child development, healthy behavior and effective interaction for families and children, as well as those who work with young children;
2) Maternal and Child Health Service - programs that provide state leadership to improve the physical and mental health, as well as safety and well-being of the Oklahoma maternal and child health population;
3) SoonerStart – Oklahoma's IDEA Part C program designed to provide early intervention services that meet the needs of infants and children with disabilities and developmental delays;
4) Women, Infants and Children (WIC) - a program to provide nutrition education and food resources to low-income pregnant and postpartum women and their young children;
5) Dental Service - provides leadership in oral disease prevention, anticipates needs and mobilizes efforts that will help protect and promote good oral health;

6) Family Support and Prevention Service - programs that promote the health, safety and well-being of young children by reducing violence and child maltreatment through public education, multidisciplinary training of professionals and the funding of community-based family support programs;
7) Community Development Service - programs that promote health equity & resource opportunities (HERO), health promotion, minority health, primary care & rural health development, and community development through the Turning Point initiative
8) Nursing Service – a service area dedicated to ensuring optimal public health nursing services, leadership, education, and advocacy; and
9) Records Evaluation and Support Division – a service area that provides support services to county health department administrators, quality assurance chart reviews and technical support for OSDH developed software, such as the Public Health Oklahoma Client Information System (PHOCIS) clinic management system and financial reporting software.



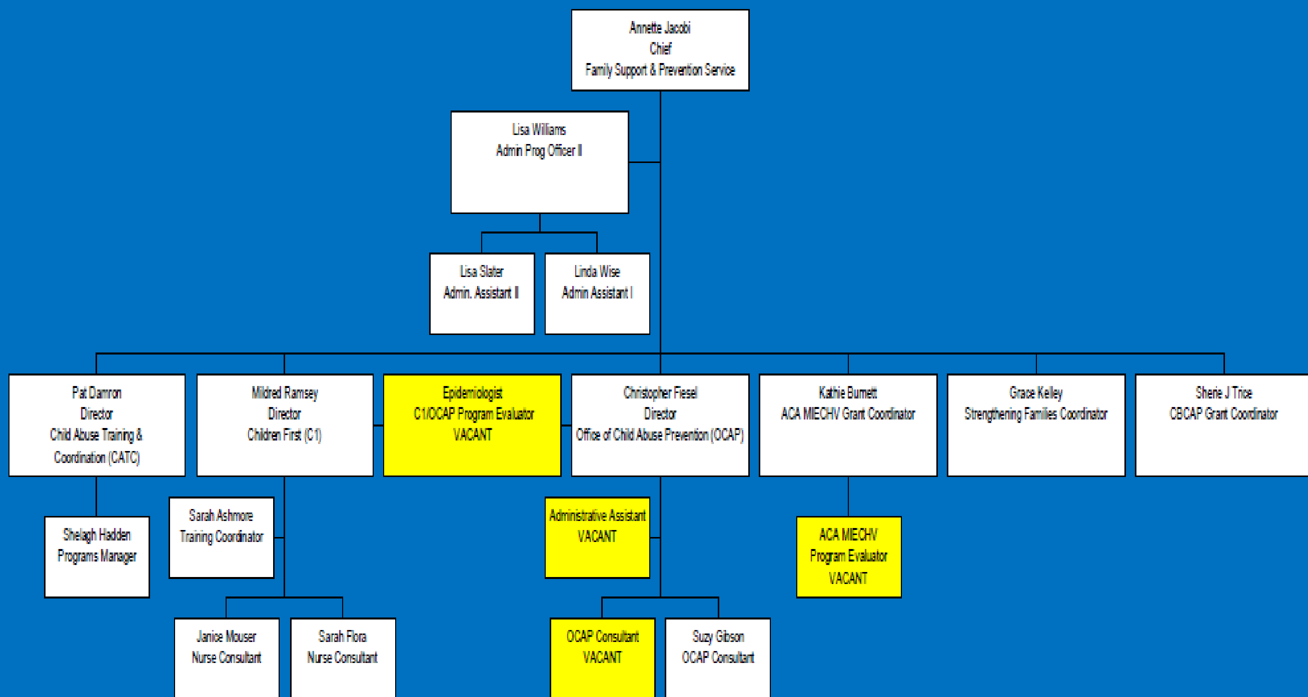
Office of Accountability Systems Dan Durocher
BOARD OF HEALTH
Internal Audit Unit Lloyd Smith
COMMISSIONER Terry Cline, Ph.D.
Board of Health Secretary VaLauna Grissom
Exec. Asst./Sr. Advisor Janice Hiner
General Counsel Don Maisch
State & Federal Policy Mark Newman
Office of Adm. Hearings Gary Payne
Civil Rights Administrator Charles Smith
Protective Health Services Henry Hartsell
Community & Family Health Svs. Steve Ronck
Prevention & Preparedness Svs. Lynn Mitchell
Chief Operating Officer Julie Cox-Kain
Long Term Care Svs Dorya Huser
Health Resources Development Svs James Joslin
Medical Facilities Svs Tom Welin
Consumer Health Svs Vernon Bolz
Q I & Eval Svs Nancy Atkinson
County District Administration
Maternal & Child Health Svs Suzanna Dooley
Nursing Svs Diana Pistole
WIC Svs Terry Bryce
Record Evaluation & Support Mike Ewald
Family Support & Prevention Svs Annette Jacobi
Community Development Svs Neil Hann
Child Guidance Svs Beth Martin, Interim
Dental Health Svs Jana Winfree
SoonerStart John Corpolongo
State Epidemiologist Kristy Bradley
Emergency Prep. & Response Scott Sproat
Acute Disease Svs Lauri Smithee
Tobacco Use Prevention Svs Sally Carter, Interim
Chronic Disease Svs Darrell Eberly
Public Health Laboratory Svs Nicole Zitterkopf, Interim
HIV/STD Svs Jan Fox
Injury Prevention Svs Pam Archer
Immunization Svs Don Blose
Screening & Special Svs Ken Cadaret
Office of Com Leslea Bennett-Webb
Performance Management Joyce Marshall
Center for Health Statistics Kelly Baker
Information Technology Patsy Leisering
Office of Human Resources Deborah Boyer
Chief Financial Officer Ray Hankins
Bldg Man. & Internal Svs Tamela Gibson
Accounting Svs Grace Brown
Budget & Funding Dennis Johnson
Federal Funds Development Yvonne Myers
Procurement Greg Morley

FAMILY SUPPORT AND PREVENTION SERVICE

The Family Support and Prevention Service's mission is to promote the health, safety and welfare of children and families by providing prevention education, multidisciplinary training of professionals and funding to community-based programs. Located within the Family Support and Prevention Service are six major programmatic efforts:

1) Children First – Oklahoma's Nurse-Family Partnership Program providing home visitation services to first-time, low-income mothers. Services begin during pregnancy and continue until the child's second birthday.
2) The Office of Child Abuse Prevention - an office that provides leadership in establishing the State's comprehensive statewide approach towards the prevention of child abuse by educating the public, training professionals and funding local community-based programs.
3) The Federal Community-Based Child Abuse Prevention Grant - funds that allow community-based organization to develop, operate and expand their services, support networks that work towards strengthening families, and foster understanding, appreciation and knowledge of diverse populations.
4) The Federal Affordable Care Act, Maternal, Infant and Early Childhood Home Visitation Grant – funds that support home visiting efforts designed to strengthen and improve the programs and activities carried out under Title V, improve coordination of services for at-risk communities, and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.
5) The Child Abuse Training and Coordination Program - a program designed to support the development and maintenance of multidisciplinary child abuse/neglect teams across the state as well as to provide multidisciplinary and discipline-specific training for professionals.
6) Strengthening Families – an initiative that works with child care, child welfare, and early childhood programs to infuse evidence-based Protective Factors into their systems work and to build supportive relationships between professionals and parents as a way to strengthen parent-child interactions and reduce the potential for harmful parenting behaviors.

Family Support & Prevention Service
Updated May 2011



A LIST OF COLLABORATIVE PARTNERS

MEMORANDUM OF CONCURRENCE: Signors

The Oklahoma State Department of Health
The Oklahoma State Department of Education
Smart Start Oklahoma: Oklahoma's Partnership for School Readiness
The Oklahoma Department of Human Services
The Oklahoma Department of Mental Health and Substance Abuse Services
The Oklahoma Health Care Authority
Oklahoma Head Start Collaborative
University of Oklahoma Center on Child Abuse and Neglect
Oklahoma Coalition Against Domestic Violence and Sexual Assault
Oklahoma's Child Care and Development Fund
The Oklahoma Advisory Council on Early Childhood Education and Care

ADDITIONAL PARTNERS

Enid Parents as Teachers
Garfield County Health Department
Smart Start Garfield County
Kay County Health Department
Northern Oklahoma Youth Services
Smart Start Kay County
Oklahoma Parents as Teachers: Osage County Interlocal Cooperative
Enid Parents as Teachers
Community Development Support Association
Pioneer- Pleasant Vale parents as Teachers
The Interagency Child Abuse Prevention Task Force
The Home Visitation Leadership Advisory Coalition
Smart Start Oklahoma Board of Directors

MANAGEMENT PLAN

Oklahoma State Department of Health (OSDH): On June 10th, 2010, Governor Brad Henry designated the health department as the lead agency to receive and implement the MIECHV Grant. He stated then that he chose OSDH to serve in this capacity because of the agency's 14+ years in providing evidence-based home visitation services to families with young children and the agency's ability to leverage and blend state, federal and private funds to support such efforts.

The Family Support and Prevention Service (FSPS): FSPS will be responsible for implementing and administering the MIECHV Grant. Currently, FSPS houses the Children First Program (Nurse-Family Partnership) and Start Right (Healthy Families America). For this reason, some aspects of implementing the new Grant will be relatively routine. FSPS Program Staff for Children First and the Office of Child Abuse Prevention (for Start Right Programs) support their respective programs and home visitors in the following ways:

- Establishing and maintaining relationships with the National Model Developers
- Developing and distributing policies and program guidelines
- Developing "Oklahoma specific" educational material to be included with model lesson plans to be used during home visits
- Contracting, when necessary, with agencies to provide home visitation services
- Assuring that home visitors are appropriately trained in their respective model as well as specific topics such as adoption, substance abuse, domestic violence, etc.
- Providing technical assistance to home visitors upon request
- Developing and distributing quarterly performance measurement tools and reports
- Conducting annual site visits to assure fidelity to the model and quality of services
- Assisting program evaluators in analyzing programmatic data and producing annual reports
- Ensuring program alignment with Federal, State and program outcomes

During this first phase of the MIECHV Grant, it is Oklahoma's intent to expand existing services if possible instead of establishing new home visiting programs. Based upon the needs assessment and the input from the communities, these existing programs do meet the needs of families in their communities. However, they could use more of these services. There are two major benefits to expanding existing services: 1) MIECHV funds will not have to be used for infrastructure such as training and oversight because these components are already in place; and 2) MIECHV funds will not have to be used for supervision of additional home visitors because the supervisors are already funded on state dollars. If possible, expanding existing programs will stretch the MIECHV monies.

This is not to say that additional home visitation models and services are not needed. Two particular models have been discussed at great length:

> Early Head Start (EHS): There are existing Early Head Start Centers in Kay and Garfield Counties. Early Head Start, at the state level, has been very involved in the development of the Oklahoma MIECHV Program and local Early Head Start has been invited to community meetings. However, there are no EHS home visiting services provided in

either county at this time. All have agreed, for the time being, that the three models chosen for the MIECHV Grant should be able to provide services for the EHS center-based population. In fact, it has been suggested that the home visitation services give priority to those families receiving no services and on EHS center-based waiting lists – when appropriate. This suggestion may be incorporated into the Requests for Proposals.

Safe Care+: Although Safe Care+ was not on the Federal list of approved models, Oklahoma did consider implementing it in at least one of our at-risk communities as a "promising approach." However, that would have required establishing an entirely new program in the communities. After careful consideration, it was decided that the funding limitations on "promising approaches" would not support such a new endeavor. Safe Care+, though, is still "on the radar" and will continue to be explored – particularly if Oklahoma receives additional MIECHV funding. The fact that the Safe Care+ model is designed to serve families with the highest of risk factors is very intriguing to those in the existing home visiting programs and those in the community. The existing programs have seen the acuity levels of their clients rise over the years. Even with additional training, staff still worry that perhaps they do not always have the expertise in-house to appropriately address all families' needs.

Children First Expansion (NFP): Utilizing the procedures established by the Oklahoma Personnel Management Agency, Kay and Garfield County Health Departments will hire additional Registered Nurses to serve as public health nurses in the Children First Program. Kay and Garfield County Health Departments, like all local county health departments (except Tulsa and Oklahoma City-County Health Departments), are part of OSDH. There will be no need to develop Requests for Proposals documents or contracts for hiring of Children First nurses in these two counties.

Start Right Expansion (HFA): While Start Right Programs are funded and administered by the Office of Child Abuse Prevention within FSPS, all provide services based on a contractual relationship. Oklahoma law requires that the Child Abuse Funds (those dollars used to support Start Right Programs) be awarded through a competitive bid process to community-based organizations. Even county health departments must compete for such funding.

Because of the law and the contractual relationship, new Requests for Proposals (RFP) will have to be developed. The Start Right Contractors will begin their last year of a five year contract cycle on July 1, 2011. The possibility of giving priority to Contractors that are already providing Start Right services in Kay County has been discussed. There is only one such Contractor in Kay County. While it is desirable to include this language in the RFP, the issue will have to be explored by OSDH Procurement Services and possibly the Office of General Counsel. In addition, the issue of how to continue beyond this last year's contract cycle will have to be explored as well. Unfortunately, the existing Start Right contract cycle and the implementation of the MIECHV Grant are not perfectly timed.

Parents as Teachers Expansion: The Parents as Teachers Program is administered by the Oklahoma State Department of Education (ODE). The OSDH will establish an Interagency Agreement with ODE so that OSDH can reimburse them for PAT expansion services. The Early

Childhood Programs Coordinator of ODE, Erin Nation, has already spoken with some PAT providers/school districts in the Kay and Garfield county area and there is enthusiasm for expanding their services. School districts will have to complete the routine application process and ODE will then have to make decision about which 1districts to fund. Once that decision has been made, additional PAT home visitors will be added.

Because PAT is not one of the home visiting programs that FSPS is already managing and supporting, requirements will need to be included in the Interagency Agreement regarding the training, monitoring and evaluation. At this time, ODE does not provide much additional training outside of the PAT model, conduct site visits nor collect a broad base of data. The MIECHV Grant requirements, along with the Interagency Agreement, will obligate PAT to strengthen these aspects of their Program. FSPS staff are willing and able to provide certain services, incorporate PAT into their work when appropriate and/or assist in all areas of management.

A PLAN FOR COORDINATIONG MORE THAN ONE HOME VISITING MODEL IN THE COMMUNITY

In both Kay and Garfield Counties, there is more than one existing home visitation program. Both counties are also rich in community services. The feature that seems to be lacking and that the community focus group has highlighted is a "connector" of sorts.

For this reason, MIECHV funds will be used to contract with a community agency for a part-time employee that can serve as that "connector" in each county. This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources
- Collect referrals for home visitation programs and distribute them to the appropriate home visitation program
- Organize opportunities for the home visitation programs to meet on a routine basis so that the program can staff referrals if necessary and share programmatic information
- Organize opportunities for the home visitation programs and other community services to meet on a routine basis so that all can learn from each other

Please see the following visual.

Because of the dollar amount involved, it may be that the contract for such a position will have to go out to bid. This issue is being researched at this time. It should be noted though that while there are several community organizations that have expertise in community development, Smart Start Oklahoma appears to be uniquely positioned to partner with the home visitation programs in this manner. Smart Start Garfield County and Smart Start Kay County not only are strongly connected to community services, they also have expertise and a focus on early childhood.

Continuum of Family Support Services in Oklahoma

Home Visitation and Center-Based Services

The Community Development Coordinator will help facilitate collaboration between the three home visitation programs and the multitude of center-based services available to families locally.

Home Visitation Services

- Children First (County Health Departments)
- Parents as Teachers (Oklahoma Department of Education)
- Healthy Families America (Community-Based Non-Profits)

Center-Based Services

- Department of Human Services
- Domestic Violence Services
- Mental Health & Substance Abuse Services
- Child Guidance
- County Health Department Services (WIC, Breast-feeding Peer Educators, Sooner Start Early Intervention Services, etc.)

IDENTIFICATION OF OTHER HOME VISITING PROGRAM EVALUATIONS

Federal Evidence-Based Home Visitation Grant – Safe Care+

Oklahoma is fortunate to have been awarded one of the seventeen Federal Evidence-Based Home Visitation Grants (EBHV). Oklahoma's EBHV Grant is administered by the University of Oklahoma's Center on Child Abuse and Neglect and utilizes the Safe Care+ model developed by Dr. John Lutzker. It is anticipated that the program will serve 360 families from 2010 through to 2013 in Oklahoma County.

Safe Care+ is an in-home eco-behavioral model emphasizing the importance of the socio-cultural context in which child abuse and neglect occurs. It has been adapted for Latino communities and augmented to address risk factors of family violence, substance abuse and mental health issues. As in the original version, Safe Care+ is designed to prevent child maltreatment in high-risk families by providing direct skills training to parents related to parent-child bonding, home safety, and child health care.

Target Population: Highest-risk populations, such as families with parental substance use disorders, intimate partner violence, parental depression and/or other multiple risk factors with child birth to five years.

Process/Implementation and Program Fidelity: The process/implementation evaluation will examine the feasibility and acceptability of the modified Safe Care curriculum (augmented to address Healthy Relationships/Violence Prevention and adapted for Latino communities). Trainings in Safe Care+ curriculum will be evaluated by OU CCAN through service providers report. Implementation of services will be directly observed to evaluate fidelity. The local evaluation team will collect data on fidelity, as well as data on participants and service providers, including written evaluations and assessments, direct observation, interviews and monthly reports.

Family and Child Outcomes: For the family and child outcomes evaluation, OU CCAN will examine future reports of child maltreatment and foster care placement and changes on protective factors and risk factors proximal to child maltreatment. Safe Care+ adapted model will be evaluated utilizing a hybrid of design which merges aspects of the simple regression discontinuity (RD) design with aspects of the simple randomized clinical trial design. Two prevention service models will be provided through the Latino Community Development Agency in Oklahoma City: 1) El Programa de Familias Seguras (Safe Care+) adapted for the Latino community and designed for families with the highest of risk factors, and 2) Nuestras Families, funded through OSDH's Office of Child Abuse Prevention and utilizing Parents as Teachers as well as other curricula designed for families with few to moderate risk factors. Using a risk classification tree, families will be screened for risk with the highest risk group being assigned to Safe Care+ and those with fewer risk factors being randomly assigned between Safe Care+ and OCAP's program. OU CCAN will collect data on demographics, child maltreatment, risk factors, protective factors and services. Self-report and home observational data will be collected prior to randomization at six months and at 12 months.

Cost Evaluation: The cost evaluation will examine the time, effort and resources used to deliver program services. Both fixed and variable service costs will be included. Cost analysis will be facilitated by closely tracking all categorical funding streams for the varying population risk groups served at both program and participant levels.

Federal Tribal Maternal, Infant, and Child Home Visiting Program: Chahta Inchukka Program of the Choctaw Nation

The Chahta Inchukka Program, meaning Choctaw's Home, will provide early childhood development services to native American pregnant women or parenting women and couples of children aged from birth to kindergarten entry throughout five of the Choctaw Nation's 10 ½ counties. The program will provide high-quality, evidence-based curriculum for home visiting services and evaluation activities to increase the knowledge based on what works in Tribal home visiting programs. Parents as Teachers (PAT) curriculum will serve as the program's cornerstone, with Positive Indian Parenting offering cultural competence and INJOY providing infant developmental guidance. Project goals will be to improve maternal and newborn health; prevent child injuries, abuse, neglect or maltreatment, improve school readiness and child academic achievement; reduce crime and /or domestic violence; improve family economic self-sufficiency; and improve coordination and referrals for other community resources and supports. A collaborative and interdisciplinary approach including: 1) Intensive home visitation by Home Visit Specialists and referrals and linkages to community and Tribal resources; and 2) PAT, a strong research-based curriculum, are key components of this program.

The Choctaw Nation of Oklahoma is a federally recognized Indian Tribe providing services to a Native American population in a vast, extremely rural and economically deprived area. This project is will serve Atoka, Haskell, Latimer, McCurtain and Pushmataha counties of southeastern Oklahoma.

JOB DESCRIPTIONS FOR KEY POSITIONS

Chief, Family Support & Prevention Service (OSDH)
Annette Wisk Jacobi
This position will provide overall guidance and direction to assure that the ACA MIECHV Grant activities remain true to the established grant goals and objectives. Roles and responsibilities include supervising the Grant Coordinator and Grant Evaluator; encouraging collaboration within the FSPS, with Title V staff and partners outside the agency as related to these Grant efforts; general oversight of Grant budgets, staffing, training and contracts related to these Grant efforts; assure that Grant required data is collected and analyzed appropriately; assure that all Grant requirements are met. **Qualifications** include a Master's Degree in Public Health with an emphasis in education, promotions or community development, social marketing or a Master's Degree in a related field. Experience in organizing groups, promoting issues and/or programs is required. Knowledge of child abuse and neglect prevention, public awareness practices and community development is required. The ability to communicate effectively both orally and in writing, to interpret policy and procedure and to maintain effective working relationships with others is a must.

ANNETTE WISK JACOBI

Home
1007 Northwest 14th Street
Oklahoma City, OK 73106
(405) 235-5334
asjacobi@cox.net

Work
1000 Northwest 10th Street
Oklahoma City, OK 73117
(405) 271.7611
annettej@health.ok.gov

EMPLOYMENT EXPERIENCE

Oklahoma State Department of Health, Oklahoma City, OK

Family Support and Prevention Service, Chief: 2003 to Present
Provide administrative direction for two statewide home visitation programs, training and support for multidisciplinary teams, two federal grants and a variety of special projects. Responsibilities include budget oversight; supervising central office program staff; providing information regarding program policies and evaluation to assure quality services; and providing policy–makers/funders with evidence of effectiveness.

Children First: Oklahoma's Nurse-Family Partnership Director/Chief: December 1996 to 2003
Implemented and directed the Nurse-Family Partnership model in Oklahoma. Responsibilities included budget oversight; supervising central office program staff; assuring that program trainings and quality assurance activities were conducted; and communicated with the Oklahoma Legislature about program's progress and effectiveness.

Family Violence Project Coordinator: January 1994 to December 1996 (contract employee)
Implemented and managed the Federal Region VI project at several health department sites. In addition, provided training on the legal and psycho-social aspects of family violence for professionals, public and youth upon request.

Attorney at Law – Private Practice, Oklahoma City, OK

Guardian ad Litem: 2007 – 2010
Served as a GAL for a minor plaintiff involved in a civil law suit; plaintiff joined with several other minor victims and brought suit against a church, board of directors, university and individuals because of their negligence related to a youth minister that molested them. The case was settled before trial.

Oklahoma Institute for Child Advocacy, Oklahoma City, OK

Project Coordinator: October 1991 to January 1994
Coordinated the Oklahoma County Teen Pregnancy Prevention Project. Served as legal counsel for the Interdisciplinary Team at Community Health Centers, Inc. Assisted supervisor with legislative monitoring. Developed and oversaw a program for at-risk youth at the REST Homeless Day Shelter.

Cleveland County District Attorney's Office, Norman, OK

Legal Intern: June 1990 to July 1991

Exclusively handled all facts of the misdemeanor call docket which included making recommendations for cases and carrying them through trial.

Oklahoma County District Attorney's Office, Oklahoma City, OK

Practicum Student: September 1989 to May 1990

Aided Assistant District Attorneys with deprived (child abuse and neglect) and juvenile delinquency cases.

LICENSURE

Licensed to practice law in the state of Oklahoma, OBA #14136

Licensed to practice law in the Federal Western District of Oklahoma

EDUCATION

GRADUATE

THE UNIVERSITY OF OKLAHOMA, COLLEGE OF LAW, Norman, OK

Juris Doctorate conferred May, 1991

SPECIALIZED TRAINING

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER, OKC, OK

Department of Pediatrics: Interdisciplinary Graduate Training in Child Abuse and Neglect, 1990

UNDERGRADUATE

OKLAHOMA STATE UNIVERSITY, Stillwater, OK

Bachelor of Arts Degree conferred July 1988

Major: Sociology

Minor: Family Relations/Child Development

Additional Education: 20 hours of Spanish

PROFESSIONALASSOCIATIONS AND RECOGNITIONS

Oklahoma Child Death Review Board

Chair 2005 - 2009

Member 2003 to present

The National Alliance of Children's Trust and Prevention Funds

Vice Chair, Board of Directors 2007 to present

Member, Board of Directors 2004 to present

Oklahoma Institute for Child Advocacy

Board of Directors June 2010 – January 2011

Nurse-Family Partnership
National Advisory Committee – Fall 2000 – 2002

National Quality Improvement Center on Early Childhood
National Advisory Committee – 2009

Oklahoma Professional Society on the Abuse of Children
1997 Award for Outstanding Dedication

Oklahoma Public Health Association
1998 Exceptional Merit Award

Catholic Charities Archdioceses of Oklahoma City
President, Board of Directors 2008 - 2010
Vice President, Board of Directors 2005 - 2008
Member, Board of Director 2003 to present

William J. Holloway, Jr. American Inn of Court V
Master 2007 to present
Barrister 2000 to 2006
Associate 1998

Oklahoma State Bar Association
2009 Leadership Academy
2009 Trail Blazer Award
OBA Work Life Balance Committee: Member 2004 to 2008
OBA Strategic Planning Committee: Member 2000 & 2003 - 2006
1997 Outstanding Young Lawyer
1997 Young Lawyers Division, Outstanding Committee Chairperson
Young Lawyers Division, Children & the Law Committee: Chair 1993 - 99
Young Lawyers Division: Board of Directors 1996 – 1997

Oklahoma Lawyers for Children
2007 Buddy Faye Foster Service to Children Award

Oklahoma County Bar Association
Voices for Children Committee: Co-Chair 1999 - 2000
Young Lawyers Division: Board of Directors 1994 – 1998
Young Lawyers Division: Chair 1996 – 1997
1997 Outstanding Young Lawyer
1997 Outstanding Project: Oklahoma County Child Watch Tour
1994 Young Lawyers Division Achievement Award

Community-Based Child Abuse Prevention Grant Coordinator (OSDH)
Sherie Trice
Under the supervision of the Chief of the Family Support & Prevention Service, this position serves as the Coordinator for the federal CBCAP Grant. **Roles and responsibilities** include serving as a liaison to a variety of state and national agencies and networks; provides leadership and support for the Interagency Child Abuse Prevention Task Force as well as the Home Visitation Leadership Advisory Coalition; strengthens communication between prevention partners by creating and distributing information on a routine basis; and highly contributes to the development of the Oklahoma State Plan on the Prevention of Child Abuse and Neglect. **Qualifications** include a Master's Degree in Public Health with an emphasis in education, promotions or community development, social marketing or a Master's Degree in a related field. Experience in organizing groups, promoting issues and/or programs is required. Knowledge of child abuse and neglect prevention, public awareness practices and community development is required. The ability to communicate effectively both orally and in writing, to interpret policy and procedure and to maintain effective working relationships with others is a must.

Sherie Trice

3009 Aerie Drive, Edmond, Ok 73013
Home: 405.478.3555 Cell: 405.388.6777
Email: sherietrice@yahoo.com

Areas of Specialty

- Community Collaboration
- Building Local and Statewide Partnership Networks
- Generating and Creating Community Resource Materials
- Promotion and Marketing of Child Abuse Prevention Efforts and Activities related to Strengthening Families
- Child Development
- Individual/Group Parent Education

Education Master in Professional Services in Human Development

University of Central Oklahoma, Edmond, Oklahoma
September, 1984 - May, 1986
Bachelor of Arts in Journalism
(Minors: Speech and Sociology)

University of Central Oklahoma, Edmond, Oklahoma
June, 1977 - December, 1980

Experience

OSDH, Family Support and Prevention Service, Okc, Ok *January, 2006 - Present*
Community-Based Child Abuse Prevention (CBCAP)
Grant Coordinator

- Initiated and orchestrated replacement of the Office of Child Abuse Prevention (OCAP) Specialty License Plate with a new design and campaign (kicking off in April), which works as a fund-raiser for the OCAP programs across the state.
- Created an organized grand plan in the coordination of Child Abuse Prevention (CAP) Month efforts across the state.
- Building (in collaboration with multiple partners) an elaborate annual Child Abuse Prevention Day (during National Child Abuse Prevention Month) at the state Capitol.
- Organized and instituted a CAP Month Action Committee (assisting with the activities mentioned above) with over 60 members from various agencies and programs across the state.
- Generate and monitor the creation and distribution of materials to accompany Child Abuse Prevention Month efforts as well as other child abuse prevention related events and activities throughout the year.
- Provide leadership and support for the Oklahoma State Interagency Child Abuse and Neglect Task Force (ITF).
- Plan and organize the annual ITF/Child Advocate Retreat.
- Monitor the spending and distribution of CBCAP funds.
- Write and assist with the annual CBCAP report and application.
- Provide leadership and support for the Home Visitor Leadership Advisory Coalition.
- Development of a home visitation newsletter.

<u>OSDH, Child Guidance</u>, Okc, Ok *September, 1990 - January, 2006*
Child Development Specialist

• Created and facilitated parent, teacher and caregiver groups and workshops on topics related to child development and behavior.
• Provided developmental screenings and assessments on children birth through five years of age.
• Consulted with individuals and families on topics related to parenting and child development.
• Taught parents ways to assist in enhancing their children's development.
• Collaborated with various community agencies (libraries, churches, childcare centers, etc).
• Created, organized and marketed programs through press releases, flyers, coupons for developmental screenings, and regular contribution to the Metro Library Magazine regarding our programs.
• Development of a popular newsletter that continues to be distributed county wide three times per year.
• Media involvement in television, radio, and print to promote Child Guidance services.

<u>OCCHD, Child Guidance</u>, Okc, Ok *June, 1988 - September, 1990*
Child Development Specialist

- Same tasks and duties listed above as well as…

• Provided home visits while working in SoonerStart (working 50 percent in Child Guidance and 50 percent in SoonerStart for over three years).

<u>OSDH, Child Guidance</u>, Shawnee, Oklahoma *February, 1987 - January, 1988*
Child Development Specialist

• Created and facilitated parent, teacher and caregiver groups and workshops on topics related to child development and behavior.
• Provided developmental screenings and assessments on children birth through five years of age.
• Consulted with individuals and families on topics related to parenting and child development.
• Taught parents ways to assist in enhancing their children's development.
• Collaborated with various community agencies, such as, the libraries, head start, churches, childcare centers, etc.

<u>Community/Service Activities</u>

• Completed Oklahoma Public Health Leadership Institute ~ March, 2006
• Awarded Community Service Award ~ Tinker Air Force Base

<u>Certification</u>

Certified Child and Parenting Specialist

<u>References</u>

Available upon Request

ACA MIECHV Grant Coordinator (OSDH)
Kathie Burnett
Under the supervision of the Chief of the Family Support & Prevention Service, this position serves as the Coordinator for the federal ACA MIECHV Grant. **Roles and responsibilities** include serving as a liaison to a variety of state and national agencies and networks; provides leadership and oversight for the planning, development and implementation of the ACA Home Visiting Grant; collaborates with the CBCAP Grant Coordinator to guide the efforts of the Interagency Child Abuse Prevention Task Force as well as the Home Visitation Leadership Advisory Coalition in matters related specifically to home visitation and this Grant; collaborates with and provides direction for the ACA MIECHV Grant Evaluator to assure data collection and outcome analyses; directly supervises the work of the ACA MIECHVGrant Administrative Assistant. **Qualifications** include a Master's Degree in Public Health with an emphasis in education, promotions or community development or a Master's Degree in a related field. Experience in planning, developing and implementing new programs as well as monitoring state contracts is extremely helpful. Knowledge about evidence-based home visitation models and best practices related to home visitation is required. The ability to communicate effectively both orally and in writing, to develop and interpret policy, procedure and data and to maintain productive working relationships with others is a must.

1324 Nottoway Drive
Midwest City, OK 73130
(405) 733-7207 or 650-4090
kathie.burnett@cox.net

Kathie J. Burnett

Education	**1979 to 1982**	**Emporia State University** Degree: Master of Science Major: Clinical Psychology
	1970 to 1974	**Emporia State University** Degree: Bachelor of Science in Education Major: Elementary Education Minor: Early Childhood Education and Special Education
Professional Employment Experience		
	February 2011 to Current	Oklahoma State Department of Health Family Support and Prevention Service Oklahoma City, OK Federal Home Visitation Grant Coordinator
	June 2005 to Feb. 2011	Oklahoma State Department of Health Family Support and Prevention Service Oklahoma City, OK Home Visitation Program Consultant
	October 2002 to May 2005	Mary Mahoney Memorial Health Center Oklahoma City, OK Positive Parents Program Home Visitation Program Supervisor
	August 2001 to July 2002	Gordon Cooper Technology Center Shawnee, OK Child Care Development Instructor
	April to December 2000	Neosho County Community College Chanute, KS Director of Counseling and Retention
	1997 to 2000	SEK-CAP Head Start; Girard, KS Education Specialist

1992 to 1997	SEK-CAP Head Start; Girard, KS Lead Teacher/Site Manager
1991 to 1992	Maranatha Academy; Shawnee, KS Fourth Grade
1989 to 1990	Substitute Teacher
1985 to 1989	Victory Christian Academy; Emporia, KS First and Second Grade Combination Class
1983 to 1985	Area Mental Health Center; Scott City, KS Clinical Psychologist
1978 to 1979	Buhler Unified Schools; Buhler, KS Third and fourth Grade
1974 to 1978	Lakin Unified Schools; Lakin, KS Second Grade

Professional Certifications and Training

Oklahoma State Board of Education Certificate
Elementary Education - Early Childhood Education - # 132016

Kids Count Leader – Oklahoma Institute for Child Advocacy

Healthy Families America - Trainer
Family Support Worker Trainer (including recertification)
Great Beginnings Start Before Birth Trainer

Parents As Teachers - Supervisor
Prenatal to Three ------------- Three to Kindergarten Entry
PAT for Teen Parents ------- PAT Training for Supervisors

Ages and Stages Questionnaires - Trainer
Child Development Screening - Social-Emotional Development

American Humane - Trainer
The Front Porch Project

Zero to Three - Trainer
Preventing Child Abuse and Neglect

West Ed Certified Trainer
Program for Infant/Toddler Caregivers: Module I and II

Denver II Child Development Screening
Certified Screener

Child Development Associate Credential
Council for Early Childhood Professional Development

Committees and Memberships

Child Abuse Prevention (CAP) Action Committee
Home Visitation Leadership Coalition
Maternal Depression Work Group
Oklahoma Association for Infant Mental Heal

ACA MIECHV Grant Evaluator (OSDH)
Vacant
Under the supervision of the Chief of the Family Support & Prevention Service, this position serves as the Evaluator for the federal ACA MIECHV Grant. **Roles and responsibilities** include planning, developing and implementing evaluation related to home visiting; provide direction and support for the ACA MIECHV Evaluation Team; assure that appropriate measures are developed, collected and analyzed in relation to the required Grant outcomes; prepare technical reports, articles, and presentations as needed; with cross-training, serve as support for the evaluator(s) serving in the OSDH Children First and Start Right Home Visitation Programs. **Qualifications** include a Master's Degree in Public Health with a minimum of 12 hours in epidemiological/statistical graduate hours. Degrees in Epidemiology and/or Biostatistics preferred. Knowledge of assessment and analytic techniques, medical and public health terminology, socio-demographic conditions required. Knowledge about assessment and evaluation practices related to home visiting also required. The ability to communicate effectively, particularly as it relates to interpreting data, both orally and in writing is a must. Experience in using SAS Statistical software packages extremely helpful. Strong skills related to working with teams are a must.

<u>ACA Home Visiting Grant Administrative Assistant (OSDH)</u>
Vacant
Under the supervision of the ACA Home Visiting Grant Coordinator, this position serves as the support staff for the federal ACA Home Visiting Grant. **Roles and responsibilities** include initiating correspondence requiring knowledge of agency or program procedures and policies, assisting internal and external customers on departmental or program policies and procedures, preparing invoices and payments of claims, creating requisitions, purchase orders and managing other fiscal duties, coordinating activities/trainings/meetings with internal and external customers, scheduling appointments, handling routine office duties, and entering and retrieving information using computer or other data processing equipment. **Qualifications** include four years of technical clerical office work or an equivalent combination of education and experience. Knowledge of spelling, punctuation, business English, business mathematics, modern office methods and procedures, maintenance of complex records and of OSDH policies and procedures is extremely useful. Ability to maintain effective working relationships with others, to handle confidential work, to handle routine matters in accordance with agency policy, and to follow oral and written instructions required.

<u>Director, Children First: Oklahoma's Nurse-Family Partnership (OSDH)</u>
Mildred Ramey
Under the supervision of the Chief of the Family Support & Prevention Service, this position serves as the Director of Children First: Oklahoma's Nurse-Family Partnership Program. **Roles and responsibilities** include Interpreting and implement services consistent with standards established by OSDH Nursing Service, Oklahoma Nurse Practice Act and the Nurse-Family Partnership Model (NFP); supervise Children First Nurse consultants; develop and implement policies and procedure to insure efficient and effective delivery of services; tracking quality improvement and productivity indicators concerning services and care provided to ensure resources are available and utilized efficiently; providing educational training programs for Children First nurse home visitors; collaborating with Program Evaluator, NFP National Service Office and Service Chief to develop program goals, outcomes and measurement tools; collaborating with Service Chief to develop annual budget or other information concerning agency financial requirements; approving expenditures, purchases and other actions to insure compliance with agency financial guidelines. **Qualifications** include possession of a valid permanent Oklahoma license as a registered nurse as approved by the Oklahoma Board of Nursing and five years of professional nursing experience in a managerial or consultative capacity; knowledge of professional nursing theory, practices, federal and state laws and regulations pertaining to nursing; master's degree in nursing, public health or other related field is preferred; ability to direct and coordinate the activities of multiple work units and divisions engaged in nurse home visitation; previous home visitation experience is preferred; ability to communicate effectively both orally and in writing; and ability to establish and maintain effective working relationships with agency, state and national staff.

Mildred O. Ramsey, R.N., M.P.H.

Experience

1997 to present — <u>Oklahoma State Department of Health</u>

Children First, Family and Support Prevention Service
Children First Program Director since February 2004. Job duties include responsibility for administration of the statewide nurse home visitation program, based upon standards established by the Agency, state statutes, the Oklahoma Health Care Authority and the Nurse Family Partnership National Service Office. Program Consultant from September 1997 to February 2004. Job duties included assisting Program Chief in implementation of Nurse Home Visitation Program by developing policies and procedures, developing and providing training programs and providing technical assistance to Children First Teams. From February to September 1997 provided home visitation services to Children First clients through Tulsa Health Department.

1994-1996 — <u>Sickle Cell Disease Association</u>
Deputy Director for Oklahoma Chapter of Sickle Cell Disease Association. Responsible for administering, planning and implementing program services for persons with sickle cell disease and trait conditions.

1992-1994 — <u>Tulsa Public Schools</u> Tulsa, OK
School Nurse for Tulsa Public Schools. Responsible for primary health care, health education and screening for students and school staff.

1975-1992 — <u>OXY USA INC</u> Tulsa, OK
Medical Department Administrator for OXY USA, INC. formerly known as Cities Service Oil and Gas Company. Advanced from staff nurse to Medical Department Administrator (88-92) during employment. Responsible for administration of employee health program – primary care, occupational illness and injury, medical surveillance, international health program, health education and wellness programs and pre-employment assessments.

Education

University of Oklahoma, Master of Public Health, 1996.
St. Joseph's College, Windham, ME, BA Health Care Adm.
St. Anthony School of Nursing, Oklahoma City, Diploma.

Memberships

Oklahoma Association for Infant Mental Health, Board Member
Home Visitation Leadership Advisory Coalition, Member
Eastern Oklahoma Black Nurses Association, Member

Licenses/Certifications

Licensed Registered Nurse; Oklahoma
Certified Trainer; Bridges Out of Poverty

<u>Program Manager, Office of Child Abuse Prevention (OSDH)</u>
Chris Fiesel
Under the supervision of the Chief of the Family Support & Prevention Service, this position serves as the Program Manager for the Office of Child Abuse Prevention. **Roles and responsibilities** include supervising program consultants and support staff; developing and implementing policies and procedures related to programs; developing and releasing Invitations to Bid so that Contractors can compete for Child Abuse Prevention Funds; assuring that contract staff is well trained and technical assistance is provided when necessary; working with program evaluator to monitor program data and develop reports; and monitoring and processing all financial aspects of the contracts. **Qualifications** include a Master's Degree and one year of professional supervisory, managerial, consultative or administrative experience in public health administration, social work, or other related-field or an equivalent combination of education and experience, substituting one year of professional level experience for each year of the required education. Experience in planning, developing and implementing programs that serve families with young children as well as monitoring state contracts is extremely helpful. Knowledge about evidence-based home visitation models and best practices related to center-based services for families is required. The ability to communicate effectively both orally and in writing, to develop and interpret policy, procedure and data and to maintain productive working relationships with others is a must.

CHRIS FIESEL

5033 Eric Drive
Oklahoma City, OK 73135
(w) 405.271.7611
(h) 405.672.5069
chrisf@health.ok.gov

SUMMARY OF QUALIFICATIONS

I am highly motivated and have always well represented my organization with professionalism and loyalty. I have successfully facilitated coalitation and community/family collaboration programs. I am experienced in policy making and I have an extensive background in program administration. I am well versed in complaint investigative procedures including fact-finding and personnel dispute resolution. My background includes contract negotiating, monitoring, and administering both state and federal programs. I have experience in developing internal policies and procedures, mission objectives and long-term goal-setting, a familiarity with the incorporation process, and working with boards of directors. My understanding of business operations and planning includes effective interaction with government and other agencies.

Contract Monitoring	**Program Services Monitoring**	**Fundraising**
Program Development	**Accounts Management**	**Non-Profit**
Community Development	**Policy and Procedure Development**	**Incorporation**
Board Development	**Staff & Supervisory Training**	**Human Relations**
Public Relation	**Complaint Investigations**	**Policy Regulations**

EXPERIENCE

2006–Current **Oklahoma State Dept. of Health** Oklahoma City, OK

Programs Manager

- Supervised staff of three, overseeing operation of 22 state and federal contracts
- Experience writing Invitation to Bid for state contracts
- Familiar with Interagency agreements
- Performed regular supervisory duties including performance management plans

2002-2006 **Oklahoma Commission on Children & Youth** Oklahoma City, OK

Oversight Specialist

- Investigated complaints regarding children in residential facilities
- Monitor and report conditions in public and private juvenile children's facilities
- Represented the agency at monthly Child Death Review Board meetings
- Have completed the CLEAR Stage I and II investigative training attaining the highest score ever with OCCY employees

1998-2002 **Oklahoma Child Care Resource & Referral** Oklahoma City, OK

Executive Director

- Founding Executive Director
- Incorporated the agency in 1999 in joint effort with OU, OKDHS, NRCYS
- Developed and negotiated contracts with nine member agencies throughout Oklahoma
- Developed policies for agency staff; negotiated staff benefits and developed employee handbook
- Established statewide Health Consultant pilot project
- Served 3-year term on Federal Region VI (5-state area) NACCRRA Board of Director

1998 – 1998 **Oklahoma Committee to Prevent Child Abuse** Oklahoma City, OK

Project Coordinator

- Supervised nine AmeriCorps workers
- Developed budgets and evaluation instrument for 3 child abuse prevention programs
- Co-Chaired statewide Shaken Baby Syndrom Campaign
- Expanded faith-based outreach program connecting families with social workers

1995 - 1998 **American Lung Association of Oklahoma** Oklahoma City, OK

Regional Manager

- Responsible for managing Western Oklahoma operations (Great Plains Region)
- Worked with Oklahoma State Dept. of Health drafting tuberculosis policy
- Coordinated Oklahoma Thoracic Society Annual Conference
- Provided approximately 40 asthma education presentations to Oklahoma schools
- Grant writing and fundraising

1991 - 1995 **Oklahoma Institute for Child Advocacy** Oklahoma City, OK

Program Director

- Created professional development training programs for educators and child care professionals
- Legislative advocate
- Provided approximately 400 trainings statewide to educators, childcare professionals, and agency staff
- Grant writing and fundraising
- Provided parent outrteach training to schools for State Dept. of Education in compliance with H.B. 1017
- Represented OICA at District VII Child Abuse Prevention Task Force 1992 - 1995

EDUCATION

1994-1996 Oklahoma City University Oklahoma City, OK

- **Master of Liberal Arts**
- Graduated with high honors

1986-1990 California State University Sacramento, CA

- **Bachelor of Arts in Liberal Studies**
- Teaching credential, elementary through adult with special education certification

1982 –1984 Butte Community College Oroville, CA

- Associate of Arts, Business Data Processing
- Work study program teaching Basic, Pascal, Fortran, Cobol
- Wrote system programs for Digital RSTS/E mainframe
- Assisted in department transition from card punch and sorter machines to networked terminals

ORGANIZATIONS / MEMBERSHIPS / PUBLICATIONS

- District VII Child Abuse Prevention Task Force, 1992 – 1995
- Rotary International, 2001 – 2004
- Nat'l. Assoc. of Child Care Resource & Referral Assoc., board of directors, 1999 - 2001
- Tobacco Free Oklahoma Coalition, past state chair, 1995 - 1997
- Private Pilot's license, Member AOPA, 1994 – 2005
- "Patched" member of Bikers Against Child Abuse (BACA), 2001 – 2004
- Co-founder and Vice President of Guardians of the Children, 2005 – 2007

- Road Captain, Faith Riders motorcycle ministry, 2007 - current
- Co-Author, Beyond Violence: From Conflict to Cooperation, copyright 1995
- Author, Fathers in Transition: Returning to the Family after Incarceration, curriculum, 1995
- Author, Positive Classroom Managerment: a Guide for Middle and Elementary School Teachers, copyright 1994
- Author, The Christmas Cactus, PublishAmerica, copyright 2009

PERSONAL INTERESTS

- motorcycle riding
- church activities
- traveling
- photography

REFERENCES ON REQUEST

PHONE (405) 672-5069 • CFIESEL@YAHOO.COM
5033 ERIC DRIVE • OKLAHOMA CITY, OKLAHOMA 73135 • CELL (405) 249-0486

Coordinator, Early Childhood/Family Education (ODE)
Erin Nation

Under the supervision of the State Superintendent of Public Instruction, this position serves as the Coordinator for Early Childhood/Family Education Programs at the Oklahoma State Department of Education. **Roles and responsibilities** include assisting in the development, implementation and administration of legislation and state Board regulations affecting children from birth to age 8 and their families; providing leadership for early childhood education projects, grants, initiatives; providing consultation, on-site assistance, and in-service training to local districts to support their efforts in providing appropriate curriculum/programs for young children; coordinating the development of early childhood curriculum standards, materials, publications and conferences; collaborating with other agencies, commissions, and organizations as directed; coordinating and managing the Oklahoma Parents as Teachers Program. **Qualifications** include a Master's Degree and one year of professional supervisory, managerial, consultative or administrative experience in education, child development, or other related-field or an equivalent combination of education and experience, substituting one year of professional level experience for each year of the required education. Must hold a Oklahoma teaching certificate. Experience in planning, developing and implementing programs that serve families with young children as well as monitoring state contracts is extremely helpful. Knowledge about evidence-based home visitation models and best practices related to center-based services for families is required. The ability to communicate effectively both orally and in writing, to develop and interpret policy, procedure and data and to maintain productive working relationships with others is a must.

ERIN.GRAY.NATION

709 Northwest 48th Street, Oklahoma City, Oklahoma 73118 | 405-286-3392 | erin.nation@ymail.com

EDUCATION

Candidate for Ed.D. in School Administration
Oklahoma State University; Stillwater, Oklahoma — August 2010-present

M.Ed. in Guidance and Counseling
University of Central Oklahoma; Edmond, Oklahoma — August 2007-May 2009
Graduated with Honors
GPA: 4.0 (based on 4.0 scale)

B.S. in Human Development and Family Science
Oklahoma State University; Stillwater, Oklahoma — August 2002-July 2006
Area of Concentration: Child and Family Services
Graduated Summa Cum Laude
GPA: 3.955 (based on 4.0 scale)

EMPLOYMENT

Early Childhood/Family Education
Teacher of the Year Program Coordinator
Oklahoma State Department of Education; Oklahoma City, Oklahoma — August 2006-present
Co-coordinate all public school early childhood programs within Oklahoma
Oklahoma state leader for the Parents as Teachers program
Oklahoma state leader for the Teacher of the Year program

EXPERIENCE

Summer Intern, 375 hours
Oklahoma County Court Appointed Special Advocates; Oklahoma City, Oklahoma — May 2006-July 2006
Created county-wide community resource directory; attended all necessary advocate training

AWARDS – GRADUATE LEVEL

College of Education and Professional Studies Outstanding Graduate Finalist, *University of Central Oklahoma*
Guidance and Counseling Outstanding Graduate, *University of Central Oklahoma*
President's Honor Roll (4 semesters), *University of Central Oklahoma*

AWARDS – UNDERGRADUATE LEVEL

College of Human Environmental Sciences (CHES) Senior of Excellence, *Oklahoma State University*
Top Twenty Freshmen Woman, *Oklahoma State University*
President's Distinguished Scholar, *Oklahoma State University*
President's Honor Roll (7 semesters) and Dean's Honor Roll (2 semesters), *Oklahoma State University*
CHES Outstanding Student, finalist, *Oklahoma State University*
Outstanding Greek Woman for Senior Class, finalist, *Oklahoma State University*
Outstanding Greek Woman for Junior Class, finalist, *Oklahoma State University*

ORGANIZATIONAL SERVICE – OKLAHOMA STATE DEPARTMENT OF EDUCATION

Academic Scholars, *staff*
Capitol Christmas Tree Lighting Ceremony, *chair*
Child Abuse Prevention Action Group, *member*
Child Care Advisory Board and Sub-Committee, *designee*
Early Childhood Professional Development Council, *member*
Head Start Early Childhood Advisory Board, *member*
Home Visitation Leadership Advisory Coalition, *committee member*
Interagency Coordinating Council for Prevention of Adolescent Pregnancy and Sexually Transmitted Diseases
Infant/Toddler Early Learning Guidelines, *committee member*
Kennedy Center Performances for Young Audiences Series, *Oklahoma committee member*
Master Teacher Project, *Early Childhood Content leader*
Oklahoma Combating Autism Leadership Team, *member*

Oklahoma Institute for Child Advocacy Fall Forum, *attendee*
Oklahoma State Leader, Parents as Teachers National Center
Oklahoma State Leader, National Teacher of the Year Program
Payne Education Center, *Energizing Readiness Advisory Board member*
Response to Intervention, *state team member*
SmartStart Oklahoma Policy and Systems Committee
SmartStart Oklahoma Ready Schools Initiative, *committee member*
State Superintendent's Encyclo-media conference for counselors and librarians, *presenter*
State Superintendent's For Counselor's Only conference, *presenter*
State Superintendent's Leadership conference for superintendents and principals, *presenter & conference planning committee*
State Superintendent's Transporting Children with Special Needs conference, *presenter*
Strengthening Families Advisory Board, *member*

ORGANIZATIONAL SERVICE – OKLAHOMA STATE UNIVERSITY

Student Conduct Committee	Fall 2004-Spring 2006
President's Leadership Council Facilitator	Fall 2004-Spring 2006
Freshman Follies Steering committee	Fall 2003, 2004, & 2005
Orange Peel Hospitality committee	Fall 2003 & 2005
CHES Ambassador	Fall 2003-Spring 2005
Camp Cowboy Counselor	Summers 2003 & 2004
CHES Student Council Representative	Fall 2003-Spring 2004
Orange Peel Programming committee	Fall 2004
CHES Scholar Leader	Fall 2002-Spring 2003
President's Leadership Council	Fall 2002-Spring 2003

MEMBERSHIPS

American School Counselor Association
Early Childhood Association of Oklahoma
Junior League of Oklahoma City
    Courtesy and Recognition General Committee
    May General Meeting Provisional Committee
Kappa Kappa Gamma, Oklahoma City Alumni Chapter
    Membership Development Chair, June 2010-present
Kappa Omicron Nu Honor Society
Mortar Board
National Association of Early Childhood Specialists in State Departments of Education
National Association of the Education of Young Children
National Society of Collegiate Scholars
Oklahoma Early Childhood Teachers Association, *conference committee member*
Oklahoma State University Alumni Association
Order of Omega
Phi Eta Sigma Honor Society
Phi Kappa Phi

COMMUNITY INVOLVMENT AND VOLUNTEER WORK

Heartland Lab Rescue
Junior League of Oklahoma City
    Remarkable Shop volunteer
    Mistletoe Market volunteer, Fall 2010
Kappa Kappa Gamma, Oklahoma City Alumni Chapter
    Philanthropy Task Force Chair, Fall 2009
    Philanthropic Project committee co-chair, Fall 2010
Kappa Kappa Gamma, Delta Sigma Chapter(Oklahoma State University)
    Vice President of Organization Advisor
Kappa Kappa Gamma Foundation
    Leadership Academy — held each September
        Participant, 2008; Facilitator-in-Training, 2009; Facilitator, 2010
Oklahoma County Court Appointed Special Advocates; Oklahoma City, Oklahoma

A PLAN TO ENSURE WELL-TRAINED, COMPETENT STAFF

In as much as possible, trainings will be combined for all home visitation programs regardless of model. Each home visitor will have to be trained in her respective service delivery methods as established by their National Model Developer. OSDH has long required additional trainings for Children First and Start Right home visitors, too. Parents as Teachers home visitors will now be required to attend, too.

Please see the following training charts.

Nurse-Family Partnership Supervisor Core Education Units

Supervisor Unit One	Unit Two	Supervisor Unit Three	Supervisor Unit Four
All new, expansion and replacement supervisors are required to complete the five distance education lessons in this course prior to attending Supervisor Unit Two. Each lesson takes approximately 20 to 30 minutes to complete. The lessons are designed to orient a supervisor to her/his role and responsibilities in the Nurse-Family Partnership program and concentrate on program logistics, including agency setup, documentation, referrals, and hiring nursing staff. Supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker.	This face-to-face session takes place from Monday afternoon through Friday, and is required for all new, expansion, and replacement Nurse-Family Partnership Nurse Home Visitors and Supervisors. The goal of Unit Two is to build on the foundation provided in Unit One and prepare new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Unit Two provides interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. NFP Model diagram	This distance education session focuses on Nurse-Family Partnership implementation issues, provides the supervisor with support in assessing the quality of nursing practice and implementation, and supports the professional development of nurse home visitors. A lesson is included to help supervisors learn how to connect with their community to sustain and grow their program. Supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker.	This face-to-face three-day session occurs approximately 4-6 months after completion of Unit Two. The session again focuses on the Nurse-Family Partnership model to promote supervisor skills around teambuilding and job stress and burnout. It also builds on reflection and motivational interviewing skills learned in earlier sessions. All new, expansion, and replacement supervisors are required to attend.

Nurse-Family Partnership Core Education Units

Unit One	Unit Two	Supervisor Unit Three
The goal of Unit One is to equip newly hired nurses and supervisors with foundational knowledge of Nurse-Family Partnership and the home visiting intervention. This distance education session is completed prior to Unit Two. Unit One is comprised of three components: completion of the Unit One workbook and online self-assessment; completion of the Partners in Parenting Education (PIPE) self-study workbook and online assessment; submission of the PIPE lesson plan; and completion of the online lesson *Using the NFP Visit-to-Visit Guidelines*. Nurse home visitors and supervisors access this course by logging in to the online Tracker system. You will be asked to reset your password the first time you login to Tracker. You may use the same password for both the NFP Community and Tracker. **Unit One workbook:** Completion of Unit One and the PIPE assessments and submission of the PIPE lesson plan are prerequisites to attending the face-to-face Unit Two session. All new, expansion, and replacement nurse home visitors and supervisors are required to complete the Unit One workbook and corresponding assessment. Anticipate spending approximately 25 hours on this self-study module. To view the Unit 1 workbook online, click here. **PIPE self-study workbook:** Additionally, those nurses and supervisors attending Unit Two are required to complete the Partners in Parenting Education (PIPE) Self-Study Workbook and corresponding assignments, which focus on PIPE curriculum. This workbook is designed to provide you with a foundation for understanding and using the PIPE instructional model and curriculum with clients. Anticipate spending approximately five hours on this workbook. After completion of the workbook, you will take the online assessment and submit your PIPE lesson. Your supervisor is responsible for purchasing all necessary PIPE materials for you to complete the workbook.	This face-to-face session takes place from Monday afternoon through Friday, and is required for all new, expansion, and replacement Nurse-Family Partnership Nurse Home Visitors and Supervisors. The goal of Unit Two is to build on the foundation provided in Unit One and prepare new nurses to implement the intervention with fidelity to the Nurse-Family Partnership model. Unit Two provides interactive learning where nurse home visitors receive instruction and assistance to begin applying information and building skills in the Nurse-Family Partnership intervention. NFP Model diagram	Building on Units One and Two, the goal of Unit Three is to provide nurses an opportunity to deepen their understanding of the Nurse-Family Partnership model, specifically in regards to infant temperament, motivational interviewing, and fidelity to the Nurse-Family Partnership Model Elements. Following Unit Two, you will consult with your supervisor regarding the best time to start the Unit Three distance lessons. The distance lessons will take approximately one to two hours per month over a six-month time frame. Nurse home visitors and supervisors access this course by logging in to the online Tracker system.

Healthy Families America Core Training

Core Training is required training for all direct service staff and their supervisors/program managers within six months of hire, core training instructs staff in their specific roles.			
Assessment Core Training	**Integrated Strategies for Home Visiting Programs Training**	**Supervisor Training**	**Orientation**
The Assessment Core Training is an in-depth, formalized training designed for staff whose primary role is to conduct initial assessments. It is also ideal for home visitors, who want to advance their communication skills to more confidently address difficult situations with families. Four full days for the family assessment specialist, plus an additional fifth day for supervisors and program managers include topics such as, but not limited to: identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, communication skills, etc. The trainer is certified and has been trained to train others.	*(formerly known as Family Support Worker Core Training)* Home Visitors Core Training is an in-depth, formalized training intended for home visitors of a Healthy Families America program. In-depth, formalized training which outlines the specific duties of the home visitor's role within Health Families and covers topics including, but not limited to: establishing and maintaining trust with families, completing necessary paperwork/documentation, the role of the home visitor, communication skills, and crisis intervention, etc. The trainer is certified and has been trained to train others.	A day of training for supervisors and program managers of HFA direct service staff positions (Family Assessment Specialists and Home Visitors). In-depth, formalized training which outlines the specific duties of the supervisor's role within Health Families and covers topics including, but not limited to: the role of family assessment and home visitation, effective supervision, quality management techniques, crisis management, understanding the program's policies and procedures; and case management, etc. The trainer is certified and has been trained to train others.	Familiarize staff with site-specific operating policies and procedures. Include information on the services provided, work hours, supervision requirements, emergency procedures, confidentiality issues, etc. (3 hours)

Healthy Families America Additional Training for Assessment Workers, Home Visitors, and Supervisors

Additional Training within 6-months of Hire	Additional Training within 12-months of Hire	Ongoing Training
Infant Care • Sleeping; • Feeding/breastfeeding; • Physical care of the baby; and • Crying and comforting the baby Child Healthy an Safety • Home safety; • Shaken baby syndrome; • SIDS; • Seeking medical care; • Well-child visits/immunizations; • Seeking appropriate child care; • Care seat safety; and • Failure to thrive Maternal and Family Health • Family planning; • Nutrition; • Pre-natal/post-natal healthcare; and • Pre-natal/post-partum depression Infant and Child Development • Language and literacy development; • Physical and emotional development; • Identifying developmental delays; and • Brain development Role of Culture in Parenting • Working with diverse cultures/populations • Culture of poverty; and • Values clarification Parent-Child Interaction • Supporting attachment; • Positive parenting strategies; • Discipline; • Parent-child interactions; • Observing parent-child interactions; and • Strategies for working with difficult relationships	Child Abuse and Neglect • Etiology of child abuse and neglect; and • Working with survivors of abuse Family Violence • Indicators of family violence; • Dynamics of domestic violence; • Intervention protocols; • Strategies for working with families with family violence issues; • Referral resource for domestic violence; • Effects on children; and • Gangs Substance Abuse • Etiology of substance abuse; • Culture of drug use; • Strategies for working with families with substance abuse issues; • Smoking cessation; • Alcohol use/abuse; • Fetal alcohol syndrome; • Street drugs; and • Referral resources for substance abuse Staff Related Issues • Stress and time management; • Burnout prevention; • Personal safety or staff; • Ethics; • Crisis intervention; and • Emergency protocols Family Issues • Life skills management; • Engaging fathers' multi-generational families; • Teen parents; • Relationship; and • HIV and AIDS Mental Health • Promotion of positive mental health; • Behavioral signs of mental health issues; • Depression; • Strategies for working with families with mental health issues; and • Referral resources for mental health	The program ensures that program staff receive ongoing training which takes into account the worker's knowledge and skill base.

Parents As Teachers Training Requirements

Program Tracks	Foundational Curriculum	Model Implementation Guide	Professional Development
Beginning January 2011, there will be two pathways or tracks: **Model Implementation** Requirements include: • Parents as Teachers Foundational Training (which includes Parents as Teachers Foundational Curriculum) • Completion of an Affiliate Plan • Model Implementation Training after (which includes the Guide) **Approved User** Requirements include: • Parents as Teachers Foundational Training (which includes the Curriculum)	The Foundational Curriculum will cover: • Core competencies and educator self-assessment • Protective factors • Reflective practice • Family systems/culture • Family needs assessment • Role of PE/resourcing • Foundational personal visit plans and guided planning tool • Dove DV Intervention • Edinburgh Depression Screen • Parent Educator Tool Kit Online resources include all of the above plus: • Parent/child activities pages • Parent educator resources • Parent handouts • Family support	Model implementation for those wishing to implement an evidence-based model with fidelity: • Parents as Teachers logic model • Quality assurance guidelines and essential requirements • Reflective practice • Family systems/culture • Family needs assessment • Role of PE/resourcing • Evaluation and quality	It is essential that parent educators access competency-based professional development and training and recertify with the national office annually. Professional Development for Parent Educators: • Year 1: 20 clock hours • Year 2: 15 clock hours • Year 3 and beyond: 10 clock hours

Supplemental Training For Children First (NFP) and MIECHV HFA & PAT Funded Programs

Grief	Attachment	Breastfeeding and Nutrition	Paternity Legal Medicaid	Substance Abuse
3.5 hours	3.5 hours	2 hours	3.5 hours	3.5 hours

Child Abuse Medical Examiner Documentation	Postpartum and Mental Health	Adoption	Car Seat Safety	Tobacco Cessation
12 hours	1 hour	3.5 hours	1 hour	1 hour

Lead Poisoning Prevention	Home Visitor Safety	Home Safety	Domestic Violence	Family Planning
1 hour	2 hours	1 hour	4 hours	1 hour

Ages and Stages Questionnaires Third Edition (ASQ)	Ages and Stages Questionnaires: Social-Emotional (ASQ:SE)

A PLAN TO ENSURE HIGH QUALITY SUPERVISION

Children First Supervision (NFP):

Children First developed a Lead Nurse Manual years ago. This manual is the basis for the NFP version used across the country. Subject matters addressed in the Lead Nurse Manual include:

- Roles and Responsibilities
- Orientation
- Reflective Consultation
- Case Conferences/Staff Meetings
- Audits
- Nurse-Family Partnership Supervisory Forms
- Critical Incidents (how to report)
- The Public Health Oklahoma Client Information System (database)
- Training
- Supplies

Children First Roles and Repsonsibilites:

The *Children First* (C-1) Lead Nurse (LN) provides leadership, supervision and day-today coordination for home visit services in a designated county or counties. The Lead Nurse is the bridge of communication for the nurse home visitors on the team as well as the nurse home visitors direct link to the Nurse Manager (NM)/Supervisor.

1. The Lead Nurse must meet all the requirements for the Registered Nurse III job classification from the Oklahoma State Office of Personnel Management.

2. The Lead Nurse must complete all required Public Health Nurse Orientation Modules as required by the Oklahoma State Department of Health, Nursing Service or City-County Health Departments.

3. The Lead Nurse must complete all required *Children First* Training including those specified for Lead Nurses.

4. The Lead Nurse must comply with the requirements for supervisory education hours as set forth by the Oklahoma State Department of Health, Human Resources Service or City-County Health Departments.

5. The Lead Nurse must supervise no more than eight (8) nurse home visitors. The nurse home visitors she/he supervises may be headquartered in multiple counties.

6. The Lead Nurse serves as a role model for the nurse home visitors in professional conduct and professional dress.

7. The Lead Nurse, NM/Supervisor and County Health Department Administrator (Administrator) will determine how many clients, if any, a Lead Nurse may carry. The Lead Nurse may carry no caseload or as many as a few depending on the number of nurses she/he has to supervise, the distance she/he must travel to supervise staff. A Lead Nurse's caseload must not be so great as to interfere with her/his supervisory duties. The rationale of having a Lead Nurse carry a caseload is to maintain credibility as a competent Home Visitor.

8. The Lead Nurse is responsible for coordinating home visit services for the *Children First* clients. In the absence of a nurse home visitor the Lead Nurse may serve as a substitute or assign an alternate nurse to the client.

9. The Lead Nurse receives referrals to *Children First* and assigns the referrals to the nurse home visitors. This process may be delegated if needed such as when a Lead Nurse travels between multiple sites.

10. The Lead Nurse consults with the NM/Supervisor and Administrator regarding technical nursing issues, training needs, legal matters or any issue that is pertinent, including but not limited to audit results, DHS reports, and Critical Incidents. The NM, in turn, contacts Nursing Service and the *Children First* Program Staff when assistance from the central office is needed.

11. When a critical incident occurs, the Lead Nurse should immediately notify the NM/Supervisor and Administrator and in turn, Nursing Service and the *Children First* Program Staff. A critical incident may be defined as but is not limited to:
    a. Severe injury to a *Children First* client or the child of a *Children First* client;
    b. Severe illness of a *Children First* client or the child of a *Children First* client;
    c. Death of a *Children First* client or the child of a *Children First* client;
    d. Any harm that has come to a nurse home visitor or Lead Nurse by a client or someone connected to the client.
    e. Any other significant event that may occur

12. The Lead Nurse schedules and facilitates the following:
    a. Reflective Consultation: The Lead Nurse is to meet weekly with each Individual nurse home visitor. The purpose of reflective consultation is to provide support to the nurse home visitor.
    b. Reflective Consultation: The Lead Nurse should meet weekly with the NM/Supervisor for her/his reflective consultation. The purpose of this meeting is to provide support to the Lead Nurse. (See the Reflective Consultation section of the Lead Nurse Manual for more specific information.)
    c. Monthly Staff Meetings: The Lead Nurse is to include all nurse home visitors in her/his area in these meetings. The purposes of staff meetings are to ensure the flow of communication and promote team building and staff development.
    d. Monthly Case Conferences: The Lead Nurse is to include all nurse home visitors in her/his area in these meetings. The purposes of the case conferences are to provide an opportunity to share expertise, seek support and present successful resolutions for challenging client situations.

13. The Lead nurse should maintain good communication with the Administrator, NM/Supervisor and Coordinating Nurse in each county he/she serves. Periodic meetings are recommended to discuss particular issues or other health department matters.

14. The Lead Nurse assists the nurse home visitors to identify community resources for clients. The Lead Nurse should maintain a resource directory at the county level, which should be periodically updated and utilized during case conferences.

15. The Lead Nurse completes the Supervision Progress Report (SPR) Form #443 for each nurse. Instructions for completing this form are located in the MIS Forms Manual.

16. The Lead Nurse completes the Visit Implementation Scale (VIS) Form #442 for each nurse. Instructions for completing this form are located in the MIS Forms Manual.

17. The Lead Nurse will observe each nurse at least one full workday a minimum of twice per year. The objectives during this observation should include but are not limited to the following:
    Observing/Assessing the nurses
    a. Nursing Practice
    b. Time Management
    c. Adherence to program guidelines and Nursing G & O's
    d. Utilization of tools/resources
    The observation time should not be scheduled on a day the nurse has leave or meetings. These visits may be utilized to complete the SPR and VIS forms.

18. The Lead Nurse and/or the designee conducts in-home assessments in accordance with the *Children First* Program requirements, utilizing the Nursing Child Assessment Satellite Training (NCAST) screening tool.

19. The Lead Nurse conducts quarterly chart audits to ensure adherence to the *Children First* Guidelines, NFP model, Agency Guidelines and Nurse Practice Act. Chart audits are performed utilizing the schedule and tools identified in the *Audits* section of this manual. Additional audits may be performed at the discretion of the NM/Supervisor and/or Program Staff. Audit results are to be shared with NM/Supervisor and the *Children First* Program Staff.

20. The Lead Nurse is responsible for ordering, distributing and maintaining C-1 supplies. This task may be delegated at the discretion of the Lead or NM/Supervisor.

21. The Lead Nurse promotes public awareness and utilization of *Children First* in the community. It is important for the Lead Nurse to maintain relationships with referral sources and to periodically analyze referral resource data to ensure that *Children First* clients are being recruited from all possible venues. It is recommended the Lead Nurse participate in at least one community outreach activity per year. This should be documented on the county outreach log.

22. The Lead Nurse collaborates effectively with other disciplines and informs staff of all available services from those disciplines.

23. The Lead Nurse routinely meets with other home visitation program staff in order to exchange referrals, share information, collaborate on special projects and ensure that home visitation efforts are not duplicated.

24. The Lead Nurse monitors data entry to be certain that it occurs in a timely manner.

25. The Lead Nurse monitors home visitors productivity and provides strategies for improvement if necessary.

26. The Lead Nurse notifies NM/Supervisor when a staff member is not adhering to guidelines, policies or procedures. The Lead Nurse proceeds with disciplinary

Start Right Supervision Requirements (HFA):

Supervisor Qualifications
At a minimum the program supervisor will have a masters or bachelors degree in early childhood development, family relations, social work, human relations, psychology, adult education or other closely related field and a minimum of two years experience supervising home visitors.

Hardship Clause: If a Start Right Program can provide written documentation that there are no applicants for the Supervisor position that meet the minimum requirements, the Program may petition in writing the Chief of the Family Support & Prevention Service. The petition may request that the position be filled provisionally or temporarily with a person that does not meet the requirements.

Supervisor Activities
The Start Right Programs agree to provide program staff with a minimum of one hour of individual supervision per week to include both professional and administrative aspects of supervision according to the definitions of the OCAP/Start Right Program Manual.

The Start Right Programs agree to provide program staff with a minimum of four hours of group supervision per month to include both professional and administrative aspects of supervision according to the definitions outlines in the OCAP/Start Right Program Manual.

The Start Right Programs agree to keep written documentation of supervision. Written documentation will include:

- Dates and times of supervisory sessions
- Amount of time for each supervisory session
- Names of program staff present during the supervisory session
- Dates and times of supervisory "shadow visits"
- Specific topics and issues discussed

- Notation of decisions made
- Notation of family file folders reviewed
- Recommendations for follow-up action needed
- Notation regarding who is responsible for follow-up
- A services management record
- Weighted caseload assignments for each staff person as defined in the Healthy Families America Training Manual
- Staff training plans and staff training records

In addition, the Supervisor shall:

- Facilitate ongoing collaborations with local community partners
- Assure that program data is being collected and entered into the OCAP database and transmitted to OCAP as required
- Prepare for and participate in OCAP site visits
- Prepare and submit bi-annual and annual program performance narrative reports as required
- Attend all required Start Right Program meetings
- Organize and complete all required Start Right paperwork as required
- Maintain confidentiality
- Complete all pre-service training and required supplemental training

Parents as Teachers:

Qualifications:
Master's Degree preferred**.** Demonstrated ability for working with young children and their parents, and possession of an Oklahoma teaching certificate in one of the following:

- Early Childhood Education
- Elementary Education
- Related Field

OR
Possession of a Bachelor's Degree in one of the following:

- Child Development
- Nursing
- Family and Consumer Sciences
- Related Field

Upon employment, completion of the Oklahoma State Department of Education approved professional development training regardless of previous training and experience is required:

Initial employment with PAT
-A minimum of 30 hours preservice training from the Parents as Teachers National Center *Birth to Three Institute* of 12 hours if serving as a Coordinator only.

Continued Education During Employment
-First year: a minimum of 20 hours professional development
-Second year: a minimum of 15 hours professional development

-Third year and every year after: a minimum of 10 hours professional development

Responsibilities:

1. Plan and implement the PAT Program in accordance with the guidelines of the Parents as Teachers National Center and the Oklahoma State Department of Education.
2. Assure all legal, financial and organizational requirements are met during all phases of program development and implementation.
3. Achieve high visibility for PAT by promoting and developing relationships with community and governmental agencies.
4. Develop an annual implementation plan, including measurable objectives, activities and action timetable.
5. Recruit and supervise staff.
6. Recruit program participants and monitor provision of services.
7. Refer children and families with special needs to appropriate services in the community.
8. Develop and maintain an information management system.
9. Monitor program progress and assist in the evaluation of outcomes.
10. Prepare and submit reports to the Oklahoma State Department of Education, as needed, on services provided to children and families.
11. Provide staff support services to the Community Advisory Committee and/or the Internal Coordinating Committee.
12. Attend the annual program orientation meeting and participate in local, statewide and national networking efforts.
13. Maintain confidentiality.
14. Provide education to the community on PAT and its services
15. Assist in the development and implementation of fund-raising projects.
16. Successfully complete the supervisor training and certification through the Parents as Teachers National Center.
17. Serve a minimum of five families each program year if parent educator recertification is desired.
18. Ensure monthly statistical reports are submitted to the Child Services Demonstration Center.
19. Ensure at least one staff member attends the informational meeting, regional meetings and the Family Matters Conference.
20. Facilitate and host the program site visits made by the PAT State Leader from the Oklahoma State Department of Education.

A PLAN TO ENSURE REFERRAL AND SERVICE NETWORKS

In both Kay and Garfield Counties, there is more than one existing home visitation program. Both counties are also rich in community services. The feature that seems to be lacking and that the community focus group has highlighted is a "connector" of sorts.

For this reason, MIECHV funds will be used to contract with a community agency for a part-time employee that can serve as that "connector" in each county. This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources
- Collect referrals for home visitation programs and distribute them to the appropriate home visitation program
- Organize opportunities for the home visitation programs to meet on a routine basis so that the program can staff referrals if necessary and share programmatic information
- Organize opportunities for the home visitation programs and other community services to meet on a routine basis so that all can learn from each other

Because of the dollar amount involved, it may be that the contract for such a position will have to go out to bid. This issue is being researched at this time. It should be noted though that while there are several community organizations that have expertise in community development, Smart Start Oklahoma appears to be uniquely positioned to partner with the home visitation programs in this manner. Smart Start Garfield County and Smart Start Kay County not only are strongly connected to community services, they also have expertise and a focus on early childhood.

A PLAN TO ENSURE FIDELITY TO THE MODELS

Permission has been received from model developers to implement three evidence-based home visiting models for the ACA MIECHV Program in the State of Oklahoma. Those models are Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. To assure fidelity to all models, implementation as recommended by the model developer of each is addressed.

Healthy Families America: The plan for implementation of the Healthy Families America (HFA) model begins with the completion of the application process for formal affiliation with the HFA initiative and payment of the required annual fee ($1350 in 2011). Once affiliation is granted, a program site is considered to have provisional status. Within the first three years of HFA affiliation, programs are required to move from affiliation to accreditation and complete HFA accreditation process.

HFA affiliates go through a two-part process to become accredited. The first step is completion of the Self-Assessment. The purpose of the Self-Assessment is to provide each program with an opportunity to critically review its organizational structure and service delivery and compare its results against professionally accepted, research-based national standards. The Self-Assessment forms the basis for the second step required to become accredited which is peer review.

Once the Self-Assessment has been completed and submitted, a team of at least two external, trained peer reviewers conduct a site visit. The purpose of this visit is to provide a comprehensive and objective review and validate a program's self-assessment and adherence to the critical elements.

Based on their findings, the peer review team prepares a Site Visit Report which is sent first to PCA America and then to the applicant program. The program has 45 days to respond to the report in writing. This response is then discussed by the HFA Advisory Panel and a decision is made. Depending on the outcome of the Self-Assessment, the peer reviewer site visit, the program response and the deliberations of the Panel, the evidence will be used to determine whether to grant accreditation or a delay is necessary.

With regard to staff training specific to the model, Oklahoma has HFA certified trainers who conduct the required HFA training according to trainer licensure agreements. Program staff that were previously trained as family support workers will be required to complete the updated Integrated Strategies for Home Visiting Programs. Purchase of the updated HFA manuals will also be required. Technical assistance will be available from the HFA national office and the Southeastern/Western Regional Director.

Nurse-Family Partnership: Children First will continue to be implement NFP using the Model Elements. As described by the national model developer, the Model Elements are supported by evidence of effectiveness based on research, expert opinion, field lessons, and/or theoretical rationales. The 18 Model Elements are divided into the following categories: clients, intervention context, expectations of the nurses and supervisors, application of the intervention, reflection and clinical supervision, program monitoring and use of data, and agency. The elements, as listed below, will be used for implementation of the model.

Clients:

- Element 1: Client participates voluntarily in the Nurse-Family Partnership program.
- Element 2: Client is a first-time mother.
- Element 3: Client meets low-income criteria at intake.
- Element 4: Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of week 28 of pregnancy.
  Intervention context:
- Element 5: Client is visited one-to-one, one nurse home visitor to one first-time mother or family.
- Element 6: Client is visited in her home.
- Element 7: Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership guidelines.
- Element 8: Nurse home visitors and nurse supervisors are registered professional nurses. Although the national developer recommends nurse home visitors have a minimum of a baccalaureate degree in nursing, nurses who deliver the program in Oklahoma must meet the minimum requirements for a Registered Nurse II as outlined by the Oklahoma Office of Personnel Management. According to these requirements, the nurse must possess a valid permanent Oklahoma license as a registered nurse and one year of professional nursing experience or show completion of the requirements for a bachelor's degree in nursing which substitutes for the required one year of experience.
- Element 9: Nurse home visitors and nurse supervisors complete core educational sessions required by the Nurse-Family Partnership National Service Office and deliver the intervention with fidelity to the Nurse-Family Partnership model.

Application of the intervention:

- Element 10: Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.
- Element 11: Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods.
- Element 12: A full-time nurse home visitor carries a caseload of no more than 25 active clients.

Reflection and clinical supervision:

- Element 13: A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors.
- Element 14: Nurse supervisors 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.

Program monitoring and use of data:

- Element 15: Nurse home visitors and nurse supervisors collect data as specified by the Nurse-Family Partnership National Service Office and use Nurse-Family Partnership reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Agency:

- Element 16: A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.
- Element 17: A Nurse-Family Partnership Implementing Agency convenes a long-term community advisory board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.
- Element 18: Adequate support and structure shall be in place to support nurse home visitors and nurse supervisors to implement the program and to assure that data are accurately entered into the database in a timely manner.

<u>Parents as Teachers</u>: To implement Parents as Teachers (PAT), programs must affiliate with the Parents as Teachers national office and report annually on service delivery, program implementation and compliance with the model replication requirements through an Affiliate Performance Report.

New PAT programs must complete a three-step process for affiliation. That process is outlined below:

1. Review the Readiness Reflection and Essential Requirements. The purpose of these documents is to help communities assess their ability to fully implement the Parents as Teachers model with fidelity.
2. Complete an Affiliate Plan. An Affiliate Plan guides organizations through planning to build a strong foundation for high quality program. Designed as a logic model, it links inputs, activities, outputs and outcomes for families. It also helps determine appropriate staff and budget. Keeping the end in mind as a new program is developed leads to strong programs and maximized positive outcomes for families.

3. Send home visitors to training. Once an Affiliate Plan is approved, the organization's home visitors complete the PAT Foundational Training and the Model Implementation Training. The Foundational Training is designed to lay the foundation for home visiting as a methodology within the early childhood system and connects the theoretical framework of PAT with practice. Model implementation Training incorporates the PAT Quality Assurance (QA) Guidelines and offers implementation strategies and evidence-based practices that help organizations fully understand and bring to life quality PAT services. The training explains how to successfully replicate the Parents as Teachers model with fidelity. Demonstrating accountability, evaluation and outcomes are themes throughout.

Existing Parents as Teachers programs should already be affiliated. If so, they will proceed through the implementation process by sending parent educators to training. PAT has newly revised training and curriculum with an increased emphasis on evidence-based practices for working with vulnerable populations and a strengthened home visiting model with a heightened focus on quality and model fidelity.

COORDINATION WITH OTHER PLANS INCLUDING THE STATE ADVISORY COUNCIL PLAN AND THE STATE EARLY CHILDHOOD COMPREHENSIVE SYSTEM

The State Advisory Council Plan &
The State Early Childhood Comprehensive Systems (ECCS)

The OSDH ECCS Project works collaboratively with the Oklahoma Partnership for School Readiness (OPSR) Board housed at Smart Start Oklahoma (SSO) in order to implement the Early Childhood Comprehensive State Plan. The mission of OPSR and ECCS is to lead in the coordination of an early childhood system that focuses on strengthening families and assuring that all children are ready for school. All agree that young children across the state should have access to the following services:

- Parent education and family support;
- Social and emotion support; and
- Quality early care and education.

While various staff from FSPS participate on Smart Start committees and workgroups and have long valued our affiliation with Smart Start, the MIECHV Grant process has lead many of those working with Oklahoma home visitation programs that Smart Start's Plan and the ECCS Plan should better appreciated. In addition, perhaps the home visitation programs have not been as involved in the development of the Plans and now see that their activities could and should be included. This recognition has been just one of the many benefits of the MIECHV Grant process.

The Oklahoma Health Improvement Plan (OHIP) &
The Oklahoma Children's Health Improvement Plan (CHIP) &
The Oklahoma State Plan for the Prevention of Child Abuse and Neglect

Working in concert . . . The Oklahoma State Department of Health, along with its numerous partnering agencies and organizations, developed the Oklahoma Health Improvement Plan in 2009. Many key priorities and outcomes that will support health improvement throughout the state are outlines in the OHIP. The OHIP was mandated by the Oklahoma Legislature in 2008 by Senate Joint Resolution 41 and directed the State Board of Health to prepare a report that outlined a plan for the "general improvement of the physical, social and mental well being of all people in Oklahoma through a high-functioning public health system."

The OHIP addresses improving health outcomes in three targeted "flagship initiatives:"

1. Tobacco Use Prevention
2. Obesity Reduction
3. Child Health

These flagship issues tie closely to the efforts of the prevention of child abuse. An example of the overlap between the OHIP and child abuse prevention efforts is found in Oklahoma' home

visiting programs provide education on a myriad of parenting and health-related topics as well as referrals that directly impact the flagship issues and the risk of child maltreatment.

However, it is important to note that each of the flagship issues does have its own State Plan with specific goals and objectives. The Oklahoma Child Health Improvement Plan (CHIP) has a section devoted to preventing and reducing child abuse and neglect. In order to better coordinate efforts, members of the CHIP Advisory Panel simply adopted goals and objectives directly from the Oklahoma State Plan for the Prevention of Child Abuse and Neglect 2010 -2013. The State Plan for the Prevention of Child Abuse and Neglect was co-developed by Family Support & Prevention Staff and the Interagency Child Abuse Prevention Task Force.

It is gratifying to see State Plans referencing one another. The integration of efforts helps to articulate a cohesive system for children and families. However, it might be that three Plans were integrated so easily because the health department was the lead agency for all three Plans. While reviewing other Plans related to early childhood, it was discovered that such integration was not always as readily apparent. This is something to be mindful of when participating in the development of future State Plans of all types.

The Oklahoma Child Death Review Board

While not a Plan, the Oklahoma Child Death Review Board (CDRB) has included in its annual report since 2003 the following recommendation:

“Increased funding of primary and secondary prevention programs of the Oklahoma Department of Human Services, Oklahoma State Department of Health, Oklahoma State Department of Education and the Oklahoma Department of Mental Health and Substance Abuse Services.”

COMPLIANCE WITH MODEL SPECIFIC PREREQUISITES

Letters from the Model Developers have been submitted has required in this Supplemental Information Request on or before March 23, 2011. Every effort to comply with the Model Developers requirements will be made.

Each of the home visitation models selected for inclusion in the MIECHV Grant Program is already operating within Oklahoma. OSDH has an affiliation with Nurse-Family Partnership, Healthy Families America and Parents as Teacher. The MIECHV requirements will simply strengthen these agreements.

OSDH recognizes that implementing interventions with model fidelity has been shown to positively impact client and program outcomes. Each of the National Model Developers has drafted objectives to assist agencies track fidelity to the model and monitor program outcomes related to the MIECHV Grant.

In addition to the Model Developers tracking measures, the OSDH program consultant will strive to show model fidelity by developing reports based on information gathered during site visits, record audits and shadowing home visits.

STRATIGIES FOR MAKING MODIFICATIONS TO BOLSTER THE COMPREHENSIVE EARLY CHILDHOOD SYSTEM

New to the home visiting systems in Kay and Garfield County will be the addition of a part-time position to "connect" the home visitation programs to consumers, each other and community services.

In both Kay and Garfield Counties, there is more than one existing home visitation program. Both counties are also rich in community services. The feature that seems to be lacking and that the community focus group has highlighted is a "connector" of sorts.

For this reason, MIECHV funds will be used to contract with a community agency for a part-time employee that can serve as that "connector" in each county. This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources
- Collect referrals for home visitation programs and distribute them to the appropriate home visitation program
- Organize opportunities for the home visitation programs to meet on a routine basis so that the program can staff referrals if necessary and share programmatic information
- Organize opportunities for the home visitation programs and other community services to meet on a routine basis so that all can learn from each other

Because of the dollar amount involved, it may be that the contract for such a position will have to go out to bid. This issue is being researched at this time. It should be noted though that while there are several community organizations that have expertise in community development, Smart Start Oklahoma appears to be uniquely positioned to partner with the home visitation programs in this manner. Smart Start Garfield County and Smart Start Kay County not only are strongly connected to community services, they also have expertise and a focus on early childhood.

COLLABORATIONS WITH OTHER EARLY CHILDHOOD INITIATIVES

Respite Care: For several years, Community-Based Child Abuse Prevention Grant monies have been used to support respite care for families that were at-risk of child abuse and neglect. Families from the Start Right Programs as well as the Children First Program were eligible to participate based on an "identified need" by their home visitor. The respite program was designed to empower the family. The parents/caregivers made the decisions about who provided the respite care, when and where it was provided and much they would pay. They were also responsible for interviewing, hiring and evaluating their respite care providers. Vouchers were approved by FSPS staff of OSDH and the actual payment was made by the Oklahoma Department of Human Services.

The Front Porch Project: The FSPS has become involved in the American Humane Association's Front Porch Project – a research supported, community-based initiative built upon the belief that all people who are concerned about the safety and well-being of children in their communities need to be encouraged and taught to make a difference.

In January and February of 2010, 23 individuals were trained to conduct Front Porch Community Trainings. One such training has been held in Ponca City (Kay County) and was very well received. Additional trainings could be held in both at-risk counties to foster the citizenry's commitment to children.

Preparing for a Lifetime: This statewide initiative to improve birth outcomes and reduce infant deaths in Oklahoma focuses on seven specific areas: preconception and interconception care, tobacco use prevention, prematurity, postpartum depression, breastfeeding, infant safe sleep and infant injury prevention. Using state and community-based level partnerships (including FSPS staff), strategies include public education, policy change and support of health care providers and birthing hospitals through training and technical assistance.

The infant mortality rate, defined as the number of deaths to infants less than one year of age per 1,000 live births, is one of the most important indicators of the health of Oklahoma and the nation. It is associated with a number of factors such as maternal health, parenting practices and socioeconomic conditions.

The top three causes of infant mortality in Oklahoma are congenital defects, disorders related to low birth weight and short gestation and Sudden Infant Death Syndrome. Although child abuse and neglect may not be listed as one of the specific top three causes of infant death, some of the same positive parenting practices that often keep parents from being abusive or neglectful are the same behaviors that decrease the likelihood of a child dying during infancy from a variety of causes.

The Oklahoma State Department of Health Commissioner's Action Team on Reduction of Infant Mortality was convened in May 2007. It has expanded to engage state and community partners in a statewide initiative, "Preparing for a Lifetime, It's Everyone's Responsibility," with strategic planning, data analyses and targeted interventions. Example subject matters being addressed include breastfeeding, premature births, smoking during pregnancy, infant safe sleep practices

and preventing infant injuries – many subject matters that overlap with child maltreatment prevention. The "Injury Prevention Workgroup" developed during this process and made the decision to target "abusive head trauma" as one of their first subject matters (see the below section).

The Shaken Baby Prevention Education Initiative Task Force &
Preparing for a Lifetime – Injury Prevention Workgroup &
Period of Purple Crying Project: Almost simultaneously, House Bill 2920 was passed in 2010 requiring the establishment of the Shaken Baby Prevention Education Initiative Task Force. The purpose of the task force was to identify evidence-models for reducing the incidence of abusive head trauma in infants in Oklahoma. Prior to this legislation being passed, the Injury Prevention Workgroup of the Preparing for lifetime Initiative identified this as a priority to be addressed, creating a plan to work with all birthing hospitals in Oklahoma to implement the "Period of Purple Crying." Collaborating closely with the Oklahoma Hospital Association, the University of Oklahoma Health Sciences Center, the Office of Perinatal Quality Improvement and the Medical Services Trauma Unit, the two groups combined efforts and chose to support the implementation of the Period of Purple Crying. Materials were purchased to assure that for one full year, all parents of newborns could receive a Period of Purple Crying dvd and educational brochure. A total of 60,000 dvds were purchased at $2.00 each. The total cost was split between CBCAP and funds the OSDH Maternal and Child Health Service.

Those hospitals that agreed to participate in the project received the following:

- Program Description and Protocol – a step-by-step implementation guide;
- Online training on how to implement the "Purple" program in the hospitals with patients;
- Period of Purple Crying dvds – for new parents to view in the hospital and take home;
- Educational brochure for parents about infant crying and possible ways to soothe a baby;
- Parent Acknowledgement Statements – a form acknowledging that the parent has watched the DVD and received the DVD in the hospital take home packet;
- Client Release Form – a form that provides contact information to a home visitation program if the family is interested in services; and
- Copies of the Oklahoma Home Visitation Directory – a county-by-county listing of all home visitation programs for young children for families with young children

The Oklahoma Strengthening Families Initiative: This initiative has now been in existence for four years. The pilot sites have continued their collaborations with their local childcare centers and other community organizations. Examples include:

- Childcare centers were awarded mini grants to make some type of change in their center that would enhance families' involvement in their program. Some created clothing/diaper resource rooms for parents, while other made physical changes to their buildings that make them more family friendly.
- Pilot site implemented parent involvement projects of their choosing such as resource libraries
- Ongoing "Caregiver Cafes" continue and these cafés have been extremely helpful in breaking down barriers between the Head Start providers, parents, and community. Social networks have been developed and families and staff look forward to meetings.

- Continued partnering opportunities are taking place with the Oklahoma Department of Human Services/Child Welfare, Oklahoma State University Cooperative Extension Services, Tulsa Community College and the Early Childhood Program at the OU/Tulsa Campus.
- Collaborated with community partners to establish a community facility at a low-income apartment complex where parenting classes and student tutoring can be held, a resource library with over 1,000 donated books, and some donated computers for use by the residents to promote family literacy and enhanced job skills for the parents; project not yet completed.
- Provided two provider min-grants and one provider scholarship to promote seeking advance START levels for childcare facilities
- Oklahoma has embedded the Strengthening Families Protective Factors framework in the state's Early Childhood Comprehensive Systems Grant, the Smart Start Initiative and the State Plan for the Prevention of Child Abuse and Neglect.
- Front Porch Training – abuse and neglect intervention/prevention training for the average citizen.
- F.A.T.H.E.R Program – parenting for fathers in prison

The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS)
The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, statewide study that collects information about a woman's behaviors and experiences before, during and after pregnancy. Oklahoma PRAMS is funded by the Center for Disease Control and Prevention (CDC), the Title V Maternal and Child Health Block Grant and the Oklahoma State Department of Health. Thirty-six other states conduct a PRAMS survey. Oklahoma has been a PRAMS participant since the CDC project began in 1988.

The purpose of PRAMS is to discover why some babies are born health and why other are not , in an effort to increase the number of babies in Oklahoma who are born healthy. The information is used to help guide programs and health policy and to help make better use of limited resources.

On a monthly basis, Oklahoma PRAMS randomly samples between 200 and 250 new mothers from Oklahoma birth certificates. Mothers are sent as many as three mail questionnaires, with follow-up phone interviews for women who do not respond to the mailed surveys. All information is kept confidential.

Oklahoma currently collects PRAMS data on the following topics: health insurance, prenatal care, breastfeeding, maternal smoking and secondhand smoke exposure, alcohol use, social support and family planning. In the next version of the questionnaire, Oklahoma has added questions about home visiting.

The Oklahoma Toddler Survey (TOTS): The Oklahoma Toddler Survey (TOTS) is a two-year follow-back survey to the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), and was created by Oklahoma in 1994. TOTS re-surveys PRAMS respondents the month the child turns two years old. TOTS is funded by the Title V Maternal and Child Health Block

Grant and the Oklahoma State Department of Health. Oklahoma was the first state to begin a follow-back survey to PRAMD; currently, three other states have a similar survey.

The purpose of TOTS is to learn about the health and well-being of Oklahoma's toddler population. The information is used to help guide programs and health/child development policy and well as to direct the use of limited resources.

Similar to PRAMS, TOTS sends as many as two mail questionnaires to between 150 -175 women each month followed by phone contact for those mothers that do not respond by mail. All information is kept confidential.

Currently, TOTS includes questions about health care and insurance, illness and injury, childcare, safety, breastfeeding, secondhand smoke exposure and family structure

Smart Start Oklahoma: Established under the Oklahoma Partnership for School Readiness Act in 2003, Smart Start Oklahoma through a community approach is charged with increasing the number of children who are ready to succeed by the time they enter kindergarten. In 2008, the Partnership Board was designated by the Governor as the State's Early Childhood Advisory Council, as required by each state under the 2007 Head Start Reauthorization Act. To further solidify the Partnership's role, in 2010, legislation established the Board as the Early Childhood Advisory Council. As a public-private partnership, Smart Start Oklahoma pursues strategies for improving learning opportunities and environments for children birth to age six years.

State legislation charges the Partnership with promoting and enhancing community collaboration for early childhood programs and services. to accomplish this, Smart Start Oklahoma has an 18-member community-based network serving 52 counties across the state and reaching 88% of children under the age of six. At the state level, Smart Start Oklahoma supports communities with grants, technical assistance and fiscal management.

Smart Start Oklahoma focuses on four key strategy areas:

- Community Development
- Public Engagement
- Public Policy and Systems Development
- Resource Development

Reaching for the Stars – Childcare Rating System Promoting Quality Childcare): Research has shown that the quality of childcare impacts the cognitive, social, emotional and physical development of a child. The Oklahoma Department of Human Services developed a childcare rating system to provide an easily understandable guide to the quality of care available at licensed childcare facilities, including centers, homes and Head Start. The goals of the Stars program are to assist parents in evaluating the quality of a childcare setting; and to improve the quality of childcare by increasing the competence of teachers and raise their subsidy reimbursement rate, resulting in more slots of children whose families are receiving childcare assistance.

- One Star Facilities meet minimum licensing requirements that focus on health and safety.
- One Star Plus programs meet the minimum requirements plus quality criteria that includes additional training, reaching to children daily and parental involvement.
- Two Star programs meet further quality criteria including master teacher/home provider qualifications and program evaluation or accreditation by a national organization.
- Three Star programs meet the above quality criteria and are nationally accredited.

Oklahoma Family Resource Coalition: The Oklahoma Family Resource Coalition (OFRC) is a membership organization that is made up of individuals who believe that families are the primary influence in the lives of children. The mission of the OFRC is to support resources within communities that build on family strengths in order to ensure the best possible outcomes for families. This is an alliance of committed individuals, both professional and lay, that share their knowledge and expertise with one another.

The OFRC was formed in 1991 and was established as a non-profit in 1992. The membership represents a broad spectrum of statewide services, ethnicities and occupations. A 30 member Board of Directors is elected to provide direction for the membership.

The OSDH Child Guidance Service: This Service is a multidisciplinary program consisting of behavioral health, child development, speech/language pathology and audiology for children birth to age 13 years. The goals of the Service include improving the quality of family relationships, parent-child relationships and the family's relationship to the community. Additional goals include increasing a parent's ability to provide appropriate guidance and learning opportunities for their children and improving the capacity of communities to support for families.

The Child Guidance Service and home visitation programs certainly refer families to each other for specific services. However, the idea of an even stronger, more formal relationship should be explored. One such suggestion might be that because of Child Guidance's expertise in facilitating and administering evidence-based group services such as *Incredible Years, Parent-Child Interaction Therapy* and *Circle of Security*, home visitation programs agree to refer their families to these services and they no longer provide center-based services.

The Oklahoma Infant Mental Health Association: The Oklahoma Association for Infant Mental Health (OK-AIMH) is a 501c3 and an affiliate of the World Association for Infant Mental Health. For nearly 20 years, it has been organization focusing on the mental health needs of infants and toddlers in Oklahoma. OK-AIMH's mission is to ensure that families, professionals and community organizations collaborate to support every child's mental health through awareness of the central role that relationships play in building health lives, ensuring that one day all Oklahoma children will be emotionally healthy, equipped to learn and nurtured to develop their full potential.

Section 7: Plan for Continuous Quality Improvement

DISCUSSION OF A PLAN FOR CONTINUOUS QUALITY IMPROVEMENT

Continuous quality improvement (CQI) is essential. In order to provide the highest quality service in the most cost effective manner, it is necessary for home visiting programs to continually improve. CQI components have been woven throughout the updated plan for the Oklahoma MIECHV Program.

As the home visiting plan is implemented, there will be new and, quite possibly, unanticipated challenges. Some adjustments may need to be made immediately. Other changes may need to be made throughout the process of implementation. This is the nature of the cycle of quality improvement. It is also in sync with the rolling process that has been developed by the designers of the ACA MIECHV Program.

Continuous quality improvement and program accountability necessitate the use of statistical data. The selection, procurement, and implementation of a system for data collection is a detailed and, often, lengthy process for a state agency. Adherence to federal, state, and agency regulations is mandatory and will be carefully monitored. The feasibility of adapting existing data systems will also need to be considered. However, this may be cost prohibitive and/or simply not possible due to the limitations of older technology.

One requirement of the selected data system is the ability to generate frequent reports with information about a wide array of indicators. The reports must be customizable such that they can provide a summary of program performance with regard to process measures and outcomes in each community. Reports will be made available to program staff giving them the opportunity to learn about the effectiveness of their own practices and efforts.

National model developers are an important component of the CQI plan. Oklahoma has obtained permission from three evidence-based home visiting model developers to implement their models for the ACA MIECHV Program. Developers of the chosen models are committed to ensuring that local implementation of their respective models is strong and effective. Each has made provision for the availability of ongoing guidance, support, and technical assistance that will enable local agencies to adhere to the quality standards required by the specific model.

Immediate and ongoing training is a CQI need that has already been identified. The Parents as Teachers Program has revised both their parent educator training and their curriculum. All staff

that use PAT will need the opportunity to complete this training as soon as possible. Healthy Families America has changed the training for family support workers and supervisors. Staff that implement HFA will need the updated training. HFA also has new manuals for family support workers, program supervisors, and, eventually, for family assessment workers. The most recent editions of the HFA manuals will need to be purchased for programs using the model. As changes are developed for each model, provision will need to be made for their implementation in programs, as appropriate.

The need for specific supplemental training has also been identified. For example, in the communities to be served, the indicator for domestic violence is higher than the state average. Thus, there is a need for providers to receive training on best practice for intimate partner information and intervention. Whenever possible and appropriate, staff for all programs will be given the opportunity to receive the same training. This should be the most cost effective method of providing training. If all providers receive the same training, it should also provide a more consistent continuum of service for the community and families being served.

Another key component of CQI for home visiting programs is on-site visits conducted by administrative staff at the state or, in some cases, regional level. The site visits typically include review of program records and family files. Opportunities for technical assistance can then be made available as soon as needs are identified.

Fiscal management and monitoring is an important element of CQI. All contracts and documents will undergo the detailed and thorough process of contract monitoring required by agency policy. Federal, state, and agency financial rules and regulations will be enforced. Continuous monitoring allows for the discovery and correction of small discrepancies before they become much larger and create catastrophic problems.

CQI is most effective when it is a hands-on endeavor by people who care about their work and strive to improve themselves and their productivity every day. This includes staff at all locations in all levels and positions. Following review of the results from data reports and monitoring activities, decisions may need to be made to determine what, if anything, should be improved; the possible methods to be used to make the improvements; and the steps needed for the chosen plan of improvement. Everyone should be involved in this effort. The key to CQI is action.
All MIECHV Program partners and staff must share the commitment to continuous quality improvement and ongoing program evaluation to better meet the needs of the families that are being and will continue to be served.

Section 8: Technical Assistance Needs

Oklahoma is fortunate in that home visitation services are not a new strategy to improving the health and welfare of families with young children. There are at least six home visitation models employed by various agencies across the state. Several have been in existence for more than a decade. However, the Oklahoma State Department of Health foresees the need for technical assistance from HHS in regards to the following areas:

1. Data and Information Systems: The OSDH has a good deal of experience with data collection and information systems relating to OSDH-based Children First and Start Right Programs. Since 1997, both programs have been collecting and reporting process data and programmatic outcomes. With the addition of now needing to collect specific requirements for the MIECHV Grant and needing to include PAT data, a new system for collecting and analyzing data will have to be developed or purchased. At this time, OSDH has limited capacity (limited by the number of staff, not skill) to develop computer programming capable of sophisticated analysis. Technical assistance would be useful in this area.

2. Communication and marketing – A most definite need for all home visitation models will be a smart, relevant communication and marketing strategy. Because of limited funding and expertise, the OSDH has struggled to promote its own home visitation programs over the years to the potential program participants and communities at large. OSDH would appreciate technical assistance regarding the best practices for marketing home visitation services.

3. Outreach to potential program participants – Over the years, the OSDH home visitation programs (Children First and Start Right) have noticed a decline in the percent of persons agreeing to enroll in the programs – dropping from 50% to less than 25% in some locations. Different strategies have been put in place to discover the causes and attempt to reverse the current trend. However, OSDH has not seen tremendous gains in this area. This may be the case with PAT as well. Technical assistance would be useful in this area.

4. Participant engagement/retention - A question that has plagued many home visitation programs is how to engage and retain participants for as long as possible so that the participant can obtain the most benefits from their participation. While any length of participation in a home visitation program may be beneficial to some extent, certain "dose/response rate" issues do arise. Most literature shows that the longer a participate remains engaged in a home visitation program; the more positive impact can be quantified. This issue of keeping the participant enthused about the program is a common one among a variety of models. Technical assistance would be useful in this area.

Section 9: Reporting Requirements

ASSURANCES

The Oklahoma State Department of Health will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the MIECHV Grant.

The Oklahoma State Department of Health assures that the report will address the following:

State Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;
- Any update/revisions to goal(s) and objectives identified in the Updated State Plan;
- To the extent not articulated above, a brief summary regarding the State's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided in the Updated Plan. Identify updates or changes to logic model if necessary.

State Home Visiting Promising Program Update

- Updates on the grantee's evaluation of any implemented promising programs;
- If applicable, copies of reports developed in the course of the local evaluation of promising programs and any other evaluation of the overall home visiting program undertaken by the grantee.

Implementation of Home Visiting Program in Targeted At-risk Communities

Updates regarding experience in planning and implementing the home visiting programs selected for each community of need as identified in the Updated State Plan, addressing each of the items listed below. Where applicable, States may discuss any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges.

- An update on Oklahoma's progress for engaging the at-risk community(ies) around the proposed State Home Visiting Plan;
- Update on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on the timeline provided in Update State Plan, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by the State or the implementing local agencies;
- Update on staff recruitment, hiring and retention for all positions including subcontracts;

- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education and other social and health services);
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program and the proposed response to the issued identified.

Progress Toward Meeting Legislatively Mandated Benchmarks

Update on data collection efforts of each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, barrier/challenges encountered during data collection efforts and steps taken to overcome them.

Home Visiting Program's CQI Efforts

Update of Oklahoma's efforts regarding planning and implementing CQI for the home visiting program. If applicable, copies of CQI reports developed addressing opportunities, changes implemented, data collected and results obtained.

Administration of State Home Visiting Program

- Updated organization chart, if applicable;
- Updates regarding changes to key personnel, if any (include resumes for new staff if applicable);
- An update on Oklahoma's efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges;
    - Training efforts to ensure well-trained, competent staff;
    - Steps taken to ensure high quality supervision;
    - Steps taken to ensure referral and service networks to support the home visiting program and the families it serves in at-risk communities;
- Updates on new policy(ies) created by Oklahoma to support home visiting programs.

Technical Assistance Needs

An update on technical assistance needs anticipated for implementing the home visiting program or for developing a statewide early childhood system.

ATTACHMENTS

Affordable Care Act Maternal, Infant, and Early Childhood
Home Visiting Program

Supplemental Information Request for the Submission of the
Updated State Plan for a State Home Visiting Program

OMB Control No. 9015-0333

As required, this document ensures agreement among the undersigned State agencies on the Updated State Plan for a State Home Visiting Program. All are committed to collaboration and are in agreement with the implementation of the program and are dedicated to seeing that home visiting is part of a continuum of early childhood services within Oklahoma.

Terry L. Cline, PhD, Commissioner; Secretary of Health and Human Services
Oklahoma State Department of Health
[Title V; Title II of the Child Abuse Prevention and Treatment Act; Public Health; Public Health Injury Surveillance and Prevention Program]

Howard Hendrick, Director
Oklahoma Department of Human Services
[Child Welfare; Title IV-E; Title IV-B; Temporary Assistance for Needy Families; Supplemental Nutrition Assistance Program]

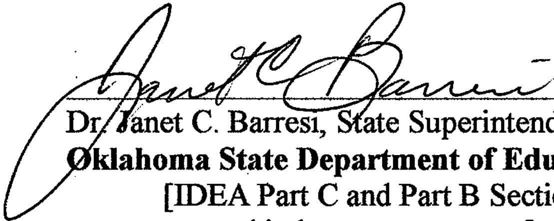
Terri White, MSW, Commissioner
Oklahoma Department of Mental Health and Substance Abuse Services
[Substance Abuse; Mental Health]

Debra Andersen, MA, CCC-SLP, Executive Director
Smart Start Oklahoma
Oklahoma Partnership for School Readiness

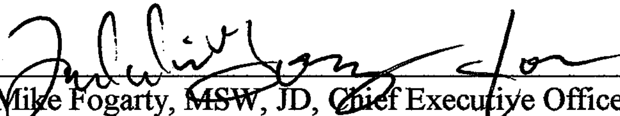
Lesli Blazer, Administrator
Oklahoma Child Care and Development Fund

Kay C. Floyd, State Director of Head Start Collaboration
Oklahoma Association of Community Action Agencies

Marny Dunlap, MD, Chair
Oklahoma Partnership for School Readiness and State Early Childhood Advisory Council

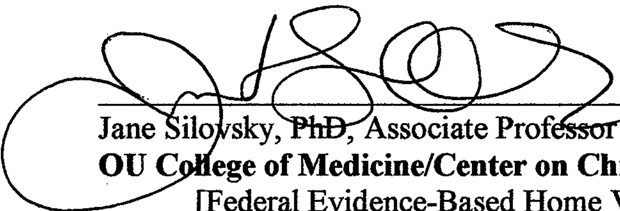


Dr. Janet C. Barresi, State Superintendent of Public Instruction
Oklahoma State Department of Education
[IDEA Part C and Part B Section 619; Elementary and Secondary Education Act Title I or pre-kindergarten program]



Mike Fogarty, MSW, JD, Chief Executive Officer
Oklahoma Health Care Authority
[Medicaid; Children's Health Insurance Program; Early Periodic Screening, Diagnosis and Treatment Program]

Marcia Smith, Executive Director
Oklahoma Coalition Against Domestic Violence and Sexual Assault



Jane Silovsky, PhD, Associate Professor
OU College of Medicine/Center on Child Abuse and Neglect
[Federal Evidence-Based Home Visitation Grantee]