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PROGRAM NARRATIVE - INTRODUCTION

In 1995, three year old Ryan Luke died in a small town in southeastern Oklahoma from physical child abuse. Sadly, this case is not uncommon in Oklahoma.[1] However, this particular case involved notable individuals and caught the attention of state legislators. Legislators asked the Office of Child Abuse Prevention (OCAP) at the Oklahoma State Department of Health (OSDH) to explore new approaches to strengthen families and reduce the incidents of child maltreatment.

Legislators did not know that OCAP staff had been reading the prevention literature and had already begun a partnership with Professors Rex and Anne Culp at Oklahoma State University to develop a pilot home visiting program. When OCAP shared their interest about home visiting with legislators, they were asked to bring a home visiting expert to share information with them. Dr. David Olds came to Oklahoma in 1996 and presented data gathered from his clinical trials involving nurse visited families.

The legislators were impressed with Dr. Olds' outcomes and in the spring of 1996, the Oklahoma Legislature passed the "Children First" law requiring that an evidence-based nurse home visitation program[2] be implemented. A little more than $1 million in general revenues was appropriated for four pilot programs, launching Children First(C1), Oklahoma's NFP program in four counties[3] with a total of 19 nurses. These nurses began visiting families in February 1997.

The OCAP home visiting pilot project, spearheaded by Drs. Culp of OSU, was developing in a parallel fashion. Utilizing a blend of state revenue from the Oklahoma Child Abuse Prevention Fund and Federal Community-Based Child Abuse Prevention dollars, OCAP proceeded to implement their home visiting program in six counties.[4]

The momentum for home visiting increased. The Oklahoma Legislature, desperate to assist at-risk families and their young children by the use of "evidence-based" programming, secured more state funding for the home visitation programs. At that time, little was known about replicating clinical trials in "real world" settings. Expectations were high and C1 was dramatically and rapidly increased in size. Within six months of implementing the four pilots, the legislature mandated that the program provide services in all 77 counties. The program was given $5.6 million and an additional 125 nurses were hired. The following year, the legislature appropriated $11 million and soon over 250 nurses were serving as fulltime visitors. Because it was fiscally impossible to send all of the nurses to Denver multiple times a year for NFP training, Oklahoma was allowed to develop its own training package. NFP staff came to Oklahoma to provide model specific training. While these were exciting and promising times, OSDH and NFP learned *many* lessons from this experience about implementing programs and taking them to scale (the importance of community buy-in, qualities needed for a successful visitor, the need for additional training particularly associated with psycho-social issues, and much more).

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[1] While the U.S. Department of Health and Human Services Administration on Children, Youth and Families, *Child Maltreatment 2006* reported that Oklahoma ranked as the very worst among the states, the District of Columbia and Puerto Rico in child fatalities, Oklahoma moved up in the rankings to #38 in the 2009 Report.

[2] At that time, Nurse-Family Partnership did not have a branded model name.

[3] Garfield, Muskogee, Oklahoma and Tulsa Counties

[4] Garfield, McCurtain, Muskogee, McIntosh, Washington and Nowata Counties

Meanwhile, the Child Abuse Prevention Fund was also increased to a little more than $3 million, allowing OCAP to contract with more than 20 community agencies across the state for home visiting services expanding the Culps' work. As the OCAP home visiting program evolved, all contractors were required to utilize the Healthy Families America (HFA) framework and the Parents as Teachers' (PAT) curriculum and collect data. Today these programs are uniformly known as "Start Right."

Because C1 and OCAP are located within the CBCAP Lead Agency (OSDH), the state revenues used to support both home visiting programs have been historically used as leverage in the CBCAP Grant process, allowing Oklahoma to increase its CBCAP award from a base of approximately $300,000 to more than $800,000. A good portion of these additional dollars have been used to support home visiting efforts (i.e. *Chepota Himmita* - The Chickasaw Nation's HFA Program, training for a variety of home visitors, C1 services in Tulsa and Oklahoma Counties, travel expenses for C1 and OCAP staff to make annual site visits, etc.).

In addition to the state appropriations and federal CBCAP funding, C1 is reimbursed by Medicaid. Early on, C1 nurses were reimbursed under targeted-case management if they determined that a family had a "new identifiable need." They were reimbursed in such cases at a rate of $43.82 per visit. In recent years, a State Plan amendment for Clinic and EPSDT benefit categories was approved by the Centers for Medicare & Medicaid Services Region and a new rate for $67.50 per visit was established for nursing assessments.

With the proliferation of home visiting models, additional programs have been initiated in Oklahoma. The Oklahoma State Department of Education (ODE) began investing in Parents as Teachers Programs in 1992 – making them the first home visitors focused on parents and young children in the state. They piloted PAT in 13 school districts. Federal funds have been predominantly used to implement Healthy Start programs in the metropolitan areas. A few county health departments have embraced Healthy Steps. Many Head Start Programs added a home visiting component to their center-based activities.

In 2002, home visiting champion Representative Ron Peters, asked OCAP to seek out home visiting models effective with families exhibiting the highest of risk factors (untreated mental illness, current substance abuse, and/or active intimate partner violence). OCAP staffed the "high-risk" task force, but eventually turned the reins over to the Oklahoma Department of Human Services (OKDHS) believing that they had more expertise in providing tertiary care. State funding was provided to implement the Safe Care+ model through OKDHS and the OU Center on Child Abuse and Neglect (CCAN) evaluates the project.

As the number of home visiting programs increased, a competitive atmosphere began to develop at both the local and state levels. For that reason, the Home Visitation Leadership Advisory Coalition (HVLAC) was created in 2002. This dynamic group, staffed by the CBCAP Grant Coordinator, is open to anyone interested in home visiting and has helped shape the home visiting community into a much more collaborative environment.

Over the years, home visiting has proven successful in supporting at-risk families. However, downturns in the economy and shrinking state revenues have taken their toll on home visiting budgets. All of the previously mentioned programs still exist, but most have had budgets reduced in the early 2000's as well as these past three years. The program that has sustained the largest cuts over time has been C1. It is still

the state's largest home visiting program supported by $7.7 million in state funds plus $2.4 million collected in Medicaid and $350,000 in CBCAP monies. Yet, services are no longer provided in all counties and only 150 nurses serve as fulltime visitors.

Still, Oklahoma has a proven track record with home visitation and the Oklahoma State Legislature continues to invest in home visiting – even when general revenues have declined. OSDH, ODE and other local agencies are constantly seeking to improve the quality of home visiting services and now enthusiastically share their knowledge and expertise relating to best practices. CCAN Staff contribute to the field by way of their research and publications and is one of the 17 Federal Evidence-Based Home Visitation Grants awardees. The Choctaw Nation is the newest member to the Oklahoma home visiting landscape. Recently named as one of the Federal Tribal MIECHV Grant Awardees, they will be implementing PAT with culturally sensitive adaptations.

It is true that Oklahoma is a relatively poor state and has its share of challenges related to the health and well-being of young children and their caregivers. Yet, we are a tremendously determined, caring, and pioneering-type of people. Oklahoma's home visitation professionals will do their utmost to assure that a Maternal, Infant and Early Childhood Home Visitation (MIECHV) *Expansion* Grant Award would improve the quality and quantity of services offered to families and ultimately improve the lives of many within our Great State.

Description of Proposed Project: The Oklahoma State Department of Health (OSDH) Family Support and Prevention Service (FSPS) proposes to build upon Oklahoma's early comprehensive childhood system by *enhancing and expanding* the continuum of home visitation services available to pregnant women and families with infants or young children. Based upon the needs assessment associated with the original MIECHV Grant as well as other variables, the following at-risk counties have been selected for the MIECHV Competitive Grant activities: Comanche, Muskogee, Oklahoma and Tulsa counties.

Problem 1: There is more than one home visiting program in each county and generally their efforts are not coordinated among each other OR with other supporting services.

Related to **Priority Element 3**: Support the development of multi-state home visiting programs; **Priority Element 4**: Support the development of a comprehensive early childhood system that spans the prenatal-through-age-eight continuum.

Solution 1A- Improve Coordination and Collaboration between Home Visiting Programs
There is a minimum of three home visiting programs and a maximum of 14 programs operating within each of the four counties with no cooperative agreements. For this reason, Oklahoma plans to contract with local organizations to serve as "connectors" in each of the counties.[5] An example of one potential *Connector* would be Smart Start Oklahoma (SSO) - a public-private agency with the mission "to lead Oklahoma in coordinating an early childhood system focused on strengthening families and school readiness for all children." They house the Oklahoma Partnership for School Readiness Board which serves

[5] Because of the dollar amount involved, this contract will have to go out for bid. Smart Start Oklahoma is used as an example of a qualified contractor.

as Oklahoma's Early Childhood Advisory Council. Title 10 O.S. 2001, Section 640.1 of the Oklahoma Statutes charges the Oklahoma Partnership for School Readiness Board, and therefore SSO, with many duties including the following: *Encourage public and private programs, services and initiatives be brought together to provide coordinated, community-based, effective and cost-efficient programs.*

A *Connector* with expertise in early childhood and community development would be in an outstanding position to facilitate coordination/collaboration between the home visiting programs in order to:

1) Avoid competition between and reduce duplication of home visiting services; and
2) Establish a local coalition between all home visiting programs (regardless of whether the programs are funded by the Competitive MIECHV Grant) so that best practices and community information can be shared.

Solution 1B - Improve Coordination Between Home Visiting Programs and Other Supportive Services

While Oklahoma has been investing in a myriad of home visiting models, it has also been developing an outstanding early childhood learning community comprised of such programs as "Stars" – a quality rating system for childcare; three EduCare Centers; innovative Head Start programs; "SoonerStart" - a top quality early intervention (IDEA Part C) program; and a nationally recognized, universal Pre-Kindergarten Program. Add to this list of impressive programming for young children Oklahoma's unique public health feature: The Child Guidance Program. Child Guidance Teams, administered regionally by local county health departments, serve children from birth to age thirteen. Each team includes a child development specialist, a speech-language pathologist, and a behavioral health specialist. Child Guidance professionals provide center-based services such as parenting education, discipline-specific interventions, child development screenings and evidence-based programming such as the "Incredible Years."

In addition to this list of quality programming for young children, services for specific challenges facing parents and caregivers such as mental health, domestic violence and substance abuse are scattered across the state. It is critical that home visitors establish solid relationships with these services, so that they can quickly and appropriately meet the individual needs of their families.

Therefore, Oklahoma plans to partner with agencies and engage in the following activities:

1) *Connectors* will assure that home visiting programs are knowledgeable about existing supporting services in their county by routinely hosting network meetings and thereby increase the number of appropriate referrals made to such supporting services by home visitors.
2) Memorandums of Agreement and/or Understanding will be established between services, and families will be asked to complete a Release of Information so that their contact information may be shared with relevant services.
3) Families on Head Start center-based services' waiting lists will be referred to existing home visiting services and priority will be given to them for service.
4) OSDH will establish a formalized mechanism to introduce and transition home visited families to supporting services - particularly to the Child Guidance Service.

Problem 2: Although home visitation services exist in the selected counties and the number of eligible families exceeds the current amount of evidence-based home visitation services available, the referral base for home visitation programs needs to be increased.

Related to **Priority Element 2**: Support effective implementation and expansion of evidence –based home visiting programs or systems with fidelity; **Priority Element 3**: Support the development of multi-state home visiting programs.

Solution 2A- Expand or Initiate Evidence-Based Home Visiting Models in the Four Selected Counties
With input from all of the three MIECHV Leadership Teams as well as local home visitors, service providers and most importantly families, three models were chosen for initiation or expansion: Nurse-Family Partnership (NFP) through the Oklahoma State Department of Health's Children First Program; Healthy Families America (HFA) through the Oklahoma State Department of Health's Office of Child Abuse Prevention; and Parents as Teachers (PAT) through the Oklahoma State Department of Education (ODE). Each of these models has been utilized within Oklahoma for over a decade. *Please refer to Needs Assessment for an explanation of current home visitation services and the counties' needs.*

However, choosing to grow only these three models does not mean that additional models would not be beneficial to the state's continuum of services. Oklahoma recognizes that by providing a variety of programs, families have a greater opportunity to participate in a program that best meets their needs, schedules and perhaps even style. Early Head Start and Safe Care+ were discussed at great lengths and should more funding become available, Oklahoma would highly consider expanding these particular programs. *Please see Attachment 1, Page 7 for "The Continuum of Home Visitation Services" visual.*

Solution 2B– Increase the Outreach to Families Eligible for Home Visiting Services through Improved Marketing Strategies
For more than two years, CCAN has pulled together a variety of professionals, mostly affiliated with home visiting, to explore and develop efforts to sustain their Federal Evidence-Based Home Visitation Grant (EBHV) activities. Just recently, that same group voted to extend its mission beyond the EBHV Grant and include all evidence-based home visiting programs within Oklahoma. The group will now be expanded to include representation from more models and other interested stakeholders.

SSO recently joined the EBHV Sustainability Group and is a welcomed addition. The EBHV Sustainability Group has chosen marketing of home visitation services to be a top priority and coincidently Oklahoma law tasks SSO to "i*mplement a public engagement campaign and establish a structure to facilitate communication between communities."* SSO has the capability to galvanize the private sector (public relations, media strategists, etc.) around the issue of home visiting and our comprehensive early childhood system. They are also allowed to seek private funding for activities. The potential to combine private dollars and/or voluntary professional marketing talent with MIECHV funds could provide long-needed branding and visibility for the home visiting system.

In addition, it is thought that the *Connector* could assist with outreach related to home visiting programs. Operating much like pharmaceutical representatives, the *Connector* will continually remind referral sources (hospitals, schools, clinics, social services, etc.) about available home visiting programs. They may also be allowed to market home visiting directly to potential families.

It should be noted that in the original MIECHV Grant, Oklahoma requested federal technical assistance related to marketing strategies. Lessons learned from such technical assistance will certainly be utilized in Comanche, Muskogee, Oklahoma and Tulsa counties if appropriate and germane.

Problem 3: As is true with home visiting programs in general, Oklahoma struggles to initially engage and later retain families in home visitation programs.

Related to **Priority Element 5**: reach high-risk and hard-to-engage populations; **Priority Element 6**: Support a family-centered approach to home visiting.

Solution 3A – Develop a "Centralized Referral/Triage System" to Assure that Families Are Quickly Referred to the Home Visiting Program that Best Meets Their Individual Needs

At this time, Oklahoma has no centralized statewide referral system for home visiting services. Oklahoma aspire to develop a referral system that will electronically capture information on parents eligible for home visiting services so that all will be approached about participating. Potential data sources for such a referral source might be Medicaid and/or the Women, Infants and Children Program (WIC). Often parents are provided contact information for services and never follow through with the referral. There are times when a family declines services to one program, but may have said "yes" to another because the other program would have been a "better fit." Oklahoma plans on learning from other state's experiences and incorporating the most effective and efficient strategies as it develops its system.

Solution 3B - Implement and Evaluate New Strategies to Increase the Number of Families that Enroll in Home Visiting Services

The trend in Oklahoma has been that one out of two families offered home visiting services will follow through with enrollment. This rate of enrollment could be better, but it does tend to look like the enrollment rate for many home visiting programs across the country. However, Oklahoma, C1 specifically, has seen the enrollment rate slip from the 50% mark over the past few years. We have not been able to determine what has caused the decline. In the original MIECHV Grant, Oklahoma has requested technical assistance regarding this issue. Lessons learned can be applied to all Oklahoma home visiting programs and this Grant's activities.

Solution 3C – Implement and Evaluate New Strategies to Determine How to Increase the Length of Time a Family Participates in Home Visiting Services

Oklahoma is well aware that the longer a family participates in home visiting, the greater the likelihood that the child and family's situation will be improved. For this reason, OSDH has long been interested in the retention of clients. C1 in particular has exerted considerable efforts to determine what strategies best keep families engaged in home visiting. Over the years, C1 has requested NFP's assistance to conduct focus groups of parents, study individual nurse practices and analyze data regarding client retention. Often improvements would be seen, but were not sustained. In January 2011, C1 partnered with NFP to submit a grant proposal through the Affordable Care Act Nurse, Education, Practice, Quality and Retention Program to continue to address client retention. The proposed work will be conducted by a consortium of state health departments implementing the NFP model, led by the OSDH and supported by the University of Colorado, College of Nursing. The status of this grant is still pending.

Problem 4: Oklahoma will strive to improve its quality of home visitation service by meeting or exceeding the required MIECHV benchmarks and constructs.

Related to **Priority Element 1**: Support improvements in maternal, child and family health; Priority **Element 3**: Support the development of multi-state home visiting programs.

Solution 4A– Implement and Evaluate New Strategies Designed to Improve the Home Visiting System
The proposed study designed by CCAN will use a mixed-method (quantitative/qualitative) approach to inform and evaluate change of the overarching areas identified for improvement. The evaluation methods used are uniquely designed to assess the epidemiology of disadvantaged early childhood populations in each of the selected counties, identify system innovations of potential beneficial impact, and assess effectiveness of implemented system level changes. Data collected for the evaluation will cross all of the problem areas, will be obtained from a diverse set of sources and will provide rich, informative guidance about strengths and weaknesses of home visitation and comprehensive early childhood systems operations.

Solution 4B – Collect Data, Analyze and Report on the Required MIECHV Benchmarks and Constructs
Oklahoma's original MIECHV Grant Plan necessitates the development of a mutual, coordinated system of data collection, data evaluation and data reporting. The MIECHV Grant Evaluator with assistance from other OSDH epidemiologists and CCAN will explore the options of developing or purchasing an "off-the-shelf" software package.

Also, Oklahoma is in the beginning stages of developing an early childhood data system and home visiting information will be included. SSO is taking the lead with this project. The SSO Data Systems and Coordination Workgroup, comprised of representatives from child serving agencies, held a Data Roundtable in December 2010 resulting in a list of key questions that a unified database should answer. The Workgroup is currently inventorying the various state databases for data elements, system regulations and possibilities to link. SSO was recently invited by the Data Quality Campaign's Early Childhood Data Collaborative to travel to Pennsylvania to learn about the *Pennsylvania Enterprise to Link Information for Children across Networks* (PELICAN). SSO took with them individuals from OKDHS, ODE and the Chair of the Oklahoma Early Childhood Advisory Council. All came back with a clearer picture of what Oklahoma needs in order to measure Oklahoma early childhood efforts.

<u>Logic Model</u>
The original MIECHV Grant logic model serves as the basis for the Competitive Grant's logic model. Long-term outcomes relating to model implementation, quality of service delivery, model fidelity and the achievement of the MIECHV benchmarks and constructs are assumed in the Competitive Grant's logic model. However, the distinguishing factors between the two logic models are:

1) The Competitive Grant's emphasis on expanding and enhancing Oklahoma's comprehensive early childhood system with home visiting being but one component; and
2) CCAN's rigorous evaluation of "system" improvements as well as the required MIECHV benchmarks and constructs analysis.

See Attachment 1, page 1 for the Competitive MIECHV Grant Logic Model.

NEEDS ASSESSMENT

State Overview: In 2009, Oklahoma had an estimated 3,687,050 residents and ranked as the 28th most populous state. With its 77 counties, the state spans some 69,898 square miles, ranking 20th in land area with approximately 53 persons per square mile and ranking 36th among all states in population density.

Considered mainly a rural state, the state has three larger cities. Nearly 60% of the Oklahoma population resides in the metropolitan statistical areas of Oklahoma City within Oklahoma County (1,189,529; 32.9%) and Tulsa within Tulsa County (903,868; 25%). A much smaller percentage of the Oklahoma population lives in the metropolitan statistical area of Lawton within Comanche County (112,653; 3.1%). The remainder of Oklahomans lives in rural locales. Recent years have seen population shifts to the more urban areas.

Approximately 25 percent of Oklahoma's population is under 18 years of age. The male-female ratio is roughly 1:1. In 2008, females of childbearing age (15 – 44 years) numbered 722,027 – about 20 percent of the population. The white population makes up 78 percent of the total population, while African American/Black equals about 8 percent. The Hispanic or Latino population comprises 7.6 % of the total population. Less than two percent of the population is of Asian descent.

American Indian/Alaska Native citizen make up about eight percent of Oklahoma's population. As a percentage of the total population, Oklahoma's American Indian/Alaska Native population is about eight times larger than the comparable United States population. Oklahoma is home to the largest number of federally recognized tribes, 38 American Indian sovereign nations with an additional tribe pending recognition. Contrary to popular perception, Oklahoma has no reservations with the exception of the Osage Tribal Jurisdictional Areas.

Selecting At-Risk Communities: Oklahoma began preparing for the MIECHV Grant in the spring of 2010. The potential to receive federal funds for home visiting became a constant agenda item on the Interagency Child Abuse Task Force (ITF) and the Home Visitation Leadership Advisory Coalition's (HVLAC) meeting agendas. Prior to the actual collecting and analyzing of the needs assessment data, the ITF and HVLAC agreed that the following criteria must be present within an at-risk community in order to expand or initiate home visiting services with MIECHV Grant funds:

- The at-risk community must have at least 10,000 residents.
- The at-risk community must have at least one operating home visiting program.
- Substance Abuse, Domestic Violence and Mental Health services must be available in the at-risk community.
- Smart Start Oklahoma must be present in the at-risk community.
- [During the spring of 2011, the requirement of a Child Guidance Team was added.]

The OSDH Title V Maternal and Child Health Assessment Division, with assistance from the MIECHV Grant Evaluation Advisory Group, conducted the MIECHV needs assessment. They first designated the administrative subdivision of "county" as the geographic area to represent an "at-risk" community. The required MIECHV indicators were then compiled for each of the 77 counties. A county level rate was computed for each of the indicators. Risk indicators held equal weight in the average risk ratio computation. The average risk ratios were ranked to reveal the counties' relative position among all counties within the state.

Of the top ten counties ranked with the highest of needs, two counties[1] did not have populations of 10,000 or more. Their removal from the rankings moved McClain and Tulsa Counties into the top ten for consideration. County data profiles were developed for each of the counties ranked in the top ten.

The original MIECHV Grant funding and efforts are dedicated to the counties falling first and second in the county rankings: Kay and Garfield counties. For the MIECHV Expansion Grant, the remaining eight counties were considered. Four of these eight counties met the earlier agreed upon MIECHV Grant criteria. Below you will find descriptions as each.

Comanche County

Located in southwestern Oklahoma, Comanche County was originally part of the Kiowa-Comanche-Apache Reservation. Comanche County's economy has been largely based on agriculture, raising livestock and the military presence of the Fort Sill Army Base. The total population of Comanche County is 112,653 – ranked as the third most populated county.

Per the MIECHV Grant needs assessment, Comanche County accounts for 3 percent of the Oklahoma population. Compared to the state as a whole, the county has a higher percentage of African American residents (17.2% vs. 8%), a lower percentage of American Indian residents (4.9% vs. 8%), and a higher percentage of Hispanic residents (9.7% vs. 7.6%). The white population makes up the balance of the Comanche County population (65.7% vs. 78%). Both median household income and per capita income for Comanche County are less than that of the state.

For eight of the MIECHV Grant indicators included in the needs assessment, the county experiences rates higher than the comparable state rates: preterm birth, low birth weight, poverty, overall and juvenile crime rates, binge alcohol and illicit drug use, and domestic violence. Comanche County reports lower rates for infant mortality, high school dropouts, marijuana use, nonmedical pain medication use, unemployment, and child maltreatment. *Please see Attachment 1, page 2 for additional information.*

Priority Element 5 - Reach high-risk and hard-to-engage populations:

Fort Sill is a major United States Army Post located on the north edge of Lawton. Ft. Sill's houses one of the country's largest field artillery units and is one of the five locations in the U.S. for Army Basic Combat Training. Many young military men and women pass through Ft. Sill – including those with spouses and young children.

The Comanche Nation total tribal enrollment is 14,557 with 7,763 living in the Lawton-Ft. Sill area. The Nation's complex is located nine miles north of Lawton. Their jurisdictional area covers nine surrounding counties. Between 2003 - 2007, the Comanche Nation provided OCAP/Start Right services. The program was supported by CBCAP funds.

Current MIECHV Selected Evidence-Based Home Visiting Programs in Comanche County:

Children First (C1/NFP): Offered to low-income, pregnant women expecting their first child. A woman must enroll prior to the 29th week of pregnancy. The household income cannot be greater than 185% of the Federal Poverty Level. Services are delivered by Registered Nurses through county health departments. During SFY 2010, there were 89 referrals made to C1. Fourteen of those families enrolled. A total of 63 families received services (new enrollees and

[1] Neither Coal (ranked #5) and Greer (ranked #10) have populations over 7,000.

carry-overs from previous years). These families were served by two C1 nurses. Approximately, 399 pregnant women were eligible for C1 in Comanche County.[2]
OCAP/Start Right (HFA) – OSU Cooperative Extension Service[3]: Offered to first-time mothers *after* the 29th week of pregnancy, pregnant women expecting the birth of a subsequent child, and/or parents who have a child less than one year of age[4]. The Kempe Family Stress Checklist is used to determine if the family would benefit from home visiting services. During SFY 2010, there were 229 referrals made to Start Right. 35 of those families enrolled. A total of 53 families received services (new enrollees and carry-overs from previous years). These families were served by four Family Support Workers.

Estimated Number of Families to Be Served in Comanche County by MIECHV Expansion Grant: Children First (NFP): 25 - 50 OCAP/Start Right (HFA) and/or PAT[5]: 50 -75

Muskogee County

Prior to Oklahoma's statehood in 1907, what is now Muskogee County was part of the Creek and Cherokee Nations. Located in eastern Oklahoma, Muskogee has a total population of 71,412.

The MIECHV Grant needs assessment indicated that Muskogee County makes up roughly 1.9 percent of the Oklahoma population. Compared to the state as a whole, the county has a higher percentage of African American residents (12.2% vs. 8%), a higher percentage of American Indian residents (14.7% vs. 8%), and a lower percentage of Hispanic residents (4.1% vs. 7.6%). Both median household income and per capita income for the county are less than those of the state.

For nine of the MIECHV Grant indicators included in the needs assessment, Muskogee County has rates higher than the comparable state rates: preterm and low birth weight, poverty, overall crime rate, high school dropout rate, nonmedical pain medication use, unemployment rate, child maltreatment, and domestic violence. *Please see Attachment 1, page 3 for additional information.*

Priority Element 5 – Reach high-risk and hard-to-engage populations:
The Muscogee (Creek) Nation has a total tribal enrollment of 66,162 with 55,162 living within Oklahoma. Their jurisdictional areas include eleven counties.

Priority Element 7 - Reach families in rural areas:
Of the four counties selected for the MIECHV Expansion Grant, only Muskogee County is considered rural.

Current MIECHV Selected Evidence-Based Home Visiting Programs in Muskogee County:
Children First (C1/NFP): During SFY 2010, there were 83 referrals made to C1. Forty of those families enrolled. A total of 111 families received services (new enrollees and carry-overs from

[2] During SFY 2008, there were 798 first-time births in Comanche County. At least half of these births were paid for by Medicaid meaning that the family was eligible for C1.
[3] This number includes families from surrounding counties as well.
[4] If Oklahoma is awarded a MIECHV Expansion Grant, OCAP will comply with the HFA eligibility criteria in all four counties.
[5] Invitations to Bid (ITB) will be released for both OCAP/Start Right and PAT services. ITB applicants will choose which model they would like to implement. This process will hold true for all four counties.

previous years). These families were served by three C1 nurses. Approximately, 209 pregnant women were eligible for C1 in Muskogee County.[6]

Parents as Teachers (PAT): Offered to parents with children less than three years of age. Services provided by teachers and other professionals. During SFY 2010, 9 of those families enrolled. A total of 27 families received services (new enrollees and carry-overs from previous years). These families were served by 2 parent educators.

Estimated Number of Families to Be Served in Muskogee County by MIECHV Expansion Grant: Children First (NFP): 25 OCAP/Start Right (HFA) and/or PAT: 50

Oklahoma County

Located in the State's geographic center, Oklahoma County has a population of 699,440 residents. Oklahoma County accounts for 33% of the total population of Oklahoma. Oklahoma City is the county seat, the State's Capitol city and is the most populated city in the state.

When compared to the state as a whole, the MIECHV Grant needs assessment revealed that the county has a higher percentage of African American residents (14.1% vs. 8%), a lower percentage of American Indian residents (2.7% vs. 8%), and a higher percentage of Hispanic residents (12.3% vs. 7.6%). Both median household income and per capita income for Oklahoma County exceeds that of the state.

For 11 of the indicators included in the MIECHV Grant needs assessment, Oklahoma County has rates higher than the comparable state rates: low birth weight; infant mortality; poverty; overall and juvenile crime rates; binge alcohol, marijuana, and nonmedical pain medication use; unemployment rate; child maltreatment; and domestic violence. *Please see Attachment 1, page 4 for additional information.*

Priority Element 5 – Reach high-risk and hard-to-engage populations:
Tinker Air Force Base is located on the eastern edge of Oklahoma City. The Base was built in 1941 and is currently home to the 72nd Air Base Wing and the AFMC Oklahoma City Air Logistics Center. The Base is the largest single-site employer in Oklahoma and is home to 26,000 military and civilian personnel.

Current MIECHV Selected Evidence-Based Home Visiting Programs in Oklahoma County:

Children First (C1/NFP): During SFY 2010, there were 461 referrals made to C1. Two hundred and sixty-five of those families enrolled. A total of 583 families received services (new enrollees and carry-overs from previous years). These families were served by 13 C1 nurses. Approximately, 2,483 pregnant women were eligible for C1 in Oklahoma County.[7]

OCAP/Start Right (HFA) – During SFY 2010, there was a combined total of 409 referrals made to Start Right Programs. 74 of those families enrolled. A total of 225 families received services (new enrollees and carry-overs from previous years). These families were served by a combined nine Family Support Workers.

[6]During SFY 2008, there were 418 first-time births in Muskogee County. At least half of these births were paid for by Medicaid meaning that the family was eligible for C1.

[7]During SFY 2008, there were 4,965 first-time births in Oklahoma County. At least half of these births were paid for by Medicaid meaning that the family was eligible for C1.

Parents as Teachers (PAT): During SFY 2010, 484 children of those families enrolled. A total of 799 families received services (new enrollees and carry-overs from previous years). These families were served by 17 parent educators.

Estimated Number of Families to Be Served in Oklahoma County by MIECHV Expansion Grant: Children First (NFP): 200 OCAP/Start Right (HFA) and/or PAT: 300 - 400

Tulsa County

Once part of the Creek and Cherokee Nations, Tulsa County is the second most populated county in Oklahoma. Tulsa is the state's second largest city surrounded by a rapidly growing ring of suburban cities. The total population of Tulsa County is 584,096.

As noted in the MIECHV Grant needs assessment, Tulsa County makes up roughly 16 percent of the Oklahoma population. Compared to the state as a whole, the county has a higher percentage of African American residents (10.8% vs. 8%), a lower percentage of American Indian residents (4.0% vs. 8%), and a higher percentage of Hispanic residents (9.5% vs. 7.6). Both median household income and per capita income for Tulsa County exceeds that of the state.

For seven of the indicators included in the MIECHV Grant needs assessment, Tulsa County has rates higher than the comparable state rates: preterm birth, overall and juvenile crime rates, high school dropout rate, illicit drug use, unemployment rate, and domestic violence. Tulsa reports lower rates for poverty, binge alcohol use, marijuana use, nonmedical pain medication use, and child maltreatment. Rates for low birth weight and infant mortality for Tulsa County were the same as those for the state of Oklahoma. *Please see Attachment 1, page 5 for additional information.*

Current MIECHV Selected Evidence-Based Home Visiting Programs in Tulsa County:

Children First (C1/NFP): During SFY 2010, there were 586 referrals made to C1. Three hundred and sixty-three of those families enrolled. A total of 818 families received services (new enrollees and carry-overs from previous years). These families were served by 18 C1 nurses. Approximately, 1,846 pregnant women were eligible for C1 in Tulsa County.[8]

OCAP/Start Right (HFA) – During SFY 2010, there was a total of 332 referrals made to Start Right. 119 of those families enrolled. A total of 218 families received services (new enrollees and carry-overs from previous years). These families were served by a combined eight Family Support Workers.

Parents as Teachers (PAT): During SFY 2010, 481 children of those families enrolled. A total of 1040 families received services (new enrollees and carry-overs from previous years). These families were served by 28 parent educators.

Estimated Number of Families to Be Served in Tulsa County by MIECHV Expansion Grant: Children First (NFP): 150 OCAP/Start Right (HFA) and/or PAT: 250 - 325

[8] During SFY 2008, there were 3,692 first-time births in Tulsa County. At least half of these births were paid for by Medicaid meaning that the family was eligible for C1.

METHODOLOGY

The three evidence-based home visiting models selected for either MIECHV implementation or expansion are:

Nurse-Family Partnership 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 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 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:

- 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.

GOALS AND OBJECTIVES

Theory of Change: All partners who support home visiting, including those at the federal, state, and community levels, must be considered components of the overall system that potentially impacts change. When individuals and organizations that share common goals team together to work on a variety of activities there is a greater likelihood their goals will be achieved.[1] Service integration plays a vital role in home visiting programs' ability, at the home visitor as well as the community level, to function effectively and to meet families' needs. Findings have suggested that home visiting programs may benefit from using community coalitions as their mechanism to facilitate linkages between home visitors and ancillary services.[2]. Coalitions provide a venue for developing coordination and collaboration that typically involves building

[1] Boller, K., and Daro, D., (2009, September). Evaluating Systems Change Efforts to Support Evidence-based Home Visiting: Concepts and Methods. *Mathematica Policy Research, Inc.,* 3-4.

[2] Tandon, D., Parillo, K., Jenkins, C., Jenkins, J., and Duggan, A. (2007). Promotion of Service Integration Among Home Visiting Programs and Community Coalitions Working with Low-Income, Pregnant and Parenting Women. *Health Promotion Practice,* 8, 79-87.

relationships, sharing ideas, exploring concepts and forging partnerships.[3] Ultimately, such linkages promote the health and well-being of the home visited families.

Goal 1: Improve the Coordination and Collaboration Among Evidence-Based Home Visiting Programs (EBHV).

a) Contract with a community-based organization for the provision of a community "*Connector*" to assist with service integration.
b) The *Connector* will develop and support a Home Visitation Coalition for the sharing of information, resources and best practices.

Goal 2: Improve the Coordination and Collaboration between EBHV and other supportive services for families.

a) The *Connector* will assure that Memorandums of Agreement/Understanding are established between EBHV and other community services to increase the number of families that are timely and appropriately referred to additional community services.
b) A formalized mechanism will be developed to introduce home visited families to the OSDH Child Guidance Service so that families can participate in their center-based activities.
c) Prioritize families on Head Start waiting lists for EBHV services.

Goal 3: Increase and Improve Outreach to Potential Home Visiting Families

a) Work with the EBHV Sustainability Group as well as messaging experts to explore new strategies and funding for marketing/publicizing the benefits and availability of EBHV.
b) The *Connector* will market the EBHV to families, service and the community at large so more know about the benefits and availability of EBHV.
c) Develop an electronic Centralized Referral/Triage System from potential resources like Medicaid and/or WIC.

Goal 4: Increase Client Engagement Related to EBHV

a) Explore and implement new strategies that will increase the rate at which families enroll.
b) Explore and implement new strategies that will increase the length of time that a family will remain engaged in the EBHV.

Goal 5: Improve Data Collection in order to Evaluate the EBHV System and Individual Client Outcomes

a) Develop or purchase a data collection system that will support the program evaluation needs of all three EBHVs.
b) Implement and evaluate the above strategies on a systems level and at the individual family level.
c) Collect data, analyze and report on the MIECHV Benchmarks and Constructs.

[3] Milner, J. (2003). *Changing the Culture of the Workplace.* Plenary session presented at the Annual Meeting of States and Tribes. Retrieved June 29, 2011 from http://www.acf.hhs.gov/programs/cb/cwmonitoring/changing_culture.htm#

WORK PLAN

For Work Plan Timeline, please see Attachment 7.

A PLAN TO ENGAGE THE COMMUNITY

Between June 17th and June 22nd, 2011, at least one community meetings was held in each of the four identified counties. There is a great deal of enthusiasm for the MIECHV Expansion Grant and the idea of developing a home visiting coalition in each county. In fact, Tulsa professionals began meeting months ago in anticipation of the Grant. During the community meetings, all recognized the benefits of routine networking for the home visiting community, other social services and ultimately the families they serve.

This coalition concept is not a novel idea. In recent years, coalition building has increasingly become a popular strategy for improving community health and well-being. [1] Based on our experience, coalitions that are led by a dynamic and consistent organizer tend to have engaged members and are sustained over time. For this reason, Oklahoma proposes to utilize MIECHV Grant funds to contract with a community agency so that a "connector" can be employed in each county.[2] This position will carry out the below activities on behalf of all home visitation services:

- Market home visitation services to potential referral sources;
- If necessary, triage referrals to the most appropriate home visitation program; and
- Facilitate a home visiting coalition so that home visitors have opportunities to learn from each other and other supporting services.

Coalitions could be valuable tools to home visitors and beneficial for families. One study suggests that "community-level service integration activities directly influenced home visitor's perceptions of available resources, service quality and referrals made."[3]

A PLAN FOR MONITORING, PROGRAM SUPPORT AND TECHNICAL ASSISTANCE

Over the years, the Family Support and Prevention Service (FSPS) has developed a routine business operation that supports the efforts of the C1 nurses and the Family Support/ Assessment Worker in the OCAP Start Right Programs. The MIECHV Expansion Grant would simply expand C1 and OCAP/Start Right services and at would be incorporated into the FSPS quality assurance system. Currently, two C1 nurse consultants and two OCAP consultants 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

[1] Backer, T. (2003) Evaluation community coalitions. New York: Springer.

[2] Because of the dollar amount involved, this contract will have to be awarded by a competitive bid process.

[3] Tandon, D., Parillo, K., Jenkins, C., Jenkins, J., and Duggan, A. (2007). Promotion of Service Integration Among Home Visiting Programs and Community Coalitions Working with Low-Income, Pregnant and Parenting Women. *Health Promotion Practice,* 8, 79-87

- Assuring that home visitors are appropriately trained in their respective model as well as specific topics such as adoption, substance abuse, domestic violence, etc.; at times, the consultants serve as trainers
- Providing technical assistance to home visitors upon request
- Developing and distributing quarterly performance measurement tools and reports
- Conducting annual site visits[4] to assure fidelity to the model and quality of services; Site visits include the sharing of data; sampling record audits; shadow visits; meetings with staff and external partners; correction plans are developed if needed
- Assisting program evaluators in analyzing programmatic data and producing annual reports
- Ensuring program alignment with Federal, State and program outcomes

PLAN FOR PROFESSIONAL DEVELOPMENT AND TRAINING

The C1, OCAP/Start and PAT programs learned years ago that training and continuous professional development is critical to a successful home visitor. All home visitors are trained according to the model requirements. Also, Oklahoma has created an additional training package, mostly centered on psycho-social topics and social services. This training regimen was developed in response to home visitors needs. PAT programs administered by OSDE have not attended these training in the past, but those funded with MIECHV dollars will be required to do so. C1 and OCAP Consultants assure that home visitors complete all required training. The same will hold true for PAT in the future.

For a list of trainings, please see Attachment 1, page 6.

PLAN FOR STAFFING AND SUBCONTRACTING

Hiring: All OSDH positions (FSPS and C1 Nurses in Comanche and Muskogee counties) will be "State" employees and fall under the law, rule and regulations of the Oklahoma Merit System of the Oklahoma Office of Personnel Management (OPM). 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. 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.

OSDH is allowed to directly contract with other governmental agencies including universities. Therefore, the OU Center of Child Abuse and Neglect will not have to compete for the MIECHV evaluation contract. OSDH is also allowed to contract with Tulsa and Oklahoma City-County Health Departments for additional C1 Nurses. Contracts with local agencies for the OCAP (HFA) and PAT services as well as the *Connector* position will have to be awarded by a competitive grant process.

In all instances, those hiring and contracting for staff will be sensitive to the communities' needs regarding bilingual staff. Typically, Spanish is the most popular second language.

[4] C1 generally conducts site visits every other year with the exception of Tulsa and Oklahoma City teams which are conducted yearly. MIECHV funded sites will have yearly site visits because of the added Grant duties.

A PLAN FOR RECRUITING AND RETAINING PARTICIPANTS

In addition to the community *Connector* position to be placed in each county and the development of a centralized referral system previously discussed in this application, following activities and strategies will be utilized:

Messaging/Marketing Home Visiting: A most definite need for the system as a whole is a smart, relevant communications plan to change the attitudes of Oklahomans about the home visiting services. The notion that "all parents need help" would perhaps help reduce any stigma associated with home visiting and perhaps make it more socially acceptable to participate in home visiting and increase assist in outreach efforts. Oklahoma has listed "marketing" as an area for federal technical assistance in the original MIECHV Grant. In addition, the Oklahoma EBHV Sustainability Group will explore new opportunities for the messaging as well.

Period of Purple Crying Project: MCH's *Preparing for Lifetime Initiative* has partnered with the FSPS to purchase and distribute the nationally recognized "Period of Purple Crying" DVDs and materials for distribution through birthing hospitals for the prevention of abuse head trauma in infants. In addition to the standard "Purple" materials, a county-by-county directory of all home visitation programs, developed by the Home Visitation Leadership Advisory Coalition, was provided to the hospitals so that they could quickly and easily refer new mothers to such services. This directory is also available online.

A Study with NFP: In January 2011, Children First partnered with NFP's Dr. Olds and submitted a grant proposal for the Nurse, Education, Practice, Quality and Retention Program Grant to continue addressing the length of time a client remains engaged in home visiting. 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. Should Oklahoma be awarded this grant, it is the intention of OSDH to disseminate the "lessons learned" once it is appropriate.

CONTINUOUS QUALITY IMPROVEMENT PLAN

Managing performance and tightening accountability has become two emerging themes in public health, social services and home visiting. One of the strategies to improve performance is the concept of continuous quality improvement. Oklahoma plans to execute the following activities as part of its CQI Plan:

- Achieve accreditation/affiliation with each of the three models;
- Conduct focus groups to gather information from home visitors, stakeholders and visited families
- Collect, analyze data and report the findings to home visitors and others in the early childhood system;
- Share information with partners at the Home Visitation Leaders Advisory Council and other appropriate venues;
- Work with model developers to increase the knowledge base and skills of the home visitors and supervisors;
- Make modifications to the home visiting/early childhood system through changes in policy, guidelines, memorandums of understanding, etc.; and
- Retrain staff as appropriate or necessary; and
- Repeat the process.

PLAN TO MAINTAIN FIDELITY TO THE MODEL

Permission has been received from model developers to implement three evidence-based home visiting models for the MIECHV Expansion Grant Program. Oklahoma has had long-standing relationships with NFP, HFA and PAT. As the first state to provide statewide NFP coverage, Oklahoma has always been proud partner of NFP. While Oklahoma has always been in good standing with HFA and PAT, not all sites have been affiliates or accredited. However, all counties/sites funded with MIECHV dollars will begin the professional processes established by the developers and comply with all requirements unless exempted. Oklahoma looks forward to meeting these standards and views them as a step towards improving professionalism and quality.

PLAN TO COLLECT DATA ON LEGISLATIVELY-MANDATED BENCHMARKS

Oklahoma's plan necessitates the development of a mutual, coordinated system of data collection, data reporting and evaluation. This system will include agreements that allow data sharing among a variety of programs, agencies, and organizations.

PLAN TO COORDINATE WITH APPROPRIATE ENTITIES/PROGRAMS

Home Visitation Coalition: In addition to the *Connector* position previously described, each county will develop a home visitation coalition or have an existing group create a home visiting subgroup devoted to home visiting. The purposes of the coalition would be threefold:

- Provide opportunities for home visiting programs to share information about community resources, best practices, possible funding, etc. so that the overall early childhood system it being constantly improved;
- Avoid competition between home visiting programs and/or the duplication of services; and
- Ensure that families are connected to home visiting services that best meet their individual needs.

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

Memorandum of Agreement or Understanding – a simple document stating the purpose of the coalition, agency members and operating procedures.

Release of Information/Referral Form- a document completed and signed by a potential home visiting participant that allows the person's contact information to be shared with appropriate service providers.

Below is a sampling of other programs and services that could be better coordinated with home visiting services:

The OSDH Child Guidance Service: This multidisciplinary program strives to improve the quality of family relationships, parent-child relationships and the family's relationship to the community. Formal introductions and automatic referrals of home visited families to Child Guidance center-based activities could enhance the parents learning and allow them to build an informal network of supportive from interactions with other parents.

Domestic Violence, Mental Health and Substance Abuse Services: These three particular services are often needed by at-risk families. Over the years, it has become evident that home visitors often cannot improve the lives of children/caregivers without these resources being available and of high quality. For this reason, an at-risk community was required to have these services in their county in order to be included in the MIECHV Expansion Grant.

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. Smart Start Oklahoma focuses on four key strategy areas: 1) Community Development; 2) Public Engagement; 3) Public Policy and Systems Development; and 4) Resource Development.

Reaching for the Stars – Childcare Rating System Promoting Quality Childcare: 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.

Respite Care: For several years, Community-Based Child Abuse Prevention Grant monies have been used to support respite care for C1 and OCAP families that were at-risk of child abuse and neglect. This program will continue and expand to PAT should CBCAP funding remain consistent.

DESCRIPTION OF HOW ACTIVITIES FIT INTO STATE ADMINISTRATIVE STRUCTURE

Oklahoma State Department of Health (OSDH)

See "Organizational Information" page 38.

PLAN TO INCORPORATE WORK AFTER GRANT ENDS

Oklahoma has seen benefits attributable to the original MIECHV and the MIECHV Expansion Grants prior to any additional services being provided. In anticipation of the original MIECHV Grant, the State's Home Visitation Leadership Advisory Coalition and the Interagency Child Abuse Prevention Task Force spent considerable time learning about nationally recognized evidence-based home visiting models. Many of the models are already operating in the state and therefore, representatives from many of the models provided presentations and shared their successes with the leadership groups. There is a new-found appreciation for the variety of existing models, the specific populations they serve and the goals they are designed to achieve.

Because of the planning that has occurred for the preparation of the MIECHV Grants, all are embracing the concept of quality home visiting for families with challenges. While Oklahoma is fortunate to have invested in several models that were designated as "evidence-based," we acknowledge that there is much to be learned from programs in the "promising approach" category.

Oklahoma has a proven track record in utilizing state funds for an early childhood system of that includes home visiting. Newly adopted practices affiliated with the MIECHV Grant such as the local home visiting coalition, the *Connector* position, the central triage system, automatic referrals to Child Guidance Services will become part of the standard way of doing business.

RESOLUTION OF CHALLENGES

Challenge: Community partners, both providers and participants, have identified a need to increase the outreach to families eligible for home visiting services through improved marketing strategies.

Approaches: The Sustainability Group was established by the Center on Child Abuse and Neglect to develop efforts to sustain their Federal Evidence-Based Home Visitation Grant. The group has identified marketing of home visitation services as a top priority. Now, the Sustainability Group will be expanded to include representation from more models and stakeholders including Smart Start Oklahoma, a group that has the potential of pursuing private funding for marketing development. Additionally, the new community *Connector* will be in a position to assist with marketing. It should be noted that federal technical assistance related to marketing strategies was requested in the original MIECHV Grant.

Challenge: Existing home visiting programs typically do not have a coordinated communication network. This often results in uncoordinated efforts among home visitation services as well as with other resources.

Approaches: A new position referred to as a *Connector* will be hired in each community for the purpose of facilitating coordination and collaboration of home visiting programs. Duties for the *Connector* will include establishing a local coalition with all home visiting programs and other community support services. Formal agreements will be established between services. Families will be asked to complete a Release of Information so that their contact information may be shared with other relevant services.

Challenge: More referrals must be made if more families are to be served.

Approaches: Three EBHV models were chosen for initiation or expansion in the identified communities with the understanding that, by providing a variety of programs, families have a greater opportunity to participate in a program that best meets their personal needs and lifestyle. During community meetings both participating families and professionals expressed a need for a system "to get the word out" about home visiting. In order to promote all home visitation programs and increase the number of referrals to them, a comprehensive marketing plan will be developed.

Challenge: Only about half the families that receive referrals to existing home visitation programs actually complete the enrollment process. That is, some families that are referred to and have been identified as having a need for home visiting programs do not enroll in programs. Families that do enroll in home visiting programs may not be retained for the full length of the program. Although this may be the nature of voluntary programs, every effort should be made to connect with families in such a way that they are willing and able to receive services.

Approaches: A referral and triage system will be developed that will electronically capture information about parents who are eligible for home visiting services. Review of that information can match individual families with the home visiting program that most closely meets their needs. Instead of waiting for parents to express an interest in home visiting services, a proactive approach will be implemented that will allow all potential participants to be offered the opportunity to enroll in the programs. An additional approach was requesting technical assistance in the original MIECHV Grant regarding referral to enrollment and retention. C1 also partnered with NFP to submit a grant proposal in order to address and improve client retention. The grant that has not yet been awarded was submitted through the Affordable Care Act Nurse, Education, Practice, Quality and Retention Program.

Challenge: Improve the home visiting system by meeting the required MIECHV benchmarks and constructs as well as implementing and evaluating strategies for improvement in identified areas of concern for home visiting programs. Areas of concern include referral, enrollment, and retention of families.

Approaches: Data collection, analysis and reporting are necessary to meet the required MIECHV Benchmarks and Constructs. There is wide variation in the three programs that use the selected EBHV models with regard to their process and system for data collection. There are also great differences in proficiency and capacity of evaluation capabilities. The plan for the original MIECHV Grant requires the development of a coordinated system of data collection, data evaluation and data reporting. Data sharing agreements between the OSDH, ODE, CCAN, OKDHS and possibly others will be included in this system.

An MIECHV Grant Evaluator will be hired as soon as suitable candidates can be recruited. That evaluator, along with the other OSDH epidemiologists and CCAN evaluators, will explore the options of contracting with local software developers to create a data system or purchasing a system that is currently being marketed to states involved in the original MIECHV Grant.

Development of a statewide data system for the entire continuum of early childhood services, including home visiting, is in the initial stages of planning. A workgroup has been established with Smart Start Oklahoma as the lead agency. The goal of the workgroup is to design an early childhood data system that links across agencies, programs, providers, and children. Home visiting staff and CCAN evaluators will continue to participate in the activities of the workgroup.

Areas of concern that have been targeted for improving home visiting programs will be studied by an external evaluator. The proposed study designed by CCAN will use a mixed-method approach (quantitative/qualitative) to inform and evaluate change of the areas identified for improvement. The evaluation methods used are designed to assess the epidemiology of early childhood populations in each of the selected counties, identify system innovations of potential beneficial impact, and assess effectiveness of implemented system level changes. Data collected for the evaluation will cross all of the problem areas, will be obtained from a diverse set of sources and will provide informative guidance about strengths and weaknesses of home visitation and comprehensive early childhood systems operations.

Challenge: There are potential barriers that may prevent home visiting family members from participating in focus groups conducted by the external evaluator. Barriers may include lack of transportation, lack of child care, and comfort level with sharing their personal experiences. There may also be barriers to prevent home-based providers and providers from other referral agencies from participating in individual Interviews with the external evaluator.

Approaches: Plans for resolution include providing participants with gas cards for transportation, having child care available during group meetings and reimbursing participants for time spent in focus groups with a $20 gift card. Participant comfort level will be addressed by choosing non-threatening meeting locations. In order to increase their comfort level with sharing personal information, participants will be grouped by program experience (i.e., engaged vs. unengaged). Also, confidentiality will be addressed at the onset of focus group sessions.

The comfort level of providers who are asked to share their experiences with an external evaluator has also been identified as a potential difficulty. One strategy is to hold interviews in a neutral or private location away from the provider's place of employment. Another strategy is to assure that the provider's comments will not be shared with current/previous employers.

The ability of the evaluator to acquire the proposed number of providers for individual interviews is also a potential difficulty. Providers who choose to participate in interviews with the outside evaluator will receive compensation for their time in the form of a $30 gift card.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

CURRENT EXPERIENCE, SKILLS AND KNOWLEDGE OF CCAN

The External Evaluator will be the Center on Child Abuse and Neglect (CCAN) housed within the Department of Pediatrics at the University of Oklahoma Health Sciences Center (OUHSC). CCAN at OUHSC brings significant resources and capacities to this project. The OUHSC is a multi-college campus housing the Colleges of Medicine, Nursing, Public Health, Allied, Health, and Dentistry as well as the Oklahoma Medical Research Foundation. Full library, data analysis, management and professional support services are available on campus. The campus is also equipped with video teleconference technology. The OUHSC computer network is a fully equipped client-server environment with a range of on-line services including e-mail, remote backup, database applications, data analysis applications (SPSS, SAS, LISREL, etc.), document servers, on-line access to library search services, and internet access.

CCAN is a university-based, interdisciplinary center dedicated to the prevention and treatment of child abuse and neglect. CCAN directs research, program administration, clinical services, professional education, program development, and public education in the field of child maltreatment. CCAN has a long-standing history in the community, state, and nation in conducting clinical implementation and dissemination research on the prevention and treatment services for child maltreatment. CCAN team members include established federally funded scientific researchers with extensive publication records, including experience conducting treatment outcome trials in real-world field settings. These include expertise in evaluating EBP uptake at client, provider, organizational and systems levels, use of mixed methods approaches (quantitative/qualitative methods), web-based surveys, automated or computerized interviews, conducting qualitative interviews and focus groups, cross-site data capture, centralized data management and data analysis capabilities ranging from basic to advanced. This includes a wide range of data capture, data storage and data analysis equipment and software, along with years of experience in programming and using these technologies. We have assisted other sites with institutional review board (IRB) application and approval and in fact helped established an IRB in St. Petersburg, Russia.

CCAN has over 60 networked PC's including a database server. Data acquired for this project would be centrally stored on the database server running Microsoft SQL Server 2008, allowing for multiple user access and data entry with security control. The server is fault tolerant (dual processors, mirrored drives, uninterrupted power source) and incrementally backed up daily with weekly off-site tape backups that are stored in a fireproof safe. CCAN has an experienced data collection and management team that includes independent data collectors, data managers and analysts with expertise in implementing state-wide studies/evaluations. CCAN has the capability to deploy audio-assisted computer self-interviewing, optical mark reader scan forms, and more traditional information collection methodologies, with direct uploading to SQL databases and automated data screening and cleaning.

As a research group our strength as investigators lies in our capacity to accommodate reasonable scientific rigor within the demands and realities of this fairly unique service context, along with our well established research-practice partnerships with state authorities and front-line service provider agencies. We believe that service quality and client outcomes are best advanced by research that involves the system and front-line service providers as partners in identifying key questions and targets. We also are committed to research that both advances current scientific knowledge and that offers direct benefit to our state agency and provider partners. Finally, our work relies on a translational framework that emphasizes comparative outcomes observed in authentic real-world settings. Although these types of studies necessarily compromise on some aspects of variable control, they offer external validity advantages which we believe outweigh their limitations.

David Bard, Principal Investigator (PI), is a quantitative psychologist and lead evaluator of CCAN's current EBHV grant with Children's Bureau (90CA1764). He has extensive experience and expertise in methodology and statistical analyses to address the complexities of social sciences research. These researchers are frequently invited to present at national and international conferences on research of evidence-based programs in child maltreatment. They serve on the boards of state, national, and international professional organizations in both psychology and child maltreatment. Federal, state, and local grants have funded a variety of studies including treatment outcome studies, program evaluations, and other clinical research as discussed in the following sections.

Details of the research, publications, and expertise of Bard and other CCAN faculty and staff on the evaluation team (Faculty; Jane Silovsky – PI on Oklahoma's EBHV grant, Mark Chaffin, Debra Hecht, and Lana Beasley; and Staff; Arthur Owora) are provided below. *For more information, please see Attachment 3 for biosketches.*

EVIDENCE OF ORGANIZATIONAL EXPERIENCE

CCAN has a long history of providing independent evaluation as well as training and technical assistance (T/TA) with state and nonprofit agencies to systematically develop, evaluate, and enhance evidence base programs with field trials examining efficacy, effectiveness, and implementation and dissemination questions. These efforts include examining primary, secondary, and tertiary prevention programs (primarily home visitation programs) targeting prevention of child maltreatment. Some of these efforts most relevant to the current application are described below.

Dr. Chaffin and colleagues led a statewide evaluation of Oklahoma family support programs from 1996 to 2000, evaluating 74 separate service programs operated at 28 sites. Pre-intervention and post-intervention data were collected on over 1,600 participants in these programs, and over 150 site visits were made, including accompanying front-line staff on over 95 home visits. The published article describing results of this multisite evaluation (Chaffin, Bonner, & Hill, 2001) was awarded the Pro Humanitate Literary Award for 2002 by the North American Resource Center on Child Welfare.

CCAN recently completed an NIMH funded (Chaffin PI; 5R01MH065667-01A1) statewide site-randomized study of tertiary prevention home visitation programs which experimentally manipulated both the intervention model (the SafeCare model vs. standard social support and case management) and also experimentally manipulates a critical aspect of dissemination and implementation strategy (presence vs. absence of an ongoing trainer/monitor deployed by CCAN to accompany front-line home visitors). We obtained multi-wave outcome data on over 2100 families served within this service system over the past four years. (It is important to note that prior to the initiation of the NIMH study, we collected service and family data from the service agencies on over 4500 families, which included data on from the home visitors on visits, and family risk and protective factors). The scope of this project required tight integration between CCAN (as the coordinating center), the state agency funding the service programs, and the provider agencies to coordinate data collection and develop a workable data collection, monitoring and management strategy. The results of this statewide study and related implementation study using qualitative and quantitative mixed methodology (Aarons PI; R01MH72961) include important implications for work force (such as, significant lower job turnover rates of home visitors trained in SafeCare with ongoing consultation; Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009) and child maltreatment outcomes (Chaffin, Bard, Bigfoot, & Maher, 2011; Chaffin, Hecht, Bard, Silovsky, & Beasley, in review; Chaffin, Bard, Hecht, & Silovsky, 2011).

For this NIMH statewide study, CCAN successfully partnered with service agencies throughout the state for purposes of data collection. We successfully contracted with the service agencies to hire data collectors that were locally based, while CCAN maintained responsibility for training them and providing oversight on their data collection efforts. We met monthly with the data collectors at CCAN in order to get the data from their computers, get the consent forms, and troubleshoot any difficulties they may be encountering. During the 5 years of the study, there were no major difficulties with these arrangements.

We have conducted multiple RCTs examining EBHV for child abuse prevention in high risk families (parent with history of domestic violence, mental illness, and/or substance abuse and child 5 years or younger). In the urban and rural RCT of SafeCare (SC) (funded by OKDHS, CDC R49 CE000449-01, and OJJDP 2006.JP.FX.0067) we (a) successfully recruited families from a variety of referral sources, enrolled, and maintained them in SC services at a rate significantly better than the control condition, (b) collected multiple waves of data on participants regardless of service attrition conducted by independent data collectors with computerized interview administration (c) assessed and maintained excellent fidelity to the SC model, (d) examined the Integrated Theory of Parent Involvement (McCurdy & Darro, 2001) to examine client enrollment and retention factors, (e) matched participant with Oklahoma child welfare data to examine child maltreatment reports, and (e) and examined changes in risk and protective factors as well as child welfare outcomes (Dameshek, Doughty, Ware, & Silovsky, 2011; Silovsky, Bard, et al., 2011; Silovsky & Doughty, 2008).

In addition, Silovsky is the PI and Bard is the Evaluator for Oklahoma's EBHV grant with ACYF *Evidence-Based Child Maltreatment Prevention for High Risk Families: Expanding to Latino*

Communities, Enhancing Family Violence Prevention, and Sustaining Prevention Programs. For this grant we are conducting a hybrid regression discontinuity/RCT study examining a culturally adapted the SC model to address the needs of our Latino communities across a continuum of risk. Two prevention service models are provided through the Latino Community Development Agency (LCDA): (a) *El Programa de Familias Seguras* SafeCare adapted for the Latino community and designed for highest risk families and (b) *Nuestras Familias,* funded through the Department of Health's Oklahoma Child Abuse Prevention (OCAP) Healthy Families programs designed for moderate risk families. Using a risk classification tree, families are screened for risk with the highest risk assigned to SC, the lowest risk assigned to OCAP, and the moderate risk being randomized to SC or OCAP. Activities related to this grant are important to highlight as we have (a) an established data sharing agreement with OSDH, (b) a quality working relationship established with LCDA who is providing Healthy Families home visitation services in Oklahoma County, (c) an established data sharing and evaluation agreement with the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, (d) consistent compliance with cross-site data collection requirements, (e) rigorous methodology to examine match of services with EBHV model and (f) established Sustainable Implementation of Evidence-Based Home Visitation committee with members from state agencies, provider agencies, and legislative staff. This committee recently voted to expand the focus of the committee to include efforts under Oklahoma's MIECHV grant.

Two other trials, one laboratory trial and one field trial have tested the Parent-Child Interaction Therapy (PCIT) model applied to physical abuse and chronic child neglect cases in CW, and examined the role of motivation in program retention and downstream outcomes. This series of RCT studies found that a focused motivational interviewing service combined with an evidence-based behavior parent training provided the best program retention (Chaffin, Silovsky, et al., 2004; Chaffin, Valle, Funderburk, Gurwitch, Silovsky, Bard, McCoy, & Kees, 2009) as well as downstream reduced risk and child welfare outcomes (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2010).

Thus, the CCAN team has been a long track record of successful (a) engagement of urban and rural field agencies in evaluation and research, including agencies currently providing OCAP (HFA) services, (b) collection of data with independent data collectors as well as from field staff including service providers, (c) retention of families in longitudinal field research, (d) establishment of data sharing agreements with OSDH, OKDHS, and OHCA, (e) collaboration with state agencies, nonprofit agencies, and legislative staff, (f) conducting mixed methods and implementation research, (g) successful compliance with cross-site data requirements, and (h) dissemination of findings in reputable peer-reviewed journals.

COSTS ASSOCIATED WITH THE EVALUATION

For the first year, a total cost of $700,000 is requested, and a grand total cost of $2,875,000 is requested to complete the entire project. *Please see Budget Narrative, Contractual Section, page 3.*

PROPOSED SYSTEM EXPANSION AND ENHANCEMENTS

The proposed study will use a mixed-method (quantitative/qualitative) approach to inform and evaluate change in the overarching areas identified for improvement. The evaluation methods used are uniquely designed to assess the epidemiology of disadvantaged early childhood populations in each of the four counties, identify system innovations of potential beneficial impact, and assess effectiveness of the implemented system level changes. Data collected for evaluation will cross all areas, will be obtained from a diverse set of sources, and will provide rich, informative guidance about strengths and weaknesses of home visitation and comprehensive early childhood systems operations.

Data Sources

Planned sources of data are diverse and include under-served clients, existing home visitation clients, providers, early childhood community agencies, and legislators. These sources will be accessed through three broad collection efforts that address our four problem areas through triangulation of information.

Focus Groups: Groups will be organized and run throughout the entirety of project funding. Participants will be recruited from one of three selection pools: 1) Home Visitation clients; 2) Agency Providers; and 3) State leaders. The first two participant pools will be divided into cross-sections of more homogenous groups. Home-visitation client groups will be stratified by three factors: 1) service engagement vs. service attrition; 2) high vs. low at-risk subgroups; and 3) urban vs. rural residential status. Agency workers will be stratified into groups of home visitors and providers who potentially refer clients to HV agencies, and each provider-type will be cross-sectioned by urban and rural agency locale. Focus group format will vary by participant pool, using one-on-one interviewing for all but the Home Visitation clients. Advantages of one-on-one interviews include access to participant opinions on all topics, ability to state opinions independently, moderator ability to probe deeper, and anonymity of responses. The number and timing of groups per participant pool are described elsewhere (see Project Timeline -Attachment 7).

All focus group discussions will be moderated by a skilled facilitator who has been trained in focus group research. The focus groups will be held at locations to be determined in consultation with OSDH, the program supervisors, and state leaders. Each focus group discussion will last for about one hour and will be audio recorded. Transportation to the meeting place will be provided as well as child care. During the client focus groups, only one parent from each household will be asked to participate, since research has shown that when both parents are present one usually is less vocal (Krueger & Casey, 2000). The research protocol for the focus group research will be approved by the OUHSC Institutional Review Board.

Stratified Random Sampling of Disadvantaged Child Populations: A random sample of participants from Medicaid records will be selected for longitudinal follow-up throughout project duration. The sampling procedure will involve stratification of participants by criteria germane to each of the three EBHV programs (see Participant Recruitment below). This

interview sample will provide data that serve a multifaceted role in the evaluation of system success and inform future enhancement efforts. First, the data will be used to study the epidemiology of client needs in each of the four project counties. A good understanding of the epidemiology of the problems uniquely facing each county will be required in order for appropriate service innovations to be devised and implemented. Second, the sample provides an unprecedented look at access-to-care issues for disadvantaged child populations. We will be able to assess, for example, breadth and depth of system-level reach among its core consumer populations. The longitudinal nature of this sample will further allow analysis of change in system reach, an aspect key to evaluation of proposed expansion and enhancement efforts. This sample will also be closely examined for evaluation of improvements in all four problem areas. For example, the size of this sample in each county will allow for self-reported system involvement outcomes to supplement our administrative and focus group data on EBHV awareness, triage success, engagement, retention, continuum of care, and program effectiveness. We believe this aspect of our project significantly enhances the rigor of our evaluation and the value of the data obtained.

Agency Records: The same data collection plan devised in the original MIECHV Grant will be extended to the four counties proposed. The plan calls for client self-report interviews during actual home visits and select provider entered electronic case-file records. Client self-report data will be collected using paper-pencil forms onsite and later hand-entered into each agency's electronic database. During the first six months of the grant (planning period) we will have regular meetings of OSDH and the Evaluation team with the local leads for the EBHV (in consultation with model developers),representatives of field agency (supervisor and home visitor) as well as parent input to examine strategies to accurately and regularly collect data via home visitors that (a) meet MIECHV benchmark requirements, (b) meet local and national EBHV requirements, and (c) is efficient and minimized burden to the provider. OSDH and the evaluation team will be working with agency IT personnel in the first months of project involvement to ensure data capture methods meet project quality standards and to adapt existing database architecture to handle new fields required for benchmark assessments. The evaluation team will perform initial site visits to all MIECHV EBHV program agencies to help coordinate routine data extraction. These methods will require a monitored query system to extract benchmarked data from agency data systems into designated tabled formats and migration of these data, quarterly, to the OUHSC evaluation site. Migration procedures will utilize the Secure File Transfer system of OUHSC which meets FIPS security encryption standards and is HIPAA compliant (http://it.ouhsc.edu/services/SecureFileTransfer.asp). A data capture and transfer manual will be developed and distributed to all agency sites.

Participant Recruitment

Focus Groups- Home Visitation Client: The proposed study will use purposive sampling procedures to select focus group participants (Morgan, 1997). The participants will be identified from a list of referred families in MIECHV EBHV programs. Home visitor logs will used to divide the parents into two categories: a) those who have successfully engaged in services and b) those that have not successfully engaged in services (failure to enroll as well as service attrition). These groups will be furthered cross-sectioned into high and low at-risk groups and

urban and rural residential locales. Six to nine participants will be randomly selected (using a random number generator) for each focus group, and a total of 8 focus groups per county are planned for each of years 1 and 4. Parents will be invited by phone to participate in the study by the qualitative research consultant (Beasley) or a member of the evaluation team.
A potential difficulty in focus group research includes barriers of participants to attend focus groups. Plans to address these barriers include providing (a) gas cards for transportation ($10), (b) child care during the focus groups as well as children's activities, and (c) reimbursement for time spent in the focus group ($20 gift cards). Other barriers include participant comfort level in sharing their experiences which will be addressed through (a) holding focus groups at a non-threatening location (community center, church, etc.), (b) grouping participants by program experience (i.e., engaged vs. unengaged), (c) providing refreshments, and (d) discussing importance of confidentiality at the onset of each focus group.

Focus Groups- Providers and State Leadership: Home-based provider participants will be identified from a list of current and past HFA, NFP, and PAT employees. Providers from potential referral agencies will be selected randomly from a list of employees identified by each county's SSO office. Both types of provider pools will be stratified by agency urban and rural locales. Approximately 21 HV providers and 21 referral providers will be selected for an individual interview during each of years 1 and 4. Providers will be invited by phone to participate in the study by Dr. Beasley or a member of the research team. Agency and state leadership informants will be identified through the Sustainable Implementation Committee and Home Visiting Coalition Planning Committee. We intend to interview one leader from each of the expansion counties in years 1 and 4.

A potential difficulty when conducting individual interviews is provider comfort level in sharing their experiences which will be addressed through (a) holding individual interviews at a neutral or private location and (b) discussing that information will not be shared with their current and/or past employer. Another difficulty includes acquiring the proposed number of providers for individual interviews. To address this issue the research team will provide compensation for their time spent in the individual interview ($30 gift card).

Medicaid Sample: A stratified random sample of Medicaid records will be used to select participants for this data source. The sample will be stratified by county and by factors related to the inclusion criteria for three MIECHV EBHV programs. Specifically, within each county, we will sample the following Medicaid-enrolled strata: 1) women who are less than 29 weeks pregnant and expecting their first child; 2) women more than 29 weeks pregnant or women expecting a 2nd or subsequent child; and 3) families with a child less than 36 months of age. Selection probabilities within counties will be equal across each stratum so that pregnant women (a key catchment group for our longitudinal continuum of care aims) are oversampled. Sampling weights will be generated based on population strata size and sampled strata size. All enrolled participants will be followed for the duration of the project with scheduled annual longitudinal interviews to follow our initial baseline assessment. Data collectors in Tulsa and Oklahoma counties will be hired as full time employees and will be expected to enroll approximately 225 new participants in each project year (including year 1). New data collectors

will be hired in those counties on an as-needed basis as longitudinal assessments begin to accumulate. We plan for data accrual in the smaller populated Muskogee and Comanche counties to be half the rate of the other two counties, so only part-time data collectors in these counties will be required in the first few years of the project. Muskogee and Comanche data collectors will gradually increase percent effort of employment each year as the longitudinal assessments and new participant interviews require. The anticipated sample sizes are 900 per Oklahoma and Tulsa County and 450 per Muskogee and Comanche county (for a grand total of 2700 participants). Assuming 20% sample attrition per year, we anticipate completing a total of 5530 interviews (2700 baseline interviews + 2830 follow-up interviews).
Recruitment pools will be constructed by evaluation team staff based on monthly queries of eligible participants from Medicaid data. The evaluation team has a data sharing agreement for Medicaid records with the OHCA for other projects and will seek to extend the agreement to this project. Mailed study advertisements will be sent to all participants selected for recruitment. Respondents will be able to enroll immediately after receiving the study advertisement by actively calling an assigned data collector or by waiting for the advertised recruitment call from data collection staff. All evaluation analyses of this data source will adjust for stratification and unequal sample selection probabilities using complex sampling design software. The population inferences are intended to describe those on Medicaid who qualify for at least one of the three identified MIECHV EBHV programs. We acknowledge that Medicaid standing does not fully capture all possible EBHV consumers, but we do feel that this is reasonable high-risk catchment population that is likely to reveal significant areas of needed improvement, particularly with regard to marketing and service engagement strategies. Recruited individuals will be excluded from this data collection effort when conditions prevent the primary caregiver from providing valid self-report data (e.g., severe psychosis, severe mental retardation, etc.). Participants will be compensated ($40 gift card) for each completed interview.

EBHV Agency Records: Data will be collected via usual service outcome procedures involving paper-pencil client-report responses during home visitations and routine provider reports on case status and outcomes. Data will be transferred electronically to OSDH and the evaluation team as described above under Data Sources. This data will only be available on clients who were recruited for and clients who enroll in one of the three MIECHV EBHV programs.

Measured Outcomes and Measurement Schedule

Focus Groups: Structured interviews will be devised based on topics summarized in the table below, and those developed throughout initial planning meetings. Content analyses will be used to identify core constructs and themes that will be used to inform system-level innovations. These analyses are described elsewhere (*see Qualitative Analysis pg. 34*). The provider interviews will be supplemented by a pencil-and-paper survey based on work by Duggan (2004). Specifically, the survey includes questions regarding how they feel about their training in risk areas, comfort level in communicating risk issues, and ability to recognize and address risk and other issues. Additionally, the survey focuses on determining provider's perception of their ability to assist parents in dealing with risk issues, their effectiveness as a provider, and their perceived success with families.

All focus group meetings and interviews will occur in years 1 and 4 of the project. A total of 32 client participant groups are planned for each of those years. A total of 42 provider participant interviews and 4 state leadership interviews are also planned in those years.

Medicaid Sample: A psychometric and health outcomes battery will be used for these participant interviews. The structure of the battery will be modeled after the OUHSC evaluation team's ongoing partnership with ACYF as an EBHV grantee. All project data collectors will be provided with a data collection manual and trained in procedures for obtaining informed consent; uses of audio computer assisted self-interviews (ACASI), and also receive training in research ethics, legal child abuse reporting requirements, managing safety concerns during home visits, cultural sensitivity and cultural competency.
Participant interviews will occur shortly after study enrollment for a baseline assessment and then once annually for longitudinal follow-up assessments. We will use ACASI interviews for all measures. ACASI items will be presented to participants on a notebook computer screen and simultaneously presented verbally over headphones connected to the computer. The audio component makes it easier for individuals with limited literacy to respond.

Data quality indicators will also be collected. These will include the proportion of data collected per wave, response rates, and information on respondent level missing data for a given measure. As part of our evaluation requirements, we will complete a data quality progress table that will capture information such as response rates and missing data for the family and child outcomes collected. The data quality information will help alert the program staff to possible technical assistance needs concerning data collection.

Tablet-PC's running ACASI software will be used to conduct the interviews. Answers to the questions are usually completely private unless the participant seeks the data collector's assistance. Data from ACASI interviews will be downloaded directly from the laptops to a server-based storage warehouse at OUHSC, and then exported for statistical analysis. All electronic data will be kept on access controlled machines, all servers are firewall protected, and server data is remotely backed-up daily. ACASI software will be programmed to reject out-of-range data and perform automatic interview skip patterns. Response data will be stored separately from client identifiers. Client identifiers will only be kept for tracking purposes in separate password protected Microsoft Access databases. Both databases will be transferred to the evaluation team weekly using the OUHSC Secure File Transfer system which meets FIPS security encryption standards and is HIPAA compliant (http://it.ouhsc.edu/services/SecureFileTransfer.asp).

Measures currently planned for assessment include:
Demographic questionnaire: The demographic questionnaire was developed to capture basic demographic information. Initial versions of the questionnaire were screened by outside consultants to insure their appropriateness for Hispanic and Native American populations, and revisions incorporated. The questionnaire is available in both Spanish and English language versions. An early version of the questionnaire was piloted on 100 parents in similar programs.

Items answered inconsistently or indicated by parents to be confusing were corrected. Mean 2-week test-retest correlation was 0.74 for continuous variable items, and Kappa was 0.79 for nominal variables.

Brief Child Abuse Potential Inventory (Brief-CAPI): The Child Abuse Potential Inventory (Milner, 1986) is a widely used 160-item agree/disagree format parent self-report questionnaire developed to estimate abuse risk. This standard version is too lengthy for longitudinal interviewing, so we propose to use the short-form version of Ondersma and colleagues (2005). The Brief CAP (or BCAP) reduces the length of the measure from 160 items to 24 items, and correlates 0.96 with the full CAP Abuse Scale in both development and cross-validation samples, and taps domains of distress, social isolation, family conflict and rigid parenting attitudes.

Conflict Tactics Scale – Parent-Child Version. (CTS-PC): The CTS-PC is a parent self-report measure of parenting, including harsh and neglectful parenting (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998).

Spanking in the past week: The 2-item measure adapted from the Early Head Start Family and Child Experiences survey (Baby FACES, 1997). This measure is a parent-report of the frequency and use of spanking as a means to discipline children who are misbehaving or acting out.

Brief Infant-Toddler Social Emotional Assessment-Parent Form (BITSEA): The BITSEA is a brief screener of children's social or emotional behavior problems and competencies based on the Infant Toddler Social Emotional Assessment (ITSEA). It was modified to identify children with deficits or delays in these areas, with positive screens to be followed by administration of the full ITSEA. The measure yields a Problem Total Score and a Competence Total Score. We will use the Parent Form which is available in both English and Spanish versions.

Ages & Stages Questionnaires, Third Edition (ASQ-3): The ASQ is a reliable, accurate and well-studied tool used to screen children for developmental delays in the first 5 years of life. The questionnaire is parent-completed and includes 17 age appropriate forms, which are used to determine whether a child is on target developmentally or needs further evaluation. The questionnaires are available in both English and Spanish versions.

Ages & Stages Questionnaires®: Social-Emotional (ASQ: SE): A Parent-completed, child-monitoring system for social-emotional behaviors and includes 8 age appropriate forms for ages 6-60 months. The *ASQ: SE* screens for self regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people. The questionnaires are available in both English and Spanish versions and will be administered by the home visitors. This measure was chosen to compliment the *BITSEA* which only covers children ages 1-3 years.

Family Resources Scale-Revised. The *FRS* (Dunst & Leet, 1987) is a 30-item self-report scale designed to measure the adequacy of resources in households with young children. The FRS is a reliable and valid tool to assess perceived adequacy of resources among economically diverse families. It assesses resources across six conceptually cohesive dimensions of: 1) basic needs, 2) housing and utilities, 3) social needs/ self care, 4) child care, 5)extra resources and 6) benefits.

Social Provisions Scale: This measure was designed to capture the degree to which a respondent's social relationships provide various dimensions of social support. The items selected are based on six social provisions: 1) attachment, 2) social integration, 3) reassurance of worth, 4) reliable alliance, 5) guidance, and 6) opportunity for nurturance identified by Weiss

(1974). The Social Provisions Scale was chosen because its theoretical base, good psychometric properties, low reading-level comprehension, and brevity.

Center for Epidemiology Studies Depression Short-Form (CESD-SF): This is a Quality of Life (QOL) tool used to measure current depressive symptoms in the general population. Items on the short form contain simple vocabulary in short sentences which can be administered by self-report or interview.

Alcohol Use Disorders Identification Test (AUDIT): The AUDIT was developed by the World Health Organization (WHO, 1989; updated in 1992) as a simple method of screening for excessive drinking and to assist in brief assessment. The AUDIT consists of 10 self report questions about recent alcohol use, alcohol dependence symptoms, and alcohol-related problems.

Drug Abuse Screening Test, 10 item version (DAST-10): This is a 10-item instrument modified to refer to the past 12 months at time of administration; a "yes" or "no" response is requested for each of the 10 questions. The DAST provides a brief, simple, practical but valid approach for identifying individuals who are abusing psychoactive drugs and yields a quantitative index score of the degree of problems related to drug use and misuse. This instrument will be administered in a self report format.

Delinquency Scale: This is a 14-item measure which asks the woman to rate on a scale from 1-6 the amount of times she engaged in delinquent behavior during three time periods: the past year, after age 18, but prior to the past year, before age 18. These questions were adapted from SAGE baseline survey and National Youth Survey (NYS) delinquency questionnaire.

Acceptance Scale: This measure was chosen based on the prior study (Edelen et al, 2008) on acceptance of aggression. There are nine questions with two 4-point scales. The first scale assesses their degree of agreement about dating violence while the second scale assesses whether the dating violence was acceptable or not. Acceptance of female perpetrated violence on males (5 items) produced a Cronbach Alpha of 0.71 and acceptance of male-perpetrated violence on females (4 items) produced a Cronbach Alpha of 0.55.

Conflict Tactics Scale 2 (CTS2): The CTS2 was developed to assess adult-to-adult conflict and to assess parent-to-child conflict (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). It includes five subscales measuring negotiation, psychological aggression, physical assault, injury, and sexual coercion. All the scales and subscales had good internal consistency with the exception of the minor injury subscale (Calvete et al, 2007).

Conflict and Problem Solving with Others: No standard measure was found to assess generality of conflict. Holtzworth-Munroe et al. (2000) created a generality of violence questionnaire which we modeled part of our structure from. Our measure is a seventeen item questionnaire that captures how often women are aggressive directly and indirectly with individuals in their life. There are two categories of people: family, friends/neighbors (informal supports), professional/coworker/service person (formal support). The measure is composed of 12 items from the CTS2 and 5 items from the Richardson Conflict Response Questionnaire (RCRQ). Participants will report frequency of events with each person in the past twelve months.

Relationship status measure: This measure will be used to track changes in primary caregivers' relationships, so that we can know if the Conflict Tactics Scale (CTS) is completed on the same person, a different person, or if the participant is not in a relationship, and if so, why they are not in a relationship.

Working Alliance Inventory Short Form (WAI-S) Client Version: The 12-item WAI Short form Horvath (1994), by Tracey and Kokotovic 1989, modified by Santos 2005 for home visiting will be used for this study. The *WAI-S* will be used to assess the working alliance between home providers and caregivers according to Bordin's (1979) formulations. We will utilize the client version for this Medicaid sample. Prior to administering the form, the data collector will inform the participant of the purpose of the assessment, encourage her/him to be as honest in her/his assessment as possible, and assure her/him that the information s/he provides will not be shared with her/his home visitor. While introducing the WAI, the data collector will let the participant know that there are no right or wrong answers and that they simply answer each question to the best of her/his ability and encourage the participant to work fast, as it is her/his first thoughts that are most important. Also, remind the participant that every item should be completed.

Service Utilization: The EBHV model (NFP, HFA and PAT) services are not intended to be the sole service resources available to clients, and we expect that home based service providers in both conditions will be linking participants to additional service programs (e.g., domestic violence services, substance abuse services, mental health services). This provides data needed for exploratory analyses regarding referral linkage; rates of retention in outside services, and the extent to which identification, linkage, and retention mediate group effects in the experimental design. Utilization of these services will be measured by modifying the services utilization questionnaire developed by Kessler and colleagues and used in the National Co morbidity Survey (Kessler et al., 1999).

Questions on immunizations, number of injuries and emergency room visits: Additional questions pertaining to Child Physical Health/Nutrition domain were adopted and modified by the Cross-site Evaluation Team from previous Large Scale Studies: Early Childhood Longitudinal Study-Birth Cohort (ECLS-B), Head Start Family and Child Experiences Survey (FACES 2009) and the National Survey of Child and Adolescent Well-being (NSCAW 2009).

Client Cultural Competence Inventory (CCCI): The Client Cultural Competence Inventory (CCCI; Switzer, Scholle, Johnson, & Kelleher, 1998) is a client report instrument reflecting the client's perception of the cultural competency of services. This scale will be completed for all services types received in the last 12 months.

Client Satisfaction Survey: The CSS was developed to measure parents' perceptions of the services including questions about their satisfaction with the program, the likelihood that they would refer friends to the program, and their self-evaluation of progress on treatment goals. This scale will be completed for all services types received in the last 12 months.

CPS Involvement

Child Maltreatment Outcome data: Future reports of child maltreatment, and related events such as out of home placements of children, are one of the targeted MIECHV outcomes of interest. Matching participants across the research database and the child welfare database will require care because the matches must be made on the basis of general identifiers which may be incomplete or inconsistent. We will use a sequential strategy with both computerized and manual matching components, that includes matching on social security numbers, and then combinations of name, gender and date of birth, including similar names and spellings. Match sets will subsequently be examined manually, line-by-line, in order to exclude likely false

positives, which has been done successfully with previous similarly sized studies. Because the child welfare database also includes unique identifiers for families, any victim or perpetrator matches will be linked back to a family-level identifier, and all reports for that family can be retrieved. Reports will then be aggregated across dates, children and incidents and within types of maltreatment and perpetrator identity. Note also, that extended follow-up for this outcome can be obtained well beyond completion of the study with only minimal effort by simply re-executing the matching and data cleaning algorithms. We will obtain consent from participants for this extended follow-up. A Data Sharing Agreement has already been established between our OUHSC evaluation team and the OKDHS. This agreement will be extended for the life of the project.

EBHV Agency Records

The planned measures for the original MIECHV Grant can be found at: (http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/MIECHV_Program_Federal_Home_Visiting_Grant/MIECHV_Program_Resources/index.html).

Home based service providers will receive training in data collection and coding the Child Well-being Scale (CWBS) measure, which is an observational scale of conditions in the home. Home visitors will also been trained on the collection and coding of the *ASQ-3 and the ASQ: SE, measures used to* screen children for developmental delays and monitor social-emotional behaviors respectively.

Qualitative Analysis

Content Analysis of the Focus Group Data: Qualitative analyses are conceptualized as providing complementary information that will facilitate interpretation of quantitative analyses as well as provide the basis for refinement of measurement in future studies. Qualitative interviews will be recorded and transcribed. Qualitative analysts will review both *a priori* concepts that emerge from analyses of the quantitative survey data as well as emergent concepts. In each of the domains studied, the primary issues raised by respondents will be identified and coded. A catalog of such points will be developed in each domain and the number of individuals raising each point will be recorded.

Transcription will be conducted by two graduate research assistants. Once an interview is transcribed, the lead focus group researcher will re-listen to each tape while reading the transcript in order to verify that the information provided truly represents the discussion held. If needed, the transcription will be edited. A copy of the final transcript will be given to at least two investigators (graduate students TBH and Beasley) who will code the transcript independently. Coding refers to the process of grouping comments or responses with similar meaning. Once the coding is completed, the coders will compare their results, reach a consensus regarding the coding scheme, and a codebook will be developed. The graduate students will work together on the same transcripts until inter-rater reliability of at least 80% for primary codes is achieved. The transcripts will be coded in a software program (QSR N*Vivo) to generate a series of categories arranged in a treelike structure connecting text segments grouped into separate categories or “nodes.” These nodes and trees will be used to examine

the association between different *a priori* and emergent categories and to identify the existence of new, previously unrecognized categories. The number of times these categories occur together, either as duplicate codes assigned to the same text or as codes assigned to adjacent texts in the same conversation, will be recorded, and specific examples of co-occurrence illustrated with transcript texts. We will use a double layer design to compare and contrast participant responses in the focus groups (Krueger & Casey, 2000).Content analysis will be based on the coded qualitative data, and the results obtained from the analysis will be merged in order to identify important themes and beliefs about factors that influence problem areas to include designated a priori topics of: 1) reasons for disconnected care (Problem 1); 2) degree of inter-agency communication within counties (Problem 1); 3) awareness of EBHV and early learning programs (Problems 1 and 2); 4) reasons for recruitment nonresponse and program disengagement (Problem 3); 5) degree of inefficiency in system referral process (Problem 3); 6) Perceived impact of EBHV and early learning programs within counties (Problem 4). Comparisons of theme frequencies from Year 1 to 4 focus group analyses are also planned for evaluating system-level change.

Quantitative Analysis

Medicaid Sample: All analyses will be conducted in the Mplus (Muthen & Muthen, 1998-2010) software package controlling for the complex sampling design variables (sampling weights and strata membership). The general strategy for evaluation of data from this longitudinal sample will be to use latent growth cure (LGC) analysis. Outcomes will be modeled as functions of time, where a time covariate predictor is quantified as a running clock that begins at 0 for each participant during their month of enrollment and increases one unit for each subsequent longitudinal assessment of the outcome (e.g., the time covariate equals 1 for the first annual interview outcomes that later follow the baseline assessment). By including individual-level cohort indicators that define the period of participant's enrollment (e.g., using a running quarter count from 1 to 14, where 14 represents involvement in the final quarter of the project), the LGC can be viewed as a times series analysis with individual-level data (instead of the traditional aggregate county- or state-level data) informing system-level outcomes. That is, subgroup estimates of cohort incidence and rates of change can be compared one to another to detect system-level trajectories and improvements. For example, we might semi-parametrically estimate outcome changes that occur during each quarter of project operation. A series of dummy coded indicators that capture each quarter-year interval can be explored within planned contrasts to test whether outcomes increased steadily over time, remained stable over time, worsened over time, etc. Change over time can also be evaluated with enrollment cohorts as a function of the time covariate (e.g., to assess whether outcomes increase for the 1st enrolled cohort, we might test the significance of a linear increase in the outcome as a linear function of the time covariate and a cohort membership indicator). Ignoring cohort differences, time-varying covariates can be incorporated to assess the impact of specific system-level innovation change in each county. For example, if our Data System innovation is implemented in Oklahoma County at the 18 month mark of enrollment, a simple binary covariate can be introduced to the LGC model to assess change among Oklahoma County participant outcomes measured after the 18th month of enrollment. Similar individual-level binary covariates can be introduced to assess service utilization changes like self-reported

engagement in EBHV or completion of EBHV (note: service utilization measures will be analyzed as covariates- when predicting change in psychometric outcomes- but also, in separate models, as outcomes themselves). Of course, cohort indicators can be re-introduced in these models as well, to assess whether innovation impact depends on cohort (e.g., the effect of a data system may be greater for later cohorts as this innovation becomes more established). Likewise, factors related to strata membership can be directly modeled to assess whether system change is dependent on pregnancy status, age of a target child, number of children in the home, etc. Given the flexibility of this analytic framework and the vast number of model trajectory options available, we intend to build up the complexity of each outcome model by fitting separate county level models; first, before attempting any aggregate cross-county model building exercises.

The anticipated structure of the LGC's can broadly be defined as generalized linear mixed model (GLMM) growth curve analyses (Breslow & Clayton, 1993). These analyses will be conducted in a series of steps: 1) outcomes will be plotted, and an initial distribution (with canonical link function) for each will be selected; 2) a variety of different growth trajectory models will be fit to the time series data, separately, and each model's AIC (Akaike, 1987) and BIC (Schwarz, 1978) fit criteria will be recorded; 3) graphical residual analyses will assess distributional assumptions, and if necessary, steps 1 and 2 will be repeated with a new distribution and/or a transformed (e.g., recoded to categorical) outcome; 4) the AIC and BIC will then be used to select a best fitting model[1]; finally, 5) hypothesis tests will be conducted via contrasts among the GLMM estimated linear predictors and significance will be assessed using a Chi-Square likelihood difference test. We plan to use maximum likelihood estimation with adaptive quadrature integral approximation and sandwich estimator standard errors.

A few outcomes will not be amenable to the general LGC model described above. For most of the service outcomes, for example, we plan instead to condense longitudinal outcomes into single variables of service utilization or service outcome. These analyses will also occasionally involve subgroups of the full sample, when responses to scales like our cultural competency measure or our client satisfaction require actual service engagement. These analyses will be analyzed as univariate generalized linear models with careful inclusion of participants that share a common follow-up length. For example, we will not include participants enrolled in year 4 in any model that assesses use of a service within 2-years of enrollment. Likewise, we will be careful to exclude participants who do not meet service eligibility requirements when assessing service utilization outcomes. We will also explore survival analyses of length of time until service utilization, and latent transition models (Collins, Hyatt, and Graham, 2000) of movement from one program of care (e.g., NFP) to the next developmentally appropriate program (e.g., HFA). All of these models will utilize the cohort indicators for assessing changes over time.

[1] If AIC and BIC favored different models, the simpler (in terms of model complexity, i.e., number of parameters estimated) of the two models will be selected.

Maltreatment referral outcomes will be analyzed using survival analysis with the same timing variable described for the LGC's and the same cohort covariate predictors described above. Both nonparametric Kaplan-Meier analyses controlling for cohorts as strata and Cox-based regression analyses with cohort predictors will be estimated. Both types of analyses will consider time to a 1st post- enrollment report to child welfare.

Handling of Missing Data: The mixed models describe above will attempt to adjust for missing data bias under the assumption that data were missing at random (Rubin, 1976) for the Normal-distributed error models, and under a variation of MAR for the non-Normal error models. This full information maximum likelihood (FIML)-based approach is closely related to the use of state-of-art multiple imputation methods (see Collins, Schafer, & Kam, 2001). Best fitting models will also be estimated with baseline covariate main effects and trajectory interactions to improve prediction of individual differences in outcome trajectories. Multiple imputations will be used for univariate outcome models.

EBHV Agency Records

The agency records data source will be used to assess the benchmarked outcomes in the expansion counties. These analyses will address Problem Area 4 and will be implemented following the analytic plan developed in the original MIECHV Grant: (http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/MIECHV_Program_-_Federal_Home_Visiting_Grant/MIECHV_Program_Resources/index.html).

As with the SIR plan we will qualify improvements on the benchmarks during the first year of project operation as an increase in proper reporting of agency outcomes. Year 1 outcomes on the benchmarks will than serve as a baseline indicator for progress in years 2 through 4. Analyses of change relative to the baseline outcomes will be based on t-tests of aggregate county-level change in continuous measured outcomes and aggregate binomial tests of change in proportional outcomes.

Human Subjects

Involvement of Participants: Prior to research participant recruitment for the qualitative and quantitative data, approval from relevant Institutional Review Board (IRB) will be obtained. The evaluation team has a long history of successful application for IRB approval with OUHSC, state agencies (including OSDH), and field agencies (when needed). Research-related HIPAA requirements will also be addressed in IRB approval. A Certificate of Confidentiality for the family participant data will be requested. In addition, the following assurances will be adhered to: (a) participation is voluntary and consent can be withdrawn at any time without penalty, (b) clients who do not want to volunteer will not lose access to services, (c) participants will be informed of all foreseeable benefits and risks, (d) mandatory child abuse reporting and duty to warn requirements will be clearly articulated to the parent, and (e) data will be stored on a secure computer and/or locked file cabinet.

See Attachment 9, Page 2 for reference list.

ORGANIZATIONAL INFORMATION

THE OKLAHOMA STATE DEPARTMENT OF HEALTH: On June 10th, 2010, then Governor Brad Henry designated the Oklahoma State Department of Health (OSDH) as the lead agency for the Maternal, Infant and Early Care Home Visiting Grant (MIECHV) because of its "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 mission of OSDH is to protect, maintain and improve the public's health status.

Community and Family Health Services (CFHS) is responsible for the oversight of the 68 local county health departments and partners with the two independent city-county health departments[1] and serves 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, nutrition services, child developmental services, environmental health, and early intervention.

CFHS is also responsible for the programmatic efforts that support most of the local health department efforts. Policy development, training and evaluation are provided by professionals at the OSDH central office. The following supportive Services are located within CFHS:

1) Family Support and Prevention Service - programs that promote the health, safety and well-being of young children by educating the public, training professionals and providing direct services, including home visiting, to families;
2) Child Guidance Service - programs designed to promote optimal child development, and healthy interaction for children and those that care for them;
3) Maternal and Child Health Service - programs that provide state leadership to improve the physical and mental health of the Oklahoma maternal and child health population;
4) SoonerStart – Oklahoma's IDEA Part C program designed to provide early intervention service infants and children with disabilities and developmental delays;
5) Women, Infants and Children (WIC) - a program providing nutrition education and food resources to low-income pregnant and postpartum women and their young children;
6) Dental Service - provides leadership in oral disease prevention as well as mobilizes efforts that will help protect and promote good oral health;
7) Community Development Service - programs that promote health equity & resource opportunities, health promotion, primary care & rural health development, and community development
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 related to quality assurance chart reviews, technical support for OSDH developed software, and financial reporting software.

The Family Support and Prevention Service's (FSPS) mission is to promote the health, safety and wellbeing of children and families by providing education, multidisciplinary training of professionals and support to direct services to families. Located within FSPS are six major

[1] Oklahoma City and Tulsa

programmatic efforts including OSDH's home visitation efforts:

1) Children First (C1) – Oklahoma's Nurse-Family Partnership Program providing nurse home visitation services to first-time, low-income mothers.
2) The Office of Child Abuse Prevention (OCAP) - 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 of local Start Right home visiting (HFA) programs.
3) The Community-Based Child Abuse Prevention Grant (CBCAP) - funds that allow community-based organizations 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 Maternal, Infant and Early Childhood Home Visitation Grant (MIECHV) – 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 (CATC) - a program designed to support the development and maintenance of multidisciplinary child abuse/neglect teams across the state as well as to provide training for professionals working in the child welfare system.
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.

Other OSDH Related Activities

1) Preparing for a Lifetime Initiative (PLI): In 2007, Oklahoma ranked 46th in the U.S. regarding infant mortality. The Commissioner of Health responded by creating the PLI. Led by the OSDH Maternal and Child Health Service, PLI has identified the following areas for concentration and improvement: number of women receiving preconception care and prenatal care; identification/treatment of maternal infections; premature births; postpartum depression; tobacco use; safe sleep; breastfeeding and infant injuries.
2) Oklahoma Health Improvement Plan (OHIP): In 2008, the Oklahoma Legislature directed the Board of Health to outline 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 was the result. The OHIP focuses on three "flagship initiatives:" 1) Tobacco Use Prevention; 2) Obesity Reduction; and 3) Child Health.
3) The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS): Since 1988, PRAMS has been collecting statewide information about a woman's behaviors and experiences before, during and after pregnancy. PRAMS randomly samples new mothers with a mailed questionnaire or follow-up interview. Home visiting questions are being included in the upcoming version.
4) Early Childhood Comprehensive Systems: The purpose of the State Maternal and Child Health Early Childhood Comprehensive Systems (ECCS) Grant Project is to support

families and communities in the development children who are healthy and ready to learn. In Oklahoma, the early childhood system has been developed through collaborative partnerships with other state agencies and organizations, working in conjunction with the Oklahoma Partnership for School Readiness, now known as Smart Start Oklahoma.

5) "Keeping Kids Healthy": The Oklahoma Children's Health Plan (CHIP) was developed for 2011-2014. The plan has identified the following strategic goals: Access to Primary Care; Injury Prevention; Immunization; the Impact of Mental Health and Substance Abuse; and Child Abuse and Neglect. Home visiting is a strategy included in the Plan.

ABILITY TO CONDUCT THE PROGRAM REQUIREMENTS AND MEET PROGRAM EXPECTATIONS

OSDH has the responsibility for administering the State's two largest evidence-based home visiting programs: Children First Program (NFP) and OCAP's Start Right (HFA). The Consultants for these two programs currently provide the following activities in order to support the home visitors, assure high quality care and protect model fidelity:

- Establish and maintain relationships with the National Model Developers;
- Develop policies and program guidelines;
- Develop "Oklahoma specific" educational material to be included with model lesson plans to be used during home visits;
- Contract, when necessary, with agencies to provide home visitation services;
- Assure that home visitors are appropriately trained in their respective model as well as specific topics such as adoption, substance abuse, domestic violence, etc. ;
- Provide technical assistance to home visitors upon request;
- Develop and distribute routine performance reports;
- Conduct site visits to assure fidelity to the model and quality of services;
- Assist program evaluators in analyzing programmatic data and producing annual reports; and
- Ensure program alignment with Federal, State and programmatic outcomes.

Should Oklahoma be awarded a MIECHV Expansion Grant, the Consultants will provide their services to the MIECHV expansion sites including PAT. The existing home visiting infrastructure should work well for the MIECVH Grant with some improvements and modifications.

Along with the FSPS at OSDH and ODE, the OU CCAN is a major partner for the MIECHV Program Competitive Grant. CCAN evaluators have designed the evaluation component of the grant. The newly developed community Connector will also play an important role. If the grant is awarded, the coordination and collaboration among CCAN, ODE, FSPS at OSDH and the *Connector* will result in a partnership that will be foundational to meeting program expectations and requirements as well as strengthening Oklahoma's early childhood comprehensive system.

OSDH/FSPS RECORD OF ACCOMPLISHMENTS

Please see Attachment 6.

OSDH'S RESOURCES/CAPABILITIES TO SUPPORT CULTURALLY AND LINGUISTICALLY COMPETENT AND HEALTH LITERATE SERVICES

The Oklahoma State Department of Health (OSDH) is committed to ensuring access to quality care for all consumers and works to implement strategies for recruiting and retaining a diverse staff. During the process of hiring service providers, consideration is given not only to the education and experience, but also to a supportive, nonjudgmental approach and sensitivity to the other cultures' values and beliefs. An effort is made to hire home visitors that are bilingual if that is a relevant skill for their community.

The agency has in place policies, practices, structures, procedures and specific resources to support culturally and linguistically competent and health literate services. As part of the performance management system, employees are required to attend annual training in cultural competence. Although policies and procedures are implemented throughout the agency, three divisions work closely with programs to ensure that information, materials and services are delivered in a manner that meets the needs of diverse consumers: 1) The Oklahoma Health Equity Campaign division works collaboratively with communities to develop "upstream" policies to improve health status for Oklahomans; 2) The Office of Minority Health (OMH), as a member of the Oklahoma Health Disparity Task Force, helped develop recommendations for OSDH and other health agencies to eliminate health disparities among Oklahoma's minority and underserved populations. The OMH develops standards and training for interpreters, provides telephone language services and provides assistance in developing educational materials for minority populations; and 3) The Office of Communications provides services to OSDH programs to help develop educational materials to communicate and convey information in a manner that is easily understood by diverse audiences and persons with low literacy skills.

Home visiting models, utilized in the state, have specific training requirements related to cultural and linguistic competence. Educational materials for each model are available in Spanish, since it is the most commonly spoken second language in Oklahoma. Efforts are made to hire home visitors who are bilingual or provide interpreters based on the needs of the participants. Programs that serve a specific American Indian Tribe, for example, typically provide the visit in English, but also encourage families to use words from their native language. Home visiting teams have utilized services of interpreters for the deaf, provided handouts in Braille and purchased closed-captioned videos. Assessment and screening tools utilized are standardized tools such as Ages and Stages and the Edinburgh Postnatal Depression Screen. Home visitors, also, identify and make referrals to appropriate literacy and educational programs to help families meet long term needs related to literacy.

UNIQUE NEEDS OF TARGET POPULATIONS OF THE COMMUNITIES SERVED ARE ROUTINELY ASSESSED AND IMPROVED AND DESCRIPTION OF THE ORGANIZATIONAL CAPACITY OF PARTNERING AGENCIES/ORGANIZATONS INVOLVED IN IMPLEMENTATION OF THE PROJECT

Community meeting(s) were conducted in each targeted county. The purpose of the meetings was to inform the community about the MIECHV Program Expansion Grant and to give partners an opportunity to share input about the strengths and needs of their community. Families who

are or have been enrolled in home visiting services were also given opportunity to share their opinions by written comments. The below community meetings were conducted: as listed below:

- Oklahoma County on June 17, 20, and 22, 2011
- Muskogee County on June 20, 2011
- Comanche County on June 21, 2011
- Tulsa County on June 20, 2011

Once the new *Connector* position is established, she/he will ensure that the unique needs of the families and the community are assessed on a routine basis. In addition to the general knowledge they have about the community, they can utilize the MIECHV statistical data and to track the progress made related to the target populations. The MIECHV Evaluator along with the experts at CCAN will keep all informed about the data collected and findings related to the MEICHV Benchmarks and Constructs. Such information will be useful to the Connectors as they monitor progress.

ADEQUACY OF RESOURCES TO CONTINUE THE PROPOSED PROJECT AND STATE'S COMMITMENT TO HOME VISITING

The administration and implementation of evidence-based home visiting programs using the NFP, HFA, and PAT models has been in process in Oklahoma for more than a decade. There is an existing infrastructure in place to support the expansion of these efforts. The Oklahoma Legislature, the OSDH and the ODE have repeatedly affirmed its commitment to home visiting as a means to promote the health, safety, and well-being of families with young children. Even in economic downturns, home visiting funding has not been totally eliminated. To date, the practice of home visiting is well respected and valued in our State.

ASSURANCE: The State of Oklahoma assures that cuts in state funding will not be made to a broad array of home visiting programs in the future.