GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Maternal Infant & Early Childhood

Home Visiting Program

Table of Contents

I. Introduction 1
A. Purpose 1
B. Previous Steps toward Building High Quality HVPs 2
II. Needs Assessment 3
A. District of Columbia Demographics 3
B. Existing Evidence-based Home Visiting Programs 4
C. Justification of Selected Communities 5
III. Methodology 7
A. Promising Evidence-based Model (DC Healthy Families America) 7
B. Assessment as a Service 9
C. Goals & Objectives 10
D. DOH Home Visiting Programmatic Goals and Objectives 11
IV. Work Plan 13
A. System Infrastructure 13
B. Program Oversight 16
V. Evaluation & Technical Support Capacity 21
A. Evaluation Approach and Principles 21
B. Overview of the Evaluation Design 22
C. Research and Evaluation Questions 23
D. Implementation Study 23
E. Impact Study 26
F. Theory of Change 28
I. Works Cited 29
II. Works Cited 29
VI. Evaluation and Technical Support 30
A. Organizations Experience 30
B. Evaluators Experience 31
VII. Organization Information 31
A. DC DOH Organizational Structure 31
VIII. Home Visiting Program Sustainability 32

I. Introduction

The District of Columbia is home to 601,723 residents with approximately 38,156 children between the ages of 0 and 5 years. Historically, many of the District's residents have experienced some of the nation's most alarming social, economic, and health status disparities. Many children have resided in communities with alarmingly high prevalence of poor birth outcomes, poverty, crime, substance abuse, child abuse and neglect, and low academic achievement.

The American Academy of Pediatrics (AAP) has long recognized home visitation as a strategy to mitigate health and developmental outcome disparities.[1]According to the District of Columbia's Early Intervention and Strong Start programs, 1,041 children, ages 0-5, were diagnosed with developmental delays or disabilities. In an effort to address these findings, the Department of Health (DOH) and community-based organizations currently provide across eight (8) District Wards to eligible residents. These programs currently have the capacity to serve approximately 1,630 families.

The limited availability of early childhood home visiting services to meet the demonstrated need is further compounded by a lack of coordination among the existing programs offering these services. When compared to other states the District receives limited funding to adequately address integration and coordination of services to serve the at-risk families in critical need of home visitation services. The funds from this grant award will be used to help expand Home Visitation Programs (HVP) utilizing the Healthy Families America (HFA) model, which is designed to improve outcomes for program participants. The expanded HVP will be coordinated and integrated with current service providers that do not currently have an evidence-based component in their service model. These activities are aimed at enhancing assessment of program service effectiveness and impact to the populations targeted throughout the District with the greatest need.

A. Purpose

The District's DOH HVP is requesting the investment of Federal grant dollars to support the DOH's goal of increasing evidence-based HVPs throughout its targeted high-risk populations and implementing the HFA model to expand evidence-based service delivery. The funds will also provide monetary investment and facilitate the DOH's ability to standardize the universal screening and assessment process to identify at risk children and families; create a HV Training Institute (HVTI) directed toward community based home visitation service providers, to enhance home visitor's knowledge, skills, and abilities to provide developmentally appropriate activities and support to families; and to develop a coordinated client referral and tracking system. The funds will also enable comprehensive data collection, monitoring and evaluation of the HVP's impact on identified legislative benchmarks and evidence-based program implementation. More importantly, this will lead to improved outcomes of families at highest risk and need. This rigorous evaluation study will also provide critical information on program effectiveness. Program activities are also designed to enhance partnership building and interagency

[1] http://pediatrics.aappublications.org/content/123/2/598.abstract

collaborations to foster cross sector coordination and identify opportunities for sustainability through leveraging resources with other agencies serving the priority populations.

Through this funding, we seek to enhance and sustain comprehensive evidence-based high quality HV services that target high-risk residences that include: low-income families; pregnant women under 21; families with a history of child abuse and neglect; and families with children who have developmental delays or disabilities in the District. These efforts will lead to measurable improvements in the current Early Childhood system and improved school readiness and social emotional outcomes for children.

B. Previous Steps toward Building High Quality HVPs

Since 1989, DOH has provided home visiting services which ranged from maternal-newborn support to sexually transmitted diseases and tuberculosis outreach and education. In 1989, the District's infant mortality rate was reported at a staggering 23 infant deaths per 1000 births. This high infant mortality rate led to the District being one of the fifteen original recipients of the Federal Health Resources and Services Administration's Healthy Start grants. As a part of the DOH Healthy Start Program, nurses, and case managers provided education and support in the home, as well as provided referrals to appropriate services. These in-home services contributed to a significant reduction in the infant mortality rate. However, the original Healthy Start grant also had a major limitation in that it required families to age out of the program after the child's first birthday. Research from the original Healthy Start grantees illustrated the importance of long term family engagement during the 0-5 years to obtain significant impact relative to future pregnancy planning and second pregnancy improved health status.

In 1995, several District partners were awarded funding from the Freddie Mac Foundation to implement the HFA home visitation model. Four HFA sites were implemented in the District. The HFA model was selected due to its demonstrated focus on building multi-year relationships with families to reduce risk factors. One of the four sites that received funding; the Mary's Center continues to implement the HFA in their home visitation program.

During 2000, the DOH, Mary's Center, and the Healthy Babies Project collaborated to form the District of Columbia Home Visitation Council (HV Council). The HV Council united public and private partners throughout the District to collaborate on the myriad of services being offered throughout the District to at-risk families. The HV Council was instrumental in developing best practices, training support, promoting shared outcomes, and data collection strategies with the aim of building a continuum of support for families throughout the District. These earlier activities have led to a growing recognition of the importance of implementing evidence based home visitation models.

The Mayor's District-wide Early Success Framework was designed to ensure that children are healthy and ready to learn. This initiative brings together all the agencies that focus on early childhood which include: Office of State Superintendent of Education (OSSE); DOH; CSFA; Department of Environment (DOEE); Department of Housing (DCHF); Healthcare Finance Administration (DHFA) as well as those with targeted intervention services including the Department of Mental Health (DMH) and the DOH and Human Services (DC HHS). The Framework is a key strategy supporting the efforts of this grant application and facilitates the

home visitation proposed program in achieving the critical indicators outlined in the Framework (See Attachment 10).

II. Needs Assessment

A. District of Columbia Demographics

The United States Census reported that in 2010, the total population of the District was 601,723 residents. This represents an increase of 5% between decennial census years from 572,059 in 2000 to 601,723 in 2010. The District is geographically divided into four quadrants (northeast, northwest, southeast and southwest) and eight electoral wards (Figure 1).

Figure 1. Map of the District of Columbia with Electoral Wards

Located in the northwest quadrant of the District Wards 1 and 4 are home to a substantial number of the District's Hispanic residents; while, Wards 5 and 6 located in the northeast quadrant of the District and are predominantly 'middle-class' African-American. More than ninety percent of the residents of Wards 7 and 8 are African-American. As indicated in Table 1 below, these residents; earn the District's lowest incomes, have the city's highest rates of unemployment, the highest rates of families and children living in poverty and the highest number families receiving Temporary Aid for Needy Families (TANF) and Food Stamps.

The 2010, Census data indicates that the District has approximately 38,156 children between the ages of 0 and 5 years. This number represents 6% of the District's total population. Many of these children reside in communities throughout the District with high rates of: poor birth outcomes; poverty; crime; substance abuse; child abuse and neglect; and low academic achievement.

Table 1: District of Columbia Demographic and Socio-Economic Indicators by Ward

Ward	Total Population 2010[2]	Average family income 2006-2010	% Population by Race and Ethnicity 2010				Household Total # 2010	% Children in Population 2010[3]
			Black	White	Hispanic	Asian/PI		
1	76,197	$ 89,921	33	36	22	5	31,309	12
2	79,915	$116,794	13	67	9.5	10	34,811	5.8
3	77,152	$150,629	5.6	78	7.5	8.2	36,040	13
4	75,773	$97,355	59	20	19	2	29,029	20
5	74,308	$ 62420	77	15	6.3	1.7	29.340	17
6	76,598	$103,014	42	47	4.8	5	34,449	13
7	71,068	**$ 48,305**	**96**	1.4	2.3	.2	29,838	**25**

[2] *US Census Bureau 2010 American Community Survey*
[3] *US Census 2010 American Community Survey. Note: Children are defined as all persons less than 18 years of age.*

8	70,712	**$ 44,550**	**94**	3.3	1.8	.5	25,827	**30**
DC	**601,723**	**$92,959**	**51**	**38**	**9**	**4**	**n/a**	
Ward	**% Population 16+ Employed 2010**	**% Population Unemployed 2010**	**% Population without a HS Diploma 2005-2009[4]**		**% Population in Poverty 2010**	**% Children in Poverty 2010**	**# of people receiving Food Stamps 2010**	**# of people receiving TANF 2010**
1	71.4	5	19		13	23	9,807	3,174
2	65.4	3	8.1		4.5	18	3,617	917
3	66.3	3	3.4		2.1	3.1	412	47
4	60.3	6	17		7.0	12	12,644	3,965
5	54	9	19		15	29	18,074	6,256
6	64.4	6	12		15	31	14,798	4,186
7	50	**12**	20		**23.2**	**40**	**27,462**	**11,528**
8	43.4	**11**	21		**32.0**	**48**	**35,423**	**16,386**
DC	**58.0**	**8.2**	**7.9**		**14.1**	**22.5**	**86,814**	**30,073**

A substantial number of these children have not been served by the District's existing Maternal, Infant and Early Childhood Home Visiting (MIECHV) program because they do not reside the target communities (Wards 5, 7 and 8). With this funding opportunity, DOH's new approach to addressing high-risk populations in need of evidence-based home visitation services will be based on population needs versus geographic location. It is recognized that many residents of Wards 5, 7 and 8 have high-risk factors, but there are pockets of high-risk populations throughout the District.

To ensure the opportunity that all at-risk families receive appropriate evidence-based home visiting services regardless of their address, the Universal Screening Tool (UST) will be administered throughout the District by a variety of service providers; will determine participants' eligibility for home visitation services. This information will be entered into the Central Intake and Referral System (CIRS), and an algorithm will assign the participants to a specific home visiting program based on caseload capacity and participant needs.

B. Existing Evidence-based Home Visiting Programs

Currently, there are ten early childhood home visiting programs that provide home visiting services with an approximate total capacity of 1,630 families. Of these programs, only eight have an early childhood focus and only four of those programs use evidence-based program models. The four programs currently have a capacity to serve of approximately 629 families (approximately 30%) of the current home visiting programs. The limited availability of District-wide evidence-based Early Childhood home visiting services is further compounded by a lack of coordination and uniformed data collection among the existing programs that offer these services.

[4] *Neighborhood Change Database, created by GeoLytics and the Urban Institute, with funding from the Rockefeller Foundation. Data on TANF and Food Stamps are from the DC Department of Human Services, Income Maintenance Administration Source: Neighborhood Info DC, a partnership of the Urban Institute and the Washington, DC Local Initiatives Support Coalition (LISC); information accessed on 07.15.12 at* http://neighborhoodinfodc.org/wards/wards.html

The four organizations currently providing evidence based home visiting services in the District, have a current capacity to serve of 629. With this Development Grant the number of organizations implementing evidence based home visiting models will increase by 75%. It is anticipated that this increase in capacity will result in an increase in the number of families receiving evidence based home visiting services. We project that the service delivery will increase from 30% (n=629 families) to 67% (n=1100 families).

Table 2 below summarizes the current evidence-based home visitation home visitation programs including wards and number of families currently being served in the District.

Table 2: Current Home Visitation Program in the District

Program Name	Evidence-based Model Used	Services Provided	Wards Served	Number Served to date
Mary's Center	Healthy Families America	• Prenatal care • Parenting Groups • Screening and Assessment • Case management • Referrals	1,2,4,5,6, 7, 8	294
	PAT	• Prenatal care • Parenting Groups • Screening and Assessment • Education • Referrals	5,7 and 8	Recruitment phase
DOH Healthy Start	PAT	• Prenatal care • Case management • Parenting Groups • Screening and Assessment • Education • Referrals	5,6 7, and 8	267 families
The Perry School	HIPPY	• Parenting Groups • Education	Not reported	
The Family Place	HIPPY	• Parenting Groups • Education • Case management	Wards 1, 4, 5, 7, 8	68
Total Families served by evidence-based				**629**

C. Justification of Selected Communities

Funds from this grant opportunity will be used to further expand the District's current home visiting program from solely Wards 5, 7 and 8 to provide home visitation services District-wide. In an effort to identify at risk communities, risk factors and community strengths were taken into consideration. While Wards 5, 7 and 8 clearly have and continue to have the populations that would benefit from HV services, there are other identified priority populations residing in all wards that would also benefit from home visiting services. Risk factors were also identified by the analysis of data, detailing the following identified high-risk priority areas:

- Low-income eligible families;
- Eligible families who are pregnant who have not attained age 21;
- Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; and
- Eligible families with children with developmental delays or disabilities.

Table 3: District of Columbia High Risk Population Summary and Comparison

Risk Factors	DC	US
Percentage of Population who are Children Aged 0-5 years	6%	7%
Low-income families[5]	25%	21%
Percentage of Children 0-5 living in Poverty[6][7]	[8] 30%	21%
Number of Children 0 – 5 in Foster Care[9]	418	171,699[10]
Percentage of pregnant women and who have not attained age 21	15%	9%[11]
Number of children with developmental delays or disabilities (ages 0-5 years)[12]	1,041	n/a

Percentage of Low-Income Families Below the Poverty Level

The Federal poverty definition consists of a series of thresholds based on family size and composition. In 2010, the preliminary estimate of the average poverty threshold for a family of four was $22,314[13]. Research indicates that children who are raised in poverty are at a higher risk of being exposed to risk factors that might impair brain development and affect their social and emotional development. These risks can include environmental toxins, inadequate nutrition, maternal depression, poorer birth outcomes, lack of adequate prenatal care, parental substance abuse, trauma and abuse, violent crime, divorce, and low quality childcare. It is estimated that

[5] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2010 and 2011 Current Population Survey (CPS: Annual Social and Economic Supplements).

[6] Number of children at or below the 100% Federal Poverty Level

[7] Source: U.S. Census Bureau, 2010 American Community Survey available at http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_S1702&prodType=table

[8] Includes all children n< 18 years of age. US Census 2010, compiled by DC Action for Children http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=DC&group=Featured&loc=10#6747

[9] CFSA 2011 Annual report on performance in meeting requirements of the local version of the Adoptions & Safe Families Act (ASFA)

[10] Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2011 data

[11] National Center for Vital Statistics Births Preliminary Data for 2010. Includes births to mothers less than 20 years of age.

[12] This is a combined total of all children 0-5 diagnosed with a developmental delay or disability in the District. Sources DC Early Intervention Program 2011 (n=467) and Early Stages Data School year 2011-2012 (n=574)

[13] Persons in poverty are defined here as those living in "health insurance units" with incomes less than 100% of the Federal Poverty Level (FPL) as measured by the U.S. DOH and Human Services' (HHS) poverty guidelines. Health insurance units are related individuals who would be eligible as a group for "family" coverage in a health plan. The federal poverty guideline for a family of four in the 48 contiguous states and D.C. was $22,050 in 2009 and 2010. The U.S. Census Bureau produces simplified - but very similar - versions of federal poverty guidelines called "poverty thresholds." For more information on measures of poverty, please see the detailed description provided by HHS available at http://aspe.hhs.gov/poverty/faq.shtml.

30% (11,294) of children in the District ages 0 to 5 live in poverty. Moreover, approximately 25% of all District residents live in poverty, which is higher than the US average of 21%.

Percentage of Mothers who are Pregnant and Have not Attained age 21

Children who are born to mothers who are less than 21 years of age are more likely to be born in poverty, have a low birth weight, and be born prematurely[14]. These children are more likely to enter school with behavioral, academic, and medical problems. In addition, teen mothers are more likely to drop out of school, receive public assistance, and have an income at or below the Federal poverty level. In 2010, approximately 15% (1,368)[15] of all live births in the District were to mothers who were less than 21 years of age at the time of delivery, compared to the US rate of 9% for the same population. Of live births, 11% were of low birth weight. Ninety-seven percent of these young mothers were single, and 46% had between a 9th - 12th grade education, had not graduated from high school, or obtained their General Educational Development degree (GED). Additionally, 4% of these young mothers had a previous live birth.

Children Zero to five that are currently in Foster Care

The District recognizes the unique vulnerabilities of children between the ages of 0-5 years. In Fiscal Year (FY) 2011, 33% of new entries/re-entries into foster care were under the age of three, while children ages 4-6 years comprised 15% of total entries/re-entries. As of March 31, 2012, children 0-3 comprise 26% of all new entries/re-entries into foster care, with children ages 4-6 years old comprising 18% of new entries/re-entries. This represents a total of 391 children ages 0 to 5 in foster care ages. These children are at higher risk for experiencing problems with cognitive, behavioral, or social-emotional development that negatively impact upon their functioning, development and school-readiness.

Families with Children with Developmental Delays or Disabilities

Identification of those aged 0 to 5 years with developmental delays or disabilities continues to remain a priority of the District. The District's Early Intervention and Strong Start programs reported that in 2011, a total of 1,041 infants and children ages 0-5 years were diagnosed with a developmental delay or have a diagnosed condition known to result in a developmental delay. These children reside in all Wards, cut across all family structures, and income levels. For children ages 2-5 years, 51% were diagnosed with developmental delays, and approximately 29% were diagnosed with speech or language impairments.

III. Methodology

A. Promising Evidence-based Model (DC Healthy Families America)

HFA is an intensive evidence-based home visitation program currently serving families in seven of eight wards in the District of Columbia. HFA meets the Health and Human Services Criteria for Evidence of Effectiveness. Since the inception of HFA in the District in 1995, HFA has provided intensive home visiting services to over 2,036 high-risk families. The comprehensive

[14] Holcombe, E., Peterson, K., & Manlove, J. (2009). *Ten Reasons to Still Keep the Focus on Teen Childbearing*. Washington, DC: Child Trends, Inc.

[15] District of Columbia State Center for Health Statistics (SCHS) 2010 Birth file. In 2010, there were a total of 9,136 live birth to DC residents.

services offered by HFA are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect, improve maternal and child health outcomes, and promote optimal child development. Over the past sixteen years, HFA has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding challenges, expansion and infrastructure changes, and a changing political landscape. The program's ability to achieve positive outcomes with targeted high-risk families will be accomplished through strict adherence to rigorous quality standards and research-based effective practices.

Mary's Center's HFA program targets mothers who are either prenatal or within 90 days postpartum, reside in the District and are at risk for poor maternal and child outcomes. HFA program, families are recruited community-based outreach in variant locations (i.e., MCO's, community events, local primary care clinics). These families have been identified to be at risk for child abuse and neglect based on the Parent Survey, a standardized screening and assessment tool. During Year 16 of this evidenced-based program approximately 80% scored positive for risk and were eligible for the program. However, due to space limitations, less than half of the identified families (41%) were enrolled into the program. The remaining families were referred to other services as indicated by their assessment and as services were available within the District. Of the mothers who were enrolled, 67% were enrolled prenatally, increasing the likelihood of healthy birth outcomes. Including the new enrollees, there were 294 active participant families in the Healthy Families program in Year 16.

Demographic data reveals a population characterized by a number of risk factors. Eighty-one percent were single or divorced, with low levels of education (only 44% with HS degree) and employment (75% unemployed). Seventy-six percent were between 20-35 years of age, but 16% were teens under the age of 20 years. Sixty-six percent of the mothers are Hispanic/Latino, while the remaining mothers are primarily African-American (33%), with a small percentage Anglo-American (1%). Sixty-one percent of mothers speak Spanish as their primary or only language, limiting their ability to access services and community support, as well as to find employment. The majority of the mothers reside in Wards 1, 4, 5 and 8. Although 66% of mothers had stable housing at program entry, another 34% had no permanent housing or were homeless. Scores on the Family Stress Checklist (FSC) confirm the risk status of mothers. Eligibility requires that families score in the At Risk range to be eligible for HFA. However, 44% of mothers and 22% of fathers scored in the Very High/Severe Risk range. Despite the initial risk status of families, the HFA program sites continue to meet or exceed targets, as well as national and local comparative rates for most of its objectives.

Health status data reveals that 97% of children were linked with medical providers and were enrolled in the District's Medicaid and State Child Health Implementation Program. This exceeded the program's goal, as well as comparative national (89%) and DC (94%) rates. In addition, 99% of all target children were current with their immunizations. This is especially impressive when compared to the national (75%) and the District of Columbia (81%) percentages. The high percentage of children born with a healthy birth weight (95%) exceeds national (92%) and DC (90%) rates, and is particularly notable in light of the number of mothers who are enrolled based on medical risk. This finding is highly correlated with the percentage of mothers who enrolled prenatally (67%), were linked with health insurance (99%), and who received early prenatal care (90%). Additionally, 96% of mothers completed their post-partum

visit, which significantly exceeds National (78%) and DC (84%) rates. Post-partum visit compliance is highly related to the program's success in preventing repeat births in less than 24 months, as 98%of mothers did not have a repeat birth within two years of the target child's birth. This is particularly impressive when compared to the National rates for adults (55%) and teens (81%), as well as the District's rate for teens (84%).

Mary's Center HFA program efforts in reducing risk and promoting maternal and child, health and development are significantly reflected in the high percentage of mothers who exhibit positive parenting, and who do not have a substantiated report of child abuse or neglect. During Year 16, of the 294 program participants, 99% did not have a substantiated CFSA report. As in past years, participant satisfaction with the program remains high. Additionally, results demonstrate a high degree of program fidelity as evidenced in participant reports of: the timing of first home visits; the frequency of home visits; content of home visits focusing on child development, parenting efficacy, and self-sufficiency; and the cultural competence and sensitivity of their FSW and the program. Comments also reveal a population that recognizes the strength of the relationships they have developed with their FSWs and see these relationships as key in their children's healthy development and their growth as parents.

In summary, examination of the District HFA program which included qualitative data from participants, staff and management, as well as quantitative program service data and standardized measures, have provided solid evidence of the fidelity of the program implementation. It also reflects the successful achievement of outcomes that exceed comparative national and local rates.

B. Assessment as a Service

The District's HFA program considers the assessment process a valuable service that identifies prevalence of risk factors and unmet needs in the target population. It is often able to provide linkages to appropriate services, even if the family is not eligible for HFA, and declines enrollment or if the program is at capacity. Additionally, the assessment team tracks the types of referrals that are made for families, whether the referral was successful, and barriers to follow-up on referrals. Efforts are made to expedite the assessment, referral, and linkages so that families stay connected. The HFA assessment team follows-up on referrals for assessment within two week, which is an integral part of the early childhood framework.

In one year of HFA, Family Assessment Workers made over 1,700 internal referrals for 490 families. These are referrals and linkages that are made to the current HFA host agency, Mary's Center. Of the 1,323 internal referrals in Year 15, most (25%) were for the prenatal and parenting classes and resources. Other referrals were primarily to the HSHF program (19%), to the car seat program (18%), and for baby items (16%), such as clothes, cribs, and furniture. Additional referrals were made to the ESL and Even Start Literacy programs at Mary's Center (8%), to WIC and TANF/Food Stamps assistance resources at Mary's Center, to the Fatherhood Program (4%), and to Mental Health/Counseling services (3%). A smaller number of referrals were made for Health Insurance (2%), and the Medical and Dental services (2%) for both children and adults, as well as to the Child Development Associate program (CDA) for employment training (1%). The remaining referrals were to the Options Family Planning counseling (1%) and "Other" (1%).

Family Assessment Workers (FAWs) provided 423 referrals to external resources (those not

offered at Mary's Center). Services that increase families' self-sufficiency received the most referrals, including: Employment Job Training and Placement (40%); Child Care and Day Care (20%); and Temporary and Permanent Housing (16%). Additional referrals were made for Legal Advice and Services (6%); Education (5%) for both adults and children; Emergency Assistance (3%) and Utility Assistance (1%). Referrals were also made for Domestic Violence support and counseling, and two referrals (1%) were made to CFSA. The remaining referrals (5%) were for help in obtaining a child's birth certificate, to the Social Security Office, for free yoga classes, to the Marriage Bureau and for furniture.

C. Goals & Objectives

The District's Home Visiting Program aims to ensure the implementation of a unified vision for early childhood development throughout the District. The program will adopt the vision currently practiced by other early childhood programs–notably, ECCS and Project LAUNCH and in coordination with the Mayor's Early Success Framework.

> ***The District's Vision for Early Childhood Development*** *– All children and families will have access to a continuum of comprehensive, high-quality early childhood programs and services that promote child well-being and school readiness and ensure that all children are healthy, ready to learn and have safe passage through the early years.*

Systematic Goals

Home Visitation is a major strategy within the Districts Mayor's *Early Success Framework*. This framework outlines overarching outcomes for the District's Early Childhood System. The goals of the framework are as follows:

1. All District children develop in comprehensive and enriching environments.
2. Families are linked to opportunities and resources that strengthen their role as parents.
3. Professionals working with young children have the knowledge, skills, and support to work effectively with, and on behalf of children and families.
4. Communities are safe places where resources are available to help children and families thrive.
5. Improve sharing of client and program information across home visiting and early childhood programs to improve service coordination and reduce the duplication of effort.

The Early Success Framework expected outcomes are as follows:

- Improvements in early learning and development
- Improvements in early detection of developmental delays
- Improvements in family engagement and service agencies support
- Improvements in children's social, emotional, mental, and physical health

D. DOH Home Visiting Programmatic Goals and Objectives

The strategies and emphasis areas previously presented in this grant application and the Mayor's District Wide *Early Success Framework* guided the development of the goals, objectives, and activities for the implementation of the DOH Home Visitation Program. The overarching program expansion goals, objectives and action steps build upon the current formula funding and those listed in the updated State Plan. The proposed outcomes will also assist DOH in supporting the Mayor's Early Success Framework key indicators; and the vision of the District's HV Council for all district children to be healthy and ready to learn. The Timeline (Attachment 6) outlines in detail action steps, responsible designees, timelines, measures and expected outcomes for the proposed program goals.

The following outlines specific problems that will be addressed by strategies, goals and objectives relative to the stated Emphasis Areas; expansion of the District's original HVP services and activities; and how expected outcomes will be addressed by the HVP Development grant.

Problem 1: Of the 10 agencies in the District currently providing home visitation services only three use evidence-based home visiting service models (i.e., Healthy Families America; Parents As Teachers; Home Instruction for Parents of Preschool Youngsters.

Strategy 1: Enhance families' access to evidence-based home visiting services by incorporating HFA into existing home visitation programs.
Goal 1.1: To increase the number of HV organizations in the District of Columbia implementing evidence-based home visitation models from 4 to 7 organizations by October 1, 2013.
Objective 1.1.1: By the end of Year One, 100% of funded home visitation providers are trained and implementing Healthy Families America.
Objective 1.1.2: Beginning in October 2013, providers offering evidence-based programs will achieve fidelity to the original models.
Objective 1.1.3: Beginning in January 2014, families participating in new HFA programs will achieve measureable improvements in the MIECHV benchmark outcomes relative to families in a comparison condition.

Problem 2: Currently, the District of Columbia does not have a centralized intake and referral system to link high risk families to needed home visitation programs and other services.

Strategy 2: Enhance families' access to evidence-based home visiting services by identifying high risk families living in the District and referring them to appropriate home visitation services.
Goal 2.1: Create and launch a centralized comprehensive early childhood system by July 2013.
Objective 2.1.1: By April 2013 incorporate a Centralized Intake component to the existing HV data base system that identifies and tracks high-risk families, linking them to community- based HV programs and other services, as needed.
Objective 2.1.2: By September 2014, at least 67% of eligible families will receive appropriate evidence-based Home Visitation Services.
Objective 2.1.3: By January 2013, DOH will enter into a formalized partnership with relevant private/public organizations which will act as service referral sources for the District's Home Visitation programs.

Problem 3: The District does not have a coordinated professional development training infrastructure in place that supports implementation of evidence-based home visitation programs to fidelity.

Strategy 3: Enhance families' access to quality evidence-based home visiting services by developing a District-wide workforce of home visitors that have the knowledge, skills and abilities required to deliver high-quality evidence-based home visitation services to families.
Goal 3.1: Build a professional development infrastructure for Home Visitation providers to support quality implementation of evidence-based HV practices.
Objective 3.1.1: By April 2013, develop the District's Home Visitor Core Competencies training modules based on standards and recommendations provided by HV Council.
Objective 3.1.2: By May l 2013, develop HVTI that provides trainings that meet the requirements of the HV Core Competencies
Objective 3.1.3: By September 2014, 100 of DOH funded HV providers are trained in DC Home Visitor Core Competencies training modules.

Problem 4: Currently, there is not a mechanism in place to increase access for families involved in CFSA and also provide services to children who are placed in foster home in surrounding jurisdiction.

Strategy 4: Enhance access to evidence-based home visitation services for families who are involved with CFSA and those families whose children have been placed in foster care by partnering with CFSA and neighboring jurisdictions[16] who have children (0-5) placed in their states.
Goal 4: To ensure that children 0-5 in foster care are a priority population to receive evidence-based home visitation services
Objective 4.1.1: Identify children 0-5 who have newly entered the District's child welfare system.
Objective 4.1.2: By May 2013, partner with surrounding jurisdictions to identify the appropriate evidence-based home visitation service delivery mechanism for children 0-5 residing in their state.
Objective 4.1.3: By September 2013, all eligible families involved with CFSA will be linked to the appropriate evidence-based home visitation service.

Problem 5: The District's Home Visitation Program has not yet been evaluated for success of implementing evidence-based programs and has little data about program efficiency and effectiveness to guide decision making.

Strategy 5: Enhance families' access to evidence-based home visiting by developing the District's capacity to use research and data to informed planning and decisions.
Goal 5.1: Use an empowerment evaluation approach to provide regular feedback to staff and stakeholders from January 2013, through the end of the grant period.
Goal 5.2: Design and complete a rigorous evaluation that contributes to Health Resources and Services Administration's (HRSA)**,** priorities for developing knowledge about effective strategies for implementing evidence-based home visiting models and efficacy in improving benchmark outcomes for priority populations from October 2012 through September 2014.
Objective 5.2.1: Conduct an implementation study that is informed by implementation science, beginning October 1 2012 through September 30, 2014.

[16] In the current child welfare system in the District, children that are District residents and have become wards of the District can be placed in foster homes in Maryland or Virginia

Objective 5.2.2: Conduct a rigorous impact study that meets home visiting standards of quality research, beginning October 1 2012-September 30, 2014.

Problem 6: The District's has limited funding to support the sustainability of Home Visitation services.

Strategy 6: Enhance families' access to evidence-based home visiting services by securing a sustainable source of funding.
Goal 6.1: Enhance sustainability of HV programs through collaborative advocacy and networking for HV to use Medicaid resources to support home visiting initiatives.
Objective 6.1.1: By September 2013, the District's Home Visitation program will collaborate with the District's Medicaid Agency, the Department of Health Care Finance to explore how the District may be able to use Medicaid resources to support home visiting initiatives.

IV. Work Plan

A. System Infrastructure

SECDCC is the District's State Advisory Council that works to ensure that high quality early childcare and education is available to all District residents, irrespective of the financial resources of the family. The membership is comprised of public and private entities, including all child-serving agencies.

Each child serving agency, including DOH, is working toward outcome measures that focus not only on children and families, but also on service professionals, community capacity-building, and enhanced access to services for all children. To that end, SECDCC is a supporter of the District's proposal and if funded, will be kept apprised of all funded HV activities. The development and implementation of this application's work plan are aligned with current Early Success strategies.

The HV Council in collaboration with DOH has been working towards the development of home visiting policies and procedures and setting standards for the District, with the aim of achieving quality and improved child and family outcomes. As a part of this process, a subcommittee has been formed to define and establish standards for high quality home visitation and core competencies for home visitation providers.

While this initiative is still in its infancy, the HV Council has developed a valuable foundation from which to continue this work. As a result, the District's HVP will continue working closely with the HV Council on this initiative. Strategies to continue this work will include ensuring coordination and collaboration between public and private partners in the planning and implementation of high quality home visiting strategies.

In addition, to the various early childhood councils, the District recently unveiled its comprehensive cradle-to-career initiative called *Raise DC*[17]. This initiative is a framework that delineates measurable outcomes and targets to ensure that all District youth are career-ready by age 24. This cross-sectional approach coordinates early childhood leaders around a set of

---

[17] http://dme.dc.gov/DC/DME/Programs/Raise%20DC%20-%20Partnership%20Summary%20FINAL.pdf

common goals and is committed to using data to drive change in educational outcomes for children.

Raise DC, co-chaired by the Deputy Mayor for Education, is shaped by a core group comprised of District officials and businesses, non-profit, philanthropic and community members. *Raise DC* uses "*Change Networks*" that utilize data to identify effective practices, and collaborate to implement these practices. The HV Council is identified as a Change Network. Change Networks also engage their particular constituents and community residents and bring this feedback to *Raise DC* and SECDCC. This funding opportunity would align and enhance the District's larger integrated approach to develop a comprehensive early childhood system.

Staffing and Subcontracting

Home Visiting Coordinator

To address a District-wide approach for home visitation services, DOH will hire a Local Coordinator to collaborate with the State Program Coordinator who coordinates the efforts of the MIECHV Formula grant and the ECCS grant. In addition to being responsible for the overall administration of funds related to this program and managing the related sub-contracts, this individual will also serve as the liaison between DOH and all organizations (public or private).

Program Analyst/Evaluator

The program analyst/evaluator's responsibility is to ensure that there is capacity to determine the effectiveness of the evidence-based programs being implemented District-wide, and ultimately that participant outcomes are being achieved, DOH recognizes that it is essential to hire a Local Program Evaluator. Unlike the existing State counterpart who will be responsible for monitoring and reporting of the legislatively-mandated benchmark, this new position would liaise with the Georgetown University evaluation team.

Program Specialist

The program specialist's responsibility is to mitigate challenges caused by the presence of multiple home visiting programs with various criteria for services, DOH proposes to develop the CIRS. Key to the CIRS process will be the availability of an individual to assist families in accessing appropriate home visitation services. DOH will hire a Program Specialist who will assist in coordinating existing home visiting services by determining what services and supports are most needed by the family, based on their specific needs and eligibility criteria. Additionally, the CIRS Program Specialist will also be integral to minimizing some of the barriers encountered by families as they navigate the system

Service Delivery Contracting Process

Enrollment in home visiting services is currently a voluntary process. DOH will utilize contractors to deliver home visiting services.

Vendors will be obtained through the contract process outlined below:

1. Scope of Work (SOW) developed by DOH
    a. The SOW will solicit organizations able to provide necessary documentation to prove they are capable of successfully implementing HFA to fidelity.

b. The SOW will require that the vendor submit a plan that outline staffing, implementation, evaluation, and continuous quality improvement.

2. SOW released to the public through the District's Office of Contracts and Procurement
3. Applicants submit applications.
4. Submissions reviewed: All submissions will be reviewed by a panel. Each panel member will be provided the same instructions and guidelines to be utilized in scoring the applications
5. Selection and award made: This selection will be made based on the scores tabulated during the review process and the Contract Awards Notification is issued.
6. The contact is monitored by DOH's Local Home Visiting Coordinator.

Unlike the service contracts that will be awarded via a competitive process, the evaluation contract will be a single source contract with GUCCHD. DOH has chosen GUCCHD because of their expertise in Early Childhood Development and evaluation.

Collaboration with External Partners

The ability to strengthen inter-agency and cross-program coordination will be a key component in establishing systematic mechanisms to make appropriate and timely referrals to needed services. As a result, The DOH Home Visiting Program will partner with programs such as the ECCS program and Project LAUNCH to enhance partnerships and ultimately improve coordination among early childhood programs such as:

- Early Intervention Programs (Parts C and B)
- Healthy Futures (an early childhood mental health consultation program operating in child development centers in the District
- Applicable child welfare programs; parenting support groups (e.g., Effective Black Parenting Program and Chicago Parenting Program)
- Substance abuse support services; and
- PIECE Program (Parent Infant Early Childhood Enhancement Program operated by DMH).

The DOH Home Visiting Program will also develop mechanisms to ensure that families have necessary support once their children age out of these programs.

National Model Developer

The model developers of the HFA programs have been integral in developing DOH's plans to implement the model District-wide. HFA staff assisted the DOH staff in all steps in the development and implementation of the model. This includes, but is not limited to consultations/collaborations to:

- Determine how HFA training can be coordinated for various community-based organizations that will be awarded contracts;
- Create a plan so that the DOH can become an HFA certification and training site for the District;
- Develop the HFA implementation plan; and
- Address concerns/barriers that may arise during the implementation of HFA.

DOH will continue to consult with HFA and seek technical assistance on issues related to ensuring that the program is implemented to fidelity, and addressing concerns/barriers that may arise during the implementation of HFA.

B. Program Oversight

The quality of a program is characterized by its specific activities and whether or not they are being implemented in accordance with an established set of standards and/or best practices. DOH home visiting programs will be assessed through monitoring the contracts by the Local Program Coordinator and the Local Program Evaluator, focusing on quality assurance and program monitoring.

Monitoring

The Local Home Visiting Coordinator will be responsible for managing the home visitation services to be provided through the contracts. This individual is the primary point of contact for communication between the DOH and the contractors. Some of the responsibilities of monitoring the contract include, but are not limited to:

- Ensuring that the contractor has a clear understanding of how the contract will be managed and monitored.
- Providing the vendor with guidance and technical assistance, as needed, to promote effective program performance.
- Ensuring that funding is used only for authorized purposes by reviewing invoices and verifying that delivery of services is rendered.
- Resolving issues or problems that arise during the contract.
- Reviewing the vendor's progress reports to determine if the amount of work accomplished and/or hours spent are in line with the contract schedule.
- Acting promptly to problem areas and taking corrective action, as applicable.

Another aspect of contract monitoring is the control of tasks or deliverables and due dates. The Local Home Visiting Coordinator is responsible to assure that all deliverables are met in a timely manner.

Quality Assurance

Quality assurance (QA) refers to the actions that provide confidence that the activities and services delivered by DOH's Home Visiting Programs meet or exceed the need of the families and stakeholders in the at-risk communities.

Plan for Quality

Understanding how a home visiting program operates and delivers services helps to identify components that should be critically monitored. The observations and evaluation of HFA will assist in the development of standards and requirements to be outlined in the contract. For example, a lack of adequate training can result in issues with program quality and implementation fidelity. Therefore, the Local Program Coordinator will schedule trainings with the HFA model developers. Likewise, the Local Program Coordinator will collaborate with District agencies and community-based organizations (CBOs) to establish a training calendar for home visitors on issues they may face when they enter families' homes. General topics currently identified by stakeholders are: domestic violence; behavioral health child abuse and maltreatment; lack of knowledge of child developmental milestones; and substance abuse.

During program implementation, home visitors will be surveyed to identify additional training needs.

Framework

As mentioned earlier, ongoing communication will be an important aspect of implementation at all levels. In addition to training, it is important that home visitors are aware of the standards, procedures, and guidelines for the evidence-based model that they will be implementing. The contract will require that contractors ensure that standards and guidelines are appropriately followed. Managing quality is critical throughout the life-cycle of a client's participation in the program.

Quality Control

To ensure that contractors are adhering to the requirements and guidelines of the model developers, the following activities will be conducted on an annual basis and monitored by DOH:

- Staff Qualifications and Training: Contractors will be required to submit a report of all employees' qualifications and a training log. Programs will be expected to ensure that their employee's qualifications and trainings are current through a quarterly assessment. Likewise, programs will be expected to inform DOH of any special training needed to implement the home visiting program.
- Record Review: This method of quality controls allows the contractors to determine the integrity of data and documentation and assists them with appropriately completing and maintaining records. During the individual supervision with the home visitor, the supervisor of the program will be required to randomly select and review one case on their case load quarterly, to ensure that the required documentation has been completed and is up-to-date. This includes paper, as well as electronic records. This process may also improve performance and maintain standards.
- Identification and Resolution of Issues: As deviations and deficiencies are identified in implementing the home visiting model, contractors will be required to log, track and report these issues. Each issue will be evaluated for its potential impact on the program's targets and performance, and the level at which corrective action will effectively resolve the issue. The log will include, but not be limited to the: 1) Key cause of deficiency; 2) Impact on the program; 3) Resolutions implemented to address the deficiency; and 4) Program's current status.
- Program Procedures: Contractors will be required to document the processes and procedures used during their operations. In order to accomplish this, each program will be required to provide their home visitors with guidelines that define the duration of the home visits, data recording protocols, individual's responsibilities and expectations, and reporting requirements and timelines.

<u>Technical Assistance</u>

DOH will be responsible for ensuring oversight and providing technical assistance to the various home visiting programs. This includes the development of standards, policies and coordination among existing home visiting programs. The first source of technical assistance and support will

be obtained from the HFA the national offices. DOH will work with the HFA on all issues related to, but will not limited to:

- Implementing the models to fidelity;
- Providing the necessary professional development workshops to home visitors; and
- Collecting and reporting data required by model developers.

Likewise, HFA National Regional Centers (HFA-NRC) for the Northeast & Mid-Atlantic Regions is located in Arlington**,** Virginia. The purpose of the HFA-NRC is to provide training and quality assurance support to increase uniformity of implementation within states. [18] With the HFA-NRC being in close proximity to District, we hope to establish a strong relationship with the regional representative.

There is also internal support through members of the Mary's Center HFA model who have Technical Assistance & Quality Management Specialists that were certified by Great Kids, Inc. (GKI).[19] They have approximately 16 years of experience implementing HFA in the District and assessing program performance within Mary's Center. Their expertise will be valuable in implementing HFA with quality and fidelity throughout the District.

Meeting Legislative Requirements

Currently, the information needed to address the legislative benchmarks is collected by home visitors during each visit and entered into the District's Home Visitation Data Collection and Reporting System. In order to collect information on participants receiving HFA, the following will occur:

1. Modify existing DC Benchmark data collecting reports to include and align benchmark indicators with the HFA model.
2. Submit revised benchmarks to HFA National Center for review and approval.
3. Submit revised benchmarks to HRSA for technical assistance, review and approval.
4. Expound upon the District's Home Visitation Data Collection and Reporting System features to capture the necessary data for the HFA model.
5. Create legislative benchmark reports

Continuous Quality Improvement

Continuous Quality Improvement (CQI) will be measured through quarterly assessments of the home visiting programs and the ability to reach the targets identified in the work plan. A Quality improvement action plan will be developed in the Plan-Do-Study-Act framework (PDSA). And reported on different strategies that may be required that ensure appropriate linkage to services, training of staff, barriers to hiring appropriate staff, barriers to reaching quarterly targets.

The CQI plan will develop tracking measures on:

- Numbers identified as at risk;
- Where persons were referred;

[18] http://www.healthyfamiliesamerica.org/network_resources/reg_resource_centers.shtml
[19] http://www.greatkidsinc.org/training-ta-qa.html

- Success of referral;
- Ability to provide feedback to referring providers as to outcome of referral;
- Ensuring that staff are trained according to the recommendations of the evidence-based protocol; adherence to those protocols;
- Identifying the barriers to reaching the quarterly targets of quality.

As the CQI plan identifies the outcomes, targets to achieve, evidence-based protocols, the plan must also track the quality. The HFA model tracks certain measures to ensure quality: Shadowing of staff; training review; success at linkages to referrals; participant satisfaction surveys; random phone calls to participants; and chart reviews to ensure quality. In addition, CQI will also include tracking the data from the Universal Screen.

The DOH will work to develop the CQI measures and work with the funded programs and staff/agencies supporting the infrastructure development to track outcomes. All information will be reported to the HV Council and representative stakeholders who will help design activities and PDSAs that can work to address challenges.

Participant Satisfaction Surveys will be used as a qualitative measure to address quality, and adhere to requirements of the evidence based programming in place. The Participant Satisfaction Surveys will inform the ability of the evidence based programs in meeting the standards of best practices as identified by the model implemented.

Community Engagement

"Community engagement reflects the degree to which a program involves multiple stakeholders from the community in its development, execution, and expansion."[20]

In the District of Columbia, community engagement is supported by the cross-agency commitment to the Early Success Framework. In August 2011, SECDCC was sworn in by the Mayor of the District of Columbia and began its work to ensure that high quality early childcare and education is available to all District residents, irrespective of the financial resources of the family. The SECDCC is a State Advisory Council comprising membership from public and private entities including:

- DOH
- HV Council
- CFSA
- OSSE
- DCPS
- DMH
- DHS
- Mary's Center
- Fight for Children
- Centro-Nia
- Washington East Foundation

The SECDCC has an ambitious goal-oriented agenda that focuses not only on children and families, but also service professionals, community capacity-building, and enhanced access to

[20] http://www.hrsa.gov/ruralhealth/pdf/ruralbehavioralmanual05312011.pdf

services for all children. The group steers the inter-agency District-wide strategy (Early Success Framework) to:

- Promote early learning and development awareness among residents;
- Increase the effectiveness of early learning and intervention programs;
- Create training opportunities for service professionals;
- Develop resources to improve program sustainability; and
- Improve safety, health, well-being, developmental and academic outcomes for all children in the District.

SECDCC has identified home visitation as a strategy to support families in achieving the outcomes identified in the Early Success Framework.

The HV Council and other Early Childhood groups such as the District's Council on Young Child Wellness (DCCYCW), were integral partners in ensuring that the communities (particularly those in Wards 5, 7 and 8), were engaged throughout the process of developing the District's Home Visiting State Plan, as well as the needs assessment that helped to inform it. The DOH staff made a concerted effort to ensure that concerns and/or ideas of these communities, and of the larger District, were integrated throughout these documents. Additionally, DOH sought input from the HV Council regarding this current MIECHV Developmental Grant application. DOH will continue to collaborate with these groups to ensure that it continually receives feedback on the services being provided and how these services are being received by the community so that adjustments may be made, if necessary. The members of these groups will also be major stakeholders in implementing initiatives related to the coordination of home visiting services as well as integrating these services into the larger early childhood system.

The HV Council currently consists of organizations implementing evidence-based and non-evidence-based home visiting programs in the District and other key stakeholders in the field of maternal and child health, early education and community advocacy, leveraging of resources; and prevention of duplication of services. Communication at this level will foster quality and sustainability by providing an opportunity for:

- Learning Collaboratives among Home Visiting programs;
- Continuum of services within communities;
- Leveraging of resources, and;
- Preventing duplication of services.

Professional Development

As noted in the Needs Assessment, there is a need to improve the quality of home visiting services and to ensure that all organizations that provide home visitation services meet the standards for best practices and delivery. Workforce development training will be coordinated by the DOH Home Visiting Program Coordinator in collaboration with the District's HV Council. Training will be offered to all home visitors in the District's to ensure that all individuals are aware of current best practices and meeting the core competencies for home visitors. These trainings will cover a variety of topics related to child development, effective parenting skills, available the District's resources and others. In accordance with standard practice of direct

services provided to families, all home visitation programs funded by DOH will be required to conduct reflective supervision with their home visitors.

Recognizing the unique context in which home visitors provide Early Childhood services, the Local Home Visitation Program Coordinator will work with the Office of the State Superintendent for Education to improve the existing Early Childhood Core Competencies. These additional competencies will be added to OSSE's existing Professional Development Registry to track home visitation providers' utilization of trainings that align with the Core Competency Areas. DOH will partner with The University of the District of Columbia and GUCCHD to develop trainings that align with these competencies. In addition to training development, these partners will also develop a curriculum for a Certificate Program, specific to home visitation providers. Attachment 11 outlines the relationship between the Core Competency areas, the legislative benchmark requirements and the related training topics that will be developed.

Recruiting and retaining participants

Participants will be recruited through mobile outreach, MCOs, District's agencies, pre-kindergarten programs, childcare providers, pre- and post-natal providers.

Per the HFA model, within 48 hours of the universal screen completion, the participant is contacted by a Family Assessment Worker (FAW) to schedule an appointment for an assessment. Within 48 hours of the completion of the assessment the participant is contacted by phone and is informed of their eligibility for home visitation services. Referral follow-ups are also completed at this time. If the participant is unreachable by phone, the FAW will go to the participant's home and attempt to initiate contact. Active recruiting will continue with repeated telephone calls and visits to the residence for up to three months. If there is no contact made, the participant is classified as having declined home visitation services.

Once the participant is enrolled in home visitation services with a FAW, weekly visits begin. These initial visits are intended to develop a strong relationship with families. The HFA program and curriculum are also introduced during these initial visits. High participant retention can be correlated to the program's emphasis on building and maintaining a supportive relationship between the FSW and the family.

V. Evaluation & Technical Support Capacity

A. Evaluation Approach and Principles

DOH is committed to incorporating a rigorous evaluation plan into this request for competitive funds under the MIECHV Developmental Grant. DOH has demonstrated this commitment by allocating 15% of the total request for funding to our external evaluation partner, the GUCCHD, and by agreeing to a randomized design to study implementation and outcomes. The evaluation plan incorporates qualitative and quantitative methods, and makes use of administrative data collected through our DC Home Visitation Data Collection and Reporting System**,** as well as primary data collection from multiple stakeholders. GUCCHD has a long history of community-based participatory research projects and will be using an empowerment approach that ensures

the data gathered from this evaluation will be used to improve the quality of HV services delivered in the District.

All evaluation activities are grounded in relevant empirical work and are consistent with best-practices in research and evaluation. Several theoretical and empirical bodies of work inform the evaluation methodology: the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) evaluation framework for monitoring goals and objectives; National Implementation Research Network's implementation driver's framework for evaluating implementation strategies; and state of the art methods for evaluating program impact on program, staff and child/family outcomes.

The evaluation plan includes two inter-related studies which parallel the national MIECHV evaluation[21]. GUCCHD will collect and analyze data to assess: (1) The quality of implementation of HFA as well as; (2) The outcomes of implementing HFA for parents and young children. In addition, the evaluation activities outlined in this section are designed to build the capacity for DOH to use research and data to inform planning and decisions (Strategy 6). The conceptual model for the evaluation follows the model used by the national evaluation in an effort to increase the applicability of this evaluation to other research being conducted nationally.

The evaluation team will partner with key stakeholders using an empowerment evaluation approach. Immediately after the grant has been awarded, the evaluators will assemble a cross-functional implementation team of DOH staff and community partners who will form a Community Advisory Board (CAB) for this evaluation. The GUCCHD team will provide a primer in implementation science. The team will work together to finalize the details of the implementation and impact studies. These studies will prioritize key indicators that will be reviewed regularly and define data feedback loops that specify when and how data will be shared. The CAB will meet monthly during the first year of the grant, and then quarterly thereafter. Tools for measuring impact will be reviewed as well as approaches to measuring fidelity to ensure congruence with existing practices.

B. Overview of the Evaluation Design

The proposed evaluation design balances rigor with realism, and will take full advantage of the data the DOH is collecting through the formula grant DC Home Visitation Data Collection and Reporting System as well as collect additional data that will help the DOH scale up other evidence-based HV models in future grant cycles. Through this grant, DOH will be expanding the continuum of evidence-based HV models available to eligible families in the District's by offering intensive training and support in Healthy Families America.

As mentioned earlier, upon receiving funds from HRSA, DOH will issue a request for applications from community-based agencies currently providing HV services to pregnant women and young children up to age 3. Once these agencies have been designated as eligible for funding, they will be randomly assigned to cohort 1 or 2. Cohort 1 will receive the HFA training

---

[21] Michalopoulos, C. et al (2011). ACF-OPRE Report 2011-16. *Design Options for the Home Visiting Evaluation: Draft Final Report*, U.S. Department of Health and Human Services, Washington, DC.

in the second quarter of the grant while cohort 2 will receive the HFA training six months later. This will create a “wait-list” comparison group of agencies, home visitors, and families to collect six months of data for cohort 1. But it will also ensure that families in all the different wards in the District are provided expansion of evidence-based HV services.

C. Research and Evaluation Questions

The evaluation will be guided by a series of research questions that will draw upon data collected from the DC Home Visitation Data Collection and Reporting System, as well as data collected from community stakeholders and participating families.

Monitoring and Progress:

(1) Is DOH making progress toward their defined goals and objectives?

Implementation Study:

1. Are HFA services being delivered with fidelity to the HFA model?
2. Are HFA providers operating with adherence to the 12 HFA critical elements?
3. Are professional development activities improving staff capacity to deliver high quality HV services?
4. How are implementation strategies used by DOH and provider agencies related to fidelity of HFA implementation?
5. How could implementation strategies be improved to improve implementation outcomes?

Impact Study:

(1) What are the effects of implementing HFA with eligible families in the District?
   a. What are the differences in outcomes when community agencies implement HFA versus a non-evidence-based home visitation model?
      - Maternal depressive symptoms?
      - Maternal social support?
      - Maternal efficacy?
      - Maternal/Infant attachment?
      - Maternal knowledge of infant development?
      - Maternal nutritional practices (i.e., breastfeeding initiation and duration)?
      - Sleep routines (i.e., sleep location and positioning)?
      - Maternal use of alcohol, tobacco and other drugs?

(2) Do the effects vary across subgroups of families?
   a. Examine effects for women enrolled prenatally versus early postpartum
   b. Examine effects for women by agency/cohort/risk status?

(3) What is the relationship between fidelity of implementation and outcomes?
   a. Analyses to look at the interaction (or moderation) of effects when fidelity is factored into analysis.

D. Implementation Study

Implementation research is a developing field designed to examine the impact of activities intended to integrate an existing intervention into a new setting, with the goal of achieving

similar outcomes in a different environment. Conducting implementation research relies on observing, measuring and relating the concepts of *implementation strategies*—activities that agencies use to implement programs, and *implementation outcomes*—indicators of how successfully an intervention is carried out in the new setting.

Implementation Outcomes

Recent work by Proctor and colleagues[22] has made tremendous strides in identifying and defining critical implementation outcomes that should be examined in implementation research studies. Two implementation outcomes are particularly important to this grant.

Fidelity, degree to which an intervention was implemented as it was prescribed in the original intervention protocol, will be measured using self-reporting checklists completed by home visitors immediately following every home visit with every family. The checklist is designed to support successful implementation by reinforcing the frequency, duration, and content outlined in the HFA practice standards. Agencies will have the option of using a web-based data collection system or a paper/pencil form to collect data. Additionally, a sample of visits (one per home visitor every six months) will be observed and assessed by an independent rater using a similar checklist.

This process will help to ensure *consistency* in research procedures and *neutrality* of raters. Agencies will have the option of recording visits without a rater present or inviting the observer to attend the visit in person. Fidelity assessments will be completed in both the HFA and comparison sites throughout the entire study period. This will increase the *credibility* of our comparison condition, and allow the evaluation team to assess whether any HFA practice standards were also being met by providers who had not yet received training. It will also provide a baseline assessment of current practices in the second cohort. Results of the fidelity assessments will be shared with agency leaders to support their internal CQI process and the CAB.

Another relevant outcome is *staff capacity*, the knowledge, skills and abilities to deliver home visiting services consistent with evidence-based practices. During the first quarter of the grant award, the evaluation team will work with the committee tasked with developing core competencies for home visitors (Objective 3.1.1) to develop a capacity exam that is designed to assess a home visitor's capacity to implement HFA. Staff will take the exam before and after training activities to assess their competency before and after training. Individual results of the exam will be shared with staff supervisors for ongoing supervisory support. Aggregate results will be used to identify additional training needs District-wide (Objective 3.1.2).

Implementation Strategies

The implementation strategies evaluation is grounded in the National Implementation Research Network's (NIRNs) implementation drivers' framework[23]. The NIRN framework defines

---

[22] Proctor et al. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment. Health*, 38:65-76.
[23] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* National Implementation Research Network.

several implementation drivers that have been associated, through prior research, with successful implementation. Those drivers include:

- Leadership: Active engagement of executives and managers throughout the agency
- Performance Assessment: Monitoring inputs, outputs, and outcomes and feeding information about to the implementation teams (Strategy 5)
- Staff selection: Staff recruitment, assessment and selection are specifically tailored to the knowledge, skills and abilities needed for the job.
- Training: Informing and educating staff, stakeholders, and/or clients (Strategy 3)
- Coaching: Providing ongoing supervision and encouragement to support continued development of knowledge, skills and abilities.
- Systems Intervention: Engaging internal and external stakeholders to support the new vision (Strategy 1).
- Decision Support Data System: Administrative and other information technologies are designed to support the intervention and collect data necessary to monitor implementation (Strategy 2).

Together with the evaluation team, the DOH implementation team will meet quarterly to review their progress (see Monitoring and Progress section, below) and discuss their use of implementing best practices using the Implementation Strategies Review Instrument. This instrument was developed based on the NIRN implementation drivers' frameworks and is currently used in over 26 systems change projects around the country. It is completed by the evaluator after qualitative discussions with a group of key informants. This action-oriented research design is intended to collect objective data about evidence-based implementation strategies employed by DOH, while facilitating conversation about strategies that might be used to overcome any barriers that are encountered.

In addition to the assessment of implementation strategies at the District level, the evaluation team will use in-depth qualitative methods to examine the implementation process and status at each contractor implementing HFA at key points in the implementation process. In-depth qualitative methods are most appropriate for this type of study because we want to allow participants to generate responses based on their insight and experience without topics pre-defined by the evaluation team.

After all staff have been introduced to the HFA model, the evaluation team will conduct focus groups and interviews with staff at all levels of the organization. The purpose is to explore their readiness for implementation and perception of critical early implementation outcomes of acceptability of the intervention; appropriateness and fit with their organization/population; and feasibility of implementing in the way that has been proposed. These results will be used to identify potential barriers and to brainstorm solutions to improve the implementation plan at the provider organization.

After the organization has been implementing the model for five months, the evaluation team will conduct focus groups and interviews with staff at all levels of the organization to explore their perception of implementation strategies and the status of the implementation. Consistent with other studies of HFA implementation, the HFA Self-Assessment checklist will be used to rate the providers' adherence to key organizational-level supports enumerated in the 12 critical elements of HFA. These results will be used to improve implementation within the provider and to generate lessons learned that could be used to improve implementation in the second cohort.

All of the data collection activities for the implementation study are outlined in the table below.

Construct	*Goal*	*Possible Data Source*	*Sample*
Readiness: appropriateness, acceptability, feasibility	1.2	Qualitative interviews and focus groups	HV staff and administration preparing to implement HFA
Fidelity to HFA	1.2	Online or pencil/paper fidelity checklists (self-report)	HV staff implementing HFA and in the comparison condition, every visit, every family
Fidelity to HFA	1.2	Online or pencil/paper fidelity checklists (independent rater)	HV staff implementing HFA and in the comparison condition, randomly selected family for each home visitor every 6 months
Staff capacity	3.1	HV Capacity Assessment of staff knowledge, skills, abilities	All HV staff attending training and workforce development activities
Implementation strategies	all	Implementation Strategies Review Instrument	Key informant interviews/ focus groups with DOH implementation team
Adherence to HFA's 12 critical elements	1.2	HFA Self-Assessment Checklist	Key informant interviews/ focus groups with provider staff and administration

E. Impact Study

The impact evaluation will determine the extent to which the community agencies that are selected to implement HFA are able to achieve short-term outcomes to improve maternal and child health. Community agencies that are implementing home-visiting services with pregnant women and young children, but are not currently implementing one of the HRSA-approved evidenced-based models, will be eligible to apply for the competitive funding under this grant. Each of the community agencies selected by DOH to implement the HFA program will be randomly assigned to one of two cohorts: the first cohort will receive the HFA training within 60 days of being selected. The second cohort will receive the HFA training 6 months later. In this way, cohort 2 can serve as a comparison group for cohort 1. The evaluation team will utilize all of the relevant data collected by DOH through their DC Home Visitation Data Collecting and Reporting System to support their internal CQI process to support their internal CQI process to assess the impact of HFA on maternal and child health and developmental outcomes. In addition, women will be enrolled in the impact study (by consent) to collect additional data at baseline and at six months, as described in the table below. Cohorts 1 and 2 will begin enrolling pregnant women in the impact study at the same time; this will allow the evaluation team to compare outcomes for women who received HFA as compared to other home visiting services that are not evidence-based.

Data will be collected at enrollment, 3 and 6 months postpartum, unless otherwise noted. The Healthy Families Parenting Inventory will serve as the main outcomes measure for the impact

study. It has subscales that measure nearly all of the important proximal outcomes for this short-term impact study including: depression; social support; problem-solving; parenting efficacy; home environment; mobilizing resources; commitment to parent role; parent/child behavior and personal care. It has been used in the Arizona Healthy Families Evaluation Report (2010 and has good psychometric properties. In addition, we will ask the parents to complete the Devereux Early Childhood Assessment (infant version) for their 6 month old to measure attachment and initiative.

Monitoring Efficiency of Activities and Progress toward Intended Outcomes

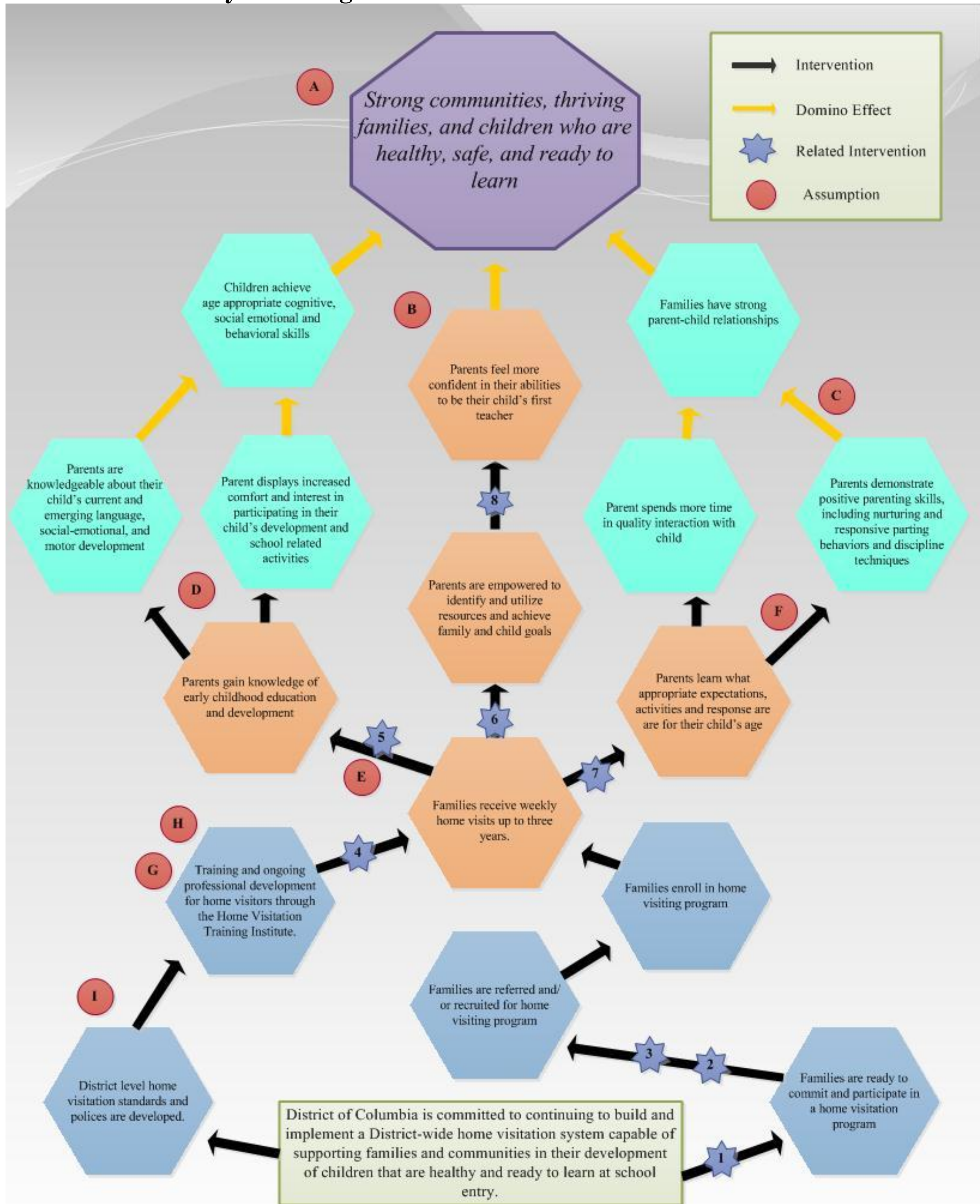
The RE-AIM evaluation framework will be used to define data indicators used for tracking and feedback. RE-AIM was originally developed by Glasgow and colleagues[24] to assess the public health impact of interventions. It suggests that in order to have a complete picture of the total impact of any intervention, evaluations should examine the following indicators, which are aligned with several of DOH's goals and objectives. Measures representing each of the RE-AIM constructs will be prioritized from the list of measures included in the work plan. Specific data sources and data collection mechanisms will be collaboratively defined in the first quarter of the grant award. Examples are provided in the table below.

Construct		*Goal*	*Data Source*	*Sample*
R	Reach of the intervention into the target population.	2.1	Centralized intake data system	All high risk families assessed by intake
E	Effectiveness of the intervention in achieving desired outcomes.	1.3	Impact study (described above)	All families receiving HFA HV services
A	Adoption of the intervention by target settings, institutions and staff.	1.1	Respondents to DOH RFA	All HV providers selected to implement HFA
I	Implementation quality and consistency (i.e., fidelity).	1.2	Implementation study (described above)	All HV providers selected to implement HFA
M	Maintenance of intervention effects in individuals and settings over time.	1.3	DOH MIS	All HV providers selected to implement HFA

The DOH implementation team will meet monthly with the evaluation team to review progress toward completing proposed activities and update the measures identified in the work plan. This meeting will be the place to provide feedback, identify barriers and brainstorm solutions.

[24] Glasgow, R.E., Vogt, T.M., & Boles, S.M. (1998). Evaluating the public health impact of health promotion interventions: The RE-AIM Framework. *American Journal of Public Health*, 89:1322-1327.

F. Theory of Change



This diagram was developed by research and Information gathered from Healthy Family America (http://www.healthyfamiliesamerica.org/home/index.shtml)

Assumptions

A Evidence-based Home Visiting services are available and accessible to families.

B Families will gain an awareness of the resources and programs in their communities and how to access and utilize the services that they need.

C Parents will learn appropriate discipline techniques and reduce their parenting stress levels. Accordingly, there will be an improvement in the home environment and a reduction in the incidence of child maltreatment.

D Parents will demonstrate a high level of involvement in their child's development and will support their child's learning. Parents will read more with their children and plan activities to do with their child.

E Parents participating in home visiting program will improve their knowledge, parenting behavior, and parenting attitudes.

F By participation in evidence-based home visiting services, parents learn how to encourage their child and capitalize on his/her strengths. As a result, their child gains positive expectation of self and builds independence and self-confidence.

G High Quality training supports the professional growth of all staff and increases staff competence in delivering services to children and families.

H By expanding and implementing home visiting programs to the fidelity of the models, families will acquire sustainable positive outcomes.

I All stakeholders actively participate in planning and implementation to enhance existing home visiting services and expand to communities in need of services.

Intervention

1 Implement outreach and recruitment campaign/marketing

2 Match families to appropriate home visiting programs.

3 A centralized home visitation intake and referral system/process is implemented and utilized.

4 A new evidence-based home visiting model (HFA) will be implemented in Wards 1,2,4,5,6, 7 & 8.

5 Children will receive annual developmental, hearing and vision screening.

6 Help parents set goals for themselves and their children.

7 Provide families with books, activities, and other resources and materials.

8 Home visitors will assess the needs of the family and connect families to needed resources. Families will gain knowledge of the available resources in their communities.

Sample Indicator

Indicator: Home Visitation Benchmark measures

Target Population:

- Low-income families;
- Pregnant woman who have not attained age 21;
- Families with a history of child abuse or neglect or have had interactions with child welfare services; and
- Families with children with developmental delays or disabilities.

Baseline: 5% of the total eligible population is receiving home visitation services.

VI. Evaluation and Technical Support

A. Organizations Experience

The Georgetown University Center for Child and Human Development (GUCCHD) was established over four decades ago to improve the quality of life for all children and youth, especially those with, or at risk for, special needs and their families. Located in the nation's capital, this center both directly serves vulnerable children and their families, as well as influences local, state, national and international programs and policy. There are several large national centers funded at GUCCHD including the National Technical Assistance Center for Children's Mental Health, the National Center for Cultural Competences and the University Center for Excellence in Developmental Disabilities. The GUCEDD focuses its work on vulnerable families in the District of Columbia. In addition, the GUCCHD has a strong early childhood team that is participating in research, technical assistance and policy development at the national, regional and local level.

Research and evaluation is an integral component of the GUCCHD, informing, improving and sustaining the other core activities—policy development, technical assistance, training, and clinical and community service. The Research and Evaluation Team (RET) guides the Center's internal and external research and evaluation activities.

GUCCHD's Approach to Research and Evaluation:

- **Effective (Strong) Partnerships:** Collaborating with families and youth, communities, local agencies, national organizations, and universities in developing, designing and conducting research projects.
- **Innovative Evaluation Strategies:** Moving beyond typical evaluation strategies to develop models to measure and advance the scope and quality of the Center's work and that of our partners. We carefully tap the opinions of all stakeholders to capture their experience.
- **Applied Research:** Balancing scientific rigor with practical considerations regarding what is relevant and useful for children, families, communities, providers, and policy makers.
- **Building Research and Evaluation Capacity:** Providing technical assistance to "non-evaluators" to enhance understanding of evaluation and guide development of compelling, data-driven strategies that will help transform, improve and sustain programs.

This evaluation will be led by Deborah Perry who is an associate professor at the Georgetown University Center for Child and Human Development. Dr. Perry has spent the last two decades working on early childhood systems and policy work at the national, regional and local levels. Her research collaborations use an empowerment approach to engage stakeholders in the design, implementation, and interpretation of the research findings. Dr. Perry's research has focused on

services and supports for pregnant women and young children at high risk due to poverty, disability or mental health needs. She has been the co-Principal Investigator for two research grants from the federal Maternal and Child Health Bureau that focused on high risk perinatal populations. She has also served as the lead evaluator for several statewide early childhood mental health consultation evaluations, including Maryland and DC. Dr. Perry has more than 30 peer-reviewed publications.

B. Evaluators Experience

To support the evaluation principle of *neutrality*, the evaluation will not be conducted by DOH or private HV providers. The evaluation will be conducted by GUCCHD, led by Dr. Deborah Perry. Dr. Perry will be the Principal Investigator for the evaluation and will lead the design and completion of the intervention study at Georgetown. She is an Associate Professor in the department of Pediatrics and has several decades of experience leading community-based participatory studies of preventive interventions for pregnant women and young children. (See corporate capabilities statement and CV).

Dr. Sarah Kaye will serve as a consultant to GUCCHD and lead the design and completion of the implementation study. Using an empowerment approach, Dr. Kaye has led state and federally funded evaluations examining the implementation of evidence-based and promising practices in 6 state child-serving systems and 15 community-based organizations. She has developed numerous publications about implementation and evaluation for local, state, federal and academic audiences. (See CV).

To ensure the protection of human research subjects, all relevant research activities will be reviewed and approved by Georgetown's IRB. Families who consent to participate in primary data collection as part of this evaluation will receive an incentive (i.e., gift card). All evaluation measures will be selected to adhere to the highest standard of reliability and validity. Research assistants will be highly trained and data will be double-entered to ensure accuracy. Quantitative and qualitative software will be used to analyze the data gathered for this study. Longitudinal modeling will account for the data being collected from multiple program sites, over the two-year grant.

VII. Organization Information

A. DC DOH Organizational Structure

This grant application is submitted by the DOH CHA. The Mission of the DOH is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. DOH is divided into six administrations, each of which has a specific function in addressing the health and safety of the District's residents. The mission of the CHA is to improve health outcomes for targeted populations by promoting coordination within the health care system. This is achieved by increasing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members. CHA administers the Title V Block grant and is the designated unit

for adolescent, child, and family health related activities within DOH. CHA has six bureaus under its jurisdiction:

- Child, Adolescent & School Health Bureau (CASH)
- Cancer & Chronic Disease Prevention Bureau
- Pharmaceutical Procurement & Distribution Bureau
- Perinatal & Infant Health Bureau (PIHB)
- Nutrition & Physical Fitness Bureau
- Primary Care Bureau

In addition to the Title V program, CHA (specifically the CASH Bureau) also administers the Project LAUNCH and ECCS programs. Both programs play an integral role in building and implementing a District-wide comprehensive and coordinated early childhood system capable of supporting families and communities (especially the most vulnerable residents) in their development of children that are healthy and ready to learn at school entry. Further details of both programs are provided in Section I – Introduction, above. Another key program related to home visiting services found within CHA is the Healthy Start Program administered by PIHB. PIHB has been administering the DC Healthy Start Project since 1991. In March of 2011, the DC Healthy Start Project incorporated the PAT into its existing home visitation program as a natural extension to services already being provided by the DCHS project.

List of MIECHV Program Staff and Their Demonstrated Experience

CHA, under the leadership of Dr. Samia Altaf MD, MPH, is the Department of Health's designated unit for community health-related activities and initiatives. CHA consists of two main offices (Program Support Services and Grants Monitoring and Program Evaluation) and six bureaus (Attachment 5). CHA plans, coordinates, manages and evaluates health programs and services targeting children and families. Other units within the Administration, such as the Data Collection and Analysis Division within the Grants Monitoring and Program Evaluation Office, will continue to support the Child, Adolescent and School Health Bureau (CASH) in its health initiatives in the coming years.

Vinetta Freeman is the Child and Adolescent Health Division Chief located within CASH, and will provide general oversight of the project. She is responsible for: the development of District-wide child and adolescent health plans; monitoring; implementation; program evaluation of the District's Project LAUNCH and ECCS grants; and policy development.

The Local Home Visiting Program Coordinator – the incumbent – will be responsible for providing coordination of the District's early childhood home visiting efforts through work with the District's Home Visiting Council and other key partners. The person selected for the job will have expertise in the public health approach and early childhood development and will serve as the official responsible for the fiscal and administrative oversight MIECHV Development Grant.

VIII. Home Visiting Program Sustainability

The District has, and will continue to, prioritize the wellness of children. The District has demonstrated its commitment to promoting the wellness of young children so that they can thrive in safe, supportive environments and enter school ready to learn and able to succeed by

developing and implementing a comprehensive early childhood system of care that includes quality early childhood home visiting programs.

To explore potential funding streams that are not currently being used for home visiting services, District leaders weighed the available funding, stability, and flexibility of several programs, including TANF, Title I, Part A, CAPTA, and Title IV-E to determine the best financing strategies for the desired outcomes outlined in this proposal. After deliberating, agency leaders decided to explore two viable funding streams not previously used for home visiting services: Medicaid and Early Head Start.

Medicaid Targeted Case Management: (Stable funding source, allows for targeted reimbursement of funds) Given the large number of low-income families served by home visitation in the city, and the focus on preventive early intervention screenings in the EPSDT program, Medicaid is a logical option for funding home visiting services in the District's. States can use a number of financing mechanisms to apply Medicaid funding toward home visiting services (cite Pew report). The District's plans to adopt the targeted case management approach, where home visiting can be reimbursed by Medicaid by targeting and tailoring services to specific beneficiaries, such as high-risk, first-time parents, or certain geographic areas. This also allows an exemption from the rule that any Medicaid benefit offered be available to all enrollees in the state. To pursue this financing mechanism, the DOH is working closely with representatives at the DHCF to determine the range of services to authorize for targeted case management and then file an amended Medicaid state plan with Centers for Medicare & Medicaid Services (CMS).

Early Head Start (EHS) provides support to low-income infants, toddlers, pregnant women and their families. Funds are administered directly to grantees from the Federal Office of Head Start. EHS programs can be broad in scope, allowing for innovative partnerships with other funding streams and services. For example, home visiting programs may be able to access discretionary grants to work in collaboration with EHS leaders and focus on school readiness, child care, early child development, and prenatal services.