MASSACHUSETTS MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING INITIATIVE

COMPETITIVE FUNDING OPPORTUNITY ANNOUNCEMENT APPLICATION

AFFORDABLE CARE ACT (ACA) MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAMS

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES
HRSA-11-179 CFDA # 93.505
EXPANSION GRANT
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SECTION 1. INTRODUCTION

Brief Description of Project's Proposed Purpose

The goals of the current MIECHV Initiative are to 1) strengthen and improve the programs and activities carried out under Title V, 2) improve coordination of services for high need communities, 3) identify and provide comprehensive services to improve outcomes for families in high need communities, and 4) build and enhance a statewide system of care for families and young children. The current MIECHV Initiative, with funds from the competitive Funding Opportunity Announcement, plans to expand to serve additional communities across the Commonwealth and enhance collaborative efforts with state and local partners to build a comprehensive statewide early childhood system of care.

Description of MA's History of Significant Progress Implementing High-Quality Home Visiting Programs

Home visiting programs have been an integral component of Massachusetts' comprehensive service delivery system for children and families. Over the years the Commonwealth, large statewide non-profits and local community agencies have developed and implemented high-quality home visiting programs, building an integrated system of care and wrap-around services. Since its inception in 1997, Healthy Families Massachusetts (HFM) home visiting program has been a vital service for first time pregnant and parenting teens (age 20 and under) with children through age three in Massachusetts. Twenty-five community-based lead agencies offer the HFM program in every Massachusetts community. Program services include family-centered assessments, child development screenings, groups, goal setting activities, and referrals to other community services. HFM has achieved a number of successes in Massachusetts including:

- The rate of child abuse among HFM teen mothers is 66% lower than the rate for teen mothers not enrolled in the program:
- Eighty-three percent of HFM mothers are enrolled in school or graduated, a rate significantly higher than the national average of 53%
- On average, children in HFM are on target developmentally, despite the fact that children of teen parents are at greater risk for developmental delays[1]

In addition, there are 21 public and private home visiting programs for Massachusetts families. Massachusetts' home visiting programs offer voluntary services to individuals predominately in a home setting, although many offer group services as well. The home visiting programs in the state are tailored to address high-risk populations, such as families experiencing domestic violence, substance use disorders, and parenting teens. The state's home visiting programs also address high risk issues, such as children with special health care needs, family literacy, school readiness, economic self sufficiency, maternal depression, and child development. Services are delivered from trained home visiting professionals or paraprofessionals with the goal of addressing specific issues based upon the individual's eligibility for the program. Home visits are structured to ensure consistency that allows for evaluations to link program components with intended outcomes.

Table 1. Massachusetts Home Visiting Programs below summarizes the home visiting programs (both public and private) currently operating in Massachusetts. This information was compiled from the Home Visiting Program Survey, conducted over the summer 2010 by the Massachusetts Department of Public Health for the Maternal, Infant, and Early Childhood Needs Assessment. The survey gathered information from all of the current home visiting programs in the state, including program goals, objectives, caseloads, cost, and communities served. The survey also captured valuable details of statewide capacity, needs, and service gaps. Four evidence-based home visiting programs currently operate in the state.

Overview of Massachusetts Home Visiting Programs

Massachusetts currently has a wide variety of community-based and statewide programs including 21 home visiting programs, 5 national home visiting models, 4 national evidence-based home visiting,

[1] http://www.mctf.org/programs/Pages/hf.aspx

programs, 3 program that provides services to one specific community (2 in Boston & 1 Springfield), and 6 programs that provide services statewide (on an as needed basis).

Table 1. Massachusetts Home Visiting Programs

Home Visiting Program Name	Average Number of Families Served per Year	Programmatic Cost per Family
Boston Healthy Start Initiative	1,792	$781
Boston Home Visiting Collaborative	38	$3,300
DCF Substance Abuse Engagement Project	80	$1,603
Early Connections	83	$1,300
Early Head Start	**358**	**$10,000**
Early Intervention	33,346	$3,000
Early Intervention Partnership Program	669	$1,397
Family Recovery Project Program	84	$1,417
FRESH Start	100	$1,900
FORFamilies	3,196	Unknown
Good Start	338	$1,700
Healthy Baby Healthy Child	1,414	$2,829
Healthy Families Massachusetts	**3,131**	**$3,300**
Healthy Steps	**600**	**$413**
Parent Child Home Program	1,500	$2,750
Parenting Works	20	Unknown
Parents as Teachers	**279**	**$1,000**
Project RISE	605	$1,243
Strong Families, Strong Forces	130	Unknown
Visiting Moms	190	Unknown
Young Parents Support Program	1,122	Unknown
TOTAL/ AVERAGE COST	**Total Families: 49,075**	**Average Cost: $2,370**
MEDIAN	**Median: 358**	**Median: $1,603**

The home visiting programs in Massachusetts operate within the statewide early childhood system and participate in the following activities that connect them to the system: 1) community-level Advisory Councils or Community Boards with diverse representation from across the maternal, infant, and early childhood continuum; 2) collaborative referral relationships or Memorandums of Understanding with school systems, WIC offices, community health centers, Head Starts, mental health and substance use agencies, playgroups, day care, etc.; 3) collaborative agreements between state agencies including the state child welfare agency (Department of Children and Families – DCF), transitional assistance to families in need (Department of Transitional Assistance - DTA); and 5) Collaborative play groups or parent support groups.

Commitment to Sustaining Support for Early Childhood Home Visiting Programs Using State and Federal Funds

Massachusetts will leverage its state and federal funds to support early childhood home visiting programs by: 1) collaboration with MassHealth (Medicaid) to reimburse for home visiting; 2) seeking public and private insurance reimbursement for individual and group services provided by nurses, clinical social workers and other clinicians; 3) engaging with the public to encourage state legislative support for the Healthy Families Massachusetts and Early Intervention programs; and 4) continuing to support Early Intervention Partnership Programs (EIPP) using Title V MCH block grant funds.

Description of the Problem, the Proposed Intervention, and the Anticipated Benefit of the Project

Problem

Despite Massachusetts' strong foundation of high quality home visiting programs, significant gaps persist in home visiting services leaving families with high needs across the maternal, infant, and early childhood continuum. Data collected from the Home Visiting Program Survey, conducted by the Department of Public Health in 2010 found the following programmatic gaps to be of highest concern amongst home visitors and providers across the state:

Lack of maternal mental health services: There is a dearth of mental health clinicians and services, including long waiting lists in Massachusetts.
Immigrant Services: With an influx of immigrants, appropriate services are needed, including services in immigrant's native languages, as well as services in domestic or sexual violence tailored to immigrants.
Family Economic Self-Sufficiency Supports: The persistent economic crisis has created a growing need for housing resources, financial literacy courses, career and workforce development support, food security supports, and transportation as well as services for homeless families in shelters and motels.
Child Health and Development: Providers have noted a growing need to close the achievement gap, promote healthy development of premature infants, infant and early childhood mental health, enhance screening and treatment for children with special health care needs, family literacy, and parent education.
Family Violence/Trauma: More services are needed to address family violence, including intimate partner violence (IPV), child risk prevention, including child maltreatment, and families experiencing trauma, such as refugees or military families.
Non-Traditional Populations: Greater home visiting support is needed for fathers, grandparents who are parenting, and individuals with non-felony Criminal Offender Record Information (CORIs).
Comprehensive System of Care: A comprehensive approach is needed to data collection and sharing in order to avoid duplication of services, along with the need to provide clear and consistent information. There is a need to hire and maintain allied health professionals, address service gaps in primary care, dental care and the medical home. More clinicians of color and/or multi-lingual, multi-cultural workforce are needed who are highly trained and have the competencies to provide home visiting services to address at-risk communities, continuity of care for transition populations, such as teens and adolescents or families with complex needs

In addition to service gaps the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative's Needs Assessment found significantly high rates of the following data indicators across the identified highest need communities in the state: 1) premature birth, 2) low birth weight, 3) infant mortality, 4) poverty (below 100% FPL), 5) violent crime, 6) substance use disorders, 7) domestic violence (abuse-prevention filings: restraining orders), 8) vulnerable populations (% non-white), 9) school drop-out, 10) unemployment, and 11) child maltreatment.[2]

Proposed Intervention

After careful consideration from the Massachusetts MIECHV Initiative leadership and significant input from community members, providers, and other key stakeholders, the state's proposed interventions will focus on expanding the four evidence-based home visiting programs currently in operation in Massachusetts: Early Head Start, Healthy Families Massachusetts, Healthy Steps, and Parents as Teachers.

The MIECHV Initiative will expand its program in Massachusetts by: 1) providing additional funding to the five home visiting programs currently selected as part of the formula-funded MIECHV Initiative, and 2) fund evidenced-based home visiting programs in the remaining 12 identified high- need communities. This will significantly increase the number of families having access to comprehensive services in Massachusetts

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Table 2. Highest Need Communities & Proposed Home Visiting Programs indicates all 17 communities and their corresponding self-selected evidence based home visiting model(s).

Table 2. Highest Need Communities & Proposed Home Visiting Programs

Community	Funding Source	Proposed Home Visiting Model(s)
Boston	Competitive Expansion Funds	HF Teens
Brockton	Competitive Expansion Funds	HF Teens

[2] Massachusetts Statewide Needs Assessment for Maternal, Infant and Early Childhood Home Visiting Programs, Section II, pp. 10 – 41, September 2010

Chelsea	*Formula Funding*	*HF 1st Time / HS*
Everett	Competitive Expansion Funds	HF < 22
Fall River	*Formula Funding*	*HF 1st time*
Fitchburg	Competitive Expansion Funds	HF 1st time
Holyoke	*Formula Funding*	*HF Teens / EHS*
Lawrence	Competitive Expansion Funds	HF Teens
Lowell	Competitive Expansion Funds	HF Teens
Lynn	*Formula Funding*	*HF Teens*
New Bedford	Competitive Expansion Funds	HF Teens / PAT
North Adams/Pittsfield (these communities planned a join program)	Competitive Expansion Funds	HF 1st time / PAT
Revere	Competitive Expansion Funds	HS
Springfield	Competitive Expansion Funds	HF 1st time / PAT / EHS
Southbridge	*Formula Funding (FY11)*	*HF 1st time*
Worcester	Competitive Expansion Funds	HF Teens

Moreover, the Commonwealth will add several enhancements and innovations to the models in order to tailor services to the identified gaps and needs of families in the identified high need cities and towns. For a complete list of enhancements and innovations see Section 3. Methodology and Section 4. Work Plan. Please find a few highlights below:

- All participating parents with mild to severe depression will receive In-Home Cognitive Behavioral Therapy (IH-CBT) and support groups will be provided to all project participants to decrease social isolation and relieve mild depression.
- Train all home visitors in the New Child Project (NCP) tool, a tool to help parents with the ***transition to parenting: an evidence-based approach*** that promotes healthy relationship-building, mandatory for all programs
- Implement FIRSTLink –a centralized in-take/universal (voluntary) one-time home visit in all 17 identified communities, which will provide linkages for families triage to appropriate services
- Phase in the availability of a nurse, as a standard component of the evidence-based home visiting model, on a regional or program basis to all home visiting programs
- Enhance Massachusetts' statewide early childhood system of care by building up community-level Advisory Councils, standardizing common language and guidelines, such as Strengthening Families, across early childhood continuum, collaborate to reach all eligible families via FIRSTLink

Anticipated Benefit of the Project

The anticipated benefit of implementing and expanding the MIECHV Initiative will be to further enhance and integrate home visiting programs into the existing statewide system of care, building up and making available more resources and services to vulnerable families. In particular, the benefits of the MIECHV Initiative on families will be: 1) improved physical and mental health children and families, 2) improved parenting and parent-child relationships, 3) reduced rates of child injuries, abuse, neglect or maltreatment, 4) optimal child development, including improved school readiness and achievement, 5) reduced domestic violence and substance use in families, 6) improved family economic self-sufficiency, 7) seamless systems of care and support for families with young children, and 8) enhanced early childhood systems of care. See *Attachment 1* for the MIECHV Initiative's *Logic Model* for more details.

Description of Priority Elements Identified and Proposed Will Enhance Existing MIECHV Program

Massachusetts will focus on all eight of the priority elements as part of this Expansion funding. All eight priority elements are critically important and inherently tied to the delivery of high quality early childhood home visiting services, and the Commonwealth is committed to achieving innovations in each of the eight elements over the course of the four-year grant cycle. See Section 3. Methodology and Section 4.

Work Plan for a detailed description of how the elements will be addressed through the MIECHV Initiatives goals, objectives, and program activities.

Priority Element 1: The MIECHV Initiative will support improvements in maternal, child and family health by linking the MIECHV Initiative with Title V activities, helping families build healthy relationships, and strengthening program capacity to screen, support, and link families to maternal and child health services and resources. Specifically, MIECHV will enhance the existing program models by providing individual and group mental health services, adding a nurse to the home visiting team and providing evidence-based training on to enhance relationships between new parents.

Priority Element 2: The MIECHV Initiative will build on the existing MIECHV program by supporting the effective implementation and expansion of evidence-based home visiting programs, with fidelity to evidence-based model. There will be additional training in core competencies, supervision, and expanded evidence-based tools and assessment to strengthen program capacity to screen, respond, and refer high need families.

Priority Element 3: The MIECHV Initiative will support the development of statewide home visiting programs by expanding the MIECHV initiative to the additional (in the MIECHV Needs Assessment) 13 identified highest need communities in the state, including increasing funding to the four communities funded through the formal funds and will also enhance existing home visiting program Advisory Councils.

Priority Element 4: The MIECHV Initiative will support the development of comprehensive early childhood systems that span the prenatal through age eight continuum by implementing and a universal one-time/centralized in-take system (FIRSTLink) in all 17 highest need communities, and leveraging MIECHV visibility to strengthen cross system standards and infrastructure.

Priority Element 5: The MIECHV Initiative will improve outreach to high risk and hard to engage populations by developing and enhancing home visiting strategies to facilitate outreach, enrollment, and retention of the Commonwealth's most vulnerable families. Particular focus will be on the populations of first time parents, families involved with the child welfare system, families whose primary home language is not English including recent immigrants, homeless families, underserved populations and low income families. In program year two, particularly promising strategies aimed at developing an evidence-base on specific vulnerable populations will be supported

Priority Element 6: The MIECHV Initiative will provide a family-centered approach to home visiting by providing training, technical assistance, and materials development on working with fathers and co-parenting. This will enhance the already existing MIECHV Initiative by increasing the emphasis on father-friendly and co-parenting initiatives to support optimum family health and development.

Priority Element 7: The MIECHV Initiative will reach families in rural areas by expanding the MIECHV program to three rural communities, two in Western, Massachusetts, and one in Southeastern, Massachusetts..

Priority Element 8: The MIECHV Initiative will support fiscal leveraging strategies to enhance program sustainability by developing and enhancing current fiscal leveraging strategies such as expanding on public/private partnership, Medicaid, and state funding streams.

SECTION 2. NEEDS ASSESSMENT

Current Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative

The current Massachusetts Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative, funded through federal formula funds, will expand with fidelity, evidence-based home visiting programs in four of the highest need communities in Massachusetts (highest need communities identified in the MIECHV Needs Assessment). See *Table 1. Summary of Models Selected* for the four communities and their self-selected models.

Table 1. Summary of Models Selected

Community Name	Selected Model/s
Chelsea	Healthy Steps and Healthy Families (all 1st time parents)
Fall River	Healthy Families (all 1st time parents)
Holyoke	Early Head Start and Healthy Families (1st time parents ≤ 20 years old)
Lynn	Healthy Families (1st time parents ≤ 20 years old)

Identification of Selected Communities and Rationale for Selection

The MIECHV 2010 Statewide Needs Assessment identified 17 highest-need communities in the state. Four of the identified communities were selected to be funded through the formula grants as described in the Updated State Plan mentioned above (a fifth community has been proposed to be funded through the FY11 formula grant). The remaining 12 communities[3] (with additional funding going to the original four) will be funded with through the expansion grant.

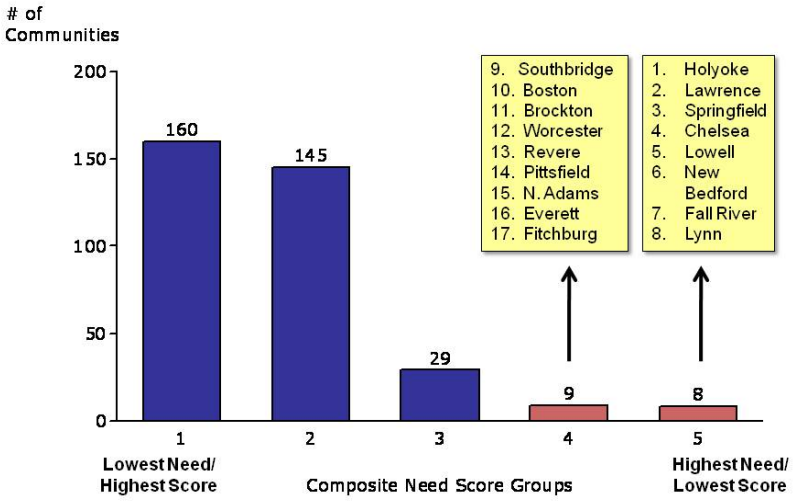
Identification of 17 Communities

In the 2010 Needs Assessment, Massachusetts examined data from multiple sources with information on maternal, infant, and early childhood health needs in the state, including the following: vital statistics, survey/surveillance, programmatic, education, and public safety. Initial indicators were chosen as specified in the Supplemental Information Request for the Submission of the Statewide Needs Assessment (Required Indicators). Additional indicators were recommended by an inter-agency Task Force convened to provide oversight for the needs assessment and program development.

Indicator data was examined on a community level to gain information that was most relevant for the process of identifying home visiting service needs in Massachusetts. Data for each identified health indicator was stratified by geographic region using the 351 Massachusetts cities and towns. When necessary, data from multiple years were aggregated to produce the most stable community-level analyses. The indicators included in the analysis were then grouped into one of nine outcome domains.

The 351 cities and towns were ranked ordered from highest to lowest risk on each identified indicator. Each community received a composite score, which summed each of the selected standardized indicators across outcome domains. Communities were then placed into one of five sub-groups (quintiles) of the calculated range, depending on their composite score. The 17 cities and towns that fell into the top two high-need quintiles (Table 1) were selected as the potential communities to receive funding in order to expand their home visiting services.

Table 2. Composite Need Score for All 351 MA Cities/Towns



The 17 high-need communities in Massachusetts listed in Table 2 exceed the statewide average for a number of indicators including teen birth, infant mortality, crime, and poverty. To determine which communities would receive funding from formula grant in FY11, the state invited each of the 17 highest-

[3] Please note, two communities submitted a joint proposal, so 11 additional grants will support 12 communities

need communities to submit a plan, for up to $200,000, proposing how they would expand or implement an evidence-based home visiting model that would address their community's identified needs.

The MIECHV Initiative staff and affiliates initially reviewed the 16 community proposals (two communities joined together to submit a proposal). Each proposal was discussed in light of its strengths, needs and capacities. The Home Visiting Task Force and Workgroup members then discussed the strengths and needs of each community, combining information gathered from the proposals with their prior experience with the communities. By the end of this second-level review, the participants reached a leadership decision and selected four communities for formula-based funding in the Updated State Plan: Chelsea, Fall River, Holyoke, and Lynn. With increased formula funding in FY11, the state plans to add a fifth community, Southbridge, MA.

Building on formula-based funding, competitive Funding Opportunity Announcement expansion grant funding will allow Massachusetts to fund the remaining 12 communities (11 proposals) at $200,000 each as part of their core funding. Further, the expansion grant will provide supplemental funding for an average of $105,000 per site for 16 sites which may be distributed according to both population size and unmet needs of specific communities. *Table 4. Community Demographics etc.* below, differentiated by formula funding and competitive expansion funding, details the risk factors, proposed home visiting expansion, and minimum number of new families served for each of the 17 high-need communities.

Description of How Selected Priority Elements Will Reach Desired Outcomes of Proposed Program

Priority Element 1: Support Improvements in Maternal, Child, and family Health: Priority element one will reach the intended outcomes of the MIECHV by linking the Initiative with Title V activities, including medical and dental homes, enhancing home visiting model nursing capacity, strengthening program capacity to screen, and support families experiencing maternal depression, domestic violence, substance use issues, and educate families on life planning and nurturing care giving using a curriculum that supports new parents through building healthy relationships (New Child Program).

Priority Element 2: Support the Effective Implementation and Expansion of Evidence-Based Home Visiting Programs with Fidelity to the Model: Priority element two will reach the intended outcomes of he MIECHV Initiative by, by enhancing core competency training, including the Ages and Stages Questionnaire (ASQ), Screening, Brief Intervention and Referral to Treatment (SBIRT), enhancing supervision, strengthen data collection and analysis incorporating all federally mandated benchmarks, and expanding technology and multimedia use.

Priority Element 3: Support the Development of Statewide Home Visiting Programs: Priority element three will reach the intended outcomes of the MIECHV Initiative by expanding the MIECHV initiative to the additional 13 identified highest need communities in the state, including increasing funding to the four communities funded through the formal funds. MIECHV also will enhance existing home visiting program Advisory Councils to include providers from all services on the maternal, infant, and early childhood continuum, and to support communities in developing informal and formal linkages across agencies to avoid duplication, enhance coordination of care, and ensure a seamless system of identification and management.

Priority Element 4: Support the Development of Comprehensive Early Childhood Systems that Span the Prenatal through Age Eight Continuum: Priority element four will reach the intended outcomes of the MIECHV Initiative by implementing a universal one-time/centralized in-take system (FIRSTLink) in all 17 highest need communities, integrating the MIECHV Initiative into other maternal, infant, and early childhood programs and systems in the state, leveraging MIECHV visibility to strengthen cross system standards and infrastructure, supporting continued collaboration with key organizations/state agencies, civic partners, and stakeholders at the state and community levels, and building capacity to affect policies and systems across the Commonwealth.

Priority Element 5: Reach High Risk and Hard to Engage Populations: Priority element five will reach the intended outcomes of the MIECHV Initiative by developing and enhancing home visiting strategies, such as creating a central contact person at each Department of Children and Families office, to facilitate outreach, enrollment, and retention of the Commonwealth's most vulnerable families. Particular focus will be on the populations of first time parents, families involved with the child welfare system,

families whose primary home language is not English including recent immigrants, homeless families, underserved populations and low income families. MIECHV will also support promising approaches that target specific vulnerable populations, particularly substance using families and military families in the second year of the grant.

Priority Element 6: Provide a Family-Centered Approach to Home Visiting: Priority element six will reach the intended outcomes of the MIECHV Initiative by providing training, technical assistance, and materials development on working with fathers, co-parenting, and healthy relationships.

Priority Element 7: Reach Families in Rural Areas: Priority element seven will reach intended outcomes of the MIECHV Initiative by expanding the MIECHV program to three rural communities, two in Western, Massachusetts, and one in Southeastern, Massachusetts.

Priority Element 8: Support Fiscal Leveraging Strategies to Enhance Program Sustainability: Priority element eight will reach intended outcomes of the MIECHV Initiative by developing and enhancing current fiscal leveraging strategies such as expanding on public/private partnership, Medicaid, and state funding streams.

Please refer to *Section 3. Methodology* for full description of priority elements. Please refer to the *Logic Model in Attachment 1* for a description of intended project outcomes.

Table 3. Community Indicators, Top 17 High-Need Communities

Community	Premature Birth	Low Birth Weight	Infant Mortality	Teen Birth	Poverty	Crime	Domestic Violence	School Drop-out Rate	Unemployment	Child Maltreatment
Statewide Average	***9.0***	***7.9***	***4.9***	***20.1***	***9.3***	***449.0***	***5.5***	***2.9***	***8.0***	***19.5***
Formula Grant Funded:										
Chelsea	8.7	8.5	6.2	81.2	23.3	1,732.2	9.7	8.6	9.9	30.1
Fall River	8.3	8.9	7.6	55.4	17.1	1,198.8	10.4	10.1	13.3	44.6
Holyoke	8.2	9.3	8.9	95.7	26.4	1,135.4	13.2	10.4	11.7	56.6
Lynn	9.1	8.3	5.2	49.7	16.5	906.2	9.3	5.5	10.5	29.0
Southbridge	8.7	10.2	9.5	67.0	15.4	473.8	8.7	7.7	10.3	51.8
100% Expansion Grant Funded:										
Boston	10.2	9.3	6.1	29.0	19.5	1,104.4	3.4	8.0	8.7	22.9
Brockton	11.5	10.6	8.5	43.5	14.5	—	6.9	5.8	10.9	32.7
Everett	7.9	7.7	3.9	36.3	11.8	505.7	6.7	4.0	8.8	25.4
Fitchburg	8.1	8.4	5.8	45.3	15.0	—	10.3	8.4	11.7	37.8
Lawrence	9.5	8.9	6.7	76.8	24.3	653.2	10.2	12.4	16.4	12.9
Lowell	8.9	8.9	6.1	50.8	16.8	1059.6	9.8	4.2	11.5	32.4
New Bedford	9.7	10.4	7.1	64.1	20.2	1,302.0	8.6	8.6	13.3	64.5
North Adams	10.2	8.6	3.7	37.8	18.2	616.8	8.9	6.8	9.4	74.3
Pittsfield	7.8	8.9	3.8	49.8	11.4	699.6	8.1	6.2	8.5	66.8
Revere	9.1	8.9	7.9	43.7	14.6	419.9	9.7	5.9	8.8	16.9
Springfield	11.3	10.5	9.0	73.7	23.1	1,254.9	9.6	9.3	11.4	58.8
Worcester	8.3	8.2	8.9	35.8	17.9	969.8	3.5	5.2	10.6	37.7

Indicator Definitions:

- Premature Birth – % before 37 weeks
- Low Birth Weight – % live birth <2,500 grams
- Infant Mortality – Infant deaths per 1,000 live births
- Teen Birth – Teen (age 15-19) birth rate per 1,000 live births
- Poverty – % below 100% FPL
- Crime – Violent crimes per 100,000 residents
- Domestic Violence – % abuse prevention filings (restraining orders) by district court
- School Drop-out Rates – % high school drop-outs
- Unemployment – % unemployed
- Child Maltreatment – Rate of substantiated reports per 1,000 (0 - <9 year)

Table 4. Community Demographics, Risk Factors & Proposed Home Visiting Expansion

Community	Population (2010)	Race/Ethnicity (% Non-White)	Median Income	Resident Births (2008)	Community Risk Factors	Proposed Funded Model(s)	Minimum Proposed # New Families Served with expansion grant
Statewide	6,547,629	19.0%	$64,057	76.969	N/A	N/A	N/A
Chelsea (formula funding)	35,177	64.1%	$39,710	745	• Violent crime • Vulnerable populations • Parenting stressors	Healthy Families/ Healthy Start	Formula: 100 Expansion: 75 **Total: 175**
Fall River (formula funding)	88,857	11.9%	$35,814	1,251	• School readiness • Parenting stressors • Violent crime	Healthy Families	Formula: 50 Expansion: 38 **Total: 88**
Holyoke (formula funding)	39,880	50.7%	$34,946	701	• Parenting stressors • Economic self-sufficiency • Violent crime	Healthy Families/ Early Head Start	Formula: 30+ Expansion: 23+ **Total: 53+**
Lynn (formula funding)	90,329	44.2%	$41,933	1,501	• Vulnerable populations • Education	Healthy Families	Formula: 45-60 Expansion: 34-45 **Total: 79-105**
Southbridge (formula funding FY11)	16,719	27.4%	$40,788	237	• Child health • School system	Healthy Families	Formula: 60 Expansion: 45

Table 4. Community Demographics, Risk Factors & Proposed Home Visiting Expansion

Community	Population (2010)	Race/Ethnicity (% Non-White)	Median Income	Resident Births (2008)	Community Risk Factors	Proposed Funded Model(s)	Minimum Proposed # New Families Served with expansion grant
							Total: 105
Boston (expansion grant funding)	617,594	50.1%	52,433	8,019	• Child health • Vulnerable populations • Violent crime	Healthy Families	93
Brockton (expansion grant funding)	93,810	43.6%	$50,197	1,552	• Child health • Vulnerable populations • Economic self-sufficiency	Healthy Families	105
Everett (expansion grant funding)	41,667	23.8%	$49,830	655	• Vulnerable populations • Economic self-sufficiency	Healthy Families	53-61
Fitchburg (expansion grant funding)	40,318	27.6%	$47,369	615	• Unemployment • Education	Healthy Families	67
Lawrence (expansion grant funding)	76,377	74.8%	$32,337	1,379	• School readiness • Vulnerable populations • Economic self-sufficiency	Healthy Families	50
Lowell (expansion grant funding)	106,519	42.1%	$49,816	1,775	• School readiness • Vulnerable populations	Healthy Families	50
New Bedford (expansion grant funding)	95,072	22.7%	$36,775	1,389	• Maternal & infant health • Violent crime • Economic self-sufficiency	Healthy Families/ Parents as Teachers	105
North Adams-Joint Proposal	13,708	6.1%	$35,020	150	• Child maltreatment • Maternal &	Healthy Families/ Parents as Teachers	110-123

Table 4. Community Demographics, Risk Factors & Proposed Home Visiting Expansion

Community	Population (2010)	Race/Ethnicity (% Non-White)	Median Income	Resident Births (2008)	Community Risk Factors	Proposed Funded Model(s)	Minimum Proposed # New Families Served with expansion grant
(expansion grant funding)					infant health		
Pittsfield-Joint Proposal (expansion grant funding)	44,737	9.2%	$43,507	520	• Maternal & infant health • Child maltreatment • Substance abuse		
Revere (expansion grant funding)	51,755	18.4%	$49,178	761	• Vulnerable populations • Economic self-sufficiency	Healthy Steps	263
Springfield (expansion grant funding)	153,060	55.0%	$34,113	2,458	• Maternal & infant health • Parenting stressors • Violent crime	Healthy Families/ Early Head Start/ Parents as Teachers	105
Worcester (expansion grant funding)	181,045	33.3%	$45,944	2,760	• Vulnerable populations • Infant health	Healthy Families	50

Sources:

- Population – 2010 figures from US Census via http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
- Median income – Community Profiles, Massachusetts Maternal, Infant, and Early Childhood Home Visiting Needs Assessment, 2010
- Resident births – Resident births by geography 2008, MassCHIP, 210
- Community risk factors – Community Profiles, Massachusetts Maternal, Infant, and Early Childhood Home Visiting Home Visiting Needs Assessment, 2010
- Proposed funded model(s) – Massachusetts Maternal, Infant, and Early Childhood Home Visiting Home Visiting Community Contract Award Opportunity Proposal(s)
- Minimum proposed # new families served with expansion grant – Community Award Opportunity proposals; proportional estimate

SECTION 3. METHODOLOGY

The Massachusetts Maternal, Infant and Early Childhood Initiative (MIECHV) will implement interventions on three levels: individual/family, community, and systems of care. At the individual and family level, MIECHV will improve health and education outcomes by expanding evidence-based home visiting services for prenatal – age eight families in high-need communities. At the community level, MIECHV will work with local partners to develop an early childhood system of care in the 17 high-need communities to identify, engage and provide comprehensive coordinated services across multiple sectors. And finally, MIECHV will work at the statewide level to strengthen and enhance systems of care for families by integrating the MIECHV Initiative into a broad system of early childhood care, deepening state capacity to provide services to all Massachusetts families, and leveraging civic leadership and fiscal resources to provide a continuum of care to improve maternal, infant and early childhood outcomes across the Commonwealth.

In the table that follows, all bolded objectives refer to program elements unique to the proposed Expansion Grant. Non-bolded objectives were included in the Massachusetts Updated State Plan as part of formula grant funding and are also relevant to the new communities to be funded under the Expansion Grant

Goals	Objectives
Goal 1: Strengthen and improve the programs and activities carried out under State Title V Agency Priority Element 1 Support improvements in maternal, child and family health	1. Align Massachusetts Maternal, Infant and Early Childhood Home Visiting (MIECHV) Initiative with State Title V priorities by the end of year one 2. Promote medical and dental homes for MIECHV program participants by linking to a coordinated system of health care by the end of year one **3. Strengthen program capacity to screen, assess and provide support to families experiencing mental health stresses and social isolation by the end of year two** **4. Enhance capacity of MIECHV program to improve maternal and child health by including a nurse as a standard component of the evidence-based home visiting models; implement by the end of year two** 5. Integrate and enhance screening, assessment and/or referrals for home safety, child development, substance use and family violence into all MIECHV programs by the end of year one **6. Integrate education and support on preconception care, breastfeeding, nurturing caregiving and early parenting into all MIECHV programs by the end of year one**
Goal 2: Identify and provide comprehensive evidence-based home visiting services and improve the coordination of services for families from prenatal through age 8 to improve outcomes for families in high-need communities Priority Element 2: To support the effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to evidence-based model Priority Element 3: To support the development of statewide	1. Support diverse evidence-based home visiting models at the community level in 12 additional high need communities by the end of year one **2. Expand training and high quality supervision for MIECHV Program staff starting in year one with additional training continuing throughout the project, including training on interventions in the Strengthening Families framework** **3.** Develop program strategies to outreach, enroll, and retain vulnerable families, including first time parents, families involved with the child welfare system, families whose primary home language is not English including recent immigrants, homeless families, underserved populations, rural families, and low income families by the end of year one. **Support promising approaches that target specific populations by the end of year two** **4.** Support communities in developing formal and informal linkages across agencies to avoid duplication, enhance coordination of care, and ensure a seamless system of identification and management by the end of year one **5. Enhance capacity to collect, analyze and report on MIECHV program data by the end of year one** **6. Promote inclusion of fathers among program participants by the end of year two** **7. Evaluation: 1) Conduct cross-site implementation study of MIECHV Initiative, using findings to inform and improve program effectiveness by year four. 2) Use findings from MHFE-2 EC longitudinal study to inform and improve program practices at the agency and system-wide levels by year four**

Goals	Objectives
home visiting programs Priority Element 5: Reach high risk and hard to engage populations Priority Element 6: Provide a family-centered approach to home visiting Priority Element 7: To reach families in rural areas	
Goal 3: Build and enhance a statewide system of care for families and young children Priority Element 4: Support the development of comprehensive early childhood systems that span the prenatal through age eight continuum Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability	**1. Develop and expand Central Intake System (Massachusetts FIRSTLink) to identify and screen all women giving birth in 17 highest-need communities by year four. Starting in year two, build on FIRSTLink to include referrals for families with children 0 – 8 years through early education and care programs, elementary schools, community health centers, and other local resources** 2. Integrate the Massachusetts MIECHV Initiative into other maternal, infant, and early childhood programs to strengthen and ensure access for families to statewide systems of early childhood development, family support and engagement by year one **3. Leverage the MIECHV Initiative's resources and visibility to strengthen cross systems tools and standards to enhance services and ensure that supports for children and their families are coordinated within and across the early childhood system. Support continued collaboration with key organizations, civic partners, and stakeholders at the state and community levels including sister state agencies by the end of year one** 4. Support continued collaboration and communication streams with key organizations, civic partners, and stakeholders at the state and community levels by year one **5. Establish long-term governance structure and sustainability through transition of the MIECHV Task Force to an existing leadership entity and develop fiscal leveraging strategies to ensure program sustainability by year one and continuing work through year four.** **6. Use cross-system data and community service context analyses to build statewide systems of care and to evaluate MIECHV Initiative impact on enhancing statewide systems by year four**

Goal 1: Strengthen and improve the programs and activities carried out under State Title V Agency (Priority Element 1)

Objective 1.1: *Align Massachusetts Maternal, Infant and Early Childhood Home Visiting MIECHV Initiative with State Title V priorities by the end of year one*

The Bureau of Family Health and Nutrition (BFHN) within the Massachusetts Department of Public Health (MDPH) is the State Title V Agency. The BFHN priorities, as articulated in the MCH Title V Block Grant, include improving the health and well being of women in their childbearing years, promoting emotional wellness and social connectedness, promoting healthy weight for all family members, enhancing screening for the prevention of violence, supporting reproductive and sexual health, reducing unintentional injuries, expanding the medical home model, supporting effective transitions for children and youth with special health care needs and improving data capacity.[4] Efforts in year one will focus on achieving maximum alignment of these priorities with those of the MIECHV Initiative. Staff from multiple programs within the DPH—including WIC, the Division of Violence and Injury Prevention, the Bureau of Substance Abuse Services, Early Intervention, and the Massachusetts Early Childhood Comprehensive Systems (MECCS) Project—will work closely with the MIECHV Initiative, providing technical assistance, training, and linkages to all programs supported by Title V. Alignment of BFHN and MIECHV priorities will inform effective program development, implementation, expansion and evaluation while promoting a comprehensive system of care for MIEC in the Commonwealth. Further, Title V Block Grant will continue to fund a non-evidence based home visiting program (EIPP) that serves high need families in eight communities.

Objective 1.2: *Promote medical and dental homes for MIECHV program participants by linking to a coordinated system of health care by the end of year one*

A medical home is defined by the American Academy of Pediatrics (AAP) as a system of care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.[5] The medical home model of care has been shown to improve the quality and cost-effectiveness of care for patients with chronic diseases, a huge cost-driver in our current system.[6]

Massachusetts has a legislative mandate from MassHealth, the state's Medicaid program, to establish a medical home demonstration project.[7] Building on this commitment, the MIECHV Initiative will develop the medical home/home visiting collaborative program of Healthy Steps and Healthy Families in two of the 17 identified highest-need communities in Massachusetts. The cities of Chelsea and Revere, both immediate northern suburbs of Boston, have indicated their intention to expand the Healthy Steps medical home model to provide more home visiting and comprehensive family-centered services. The MIECHV Initiative will also focus on linking families to dental homes by collaborating with community health centers to promote dental health for both children and parents.

Objective 1.3: *Strengthen program capacity to provide support to families experiencing mental health stresses and social isolation by the end of year one*

Healthy child development relies on responsive care giving, characterized by emotional availability and responsiveness.[8] Maternal depression seriously undermines these crucial aspects of parenting and has been linked to a number of poor child health and developmental outcomes including cognitive and language delays;[9] difficulties in emotional regulation and attachment;[10] early onset of

[4] Massachusetts MCH Needs Assessment 2010, Title V Block Grant. Bureau of Family Health and Nutrition, Massachusetts Department of Public Health, 2010
[5] American Academy of Pediatrics, Committee on Pediatric Workforce. Culturally effective pediatric care: education and training issues. Pediatrics. 1999;103:167–170.
[6] American Academy of Family Physicians, Patient Centered Medical Home. http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmhsum.Par.0001.File.tmp/PCMHsummary.pdf. Accessed June 14, 2011.
[7] Chapter 305, Section 30 of Acts of 2008
[8] National Scientific Council on the Developing Child. Excessive stress disrupts the architecture of the developing brain. Working Paper. Waltham, MA: The Heller School, Brandeis University; 2005. Report No.: 3.
[9] Petterson SM, Albers AB. Effects of poverty and maternal depression on early child development. Child Dev 2001;72(6):1794-813.

depression;[11] and behavioral and educational problems.[12] Moreover, depression can significantly interfere with the efficacy of home visiting. There is a high prevalence of depression in mothers enrolled in home visiting in Massachusetts. In the Healthy Families Massachusetts Evaluation, 43% of mothers screened as positive for depression at least once. Further, 27% screened positive for depression at multiple time points, indicating chronic depression.[13] Detecting and treating depression in prenatal and parenting families will have profound effects on promoting the mental wellness of all family members, especially young children.

The MIECHV Initiative will strengthen program capacity to support families facing mental health-related issues by improving screening for mental health stresses, providing in-home intensive therapy for parents who screen positive for mental health issues, and expanding group services for all participating parents to reduce social isolation. Specifically, to provide enhanced services to participants experiencing mild to severe depression, evidence-based home visiting programs in MIECHV will expand to include the In-Home Cognitive Behavioral Therapy (IH-CBT) intervention and implement the "social network strategy" advocated by Dr. Neil Guterman.[14]

IH-CBT, developed by Dr. Robert Ammerman at University of Cincinnati, provides participants enrolled in home visiting—and identified through screening by their home visitor as experiencing depression—with 15 weekly, in-home therapy visits by a social worker. The social worker and the home visitor maintain a working relationship, with co-visits at the beginning and end of the therapy cycle. Program evaluation has indicated that IH-CBT is highly effective at reducing depression, with 66.7% of depressed mothers no longer obtaining a diagnosis of depression at the end of treatment, in contrast with a rate of 24.3% in mothers receiving home visitation alone.[15] In addition, mothers receiving IH-CBT reported increased social support and reduction in other psychiatric symptoms. A 2010 pilot of IH-CBT in Boston, conducted by United Way of Massachusetts Bay and Merrimack Valley, achieved preliminary results similar to those of Ammerman, with 90% of participants who completed the therapy reporting no symptoms of depression.[16] IH-CBT will allow MA MIECHV programs to leverage the home visitor-participant relationship to support mental health assessment, provide intensive mental health services to families who might not access services outside the home, and reduce depression in participants.

There is evidence that facilitating the development of social support networks can have positive impacts on parental functioning and help-seeking behaviors.[17] [18] [19] [20] [21] [22] [23] [24] MIECHV will pilot parent support groups that reduce depression, social isolation and lessen child abuse and neglect, building

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[10] Weinberg MK, Tronick EZ. Emotional characteristics of infants associated with maternal depression and anxiety. Pediatrics 1998;102(5 Suppl E):1298-304.

[11] Murray L, Woolgar M, Cooper P, Hipwell A. Cognitive vulnerability to depression in 5-year-old children of depressed mothers. J Child Psychol Psychiatry 2001;42(7):891-9

[12] Black MM, Papas MA, Hussey JM, Hunter W, Dubowitz H, Kotch JB, et al. Behavior and development of preschool children born to adolescent mothers: risk and 3-generation households. Pediatrics 2002;109(4):573-80.

[13] Jacobs F, Easterbrooks a, Brady A, Mistry J. Healthy Families Massachusetts Final Evaluation Report. May 2005

[14] http://www.ssa.uchicago.edu/faculty/n_guterman%20ver2.shtml

[15] Ammerman, R.T., Putnam, F,.W., Stevens, J., Holleb,L.J .,Novak, A.L., & Van Ginkel, J.B.(2005) In-Home Cognitive Behavioral Therapy for Depression: An Adapted Treatment for First-Time mothers in Home Visitation: *Best Practices in Mental Health* ,1 (1),1-14

[16] Brady, A. Boston Home Visiting Collaborative: Enhancing Child and Parent Outcomes through In-Home Cognitive Behavioral Therapy Interim Evaluation report, June 2011

[17] Stevens-Simon C, Nelligan D, Kelly L. Adolescent at-risk for mistreating their children Part II: A home and clinic-based prevention program. Child Abuse & Neglect 2001;6:153-169.

[18] DePanfilis D. Social isolation and neglectful families: A review of social support assessment and intervention models. Child Maltreatment 1996;1(1):37-52.

[19] Thompson R. Preventing child maltreatment through social support: A critical analysis. Thousand Oaks, CA: Sage; 1995.

[20] Garbarino J, Sherman D. High-risk neighborhoods and high-risk families: The human ecology of child maltreatment. Child Development 1980;51:188-198.

[21] Daro D, Harding K. Healthy Families America: Using research to enhance practice. The Future of Children 1999;9(1):152-176.

[22] Izzo C, Weiss L, Shanahan T, Rodriguez-Brown F. Parental self-efficacy and social support as predictors of parenting practices and children's socioemotional adjustment in Mexican immigrant families. Journal of Prevention and Intervention in the Community 2000;20(1-2):197-213

[23] Valentiner DP, Holahan CJ, Moos RH. Social support, appraisals of event controllability, and coping: An integrative model. Journal of Personality and Social Psychology 1994;66(6):1094-1102.

[24] Conn MK, Peterson C. Social support: Seek and ye shall find. Journal of Social and Personal Relationships 1989;6(3):345-358.

upon already existing support groups currently conducted by EHS, PAT, and HF. Dr. Neil Guterman, working at the University of Chicago's Chapin Hall Center, has developed and researched a group model, Parents Together, which has had positive effects in strengthening social support networks when implemented in conjunction with home visitation. Pilots of the program, have shown clinically meaningful increases in a variety of factors directly targeted by the intervention, including increases in the number of positively-to-negatively perceived members in their social networks, reductions in perceived stress, greater access to resources necessary for the family, improvements in mothers' positive involvement with their children, and improvements in fathers' positive involvement with their children. Most importantly, Parents Together is a manualized intervention, which will ensure that it can be replicated with fidelity and achieve the same outcomes.[25] For MIECHV participants, these groups will provide much-needed support to improve their functioning as parents.

Objective 1.4: *Enhance capacity of MIECHV program to improve maternal, infant and child health by including a nurse as a standard component of the evidence-based home visiting models; implement by the end of year two*

The MIECHV Initiative will include nurses as a standard component of home visiting teams. Most evidence-based home visiting models have not successfully improved maternal, child and family health.[26] However, one model that has shown clear effects on health and wellness—Nurse Family Partnership—explicitly includes nurses.[27] Added to home visiting teams (or provided on a regional basis), nurses can provide consultation to home visitors on health and wellness, work with women with high-risk medical conditions, conduct wellness assessments of all family members, help plan appropriate health-focused content including healthy weight, support breastfeeding efforts, provide help establishing a medical home, and develop and facilitate educational groups on health topics. By including a nurse who can fully develop focused interventions on health and wellness, MIECHV will give participants access to enhanced home visit content to support improved health outcomes.

Objective 1.5**:** *Integrate and enhance screening, assessment, response, and/or referrals for home safety, child development, substance use and family violence into all MIECHV programs by the end of year one*

The MIECHV Program will enhance screening, assessment, response and/or referrals for home safety, child development, substance use and family violence by developing protocols, and providing training on evidence-based tools for all home visitors. We will focus specifically on linking families to programs within MDPH, including programs within the Division of Violence and Injury Prevention (DVIP) and Bureau of Substance Abuse Services (BSAS).

First, DVIP just completed developing a home-safety checklist based on the Housing and Urban Development (HUD) healthy homes materials.[28] All MIECHV home visitors will be trained to use the checklist. Second, the Ages and Stages Questionnaire (ASQ-3) and Ages and Stages Questionnaire Social/Emotional (ASQ:SE), extensively researched, and provide an accurate, parent-centered approach to identifying children with developmental delays. The ASQ-3 questionnaire items are linked to developmental milestones and the tool is used to teach parents about child development and their own child's skills.[29] The ASQ: SE identifies infants and young children whose social and emotional development requires further evaluation to determine if referral for intervention services is needed.[30] All home visitors will receive training on the ASQ tools.

Third, MIECHV program staff will receive training and implement Screening, Brief Intervention, Referral and Treatment (SBIRT), shown to be an effective approach to addressing substance use. The SBIRT is a structured evidence-based methodology that gives health care providers the skills necessary to

[25] **Guterman, N.B.**, & Taylor, C.A. (2004). Parents Together Support Group Program Manual for Mobilizing Parent Social Support.
[26] http://homvee.acf.hhs.gov/document.aspx?rid=5&sid=20&mid=2
[27] http://homvee.acf.hhs.gov/document.aspx?rid=5&sid=20&mid=2
[28] http://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/healthyhomes
[29] http://agesandstages.com/asq-products/asq-3/
[30] http://agesandstages.com/asq-products/asqse/what-is-asqse/

discuss health behavior changes with their patients. The method is split into three parts: 1) Screening, which helps to determine the severity of substance use, 2) Brief Intervention, which builds motivation through a collaborative conversation, and 3) Referral to Treatment, which directly links patients with appropriate and requested services. The model effectively motivates individuals to change harmful substance abuse, but has been further expanded to address issues related to tobacco cessation and domestic violence.[31] Results of the SBIRT will be used to inform pregnant women of the link between alcohol consumption and Fetal Alcohol Spectrum Disorder (FASD).

Finally, all MIECHV home visitors will be trained to provide trauma-informed care, and will implement an evidence-based screening, response and referral for families experiencing family violence including intimate partner violence (IPV). Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Specific approaches include understanding a survivor's need to be respected, connected, and hopeful regarding their own recovery; recognizing the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, and depression); working in a collaborative way with survivors, their family and friends, and service agencies in a manner that will empower survivors.[32] Ultimately, home visitors have a unique opportunity to identify and respond to families experiencing IPV. As MIECHV staff expand their capacity to identify families experiencing abuse, more families will be linked to local domestic violence programs. Research has shown that connection to a domestic violence program is the major protective factor for high-risk cases.[33]

Objective 1.6: *Integrate education and support on preconception care, breastfeeding, and nurturing caregiving into all MIECHV programs by the end of year one*

All MIECHV Program staff will receive training on providing education and support for preconception care, breastfeeding, and early nurturing from year one onward. The Centers for Disease Control and Prevention (CDC) promote preconception care that emphasizes individual responsibility across the lifespan, consumer awareness, and preventive health care for all women as a strategy for managing health conditions, behaviors, and social risk that may contribute to poor perinatal outcomes.[34] Individual responsibility encourages all families to have a reproductive health plan, that is, a set of personal goals about whether or not to have children based on personal values, social supports, and resources.[35] Promoting consumer awareness and preventive visits is a strategy of providing risk assessment and counseling to reduce risks related to pregnancy outcomes.[36]

Exclusive breastfeeding for the first six months of life is recognized as the best nutrition for most infants and has been associated with multiple health benefits for both infants and women; the Surgeon General states that breastfeeding protects babies from numerous infections and illnesses.[37] Assessments in Massachusetts have shown that mothers receiving home visiting services in the immediate postpartum period have higher rates of breastfeeding compared with women who do not participate in a home visiting program.[38] Training MIECHV home visitors to provide breastfeeding support, linking families to WIC peer counselor support programs, and connecting families with community resources will improve breastfeeding rates and thereby positively impact maternal, infant and child health.

Finally, home visitors will be trained in the Nursing Child Assessment Satellite Training (NCAST) Promoting First Relationships Program, a prevention program dedicated to promoting children's social-emotional development through responsive, nurturing caregiver-child relationships.[39]

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[31] Babor TF, McRee BG, Kassebaum, PA, Brimaldi PL, Ahmed K, Bray J. Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a Public health Approach to the Management of Substance Abuse. Substance Abuse, Vol 28, No. 3, 2007, pp. 7 – 30.
[32] http://www.samhsa.gov/nctic/trauma.asp
[33] http://www.futureswithoutviolence.org/
[34] http://www.cdc.gov/ncbddd/preconception/documents/At-a-glance-4-11-06.pdf
[35] http://www.cdc.gov/ncbddd/preconception/QandA.htm
[36] http://www.cdc.gov/ncbddd/preconception/documents/At-a-glance-4-11-06.pdf
[37] http://www.surgeongeneral.gov/topics/breastfeeding/factsheet.html
[38] Manning, S, Massachusetts Early Intervention Partnerships Program (EIPP): Using Linked Data to Evaluate a High-Risk Maternal & Newborn Home Visiting Program, 2009
[39] http://www.pfrprogram.org/

Further, building on extensive research on the impact of becoming a parent on couples,[40] [41]MIECHV Program staff will be trained, through the New Child Project (NCP) to promote healthy relationships as a critical component to transitioning to parenthood.

Goal 2: Identify and provide comprehensive evidence-based home visiting services and improve the coordination of services for families from prenatal through age eight to improve outcomes for families in high-need communities (Priority Elements 2, 3, 5, 6, and 7)

Objective 2.1: *Support diverse evidence-based home visiting models at the community level in 12 additional high-need communities by the end of year one*

The MIECHV Initiative will expand the MIECHV program in Massachusetts by 1) providing additional funds to the five home visiting programs currently selected as part of the formula-funded MIECHV Initiative, and 2) fund evidenced-based home visiting programs in the remaining 12 identified high-need communities.[42] Data from the MIECHV Needs Assessment and community proposals revealed a high unmet need for home visiting services in the 17 identified high-need communities. Expanding the MIECHV Initiative's capacity to provide home visiting services to all 17 highest-need communities in the Commonwealth will dramatically increase the number of families able to access comprehensive services.

Community engagement has been a crucial component of the MIECHV Initiative program. In selecting community recipients for formula funding, the MIECHV Initiative engaged directly with the 17 communities through a day-long forum and proposal submission process. The forum, entitled: *In the House! Investing in our Children through Maternal, Infant, and Early Childhood Home Visiting*, brought together representatives from the 17 communities to explore the communities' self-identified needs, to discuss community readiness to expand home visiting, and to enhance statewide early childhood systems of care. Building upon efforts initiated at the forum, communities then submitted proposals outlining their plan for expanding evidence-based home visiting in their community. All four of the evidence-based programs currently operating in Massachusetts—Early Head Start, Healthy Families, Healthy Steps, and Parents as Teachers—were selected for expansion in at least one community proposal.

Objective 2.2: *Expand training and high-quality supervision for MIECHV Program staff starting in year one with additional training throughout the project, including training on interventions in the Strengthening Families framework*

There are four evidence-based home visiting models currently operating in the Commonwealth and Massachusetts intends to expand funding to them all under the Expansion Grant. All four models have robust training protocols and standards. The MIECHV Initiative will enhance the existing training structures by developing the MIECHV training system. This system will create training for all MIECHV home visiting staff based on core competencies and professional development trajectories. Further, it will focus on developing common training standards across models.

Training is a cornerstone of home visiting success. When staff have the skills and knowledge to design well-constructed home visits and to respond confidently to the emerging needs and interests of participants, those participants are more likely to stay engaged with the program, increasing the likelihood of participant success.[43] The Massachusetts MIECHV Initiative will build on the Healthy Families Massachusetts (HFM) core training and core topics infrastructure, which provides the necessary training for all MIECHV program models to meet accreditation standards. Since HFM already includes other evidence-based and non-evidence-based home visiting staff in core trainings, MIECHV will leverage this

[40] Cowan CP, Cowan PA, When Partners Become Parents: The Big Life Change for Couples. 1992. Basic Books
[41] Gottman j, Gottman JS, And Baby Makes Three. Crown Publishing, Random House, New York, 2007
[42] The MIECHV Needs Assessment identified 17 communities in the state as highest need. Formula funding for FY11 will be used to fund home visiting expansions in five of the communities. For more information on community selection and funding decisions, see the Needs Assessment section III (p. 46 - 50).
[43] Harding, K., Reid, R., Oshana, D., & Holton, J., (April 2004). Initial results of the HFA implementation study. National Center on Child Abuse Prevention Research, Prevent Child Abuse America: Chicago, IL.

opportunity to provide trainings across all four models, creating a common language for home visitors, and ultimately, a common experience of home visiting for participant parents, regardless of the home visiting model in which they are enrolled.

All MIECHV program staff will be trained in the Strengthening Families framework to understand the importance of building protective factors. In collaboration with a 'Think Tank' of stakeholders in other home visiting models, the MIECHV Initiative will develop home visiting skills through competency assessments in the field for supervisors to use in guiding and teaching staff and supporting transfer of learning. The resulting trainings will be available in a classroom or online format to support the efficient use of classroom time and match the training content (knowledge vs. skills based) to the best format.

Home visitors can also benefit from meeting and learning from their peers. In year one, the MIECHV Initiative will partner with the Children's Trust Fund (CTF) to expand HFM's Home Visiting Network. The Network will convene home visitors from the MIECHV programs and, over time, non-evidence based home visiting programs to network and enhance home visiting skills through training, technical assistance, and sharing of best practices. Lastly in year one, the MIECHV Initiative will develop a home visitor track within CTF's *A View from All Sides* conference for early childhood professionals. The result will be a well-developed and coordinated professional development system for home visitors across the various models and programs operating in the state.

Supervision is also a key component of program quality, directly linked to participant outcomes; home visitors who receive quality supervision have participants who stay engaged in program services longer[44]. For this reason, the MIECHV Initiative will work with the CTF to expand HFM's intensive training and support infrastructure for all supervisors to all MIECHV program supervisors. This infrastructure includes a Supervisor Support Forum (SSF), which brings together supervisors regionally, three times a year, to share best practices, and have a direct link to HFM program administrators. Expanding the Support Forums will provide opportunities for networking, development of common knowledge and best practices across home visiting models, and improve supervisor retention and reduce burnout by providing peer support.

Objective 2.3: *Develop program strategies to outreach, enroll, and retain vulnerable families including first time parents, families involved with the child welfare system, families whose primary home language is not English, recent immigrants, homeless families, rural families, underserved populations, and low income families by the end of year one. Support promising approaches that target specific populations by the end of year two*

Although outcomes for women, infants and children in Massachusetts compare favorably with those of United States, health disparities persist. According to the MIECHV 2010 Needs Assessment, populations of highest need in Massachusetts include homeless families, families with substance use disorders, children at risk for neglect or maltreatment, families whose primary language is not English, including immigrants and families in rural communities.

In year one, the MIECHV Initiative will support home visiting programs' reach and retain the most vulnerable families in their community. Strategies will include providing technical assistance, cultural competency training, and training on strengths-based family engagement practices. The MIECHV Initiative will strengthen provider networks to foster outreach to vulnerable families and to create a seamless system of referral and resource sharing. Beginning in year one, MIECHV will obtain a data sharing agreement with the Department of Children and Families (DCF) and establish a primary contact

[44] McGuigan, W.M., Katzev, A.R., & Pratt, C.C. (2003). Multi-Level Determinants of Retention in a Home Visiting Child Abuse Prevention Program. *Child Abuse and Neglect*, 27: 363-380.

person at each DCF office to enhance collaboration between DCF and MIECHV programs to meet the needs of children at risk for neglect or maltreatment.

In year one, the MIECHV Initiative will expand home visiting capacity in rural communities as three of the 17 highest need communities are rural communities (Pittsfield, North Adams, Southbridge). While less than 2 % of families in Massachusetts live in rural communities, these areas have significant, undetected needs. The three rural communities have demonstrated high need in several risk categories. They have the third and fourth highest rates of child abuse and neglect, the second and fourth highest rates of smoking during pregnancy, the fourth highest rate of women receiving less than adequate prenatal care, the fourth highest rate of unintentional child injury, and the fifth highest teen birth rate in the state.

In year two, MIECHV will look to support promising approach program implementation and/or evaluations for models that specifically serve vulnerable populations.

Objective 2.4: *Support communities in developing formal and informal linkages across agencies to avoid duplication, enhance coordination of care, and ensure a seamless system of identification and management by the end of year one*

One of the goals of the MIECHV Initiative is to enhance collaboration between provider organizations. Agencies will avoid duplication, coordinate referral networks, and build an integrated early childhood system of care through a) networking and exchanging information for mutual benefit, b) coordinating and aligning activities to achieve a common purpose, c) cooperating and sharing resources to achieve a common purpose and promote care coordination to the greatest extend possible, and/or d) collaborating and enhancing the capacity of other agencies to achieve a common purpose. To this end, the MIECHV Initiative will require all community-based agencies expanding home visiting services to enhance their already existing maternal, infant, and early childhood Advisory Councils. Maintaining, sustaining and developing Advisory Councils will be specified in contractual agreements with the lead community-based MIECHV agency.

At present, all communities within the MIECHV Initiative are required to have Advisory Councils to provide referrals and linkages and to ensure that the programs are up-to-date on community issues, needs, and interests. These Advisory Councils actively collaborate with other home visiting and family support providers for young parents in their catchment area to ensure that services are coordinated and non-duplicative.

The MIECHV Initiative will use these existing Advisory Councils as a springboard for enhancing and ensuring a seamless system of identification, referrals and management for high-risk prenatal to age eight families. A referral clearinghouse function will be integrated into the operations of each Advisory Council; the Initiative will provide technical assistance and training to support this enhancement, drawing on FIRSTLink as a key component (description in Goal 3).

Advisory Councils will work collaboratively with existing early childhood councils, such as the Department of Early Education and Care's (EEC) Coordinated Family and Community Engagement Grantee Councils. Advisory Councils will provide access to resources, including the EEC Professional Development Registry, to all providers working with children from birth through eight; this will encourage cross-systems training on common early childhood and family topics that address related core competencies. Data sharing from the local Councils will be incorporated into the EEC Early Childhood Information System (ECIS) to assist the Board of Early Education and Care (same entity as the MA State Advisory Council) in evaluating services and needs on a continuous basis.

Ultimately, the MIECHV Initiative will support Advisory Councils in becoming the locus of community-wide planning and integration for early childhood programs through networking, coordinating, cooperating, and collaborating.

Objective 2.5: *Enhance capacity to collect, analyze and report on MIECHV program data by the end of year one*

The MIECHV Initiative will enhance its data collection, analysis, and reporting capacity by the end of year one. To ensure high-quality data collection, the MIECHV Initiative will collaborate with the

Children's Trust Fund (CTF) to modify the Participant Data System (PDS) database to meet the reporting requirements on federally mandated benchmarks. MIECHV will seek input from both local programs and model developers to ensure fidelity to the model. CTF will provide training on the PDS database at the community level, including training all MIECHV home visitors on data collection, entry, and monitoring, issuing and updating the PDS Users Manual and providing on-site technical assistance.

Collaboration with EEC will further enhance data collection capacity. MIECHV will share data with the EEC's Early Childhood Information System (ECIS), and the two programs will work to develop the use of parental consent to support universal screening as part of Massachusetts FIRSTLink, as mentioned below in Goal 3. To facilitate data collection on-site and reduce input error, all home visitors will be provided with security-encrypted iPads or laptops. This upgrade will allow staff to access PDS during visits to record information on program activities. The enhancements in gathering data on service utilization, parent and child demographics, and other indicators will allow the MIECHV Initiative to produce more relevant data analyses. In conjunction with CTF, the MIECHV will issue data reports on all expanded programs multiple times a year. Regular meetings with the home visiting model agencies will inform data reporting, as MIECHV will be responsive to communities' data needs. The MIECHV Initiative will provide annual reports to Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF) as required.

Objective 2.6: *Promote inclusion of fathers among program participants by the end of year two*

Fathers play a key role in the lives of their children. Studies show that children with involved fathers grow up to be more emotionally intelligent and socially successful, have higher verbal abilities, are more intellectually advanced if their fathers play with them, and have lower levels of child neglect.[45] [46] Home visitors can play a key role in building healthy relationships skills to strengthen fathers' involvement with their children.

The MIECHV Initiative will build upon existing state efforts to involve fathers in years one through four. The MIECHV Initiative will provide training, technical assistance, materials, and support programs to increase father involvement. The CTF's Father and Family Network and Early Head Start's Good Guys program are two examples of existing successful programs that will be used to enhance MIECHV programs' capacity to support fathers in home visiting, co-parenting, and healthy relationships skills-building.

In addition, current practice knowledge will be leveraged to develop home visit and groups-based content on co-parenting, to be offered to all participants receiving services through the MIECHV Initiative. Healthy relationships skills will be developed by offering participants the New Child Project (described in Objective 1.6) curriculum, designed to support expectant mothers and fathers as they make the transition from couples to parents. The MIECHV Initiative will review and incorporate other appropriate healthy relationships skills building models, such as Building Strong Families.

Objective 2.7: *Evaluation: 1) Conduct cross-site implementation study of MIECHV Initiative, using findings to inform and improve program effectiveness by year four. 2) Use findings from MHFE-2 EC longitudinal study to inform and improve program practices at the agency and system-wide levels by year four.* Please see *Section 6. Evaluation and Technical Support* for information for proposed evaluation.

Goal 3: Build and enhance a statewide system of care for families and young children (Priority Elements 4 and 8)

[45] Cowan, C.P., Cowan, P.A., Cohen, N., Pruett, M.K., & Pruett. K. (2008). Supporting fathers' involvement with kids. In Jill Duerr Berrick and Neil Gilbert (Eds.). *Raising Children: Emerging needs, modern risks, and social responses*. (pp. 44-80). New York: Oxford University Press. &
[46] Cowan, P.A., Cowan, C. P., Pruett, M. K., & Pruett, K.D., & Wong, J. (2009). Promoting fathers' engagement with children: Preventive interventions for low-income families. *Journal of Marriage and the Family, 71, 663-679.*

Objective 3.1: *Develop and expand Central Intake System (Massachusetts FIRSTLink) to identify and screen all women giving birth in the 17 highest-need communities by year four. Starting in year two, build on FIRSTLink to include referrals for families with children 0 – 8 years through early education and care programs, elementary schools, community health centers, and other local resources*

During year one, the MIECHV Initiative will reestablish the Massachusetts FIRSTLink centralized intake program within the 17 identified highest-need communities. The goal of the FIRSTLink program will be to screen and connect families, regardless of the presence or absence of risk factors at birth, to necessary services. The FIRSTLink program will have two key components: 1) the universal offer of a one-time home visit to all women giving birth in the 17 highest need communities, and 2) linkage of families to any needed services or resources within their community.

The FIRSTLink program will be housed the Department of Public Health (DPH) and will closely collaborate with birth hospitals and the Office of Vital Statistics to receive the names and contact information of all women giving birth in the 17 highest-need communities. DPH will provide birth hospitals in the 17 communities with an orientation and give technical assistance to obtain parental consent; consent will be recorded in the electronic birth certificate (EBC). As birth certificates are submitted and updated daily by birth hospitals, the EBC will act as a natural screening mechanism for referring families to necessary services. For instance, if a newborn has an identified risk for developmental delay, the infant will be referred to Early Intervention, and if the mother is identified as a teen, she will be referred to Healthy Families Massachusetts. Consenting families without specific risk factors will be assigned a home visitor who will contact each family and offer a voluntary one-time home visit. The one-time visit will serve as a screening and provide a brief assessment of family needs. If consent is not documented on the EBC, the DPH FIRSTLink coordinator will send a letter and make a phone call to inquire about the families' interest in a home visit.

All families who have a one-time home visit will receive a new parent bag, developed by the DPH's New Parent Initiative. The new parent bag will contain a swaddling blanket with instructions, information on safe sleep, a children's book, a rattle, a CD with soothing music, a New Parent brochure, and a pamphlet on key questions to ask the parent's provider about maternal and child health. Research shows that parents who receive goods and services that they find valuable are more likely to remain engaged in the program. [47][48][49] Program evaluation has demonstrated that these bags are well-received by parents, and may contribute to retention in the program[50].

Over the course of the four-year grant, MIECHV will integrate FIRSTLink, with assistance from the MA211 referral line, into the larger early childhood and family support system. For families with children birth through age eight, FIRSTLink will be built to include referrals and access to the larger spectrum of services, including early education within the mixed delivery systems, elementary schools, community health centers, child maltreatment and injury prevention, home safety materials , parenting education programs, and family resource centers for applicant families on waitlists for one or more identified service(s).

Objective 3.2: *Integrate the Massachusetts MIECHV Initiative into other maternal, infant, and early childhood programs to strengthen and ensure access for families to statewide systems of early childhood development, family support and engagement by year one*

Massachusetts' early childhood system of care includes a number of well-established state and local initiatives that focus on ensuring that all children are emotionally healthy, ready for school, and nurtured to develop their full potential. Several initiatives work to develop collaborations across state

[47] Damashek, A., Doughty, D., Ware, L, and Silovsky, J. (2011).

[48] Predictors of client engagement and attrition in home-based child maltreatment prevention services. *Child Maltreatment, 16,* 9-20.; McCurdy, K., & Daro, D. (2001).

[49] Parent involvement in family support programs: An integrated theory. *Family Relations, 50*, 113-121.)

[50] MNPI Project Evaluation, Boston University School of Public Health, 2011

systems and programs to reduce gaps and avoid duplication of services, but no single program has been effective statewide. Starting in year one, MIECHV will integrate with these initiatives on a systems level through collaborative partnerships. On a local level, the MIECHV Initiative will support incorporation through membership in the community Advisory Councils and will encourage formal collaborative agreements or memoranda of understanding (MOUs). MIECHV partnerships at the state and local level will include: 1) Massachusetts Early Childhood Comprehensive Systems Project (MECCS); 2) Children's Behavioral Health Initiative (CBHI); 3) State and local substance use treatment programs and providers; 4) Early Intervention; 5) Department of Early Education and Care (EEC) initiatives including: State Advisory Council, Coordinated Family and Community Engagement Grants (CFCE), Early Childhood Mental Health Grants, Help Me Grow, Early Childhood Information System (ECIS), MA211 Referral System, Integrated Birth Through Grade 3 System Development, Strengthening Families and Head Start State Collaboration Office.

Objective 3.3: *Leverage the MIECHV Initiative's resources and visibility to strengthen cross-systems tools and standards to enhance services and ensure that supports for children and their families are coordinated within and across the early childhood system. Support continued collaboration with key organizations, civic partners, and stakeholders at the state and community levels, including sister state agencies by the end of year one*

To strengthen the Commonwealth's early childhood system, the MIECHV Initiative, in collaboration with other early childhood and family support initiatives, will promote the following statewide practices in year one: 1) Assure that protocols for early identification and effective response for the full range of developmental issues are in place, 2) promote the universal incorporation of the Strengthening Families framework into maternal, infant, early childhood, and family support programs across the state, and 3) support the enhancement of the MA211, an easy-to-use, readily accessible, well-maintained referral line and electronic database of community resources. The MA211 clearinghouse will provide materials that are easy to read and translated into multiple languages. For families who want to enroll their children in early education and care programs, MIECHV and MA211 will facilitate access to a mixed delivery system of early education and care experiences, including Head Start and public preschools. Finally, MIECHV and MA211 will provide support for children identified as needing assessment for determination of special needs by linking with their local Lead Education Agency/school.

Objective 3.4: *Support continued collaboration and communication streams with key organizations, civic partners, and stakeholders at the state and community levels by year one*

The MIECHV Initiative has consistently engaged community stakeholders at every stage of the program planning process. Beginning with the MIECHV Needs Assessment in 2010, MIECHV held three public listening sessions, conducted a home visiting program survey, and hosted a full-day home visiting program summit. The MIECHV Initiative engaged community stakeholders in the Updated State Plan by conducting a community survey of providers who work in the 17 highest-need communities, which yielded over 400 responses. The MIECHV Initiative also hosted a community forum that brought together representatives from the 17 communities to discuss community readiness to expand home visiting and enhance statewide early childhood systems of care.

From year one through year four, MIECHV Initiative will engage with home visiting model representatives, local providers, community leaders, and the home visiting lead agencies in each of the identified communities to enhance the statewide early childhood system. MIECHV will also provide training, technical assistance, and guidance to lead agencies on integrating the home visiting program into a broader system of early childhood care.

Lastly, the MIECHV Initiative will use social marketing materials to ensure that families receive clear and consistent messages, and are aware of 1) the importance of the early childhood period, 2) the support that is available to families with young children, and 3) the fact that early childhood development leads to success in later learning and in the workforce.

Objective 3.5: *Establish a long-term governance structure and sustainability through transition of the MIECHV Task Force to an existing leadership entity, and develop fiscal leveraging strategies to ensure program sustainability by year one and continuing through year four*

In 2008, Governor Patrick's Executive Order #505 set out four core principles for inter-agency collaboration and leadership: 1) each child deserves the best possible opportunity, 2) education and development occur in families, neighborhoods, communities, schools and in the broader society, 3) services, programs and delivery systems must collectively address the needs of the whole child and his/her family, and 4) accomplishing this will depend upon a consistent, efficient and effective coordination of effort among governmental agencies.

The MIECHV Initiative, in year one, will build on the Governor's principles through the collaborative work of the Home Visiting Workgroup and Task Force, vital bodies of the MIECHV Initiative. The MIECHV Workgroup and Task Force are compromised of the following state agencies: Children's Trust Fund (CTF): Title II of CAPTA, Department of Children and Families (DCF): the state child protective agency, Department of Early Education and Care (EEC); including Head Start Collaboration Office, Department of Public Health (DPH): including Title V, and Bureau of Substance Abuse Services (BSAS), Department of Transitional Assistance (DTA): the state welfare agency state, Executive Office of Education, Executive Office of Health and Human Services, MassHealth: the state Medicaid agency and Head Start Association.

The Task Force, chaired by the Medical Director of DPH and the Commissioner of EEC, will provide guidance for implementing the MIECHV Initiative as well as ensure the program is integrated into the work of member agencies. The Workgroup will align best practice standards and strategies, coordinate professional development across disciplines, and address gaps within existing service systems to facilitate referrals.

While the MIECHV Task Force will continue to function as the governing body for this collaborative in year one, during the project's second year of implementation, the Task Force will work to identify an existing leadership entity to assume the role of governance of the MIECHV Project. This transition will take place in order to avoid duplication of leadership roles and service provisions, provide long-term oversight, and leverage state resources for fiscal sustainability. One existing group that the Task Force will consider for this leadership role is the State Advisory Council[51]. The Task Force will ensure that family and stakeholders are included in decision making and governance.

Finally, the MIECHV Initiative will develop fiscal leveraging strategies to sustain the MIECHV Initiative over the long term by expanding on existing public/private partnerships, Medicaid, and state funding streams. The MIECHV Initiative will work with public and private insurers to define and develop reimbursable services such as those provided by a nurse, clinical social worker, or mental health clinician. The MIECHV Initiative will explore how to maximize and redirect funding to support cross-systems professional development in areas of competency such as Strengthening Families, CSEFEL Pyramid model on positive behavior support, and offerings by the Educator Provider Support Grantees at EEC.

Objective 3.6: *Use cross-system data and community service context analyses to build statewide systems of care and to evaluate the MIECHV Initiative's impact on enhancing statewide systems by year four*

The MIECHV Initiative will collect and share data, starting in year one and continuing through year four, with partnering state agencies to evaluate the MIECHV Initiative's impact on developing a comprehensive system of care. Specific data sharing activities will include: 1) EEC to incorporate MIECHV data elements into the Early Childhood Information System (ECIS), currently under development. The core elements of the ECIS include family engagement, child development screening

[51] The State Advisory Council is responsible for leading the enhancement of a high-quality, comprehensive system of early childhood development and care that ensures statewide coordination and collaboration among the range of programs in the State including: child care, Head Start, IDEA preschool and infants and families programs, and pre-kindergarten programs. The State Advisory Council is designated by the Governor, as required in the Improving Head Start for School Readiness Act of 2007.

and assessment data, inter-agency data sharing, strength and risk analyses, and communication. 2) Link MIECHV Initiative data with the Open Indicators Consortium (OIC). The mission of the OIC is to enable data visualization of available data anywhere by anyone for any purpose (under administrative and user controls). Through this partnership, OIC will continue to link MIECHV data with WEAVE technology through an existing partnership with UMass Lowell. Using this technology, MIECHV will incorporate outcomes data from program implementation into visualizations available on the state's website. This information will be available to state partners as well as the MIECHV grantees and the community at large. 3) Link MIECHV data into the Massachusetts Pregnancy to Early Life Longitudinal (PELL) Data system. The core PELL data set includes birth certificate and fetal death reports linked to the delivery-related hospital discharge records for both mother and infant. This core linkage is longitudinally linked to statewide programmatic and surveillance datasets, including EI, WIC, the Birth Defects Registry, other public health programs, pre- and post-birth/delivery hospitalizations, observational stay visits, and emergency room records for mother and child. Linking MIECHV to PELL will provide information on long-term health outcomes for program participants.

Finally, the MIECHV Initiative, starting in year one, will work with Tufts University to develop community service context analyses to evaluate the MIECHV Initiative's impact on enhancing statewide systems of care. The MIECHV Initiative will look to understand the impact of the MIECHV on assisting in the development of a more integrated system of care. Please see *Section 6. Evaluation* for more details.

4. WORKPLAN

KEY: ASQ= Ages and Stages Questionnaire; **ASQ-SE=** Ages and Stages Questionnaire: Social/Emotional; **BSAS=** Bureau of Substance Abuse Services; **CBHI=** Child Behavioral Health Initiative; **CFEG=** Community Family Engagement Grantee; **CTF**= Children's Trust Fund; **CYSHCN**= Children and Youth with Special Health Care Needs; **DPH**= Department of Public Health; **DCF**= Department of Children and Families; **DTA**= Department of Transitional Assistance; **ECIS=** Early Childhood Information System; **EEC**= Department of Early Education and Care; **EHS**= Early Head Start; **EOE=** Executive Office of Education; **EOHHS=** Executive Office of Health and Human Services; **FL**= FIRSTLink; ; **FLC=** FIRSTLink Coordinator; **HFM**= Healthy Families Massachusetts; **HMG=** Help Me Grow; **HS**= Healthy Steps; **IH-CBT=** In-Home Cognitive Behavioral Therapy; **MECCS**= Massachusetts Early Childhood Comprehensive System; **MIECHVI=** Maternal, Infant, and Early Childhood Home Visiting Initiative; **MIECHVP**= Maternal, Infant, and Early Childhood Home Visiting Programs (at the community level); **MIECHVTF=** Maternal, Infant, and Early Childhood Home Visiting Task Force; **MIECHVWG=** Maternal, Infant, and Early Childhood Home Visiting Work Group; **MH**= MassHealth; **NCAST=** Nursing Child Assessment Satellite Training; **NCP=** New Child Project; **OIC=** Open Indicators Consortium; **PAT**= Parents as Teachers; **PELL=** Pregnancy to Early Life Longitudinal **PS**= Project Supervisor; **SBIRT=** Screening, Brief Intervention, Referral to Treatment; **TU**= Tufts University

Goal 1: Strengthen and improve the programs and activities carried out under State Title V Agency.

Objective 1.1: *Align Massachusetts Maternal, Infant and Early Childhood Home Visiting (MIECHV) Initiative with State Title V priorities by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Provide MIECHV staff information on State Title V priorities to align with MIECHV priorities	X	X	X	X	MIECHVI, MIECHVP
Seek technical assistance and training from DPH Title V programs on women's health, social/emotional wellness, healthy weight, violence & injury prevention, medical home, CYSHCN programs and data capacity	X	X	X	X	MIECHVI, DPH

Objective 1.2: *Promote medical and dental homes for MIECHV program participants by linking to a coordinated system of health care by end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Provide training for all MIECVP on the concept of medical home	X	X	X	X	MIECHVI, DPH
Connect families to medical and dental homes	X	X	X	X	MIECHVP
Build and enhance the medical home/home visiting collaborative partnership through two Healthy Steps models and replicate in all MIECHVP	X	X	X	X	MIECHVP, HS

Objective 1.3: *Strengthen program capacity to screen, assess, and provide support for families experiencing mental health stresses and social isolation by end of year two.*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Train all MIECHV staff to screen, respond, assess and refer for mental health issues	X	X	X	X	MIECHVI MIECHVP
Provide IH-CBT to all MIECHV participants who are experiencing mild to severe depression	X	X	X	X	MIECHVI, MIECHVP, IH-CBT
Establish Parents Together social support group models parent support groups in all MIECHVP communities to reduce social isolation and foster resilience through peer support	X	X	X	X	MIECHVI, MIECHVP, CTF
Collect and analyze federally mandated benchmark data on maternal depression	X	X	X	X	MIECHVP, CTF, DPH, TU

Objective 1.4: *Enhance capacity of MIECHV programs to improve maternal and child health by including a nurse as a standard component of the evidence-based home visiting model being implemented by the end of year two*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Develop a nursing component (either per site or on a regional basis) to all MIECHV programs to improve maternal and child health outcomes		X	X	X	MIECHVI, MIECHVP, DPH, CTF
Hire or contract nurses to participate in MIECHVP home visiting teams in 17 communities		X	X	X	MIECHVP
Collect and analyze benchmark data on maternal, infant and child health outcomes	X	X	X	X	MIECHVP MIECHVI CTF, TU

Objective 1.5: *Integrate and enhance screening, assessment and/or referrals for home safety, child development, substance use, and family violence into all MIECHV programs by end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Provide on-going training on screening, assessment and response for home safety to reduce unintentional injuries	X	X	X	X	MEICHVI MIECHVP, CTF, DPH
Provide on-going trainings on child development screening, assessment and referrals using ASQ and ASQ:SE to improve linkage to early childhood services	X	X	X	X	MEICHVI MIECHVP, CTF, DPH, EEC
Provide training on use of SBIRT to screen, provide brief intervention and refer to reduce unhealthy substance use and decrease risk of FASD	X	X	X	X	MEICHVI MIECHVP, CTF, DPH
Provide training in trauma informed care and screening and response for family violence to improve identification of families experiencing violence and ensure linkage to community services	X	X	X	X	MEICHVI MIECHVP, CTF, DPH
Collect and analyze benchmark data on injuries, ER use, child development, substance use, tobacco cessation, and domestic violence	X	X	X	X	MIECHVP, CTF, DPH, TU

Objective 1.6: *Integrate education and support on preconception care, breastfeeding, nurturing care giving into all MIECHV programs by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Train MIECHV staff in providing preconception care including developing reproductive health plans and linking with primary care to receive comprehensive preventive health services	X	X	X	X	MIECHVI, DPH, CTF
Support breastfeeding through increasing awareness, linking with peer mentors, and providing immediate postpartum breastfeeding support with by nurse	X	X	X	X	MIECHVI MIECHVP, CTF DPH
Provide initial and on-going training in New Child Project (NCP) to all MIECHV programs to support healthy relationships and positive parenting	X	X	X		MIECHVI, DPH, NCP
Provide on-going training to all MIECHV providers on the NCAST screening tool	X	X	X	X	MIECHVI, MIECHVP, CTF
Collect and analyze benchmark data on reproductive life planning, breast feeding, positive parenting, literacy, and child development using the ASQ-SE	X	X	X	X	MIECHVP, CTF, DPH, TU

Goal 2: Identify and provide comprehensive evidence-based home visiting services and improve the coordination of services for families from prenatal through age 8 to improve outcomes for families in high-need communities.

Objective 2.1: *Support diverse evidence-based home visiting models at the community level in 12 additional high-need communities by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Expand evidence-base home visiting in all high-need communities by increasing funding to 5 MIECHVP funded through formula grant and funding an additional 12 communities	X	X	X	X	MIECHVI, DPH, MIECHVP, HFM, EHS, PAT, HS
Collect benchmark data from all 17 communities	X	X	X	X	MIECHVP, CTF, DPH

Objective 2.2: *Expand training and high-quality supervision for MIECHV Program staff in year one with additional training continuing throughout the project, including training in interventions in the Strengthening Families framework*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Increase advanced training and core competency training for all MIECHV programs	X	X	X	X	MIECHVP, CTF, HFM, EHS, PAT, HS
Provide training on Strengthening Families framework to all MIECHV home visiting	X	X	X	X	MIECHVP, CTF, HFM, EHS, PAT, HS
Expand HFM Home visiting network to include all evidence-based programs to network and enhance skills through training, technical assistance and shared best practices	X	X	X	X	MIECHV, CTF, HFM, EHS, PAT, HS
Include a home visitor track within CTF's annual conference for early childhood professionals, *A View from All Sides* to enhance professional development	X	X	X	X	MIECHVI, CTF
Develop skills competency assessments in the field for supervisors to use in guiding and teaching staff and supporting transfer of learning.	X	X	X	X	MIECHVP, CTF, HFM, EHS, PAT, HS

Objective 2.3: *Develop program strategies to outreach, enroll, and retain vulnerable families by the end of year one. Support promising approaches that target specific populations by the end of year two*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Provide technical assistance, cultural competency training, and opportunities to enhance provider networks to foster outreach	X	X	X	X	MEICHVI, CTF
Incorporate and monitor compliance with CLAS standards in all MIECHVP Contracts	X	X	X	X	MIECHVI, DPH

Activity	***Timeframe***				***Responsible Staff***
Link data systems with the Department of Children and Families (DCF) to better integrate services and serve families within child welfare system	X	X	X	X	MEICHVI, DPH, DCF, CTF
Establish a primary contact person at each DCF office to enhance collaboration and services between DCF and MIECHVP	X	X	X	X	MEICHVI, DCF
Expand home visiting services in rural communities (3 of the 17 highest-need communities are in rural areas)	X	X	X	X	MEICHVI, MIECHVP
Expand or support promising approaches that reach at risk populations including military families, substance using families, and/or homeless families		X	X	X	MIECHVI, MIECVHP

Objective 2.4: *Support communities in developing informal and formal linkages across agencies to avoid duplication, enhance coordination of care, and ensure a seamless system of identification and management by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Strengthen maternal, infant, and early childhood Advisory Councils in all 17 communities;	X	X	X	X	MIECHVI, MIECHVP, DPH, CTF, EEC,
Establish contractual requirement with MIECHP lead agencies for having Advisory	X	X	X	X	MIECHVI, MIECHVP, DPH, CTF, EEC

Objective 2.5: *Enhance capacity to collect, analyze and report on MIECHV program data by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Expand Participant Data System (PDS) to capture all federally required benchmarks and measures	X				MIECHVI, MIECHVP, CTF, TU
Provide training and on-going TA to all MIECHV home visitors on data collection, entry, and monitoring	X	X	X	X	MIECHVI, MIECHVP, CTF, TU
Share data with the EEC's Early Childhood Information System (ECIS)	X	X	X	X	MIECHVI, EEC, DPH, CTF, DCF
Develop the use of standard parental consent to support universal screening for FIRSTLink	X	X	X	X	MIECHVI, DPH, EEC
Provide all home visitors with security-encrypted iPads or laptops to reduce data error. Provide training on for providers on data entry on iPad or laptop.	X	X	X	X	MIECHVI, CTF, DPH, MIECHVP

Objective 2.6: *Promote inclusion of fathers among program participants by the end of year two*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Build on the existing state efforts of the CTF's Father and Family Network to enhance MIECHV programs' capacity to support fathers in home visiting, co-parenting, and healthy relationships skills-building.	X	X	X	X	MIECHVI, CTF
Using New Child Project, provide training, TA, and materials development on working with fathers/other primary caregivers, co-parenting, healthy relationships, and positive parenting	X	X	X	X	MIECHVP, CTF

Objective 2.7: *Conduct cross-site implementation evaluation of MIECHV Initiative, and longitudinal follow-up study of the randomized, controlled trial of the Healthy Families Massachusetts program, using findings from both to improve program effectiveness agency and system-wide levels by year four*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Conduct cross-site implementation evaluation of the MIECHV Initiative in order to: 1) measure and monitor program operations; 2) determine the extent to which programs are operating as intended at the agency- and system-wide- levels; 3) generate information needed for improving program practices.	X	X	X	X	TU
Conduct longitudinal study of current Healthy Families MA parents (20 and younger) to understand long-term impact of home visiting, and inform implementation and evaluation of MIECHV Initiative.	X	X	X	X	TU

Goal 3: Build and enhance a statewide system of care for families and young children

Objective 3.1: *Develop and expand Central Intake System (Massachusetts FIRSTLink) to identify and screen all women giving birth in 17 highest-need communities by the end of year four. Starting in year two, build on FIRSTLink to include referrals for families with children 0 – 8 years through early education and care programs, elementary schools, community health centers, and other local resources*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Collaborate with birth hospitals and partner state agencies to establish the centralized in-take system in MA, and develop the universal one-time home visit component (**Massachusetts FIRSTLink**)	X				MIECHVI, MIECHVP, DPH, FL
Provide initial and on-going training for hospital staff and community lead agency staff on FIRSTLink system, protocols, and procedures	X	X	X	X	FL, FLC

Activity	***Timeframe***				***Responsible Staff***
Implement FIRSTLink in 17 identified communities	X	X	X	X	MIECHVI, MIECHVP, DPH, FL
Integrate FIRSTLink into larger early childhood system, developing referral mechanisms into FL from elementary schools, community health centers, child welfare agencies, family resource centers etc.		X	X	X	MIECHVI, MIECHVP, DPH, CTF, EEC, DTA, DCF, HMG

Objective 3.2: *Integrate the Massachusetts MIECHV Initiative into other maternal, infant, and early childhood programs to strengthen and ensure access for families to statewide systems of early childhood development, family support and engagement by year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Integrate MIECHV into early childhood initiatives (see Methodology) on: 1) a statewide level through state agency collaborative partnerships or MOUs, and 2) on a community level through the MIECHV Advisory Councils	X	X	X	X	MIECHVI, MIECHVP, EEC, DPH, DTA, DCF, CTF, MH, CBHI

Objective 3.3: *Leverage the MIECHV Initiative's resources and visibility to strengthen cross systems tools and standards to enhance services and ensure that supports for children and their families are coordinated within and across the early childhood system. Support continued collaboration with key organizations, civic partners, and stakeholders at the state and community levels including sister state agencies by the end of year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Partner with Community Family Engagement Grantees and Help Me Grow program to promote the statewide use of ASQ for parent education and child development screenings	X	X	X	X	MIECHVI, MIECHVP, EEC, DPH, CTF, HMG
Partner with Community Family Engagement Grantees and Help Me Grow program to promote common standards of practice and assessment tools across early childhood continuum, particularly Strengthening Families and CSEFEL Pyramid Model of positive behavior support	X	X	X	X	MIECHVI, MIECHVP, EEC, DPH, CTF, HMG
Partner with HMG and Local Education Agencies, in MOU development for local governance structures to support the alignment of agencies to work together to enhance the continuum of services	X	X	X	X	MIECHVI, TF, EEC, HMG
Support EEC in enhancing the MA211 electronic database of resources for providers and families	X	X	X	X	MIECHVI, MIECHVP, EEC

Objective 3.4: *Support continued collaboration and communication streams with key organizations, civic partners, and stakeholders at the state and community levels by year one*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Continue engagement with community and local partners, including MA model representatives, local providers, and community leaders, including superintendents, mayoral offices, health departments, and other civic representatives, to build a larger system of care	X	X	X	X	MIECHVI, MIECHVP, MIECHVTF, MIECHVWG
Provide training, technical assistance, and guidance to all 17 MIECHV programs to maintain fidelity to the models, and build the MIECHV program	X	X	X	X	MIECHVI, MIECHVP, MIECHVWG
Use social marketing materials and MIECHV website to provide clear and consistent messages to public about the importance of early childhood	X	X	X	X	MIECHVI, EOE, EOHHS, EEC, DPH, CTF, DTA, DCF
Use MIECHV website to provide communities and families with relevant information, data, and resources	X	X	X	X	MIECHVI, DPH

Objective 3.5: *Establish long-term governance structure and sustainability through transition of the MIECHV Task Force to an existing leadership entity and development of fiscal leveraging strategies to ensure program sustainability by year one continuing work through year four*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Continue work of the MIECHV Task Force and Work Group	X	X	X	X	MIECHVI, MIECHVTF, MIECHVWG
Expand Task Force to include additional experts in the areas of maternal health, infant health, early childhood, and statewide systems building	X	X	X	X	MIECHVI, MIECHVTF
Task Force will work to identify an existing leadership entity to assume the role of governance of the MIECHV Project in the long term		X	X	X	MIECHVI, MIECHVTF
Support alignment of local governance structures to work together to enhance the continuum of services, including providing templates for Memorandums of Understanding (MOU) on referral systems, support on how to coordinate family transition, and assistance in usage of common terminology, language, curricula, and tools across system	X	X	X	X	MIECHVI, MIECHVTF, MIECHVWG
Develop fiscal leveraging strategies to ensure program sustainability by expanding on public/private partnership, Medicaid, and state funding streams	X	X	X	X	MIECHVI, CTF, IH-CBT, DPH, MH

Objective 3.6: *Use cross-system data and community service context analyses to build statewide systems of care and evaluate MIECHV Initiative impact on enhancing statewide systems by year four*

Activity	***Timeframe***				***Responsible Staff***
	Year 1	Year 2	Year 3	Year 4	
Collect and share data with partner state agencies and ECIS/ Open Indicators Consortium/PELL databases to be used in system development activities	X	X	X	X	MIECHVI, DPH, EEC, DTA, DCF, CTF, ECIS, OIC, PELL
Evaluate impact of MIECHV Initiative on enhancing statewide system of care	X	X	X	X	MIECHVI, TU

Implementation Plan

Plan to engage targeted communities

- Establish contracts with the high-need 17 communities for implementation of one or more evidence-based home visiting model currently in Massachusetts (Early Head Start, Healthy Steps, Health Families Massachusetts, Parents as Teachers)
- Conduct a day-long "Kick-Off" meeting with all contracted vendors to review and discuss program model implementation requirements and mechanisms, and develop a plan for full implementation with each community
- Implement quarterly meetings and/or include MIECHV in currently scheduled meetings with contracted vendors for ongoing support and technical assistance in person/on site
- Establish a primary contact person at each DCF office to enhance collaboration and services between DCF and MIECHV programs
- Develop FIRSTLink protocols with hospitals, lead agencies, and partnering state agencies.

Plan for monitoring, program assessment and support, and technical assistance

- Develop a policy manual and standards of care for each model being implemented, and/or assess current policy and standards of care. Support training and TA on policies and standards of care. Disseminate policy manuals and standards of care to contracted vendors
- Establish process for ongoing review and feedback loops between MIECHV Initiative and contracted vendors to support quality implementation
- Develop and require all contract vendors to adhere to MIECHV Quality Assurance Plan
- Follow-up with any contracted vendor requiring support and technical assistance in ensuring fidelity to model
- Require all programs to adhere to program policies regarding mandated reporting and safety of participants during the domestic violence screening process
- Assess, develop, and disseminate additional policies and standards required and/or recommended by the DPH, such as contract requirements specific to Community Health Workers

Plan for professional development and training

- Assess training and professional development requirements for each model implemented
- Provide training on priority screening/assessment tools and new program enhancements: SBIRT, Home Safety Assessment, ASQ, ASQ:SE, NCAST, NCP, Parents Together, and IH-CBT protocols
- Design and implement nurse component for all models
- Incorporate home visitor track or focus in existing annual conferences as appropriate
- Identify additional training requirements and needs specific to MA, including such topics as immigration law, MA health care reform options, etc.

- Implement training schedule on all required and recommended topics with contracted vendors including domestic violence, substance use, mental health, maternal/infant health, child development, positive parenting, school readiness, and family economic self sufficiency
- Align training with other key early childhood initiatives (such as CSEFEL Pyramid Model Family Modules and Strengthening Families Five Protective Factors) through common language and approaches to family support, child development, and positive behavioral support to maintain cohesion with MA's early childhood system of care
- When needed, establish contracts with expert trainers nationally or locally who are qualified to conduct trainings with contracted vendors on the use of materials and curriculum
- Assess staff training and professional development needs through evaluations and annual site visits
- Identify training space including a central location for statewide trainings and leverage existing space for shared networking sessions among contracted vendors to cultivate peer support
- Establish process to ensure that training and professional development opportunities are made available to all newly hired staff on an ongoing basis

Plan for staffing and subcontracting

- Monitor hiring of home visiting staff at contracted agencies through review of recruitment processes to ensure that national model standards are met
- Ensure that the recruitment plan for subcontractors is part of the general contracting agreement for all contracted agencies
- Assist in identifying opportunities for recruitment of professionals from identified educational, cultural, racial and linguistic venues (e.g. community-based newspaper published in Spanish, job fair at local college)
- Assess current staffing patterns at all contracted agencies
- Develop and implement a plan for ongoing supervision, training and professional development opportunities that will support staff retention
- Ensure and promote opportunities for a feedback loop that supports staff participation in the ongoing process of quality improvement

Plan for recruiting and retaining participants: Support each of the MIECHV programs/lead agencies in their specific recruiting and retention activities. Key recruiting and retention themes include:

- Regularly distribute promotional materials to all existing referral sources
- Update home visiting program materials to explain expanded program eligibility guidelines and program components
- Distribute flyers and information about the programs at local stores, farmers markets, WIC offices, health centers, community events, libraries, social service centers, daycare, schools, religious centers, and other community venues.
- Require that home visiting program representatives attend networking events, such as community resource fairs and events, to conduct outreach and raise the program profile
- Update the MIECHV website and agency websites to include program eligibility requirements and program components
- Leverage Advisory Councils to build membership across the maternal, infant, and early childhood spectrum to facilitate networking, referrals, resource sharing, and coordination
- Encourage lead agencies to visit schools, hospitals, clinics, community groups/community agencies for informational presentations
- Advertise in newspapers, local markets, and other areas; utilize mass mailings and email newsletters to local agencies and medical facilities
- Place phone calls and/or texts to referred families and call the referral source to collaborate on engaging the family and verifying contact information
- Provide information on program to telephone resource lines such as the Title V MCH line, the DPH community resource line, MA211, parent support line so they can refer families as appropriate

- Offer incentives such as child care and transportation to participants, whenever possible, to ensure appointment adherence
- Provide guidance and linkages to participants for career and educational-related opportunities
- Through home visitor staff training, ensure focus on positive reinforcement and modeling to help create successful relationships between home visitors and participants

Plan for Continuous Quality Improvement (CQI): The MIECHV Initiative's CQI approach, using the established Healthy Families Massachusetts CQI foundation, will regularly collect data to monitor program successes as well as document areas of improvement to address programmatic obstacles. The MIECHV Initiatives CQI plan approach consists of the following:

- Include all home visiting programs in a statewide orientation to review the statewide goals for an early childhood system of development based on goals established by the Governor
- Provide data orientation on benchmarks, constructs, and measures to set clear performance requirements and intended areas of improvement. Provide clear and concise information
- Expand the established HFM data system across all of the four selected home visiting models; bridge the gap between models that are familiar with the data system and those that are not
- Establish a universal protocol for reporting data to avoid confusion and/or duplication
- Report data in a timely on federally mandated benchmarks, constructs, and measures
- Report data relevant to program activities to provide insight into results and outcomes as well as areas of improvement for each specific program.
- Report performance measure change over time to enable year to year comparisons
- Analyze aggregated data to reflect statewide trends; provide aggregated data in easy-to-interpret language to enable information sharing
- Hold regular meetings to foster collaborative culture and avoid confusion or problems; incorporate feedback and implement changes as appropriate, including meetings on the new FIRSTLink system
- Provide technical assistance when needed to promote optimal program growth
- Establish regular communication with model developers and/or state contacts to monitor fidelity to the models and to address any impediments or challenges
- Maintain fidelity to the MIECHV Quality Assurance Plan
- Continue to encourage stakeholder participation including (but not limited to): senior staff at state agencies, boards, donors, and the state legislature

Plan to maintain fidelity to the models

- Maintain active communication with national model developers and state system offices for Early Head Start, Healthy Steps, Healthy Families, and Parents as Teachers
- Assess current protocols and tools utilized by MIECHVP for site visits with their respective vendors
- If needed, schedule an in-person meeting or conference call with national model developers to review implementation plan, identify technical assistance needs, and identify program contact person for on-going collaboration and support

Plan to collect data on legislatively-mandated benchmarks

- Expand electronic data collection system/participant data system (PDS) to include all mandated benchmarks
- Obtaining IRBs and data use agreements from state agencies to facilitate data/information sharing
- Ensure all MIECHV Initiative programs participate in training on data systems
- Maintain system of ongoing technical assistance and support to vendors

Plan to coordinate with appropriate entities/programs

- Support contracted vendors to participate in community initiatives whose focus is on MIEC services, such as: local child protection councils, teen parent provider coalitions, fathers support services, education and parenting skills centers, domestic violence roundtables, etc.
- Encourage contracted vendors to leverage their collaborative relationships to practice collective problem solving to address identified areas of community need

- Foster joint outreach and recruiting activities between the contracted vendors and other community groups
- Develop training for all contracted vendors on how to better ensure coordination among community-based programs
- Enhance the HMF Advisory Councils to build membership across the MIEC spectrum to facilitate networking, referral, resource sharing, service coordination
- Continue collaborative work of MIECHV Workgroup and Task Force

Description of how the proposed activities will fit into state administrative structure

The Massachusetts Department of Public Health, as the lead agency, will be responsible for ensuring the overall successful implementation of the MIECHV Initiative including: program development and implementation, contract management, data analysis and evaluation, and overall fiscal management. DPH will ensure that the MIECHV aligns with Title V priorities as well as coordinates with other DPH programs including WIC, EI, programs for Children and Youth with Special Healthcare Needs (CYSHCN) and multiple initiatives that focus on collaborating across state systems. Moreover, the Home Visiting Task Force and Workgroup, two cross-agency leadership groups that were first established in response to the initial Funding Opportunity Award, will continue to serve in an advisory role to the MIECHV Initiative, and support development and integration of the MIECHV Initiative into larger system of early childhood care.

Please see Attachment 5 – Project Organizational Chart for more information on the state administrative structure.

Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the MA Department of Public Health and other partners at the end of the grant

Collaboration among state agencies and programs is essential to achieve the desired outcomes and ensure the sustainability of the MIECHV Initiative. A strong partnership was established early to guide the Home Visiting Needs Assessment and the completion of the Updated State Plan, and will remain in place for ongoing program development, implementation, and evaluation. This partnership provides an opportunity to embed home visiting across multiple state agencies and to incorporate the project's goals, objectives, and activities into their ongoing work. Over the course of the grant, the MIECHV Initiative will seek creative ways to leverage additional state and federal support and to expand upon public/private partnerships, Medicaid, and other funding streams. To the extent possible, insurance reimbursement will be sought for nurses, groups, and other allowable expenses, and the MIECHV Initiative will strive to sustain its services to high need families beyond the four years of the grant.

SECTION 5. RESOLUTION OF CHALLENGES

While we are confident in the long-term success of this project, we anticipate challenges at the individual/family, lead agency, community, and state levels related to: 1) engaging and retaining vulnerable families, 2) integrating one or more evidence-based home visiting models into a singular program, 3) collaborating across state agencies at the community level to strengthen systems of care for prenatal – age eight families, 4) implementing the FIRSTLink centralized intake program, 5) sustaining a cross-agency governance structure for the MIECHV Initiative, 6) developing a unified data system to share information across state agencies, and 7) implementing a rigorous evaluation to build a body of knowledge on evidence-based practices.

At the individual and family level, we will develop an array of strategies to identify and engage vulnerable families. MIECHVP staff will raise awareness of the program through both informal and formal community connections, and by distributing printed promotional materials, leveraging social media, and hosting information sessions. Moreover, the FIRSTLink data system will generate lists of all women giving birth in our targeted communities and this information will enable us to connect with women who may not have engaged with services prenatally. Once engaged in a program, retaining

families can also be a challenge. To improve retention, MIECHVI will ensure that MIECHVP staff are linguistically and culturally competent, and provide services and supports that are truly valuable to families. As part of the FIRSTLink Universal one-time home visit, families will receive New Parent Bags with a range of resources and tools to support them as new parents. To track families that move frequently or change their phone numbers, MIECHVP will maintain updated contact information and utilize their network of community service providers to track all participants.

The MIECHV Initiative will address the challenge of integrating multiple evidence-based home visiting models by providing trainings across all models, creating a common language for home visitors, and ultimately, a common experience of home visiting for participant parents – regardless of the home visiting model in which they are enrolled. Staff from state agencies will also provide technical assistance to the lead agencies that choose to implement more than one model and assist them in identifying best practices that can be shared with others.

Effective collaboration and communication across state agencies can be challenging at both the state and community level. At the community level, disparate players may have different perspectives on priorities or approaches to community issues. Each agency operates from a different, categorical service perspective from which they address community problems (e.g. focus on housing, substance use, community violence, family income, etc.). To ensure that all community partners work together to strengthen prenatal – early childhood systems of care, the MIECHVI will require that community grantees to have Advisory Councils in place that actively collaborate with other local state agency providers in their area.

The MIECHV Initiative anticipates that the FIRSTLink Central Intake System using the electronic birth certificate will be a critical element of the entire program. However, in previous attempts at establishing this system, there were multiple challenges including: informing prenatal and hospital providers about the program, receiving written consent from families, tracking these consents, and providing a one-time universal home visit in a timely manner. For FIRSTLink to work well, MIECHVI will need to address each of these issues and provide on-going training and public awareness, develop a system of tracking consents between providers, lead agencies and DPH, and establishing a system for DPH staff to follow-up with families who do not have a recorded consent. DPH will work closely with community Advisory Councils and lead agencies to clarify protocols, develop a flow chart, and create a high-functioning data system to track births, consents and visits.

The cross-agency governance structure that was developed to complete the 2010 Massachusetts Home Visiting Needs Assessment and the Updated State Plan will remain in place to lead the MIECHV Initiative. The Task Force will meet quarterly or as needed to guide program development, planning, and evaluation. The Work Group will meet monthly, or more frequently as needed to oversee program implementation, training, technical assistance, and on-going support to lead agencies. In terms of data challenges, the MIECHVI will work across multiple state agencies including DPH, CTF, DCF, DEEC, MassHealth and DTA to ensure that data sharing agreements and IRB's are in place and that they allow for data sharing while ensuring participant privacy and protection. All of the state agencies represented are committed to working with their respective agencies to facilitate these agreements.

Lastly, the MIECHV Initiative anticipates challenges with the evaluation. Some programs may feel threatened at the very prospect of evaluation, while others may feel concerned that their challenges will be viewed as failures. The evaluators are committed to securing buy-in and understanding from participants, lead agencies, and communities from the start of the process. Furthermore, since we are including a longitudinal component of the evaluation, there is concern about participant retention to ensure statistical power. The evaluators plan to use incentives, social networking sites, drive-by visits, and frequent contacts to find and retain participants. In order to ensure that data is consistently maintained across program sites, the evaluators will provide technical assistance and work closely with the MIECHV Initiative to train, document, and adjust the Participant Data System, as needed.

SECTION 6. EVALUATION AND TECHNICAL SUPPORT CAPACITY

Evaluating the Maternal, Infant, and Early Childhood Home Visiting Initiative

Among the strategies and services aimed at supporting young, at-risk families, home visitation is one of the most broadly implemented. Information generated from the past several decades of research has greatly enhanced our understanding of the benefits that may result from this service. While considerable progress has been made in home visiting program development and implementation, significant areas of practice remain that require additional, targeted research. Calls for the next generation of home visiting evaluations clearly point in two complementary directions: on the one hand, the evidence-based practice that forms the core of the funding criteria for the Maternal, Infant, and Early Childhood Home Visiting Initiative (MIECHV) comes largely from findings generated from rigorously-implemented longitudinal studies;[52] judicious extension of this evidence base will help sustain attention, nationally, to this new area of federal involvement. On the other hand, states are at various stages in their development and implementation of their home visiting programs, and for those that are far enough along, federal funding encourages home visiting program expansion, adaptation, and innovation; implementation study of these newer models is critical for expanding the home visiting field and improving services for a broader range of families. The federal home visiting website highlights these two research trajectories.

The Home Visiting Evaluation of Massachusetts (HVEM) will comprise two evaluation components that reflect these research trajectories: 1) a longitudinal follow-up study of participants from a randomized, controlled trial of Healthy Families Massachusetts, with a focus on families' navigation of early childhood systems of care; and 2) a cross-site implementation study of the Massachusetts MIECHV Initiative that will provide detailed information about the expanded services in the 17 target communities. This proposal outlines our initial plans for these two evaluation components. We begin with a brief description of our team's work and theoretical approach to research and evaluation.

The Tufts Evaluation Team

For the past 15 years, our team of independent researchers[53] from the departments of Child Development and Urban and Environmental Policy and Planning at Tufts University has been contracted by the Massachusetts Children's Trust Fund (MCTF) to evaluate the Healthy Families Massachusetts newborn home visiting program (HFM). Our first-cohort evaluation of HFM (the Massachusetts Healthy Families Evaluation [MHFE-1]) was completed in 2005;[54] the second-cohort evaluation (MHFE-2), a randomized, controlled trial, began in 2008 and is currently underway. Our evaluation team has conducted several other program evaluations, including, most recently, the Touchpoints Early Care and Education Initiative Evaluation, a study of a developmentally-focused teacher training program in urban child care settings; the Massachusetts Health Passport Program Evaluation, a study of a health access program for youth involved with the juvenile justice system; and the Gender Equity Model Sites Initiative Evaluation, a study of an in-service professional development program for elementary and secondary school teachers. Given our extensive experience evaluating HFM, and other community service programs that serve vulnerable families and their children, we believe we are well-suited to evaluate this proposed expansion of home visiting programming within an early childhood service systems context.

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[52] See, for example, Olds, D.L., Robinson, J., Pettit, L., Luckey, D., Homberg, J., Ng, R.K., et al., (2004). Effects of home visits by parapropfessionals and by nurses: Age 4 follow-up results of a randomized trial. *Pediatrics, 114*, 1560-1568.; DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., et al. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(3), 295–315; Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., et al. (2004). Randomized trial of a statewide home visiting program: Impact in preventing child abuse and neglect. *Child Abuse & Neglect, 28*(6), 597–622.

[53] Principal Investigators are: Ann Easterbrooks, PhD, Prof., Eliot- Pearson Dept. of Child Development; Fran Jacobs, EdD, Assoc. Prof., Eliot-Pearson Dept. of Child Development & Dept. of Urban and Environ. Policy and Planning; & Jayanthi Mistry, PhD, Assoc. Prof. & Chair, Eliot-Pearson Dept. of Child Development. Consultants may include: Christine McWayne, PhD, Assoc. Prof. & Director of Early Childhood Education, Eliot- Pearson Dept. of Child Development; Christina Economos, PhD., Assoc Prof, Friedman School of Nutrition Science & Policy; all of Tufts University.

[54] For final evaluation report, see Jacobs, F., Easterbrooks, M. A., Brady, A., & Mistry, J. (2005). *Healthy Families Massachusetts final evaluation report*. Medford, MA: Massachusetts Healthy Families Evaluation.

The Five-tiered Approach to Evaluation (FTA)

Our evaluation framework is guided by Principal Investigator Jacobs's Five-tiered Approach to evaluation, which has been used widely to evaluate child and family programs in the U.S. and abroad.[55] The FTA is a developmental model that moves evaluation activities from a primary focus on descriptive and process-oriented information to an emphasis on program effects.[56] Tier One activities produce needs and demand assessments, and usually are conducted prior to, or in concert with, the program's implementation. Evaluation activities at Tiers Two and Three are directed at program processes: they describe program staff, services, clients, and costs; examine program implementation compared to model standards; and provide feedback to programs for improvement. Tiers Four and Five focus on outcome evaluation activities, assessing the extent to which a program is meeting its short-term and long-term goals. The primary difference between Tier Four and Tier Five is the use of an experimental design in Tier Five; when such scientific rigor is possible, researchers are more confident that changes they observe in participants are the result of the intervention being studied. The FTA is an iterative model – directing evaluators back to earlier tiers when an established program significantly changes its service profile.

HVEM reflects this developmental approach to evaluation: our Implementation Study of the MIECHV Initiative will use evaluation activities at Tiers One, Two and Three to understand how the selected program enhancements are developed and put into operation in the MIECHV communities. The Longitudinal Study moves ahead to Tiers Four and Five to establish longer-term program effects in the mature HFM program. As each of the studies evolves, we will use an iterative process: findings from the Longitudinal Study, for example, should inform both program implementation at the MIECHV sites, and the evaluation thereof. The following sections describe each of the proposed evaluation components, beginning with the Implementation Study.

Implementation Study of MIECHVI (ISM)

Our proposed utilization-focused evaluation is designed to1) answer core evaluation questions about program processes, operations, and integration into existing systems of care, and 2) respond to MIECHVI stakeholders' needs as program enhancements are developed, refined, and implemented across the 17 communities. Anticipated activities will include but are not limited to the following:

- Tier One assessments and technical assistance designed to aid MIECHV stakeholders at the state and program levels to prepare and build capacity for an implementation evaluation;
- Tier Two data collection and analysis designed to provide descriptive information about program staff, participants, and services; and
- Tier Three evaluation activities designed to assess the quality, consistency, and perceived effects of the program, and to describe the contexts in which the program services are being implemented.

Setting the Stage for Implementation Evaluation: Using Tier One Activities to Hone Theory and Build Capacity

Implementation evaluation requires both a management information system that reflects the program's theory of change (i.e., collects data about those program inputs that are expected to lead to

[55] Jacobs. F. (2003). Child and family program evaluation: Learning to enjoy complexity. *Applied Developmental Science, 7(2),* 62-75; Jacobs, F. H. (1988). The Five-tiered Approach to evaluation: Context and implementation. In H. B. Weiss & F. H. Jacobs (Eds.), *Evaluating Family Programs*, New York: Aldine DeGruyter; Jacobs, F., & Kapuscik, J. (2000). *Evaluating family preservation services: A guide for state administrators.* Medford, MA: Tufts University.

[56] See, for example, Duggan, A., Rodriguez, K., Burell, L., Shea, S., & Rohde, C. (2005). *Evaluation of Healthy Families Alaska: Final report: January 21, 2005*. Downloaded June 19, 2006 from http://www.hss.state.ak.us/ocs/Publications/JohnsHopkins_HealthyFamilies.pdf.; Titcom, A., & LeCroy, C. (2003). Evaluation of Arizona's Family Group Decision-Making program. *Protecting Children, 18,* 58-64.

program outcomes), and a staff that has been trained to document these data consistently. To that end, the Tufts evaluators, in collaboration with the MIECHV Initiative, will begin with the following Tier One activities: 1) conduct focus groups with state-, agency-, program-, and participant-level stakeholders to hone model theories of change, and to augment and refine evaluation questions; 2); choose additional measures to be used by home visiting staff for baseline data collection; 3) work with CTF and the MIECHV team to enhance the PDS based on theories of change for the proposed service expansions; and 4) provide training and technical assistance to program staff for data collection and documentation.

Detailing the MIECHV Initiative: Tier Two Data on Staff, Participants, Services, and Cost

The MIECHV Initiative will expand, enhance, and in many cases, substantially change the existing home visiting infrastructures in the 17 communities. Data on exactly *what the program looks like on the ground* and *who is using it* will provide crucial information to MIECHVI stakeholders as they roll out these proposed components during the initial implementation phases. At the program levels, Tier Two data derived from the PDS, along with some additional data collected by Tufts,[57] will be analyzed to describe, for each site staff characteristics (e.g., demographics, education), training, and supervision (frequency, content covered, etc.). At the participant level, we will use Tier Two data to document information related to outreach and referrals (referred *by* whom, *to* whom, and at what point in the target child's life?), describe the participants (who is referred? screened? eligible? enrolls?), and identify the basic model components on offer.

MIECHVI *In Vivo*: Using Tier Three Data to Deepen Understanding of Program Processes in Context

The next phase of the evaluation is designed to help us understand more fully how individuals with a stake in the program – participants, staff, community residents, community providers, etc. – experience and assess it from their perspectives. These evaluation activities represent a Tier Three investigation, and will provide critical information for program modification before an outcome evaluation is undertaken. Planned activities at this phase of the ISM will provide information to stakeholders about 1) the nature of the services being provided, 2) the extent to which services are being provided as intended (model fidelity), and 3) the manner and extent to which home visiting is integrated into early childhood systems of care.

An Enhanced Conceptualization of Program Utilization

Tier Three analyses of PDS data will allow for a finely-grained description of the services utilized by participants. With only a handful of exceptions,[58] home visiting evaluations tend to describe service utilization solely in terms of program dosage, generally as measured by the length of enrollment in the program, number of completed home visits, duration of visits, and ratio of completed to expected number of home visits. There have been few attempts to expand this measurement of program services to include other components of home visiting programs (e.g., participation in groups or collateral activities by home visitors), and to consider the community contexts in which services are delivered. The scarcity of research in this area makes it difficult to discern which particular constellations of services, among particular types of families, are needed to achieve program goal. Our evaluation is poised to make a major contribution to the field in this regard, given the richness of the PDS data, and the coding and analysis protocols the Tufts team has already developed for MHFE-2. Our conceptualization of service delivery will comprise the *full complement* of services offered, and an analysis of differential utilization by community populations.

[57] Additional data collection protocols and procedures to be determined in collaboration with MICHV Initiative and CTF.

[58] See, for example, Kisker, E.E., Paulsell, D., Love, J.M., & Raikes, H. (2002). *Pathways to quality and full implementation in Early Head Start programs*. Princeton, NJ: Mathematica Policy Research; Duggan, A., et al. (2007). *Evaluation of the Healthy Families Alaska program: Final report.* Anchorage, AL: Alaska Department of Health and Social Services; and Ammerman, R.T., Stevens, J., Putnam, F.W., Altaye, M., Hulsmann, J.E., Lehmkuhl, H.D., et al. (2006). Predictors of early engagement in home visitation. *Journal of Family Violence, 21*(2), 105-115.

Implementation with Fidelity to the Model

Testing whether a program's theory of change holds true (that certain program inputs yield particular outcomes) is only possible when the program is actually implemented as intended. Establishing the extent to which programs are operating with fidelity to the model is particularly important in the context of new initiatives, or the scaling-up of existing programs.[59] We will assess fidelity from several perspectives: 1) operations relative to the model standards, or critical elements (e.g., are families receiving the prescribed number of home visits? is the program reaching recruitment and enrollment benchmarks?); 2) fidelity to any additional program-specific, intended components or procedures, such as new enhancements, different program procedures, additional staff training and supervision, integration of program into community (e.g., how deeply the home visiting services penetrate their local communities? how well are they known to the range of constituents? how are they being by those eligible for the service?); and 3) fidelity in terms of whether programs are meeting the expectations of key constituent groups, such as participants, staff, community stakeholders, state agency representatives (is the program being implemented as imagined by its stakeholders? what are the perceived successes, challenges?).

Understanding Systems of Care

Increasing attention is being paid in the evaluation field to developing spatial understandings of service utilization, and the potential benefits of concentrating programming by geographical area. The Promise Neighborhoods Federal Initiative is a prime example of that premise in action. Our approach to evaluation accounts for the contextual factors that can mediate, moderate, facilitate, and/or challenge the successful implementation of service models in community settings. To better understand the existing systems of care in each of the 17 MIECHV communities, we propose to conduct program- and participant-level "context analyses." A context analysis makes visually explicit the ways people or programs are connected with one another,[60] and the ways those connections change over time.

We propose to map connections among community service providers in two ways: 1) a "spatial context analysis" which would use Geographic Information Systems (GIS) technologies to map the distances in miles between those social service organizations that constitute the core MIECHV advisory committees in each community (e.g., early childhood, community health, mental health, nutrition, child welfare, housing), and 2) a "professional network analysis" which would utilize online network analysis technologies[61] to visually represent the connections service providers have with each other. Data on the relationships between providers would be collected via surveys and interviews. Indicators such as the length of time providers have known each other, level of "friendliness" in their relationships, and frequency of professional and personal contact could be combined with GIS data to assess the relative closeness or distance of the connections.

Similar mapping activities would be conducted at the participant level. The same GIS indicators used at the provider level could establish the geographic service context in which the participant is embedded, and information about participants' service utilization could be gleaned from interview questions about which community services they used, how they were referred, and the extent to which they are engaged in those services. Layering participant maps onto provider maps at different time points could provide stakeholders with valuable information about the extent to which systems-level integration and alignment have occurred (i.e., the relative "seamlessness" of the participant and provider networks; literally, how much do the lines overlap?), and the ways in which these network integrations and alignments change over time in response to the MIECHV Initiative's efforts.

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[59] Koball, H., Zaveri, H., Boller, K., Daro, D., Knab, J., Paulsell, D. (2009). Supporting evidence-based home visiting to prevent child maltreatment: Overview of the Cross-Site Evaluation. Children's Bureau, ACF, UHHS. Princeton, NJ: Mathematica Policy Research.

[60] For an example of context analyses incorporated into evaluations, see Hawe, P., Shiell, A., Riley, T., & Gold L. (2004). Methods for exploring implementation variation and local context within a cluster randomized community intervention trial. *Journal of Epidemiology and Community Health, 58*, 788-793; Wickizer, T.M., Von Korff, M., Cheadle, A., Maeser, J., Wagner, E.H., Pearson, D., et al. (1993). Activating communities for health promotion: A process evaluation method. *American Journal of Public Health, 83*, 561-567.

[61] See, for example, http://netage.com/orgscope/index.html

Longitudinal Follow-up of MHFE-2 (MHFE-2 Early childhood)

Part of the power of any preventive intervention program rests on the continued benefits of the program beyond the period of program services. Benefits incurred during the receipt of program services may a) be sustained beyond the end of program participation, b) show effects immediately that diminish with time or change in circumstances/setting, or c) show enhanced effects over time, in essence "sleeper effects" whereby an experience earlier creates the capability or potential for an effect that may emerge only at a later time.[62]

Early Childhood Program Evaluations.

In a review of the effects of early childhood interventions (including home-visiting programs, and center-based early childhood programs such as Head Start) Reynolds and Ou[63] noted 1) empirical support for both short- and long-term effects of well-implemented programs on both cognitive/academic outcomes (e.g., need for remedial services, educational attainment) and socioemotional outcomes (e.g., antisocial behavior, delinquency), 2) that aspects (e.g., timing, duration) of service delivery matter (e.g., evidence is strongest for effects of programs beginning in the prenatal period or first three years of life), and 3) that mechanisms of long-term effects include processes at both the individual level (e.g., cognitive/scholastic advantage afforded to the children), as well as those at the family level (e.g., family support). As explicated in the HFM model, the aim is to enable long-term positive program effects by enhancing parental knowledge and abilities to support the child's development. Families who received HFM, for example, may be better able to identify and utilize early childhood systems resources that will enhance their children's development.

Data from several early intervention and prevention programs, many with a home visiting component, provide support for the need to continue to examine long-term effects of early service programs. Investigators of Healthy Families New York, for example, reported that their paraprofessional service model produced "sustained effects on parenting that extend past the intended period of service" [64] and afforded cognitive and educational advantages to children at age seven, particularly among children of young, first-time mothers. Similarly, there is favorable evidence for the effects of the Nurse-Family Partnership (NFP) program on both maternal life course trajectories and child development outcomes, even years after the end of services.[65]

High Risk/Opportunity Subgroups.

The HFNY evaluation, the NFP studies, and evaluations of other important early childhood programs (including Early Head Start and Head Start) indicate differential program impacts related to both proximal characteristics, for example, maternal age and parity (young, first-time), psychological vulnerability (depression), and distal characteristics, such as community context.[66] Results of the Head Start National Study, for example, demonstrated the importance of the moderating effects of parental depression, child characteristics, and family risk on program impacts when children reached kindergarten and first grade.[67] Evaluations of the NFP reported differing effects according to community factors. In general, NFP program effects are stronger for children born to the mothers at highest sociodemographic

[62] Maurer, D., Mondloch, C. J., & Lewis, T. L. (2007). Sleeper effects. *Developmental Science, 10(1)*, 40-47; Vandell, D. L., Belsky, J., Burchinal, M., Steinberg, L., Vandergrift, N., and the NICHD Early Child Care Network (2010). Do effects of early child care extend to age 15 years? Results from the NICHD Study of Early Child Care and Youth Development. *Child Development, 81(3),* 737-756.
[63] Reynolds, A. J., & Ou, S-R. (2003). Promoting resilience through early childhood interventions. In S. S. Luthar (Ed.), Resilience and vulnerability: Adaptation in the context of childhood adversities. (pp. 436-461). N.Y.: Cambridge University Press.
[64] DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., Layne, C., & Greene, R. (2010). *A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment?* Final report, U.S. Dept. of Justice.
[65] Kitzman, H.J., Olds., D.L., Cole, R.A., Hanks, C.A., Anson, E.A., Arcoleo, K.J., et al. (2010). Enduring effects of prenatal and infancy home visiting by nurses on children. *Arch Pediatr Adolesc Med, 164*(5), 412-418. ; Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J., Anson, E. A., Luckey, D. W., et al. (2010). Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending. *Arch Pediatr Adolesc Med.,164(5),* 419-424.
[66] DuMont, et al, 2010; Love, J. M., Kisker, E. E., Ross, C., Raikes, H., Constantine, J., Boller, K., et al. (2005). The effectiveness of Early Head Start for 3-year-old children and their parents: Lessons for policy and programs. *Developmental Psychology, 41(6),* 885-901.
[67] U.S. Department of Health and Human Services, Administration for Children and Families (January 2010). *Head Start impact study. Final report.* Washington, D.C.: Author

risk and who were more psychologically vulnerable.[68] In MHFE-2 we have developed Community Context Profiles (GIS census data on income, percentage minority, and population density) that serve as markers of community-level resources and risks,[69] and will combine these data with family-level data to create risk subgroup profiles.

Strengths of MHFE-2EC

In sum, evaluations of early prevention programs point to the promise of evaluating the longer-term effects of the Healthy Families Massachusetts program, especially since the program population represents the high risk/high prevention opportunity group seen as most likely to benefit from this service delivery model.[70] A longitudinal follow-up of MHFE-2 presents an opportunity to examine the longer-term benefits of HFM on the five stated HFM goals that speak to aspects of mothers' and children's adaptation (e.g., maltreatment, educational and employment trajectories, well-being, health and development, repeat births), and to expand the research questions into early childhood.

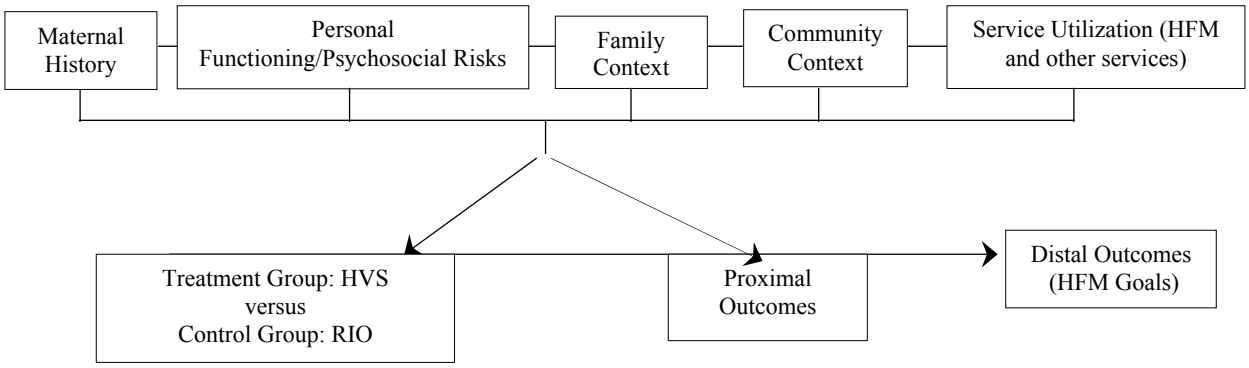
The period of early childhood (ages 0-8) presents multiple opportunities to understand how families utilize resources and opportunities, and navigate transitions among care settings and contexts. During the period prior to kindergarten entry, the majority of families utilize other early childhood systems, including child care and preschool. Some enroll in Early Intervention and Head Start programs. A longitudinal investigation of MHFE-2 families will provide important information about whether and how HFM enhances parents' knowledge and ability to access, engage with, and benefit from other early childhood resources and contexts. Use of these opportunities may enhance the early benefits of HFM by supporting continued positive parenting environments. For example, participation in center-based early childhood programs may reduce the risk for harsh parenting and child maltreatment by processes such as increased family involvement in school, and greater maternal educational attainment.[71]

The longitudinal investigation of MHFE-2 will be designed to address a) long-term follow-up of the goals of HFM, b) aspects of the intervening and current family and community context that mediate and moderate the long-term effects of HFM participation and c) effects of HFM related to MIECHV goals for families during the early childhood period. It is critical to assess aspects of the intervening family and community environments (e.g., parenting, child care/preschool, neighborhood) in order to understand whether or how characteristics of the settings may nullify, maintain, or amplify the promise of earlier prevention programs (see Figure 3).[72]

The MHFE-2 has several strengths that may distinguish it from some other evaluations of home-visiting programs. It represents a randomized control trial of a program "taken to scale" at a statewide level and it represents a randomized control trial of a program "taken to scale" at a statewide level. The sample is representative of the diverse characteristics and circumstances of the high-risk population served. The evaluation examines both program implementation and impact and MHFE-2 contextualizes HFM program implementation and impact in the communities in which they are embedded. The study will provide information about services, other than HFM, that mothers engaged in and received, in both the HFM and control groups, thus allowing key information about how families intersect with systems of care from pregnancy into early childhood.

Figure 3: Proposed Research Model

[68] Olds, D. L. (2006). The Nurse-Family Partnership: An evidence-based preventive intervention. *Infant Mental Health Journal, 27(1),* 5-25.
[69] Leventhal, T., & Brooks-Gunn, J. (2000). The neighborhoods they live in: The effects of neighborhood residence on child and adolescent outcomes. *Psychological Bulletin, 126(2),* 309-337.
[70] DuMont et al, 2010; Olds et al 2010.
[71] Mersky, J. P., Topitzes, J. D., & Reynolds, A. J. (2011). Maltreatment prevention through early childhood intervention: A confirmatory evaluation of the Chicago Child–Parent Center preschool program. *Children and Youth Services Review, 33(8),* 1454-1463.
[72] Maton, K.I. (2005). The social transformation of environments and the promotion of resilience in children. In R. DV. Peters, B. Leadbeater, & R.J. McMahon (Eds.), *Resilience in children, families, and communities.* (pp. 119-136). NY: Kluwer.



Research Questions Based on HFM Original Goals

Research Question 1: Does the HFM program show long-term effects into the early childhood years?

- Do HFM families show lower incidence of child abuse and neglect?
- Do HFM families show lower rates of repeat early births?
- Do HFM mothers attain greater educational achievement and employment?
- Do HFM mothers demonstrate more positive well-being?
- Do HFM children demonstrate better health and development?
    - Are children who received HFM functioning better in early childhood settings?
        - school readiness and adaptation (social, emotional, cognitive)

Research Question 2: Are there dosage and duration of effects of participation in HFM?

- Do families who receive greater amounts of HFM services (e.g., stayed in the program longer, received more visits, etc.) show greater program effects?

Research Question 3: To what extent are HFM program effects moderated by variations in proximal (maternal and family) and distal (community context) characteristics?

- Are there differential effects for subgroups such as:
    - Psychologically vulnerable (depressed, childhood maltreatment, insecure attachment, IPV)
    - Stable support systems (married/co-parent, residential stability)
    - Community context profiles (racial/ethnic diversity, income, population density)

New Research Questions for the Longitudinal Follow-up

Research Question 4: Does participation in HFM influence parents' ability to navigate the early childhood system? For example,

- Do HFM parents make better choices in selecting child care, preschool, and school settings for their children?
- Are HFM parents better able to identify, access, and remain appropriately engaged with community resources?
- Are HFM parents better able to coordinate multiple service providers (both simultaneously and sequentially) as they transition between services and resources?
- Are HFM parents better equipped to advocate for their children with special needs in the school setting?
- Does participation in HFM influence families' use of health care resources?

Methodology of MHFE-2EC

Sample

Between February 2008 and October 2009, eligible participants (female, 16 years or older, new to HFM, either English- or Spanish-speaking, and cognitively able to provide informed consent), seeking to enroll in HFM were randomly assigned either to the "Home Visiting Services Group" (HVS; the program group), or the "Referrals and Information Only Group" (RIO; the control group). The MHFE-2 sample included 693 participants (61% randomly assigned to HVS; 39% RIO). At the time of enrollment in the study, 66.2% of the teens were pregnant, and 33.8% were parenting. Data were collected from participants at three time points: at enrollment, 12 months post-enrollment, and 24 months post-enrollment (Time 1, Time 2, and Time 3). MHFE-2 has retained approximately 80% of the sample at subsequent points of data collection. Data collection for MHFE-2 ends in December 2011.

Proposed data collection for MHFE-2EC would begin in 2012. We will attempt to recruit all of the original 693 participants, regardless of how many data collection points they participated in. We will use recruitment and retention strategies that were successful in MHFE-2, including gift card incentives, drop-in visits to participants' homes, use of social media, and the services of a private investigator for the hardest-to-locate participants. Additionally, we will add intermittent phone call check-ins (every four months) to prevent further attrition. Given our MHFE-2 recruitment and retention rates, we anticipate a sample of at least 500 participants for each data point, which will provide sufficient power to detect hypothesized effects.

Procedures/Data Collection/Data Sources

As was the case for MHFE-2, we will use a mixed-method approach relying on interviews, observations, standardized measures, and state agency databases to provide information about the participants and their families. While specific measures and assessments are yet to be selected, Tables 1-3 below present the constructs that map onto the research questions and goals, and potential instruments and their data sources. Use of extant databases of relevant state agencies will be achieved through interagency agreements negotiated during MHFE-2 (Massachusetts Departments of Elementary and Secondary Education (DESE), Children and Families (DCF), Public Health (DPH), and Transitional Assistance (DTA). We will obtain new Memoranda of Agreement with the Office of Health and Human Services (MASSHEALTH) and the Department of Early Education and Care (DEEC) to help address the new research questions of this longitudinal follow-up study. Interagency data will be obtained at regular intervals throughout the course of the proposed data collection time period.

Phone interviews and in-person research interviews will be administered to all participants at multiple time points, depending on the age of the HFM target child. Phone interviews will take place at regular intervals (e.g., every four months) in part, to maintain contact with families and to prevent study attrition. In addition to providing basic demographic information about participants, this interview will ask participants about the following: marital status, living situation, referrals to and utilization of services, including early childhood systems, use of public assistance, maternal employment, maternal education, child care, pregnancy, health care insurance and utilization, and mental health (specifically, depression and parenting stress). In-person research interviews and direct assessments will take place in the home (or setting of the mother's choice) using a schedule based on children's age and transition into formal educational settings (e.g., kindergarten, first grade) and will focus on constructs listed in Tables 1-3.

Families whose children will be too young for kindergarten during the study period will be seen once, in childcare/preschool only (~6% of sample); families whose children will make the transition into kindergarten will be seen twice (childcare/preschool and kindergarten) (~61% of the sample); families whose children will make the transition into 1st grade will be seen twice (kindergarten, 1st grade) (~33% of the sample). In sum, 67% of the sample will be assessed during preschool, 94% will be assessed during kindergarten, and 33% will have first grade assessments. Maternal consent will be obtained to contact children's teachers in order to conduct phone/mail data collection on parental school engagement and children's school adaptation.

Table 1: Constructs and Measures for Research Questions 1-3

Goal/Research Question	Construct	Potential Variables, Measures/Instruments	Data Source
1) Reduced rates of child abuse & neglect by supporting positive parenting and parent-child relationship	Child Abuse/Neglect	Reports and substantiated cases of CA/N	DCF
	Parenting Quality		
	Harsh Parenting	Conflict Tactics Scale-Parent Child	MQ
	Knowledge of Child Development	Knowledge of Child Development Inventory (KCDI)	MQ
	Parent-Child Relationship	Parent-child Emotional Availability	O
		Attachment Q-Sort	O
	Stimulating Home Environment	Parental reading to child	MR
		Home Observation for Measurement of Environment (HOME) Inventory & Supplement for Impoverished Families (SHIP)	O
2) Reduced rates of repeat early births	Repeat Birth	Repeat birth as teen	MR, DPH
		Spacing of subsequent births	DPH
3) Enhanced education & employment	Educational attainment	H.S. Diploma, GED College/vocational school enrollment	MR, DESE
	Employment	• Employment status • Employment Experience/Quality Scale	MR, MQ
4) Enhanced maternal well-being	Depression	Center for Epidemiological Studies-Depression	MQ
	Health Risk Behaviors	Youth Risk Behavior Survey	MQ
	Health Promotion Behaviors	• Medical home • Emergency room visits	MassHealth
5) Optimal Child Health and Development	• Health Promotion Behaviors • Parental Safety Behaviors	• Immunizations • Emergency room visits	DPH, MassHealth, MR

MR=Maternal Report MQ=Maternal Questionnaire O=Observation CA=Child Assessment
TQ=Teacher Questionnaire

Table 2: Constructs and Measures for Research Question 4

Research Question	Construct	Potential Variables, Measures/Instruments	Data Source
Parents' navigation of early childhood system	Quality of Child Care/Educational Setting	Quality Indicators	DEEC, DESE
		Perceived satisfaction/ Child Care Experiences Survey	MQ
	Relationship between Parent and Caregiver/Teacher	Parent-Caregiver (teacher) Partnership Scale (PCPS)	MQ/TQ
		Parent-Caregiver Relationship Scale (PCRS)	MQ/TQ
	Parent Involvement/Engagement in Early Childhood Setting	School contact and communication	TR
		Parent participation	TR
		Parent Involvement in Children's Education Scale (PICES)	MQ
		Parent-Teacher Involvement Questionnaire	MQ
	Supporting Child Learning	Getting Ready For School Survey	MQ
	Identification and Accessing of Community Resources—awareness, use, empowerment,	Awareness/engagement with community resources	MQ, DPH
		Community Life Skills Scale	MQ
		Psychological Empowerment Scale	MQ

Research Question	Construct	Potential Variables, Measures/Instruments	Data Source
	mastery	Pearlin Mastery Scale	MQ
		Network Mapping	MR
	Coordination of Multiple Service Providers	Perceived satisfaction with resources and transitions	MR
	Advocacy for Children with Special Needs	Psychological Empowerment Scale	MQ
		Perceived satisfaction	MR
		Child receipt of services	DPH, DESE
Use of Health Care Resources	Planning and Use of Health Resources	Emergency room visits	MassHealth
		Health care insurance	DPH
		Well-child medical/dental visits	MR
Child Health	Immunizations	Childhood immunizations received	DPH
	Child Health Status	Health status rating	MR
		Child receiving care for ongoing health problems	MR
	Overweight/obesity	Body Mass Index (BMI)	CA
Child Functioning in Early Childhood Settings	School Readiness/Literacy	Test of Preschool Early Literacy (TOPEL)	CA
		Bracken School Readiness Assessment	CA
		Emergent Literacy Scale	MQ
		Mother-Child Book Reading Task	O
		"Grade promotion/retention"	MR,DESE
	Executive Function		
	Working memory	Word span, Digit span, Corsi span task	CA
	Response Inhibition	Delay of Gratification tasks	CA
		Simon Says game	CA
		Stroop Task	CA
	Set-Shifting	Dimension Change Card Sort DCCS	CA
		Delayed Nonmatch to Sample Task	CA
	Language	Receptive Language: Peabody Picture Vocabulary Test	CA
		Expressive Language: Expressive Vocabulary Test (EVT)	CA
		Woodcock-Munoz Language Survey-Picture Vocabulary Test	CA
	Socioemotional Competence (emotion regulation, behavior problems, social adaptation)	Connors Early Childhood Scale	MQ/TQ
		Preschool and Kindergarten Behavior Scales-2 (PKBS)	MQ/TQ
		Preschool/School Behavioral and Emotional Rating Scale (PreBERS/BERS)	MQ/TQ
		Behavior Assessment for Children (BASC-2)	MQ/TQ
		Child Behavior CheckList (CBCL)	MQ/TQ

Table 3: Moderators of Program Effects

Moderator	Construct	Potential Variable/Measure/Assessment	Data Source
Proximal Moderators	Maternal Depression	CES-D	MQ
	Intimate Partner Violence	Conflict Tactics Scale-Partner version	MQ
	History of Childhood Maltreatment	Supported case of child maltreatment	DCF
		Conflict Tactics Scale-Parent-Child (CTS-PC)	MQ
	Maternal Attachment	Attachment Style Questionnaire	MQ
Distal Moderators	Community Context	Community Context Profiles (based on income,	U.S Census

Moderator	Construct	Potential Variable/Measure/Assessment	Data Source
		ethnic diversity, population density)	
	Neighborhood Resources	Structural resources & activities: parks, libraries, community center	U.S. Census MR
	Neighborhood Risks	Violence, social isolation	U.S. Census MR
	Use of Early Childhood Programs	Enrollment/participation in center-based early childhood programs	DEEC, DESE, MR
		Program quality indicators	DEEC, DESE

Data Analysis Plan

In this section we briefly describe analytic techniques to be used in addressing each of the Longitudinal Study research questions. The analytic plan for Research Questions 1-3 includes additional waves of data or time points in the statistical analyses. The analytic plan for Research Question 4 includes additional variables (utilization and engagement of community services during early childhood) and examining the interaction of these variables with our existing measures of individual, family, and community characteristics.

Choices of specific multivariate analyses to test each research question will depend, in large part, on the distributions of the variables and relations among the predictors determined through bivariate analysis. If sufficient relations exist between variables of interest, all research questions can be addressed through structural equation modeling (SEM), combining the observed variables into one latent construct (e.g., parenting). When relations among individual indicators of a construct are strong, SEM is a preferred statistical method as it allows the constructs to be examined in one analysis, while avoiding problems of multicollinearity inherent to standard regressions. An additional advantage of SEM lies in its ability to examine the contribution of error variance to the overall model.

Missing Data

As can be expected with longitudinal research, some amount of attrition will occur. Statisticians and developmental theorists endorse multiple imputation (MI) as a statistical technique to address problems of missing data, given the advantages of its statistical properties, and the limitations of other methods that have the potential to significantly reduce sample size and produce biased results (listwise deletion), or that attempt to recover missing values (mean substitution).[73] Missing data pattern analyses will be employed to determine the type of missing data within the dataset (e.g., Missing Completely at Random, Missing at Random, or Non-Ignorable) and the amount of missing data. This pattern analysis will determine the appropriate number of imputations to run, as well as what variables to use as co-variates in subsequent analyses if data are determined to be missing at random or cannot be ignored.

Research Question 1: Testing for Impact of HFM

Research Question 1 tests program effects of the HFM home visiting program on distal outcomes that reflect the HFM program goals. The main inferential analyses of the relationship between HFM participation and specific distal outcomes will be conducted by fitting multivariate path analytic regression models (structural equation models).[74,75] Each set of outcomes will be regressed on HFM participation, and adjusted for potential covariates, such as maternal age at baby's birth and race/ethnicity. Each of these paths models will be tested with prior Wave data to determine if specific model parameters

[73] Allison, P.D. (2002). Missing Data. Thousand Oaks, CA: Sage.; Schafer, J.L. and Graham, J.W. (2002) Missing data: our view of the state of the art. *Psychological Methods, 7*, 147-177.; Widaman, K. F. (2006). Missing data: What to do with or without them. *Monographs of the Society for Research in Child Development, 71(*3), 42-64.

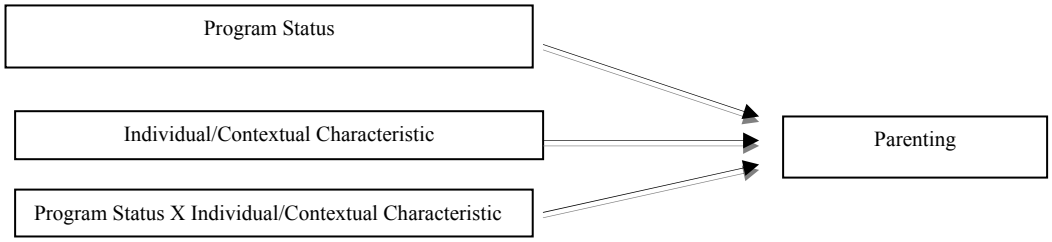
[74] Bollen (1989). Structural Equation Modeling with Latent Variables, Wiley & Sons, New York.

[75] Joreskog, K.G., and Sorbom, D. (1993). LISREL8: Structural equation modeling with the SIMPLIS command language. Hillsdale, NJ: Erlbaum.

vary across Wave.

Research Questions 2 and 3: Testing for Moderating Effects

Research Questions 2 and 3 address the role of potential moderators, such as program utilization, community context, maternal depression, and childhood history of maltreatment. Moderated models identify variables that may influence program effectiveness across certain groups and/or contexts.[76,77] In these analyses, individual and contextual characteristics will be examined as moderators by analyzing interaction effects, as illustrated by the following model.



Moderated relations will be examined using regression analyses, including only Program Status in the first model, only the moderator in the second model, and then the program and the moderator variables, along with the interaction term of the two in the third model (based on a set of dummy variables for categorical predictors, the product of continuous predictors, or the product of continuous predictors and dummy variables).[78,79] For Research Question 2 regarding differential use of the program, individual and contextual characteristics will be examined using the same moderators and analyses detailed above for Research Question 3 (replacing program status with patterns of utilization).

Research Question 4: Testing for Participant Utilization of, and Engagement of, Community Services

Research Question 4 extends the MHFE-2 framework by examining parenting and family characteristics within the community contexts in which they are embedded, and specifically addresses how families utilize early childhood services and resources within their communities. Research Question 4 can be addressed with a regression model in which each outcome of interest (e.g. parental school involvement, community resource utilization, etc.) is regressed on HFM participation, individual factors, neighborhood factors, and the interaction between individual and neighborhood factors, making Huber White adjustments to the error variance for community clustering.

Evaluation as Iterative: Providing Feedback and Recommendations to Programs Regarding Best Practices and Future Evaluation

Data from both evaluation components—ISM and MHFE-2EC—will be summarized in reports at key points in the evaluation (to be determined in collaboration with MIECHVI), and the Tufts team will disseminate, interpret, and contextualize results for stakeholders at the program, community, and state levels through presentations and policy briefs. Additionally, Tufts will collaborate with MIECHVI to make recommendations for program corrections/adjustments based on results, and will conduct substudies, when possible,[80] that respond to emerging questions and areas of interest from program stakeholders. Finally, the evaluation team will use ISM results to help MIECHV prepare and build capacity for the next phase of evaluation.

[76] Fairchild, A. J., & MacKinnon, D. P. (2009). A general model for testing mediation and moderation effects. *Prevention Science, 10*(2), 87-99.
[77] Hoyle, R. H., & Robinson, J. I. (2003). Mediated and moderated effects in social psychological research: Measurement, design, and analysis issues. In C. Sansone, C. Morf, & A. T. Panter (Eds.), *Handbook of Methods in Social Psychology* (pp. 213-233). Thousand Oaks, CA: Sage Publications.
[78] Aiken, L. S., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions.* Newbury Park, CA: Sage.
[79] Jaccard, J., & Turrisi, R. (2003) *Interaction effects in multiple regression*. Newbury Park: Sage.
[80] this will depend on available evaluation resources

SECTION 7. ORGANIZATIONAL INFORMATION

The Massachusetts Department of Public Health (MDPH) has been designated by the Governor to plan, implement and administer the funds for the MIECHV Initiative. The Bureau of Family Health and Nutrition (BFHN) within MDPH is well positioned to serve as a strong leader for the program. The BFHN and MDPH, as the State Title V Agency, is responsible for overseeing a broad array of Maternal Child Health (MCH) programs, programs for children and adolescents, and programs for Children and Youth with Special Health Care Needs (CYSHCN) and their families. The primary mission of the BFHN is to ensure the physical, emotional and social health of mothers and infants in Massachusetts. The BFHN priorities, as articulated in the MCH Title V Block Grant, include improving the health and well being of women in their childbearing years; promoting emotional wellness and social connectedness; enhancing screening for the prevention of violence; supporting reproductive and sexual health; expanding the medical home model; supporting effective transitions for CYSHCN; and improving data capacity. Divisions within BFHN include 1) Nutrition Division (including programs such as WIC, Growth and Nutrition Program, etc.), 2) Division for Perinatal, Early Childhood, and Special Health Care Needs (including programs such as the MIECHV Initiative, Early Intervention, Universal Newborn Hearing Screening, etc.), and 3) Office of Data Translation which provides data support and program analysis for all Bureau programs.

The state's extensive experience implementing both state and federally-funded home visiting programs, including evidence-based and promising approaches, encompasses the following: 1) DPH, the Title V agency, supports the Early Intervention Partnership Program (EIPP) in eight high-risk communities; 2)CTF, as the Title II CAPTA agency, provides a nationally accredited Healthy Families home visiting program to first time pregnant and parenting families aged 20 years and younger; 3) Early Intervention (EI) funding through Part C of IDEA, provides state-wide, integrated, developmental home-based services to families with children ages birth to 3 years; 4) FRESH Start is ACF funded and provides home visiting to substance using families; and 5) The federally funded MA Early Head Start program provides comprehensive child development and school readiness home visiting services in communities with poor educational outcomes. *For more information on the structure of the MIECHV Initiative please see Attachment 5.*

Describe how the elements in the organizational chart contribute to the ability of the organization to conduct the program requirements and meet program expectations

The Commonwealth of Massachusetts has both the capacity and infrastructure to support the expansion of maternal, infant and early childhood home visiting programsThe Massachusetts leadership structure for expanding home visiting services falls under the scope of the Governor's Office and the Executive Office of Health and Human Services (EOHHS). Within EOHHS, a diverse set of agencies will continue to work collaboratively to ensure an optimal organizational structure for the administration of home visiting funds.

MDPH, the state Title V agency and lead agency for this project, will be responsible for ensuring the overall successful implementation of the MIECHV Initiative, including program development and implementation, contract management, data analysis and evaluation, and overall fiscal management. MDPH will ensure that the MIECHV aligns with Title V priorities as well as coordinates with cross-agency initiatives that focus on developing family and early childhood comprehensive systems of care.

The Medical Director of MDPH, Dr. Lauren Smith and Dr. Sherri Killins, the Commissioner of the Department of Early Education and Care (DEEC), serve as co-chairs of the MIECHV Home Visiting Task Force. The Task Force members, senior-level representatives from the agencies identified on the organizational chart, are committed to providing on-going guidance and direction for developing, implementing, expanding and evaluating the MIECHV Program, as well as ensuring that the program is integrated into initiatives within each of their respective agencies that support programs for pregnant and parenting families and an early childhood system of care.

The Home Visiting Workgroup, chaired by the Title V Director, Ron Benham, Director of the MDPH's BFHN, is responsible for all aspects of program development, training, implementation, expansion and evaluation including input from community partners. The Workgroup includes staff from

MDPH, which includes the Department of Children and Families, MDPH's Bureau of Substance Abuse, the Children's Trust Fund, Massachusetts Head Start, and the Department of Early Education and Care, and will continue to meet as needed to coordinate all program implementation.

The Children's Trust Fund, (CTF) which is currently implementing the Massachusetts Healthy Families (HFM) program using the evidence-based Healthy Families model, will provide guidance on program development, technical assistance to community partners through their technical assistance system, quality assurance through their quality assurance plan, training for all home visiting staff, data management, data reporting and assessment on all HFM programs to ensure model fidelity.

The Department of Early Education and Care will continue to play an active role by ensuring that the MIECHV aligns with multiple DEEC initiatives including: Coordinated Family and Community Engagement Grants, Early Childhood Information System, Kindergarten Readiness Assessment Model Design and Pilot, Help Me Grow, MA211, Birth to Grade 3 Alignment, and their Quality Rating and Improvement System.

The Eliot-Pearson Department of Child Development at Tufts University will play a key role in the expansion of home visiting services in Massachusetts by leading the evaluation and technical support component. Ongoing evaluation will allow the state to gather data on population-based outcomes and gauge the effectiveness of its home visiting programs.

Finally, the community partners—the lead agencies of the 17 high-need communities—will contribute significantly to the MIECHV Initiative's ability to conduct program requirements and meet its goals over the course of the grant years and beyond. The community partners will provide a vital link between the target populations and the centralized Initiative, making sure that home visiting services are responsive to the needs of the MA population. *Please see Attachment 6 for organizations's record of accomplishments.*

Provide information on the program's resources and capabilities to support provision of cultural and linguistically competent and health literate services

The MDPH CLAS (Culturally and Linguistically Appropriate Services) Initiative develops and implements the CLAS standards within MDPH programs and agencies receiving direct service grants. The MDPH CLAS Initiative, developed by the Department's Office of Health Equity, focuses on developing appropriate resources in six priority areas: fostering cultural competence; building community partnerships; collecting/sharing diversity data; planning and evaluating; reflecting and respecting diversity; and ensuring language access.

The state's 17 highest-need communities are committed to providing culturally and linguistically appropriate services to their target populations. In their community proposals for expanding home visiting, many of the communities identified immigrant populations as a high priority and stated plans to hire home visitors and coordinating staff, who share the culture and language of the people that they will serve, and who also have relevant experience to reach and engage a diverse array of populations.

Describe how the unique needs of target populations of the communities served are routinely assessed and improved; also describe the organizational capacity of any partnering agencies or organizations involved in the implementation of the project

MDPH is committed to identifying the needs of its most vulnerable populations and improving outcomes in the highest-need communities. The needs of target populations were comprehensively assessed in the 2010 Home Visiting Needs Assessment, which examined data from all available sources with information regarding maternal, infant, and early childhood health needs in the state, including vital statistics, survey/surveillance, programmatic, education, and public safety.

In 2010, the Commonwealth completed a Community Survey of MIEC professionals who work in the highest need 17 communities across the state. The survey had three major goals: 1) To gather community-level insight into the needs and concerns of populations in the most at-risk communities. 2) To better understand current capacity and degree of communication and coordination around home visiting, and 3) To assess community resources available to meet the needs and concerns of those in need of services. Information from this Community Survey helped to inform the MIECHV Initiative's knowledge of community needs, assets, gaps, and readiness to expand and/or implement home visiting.

On a routine basis, target population and community needs are assessed as part of the MCH Title V Block Grant Needs Assessment, conducted once every five years by BFHN within MDPH. In selecting state measures and priorities, the BFHN seeks input from a broad array of individuals, including youth, local service providers, medical providers, state-level agencies, academics, advocacy groups and other professionals. Furthermore, the four selected evidence-based models that the Commonwealth will employ in this Expansion Grant collect data on the needs of their target populations. Home visitors assist clients in navigating the statewide system of supports and have a keen understanding of the needs of their target populations. While maintaining fidelity to their models, programs tailor and improve service delivery, expand referral networks, and provide recommendations for program enhancements based on the information gleaned from client assessments.

MDPH is confident in its organizational structure, capacity, and relationships with key stakeholders to maintain a high standard of assessment going forward. The MIECHV Initiative, in partnership with the Departments of Public Health, Early Education and Care, and the Children's Trust Fund, will use Continuous Quality Improvement (CQI) methods to expand and implement its home visiting programs. CQI is a systematic approach to continuously improving performance of systems or programs through regular data collection and dissemination to enable appropriate systemic change and the delivery of reliable consistent results and information. MDPH's in-house epidemiologists play a large role in CQI, analyzing key benchmarks and providing a data-driven framework for improvement.

In addition, community engagement will continue to be a key aspect of the overall management plan for the MIECHV Initiative. The Commonwealth will continue to involve target populations and the professionals working directly with them by assessing needs through local Advisory Councils that will facilitate networking, referrals, resource sharing, and coordination. With Expansion Grant funding, the MIECHV Initiative will work directly with the 17 community lead agencies to provide training, technical assistance, and guidance on integrating home visiting programs within a broader system of early childhood care in their respective communities. Finally, the Eliot-Pearson Department of Child Development at Tufts University will contribute to the assessment and improvement of home visiting programs through its role as Evaluator for the MIECHV Expansion Grant.

To ensure success in these endeavors, MDPH recognizes that collaborative partnerships among state agencies and program groups are essential to achieve the desired outcomes and secure sustainability of the MIECHV Initiative. These partnerships include all of the agencies identified as part of the MIECHV Initiative Task Force and Workgroup in the Organizational Chart (Please see Attachment 5). As the state agencies collaborating within MIECHV continue to grow and strengthen their own services, the MA home visiting program will strongly benefit.

Describe the adequacy of resources to continue the proposed project after the grant period ends and the state's demonstrated commitment to home visiting

After the four-year Expansion Grant period ends, Massachusetts will continue its support of maternal, infant, and early childhood home visiting programs. The Commonwealth will leverage its state and federal funds in order to demonstrate its commitment to the MIECHV Initiative's sustainability. Strategies will include 1) collaboration with MassHealth (Medicaid) to reimburse for home visiting; 2) seeking public and private insurance reimbursement for individual and group services provided by nurses, clinical social workers and other clinicians; 3) engaging with the public to encourage state legislative support for the Healthy Families Massachusetts and Early Intervention programs; and 4) continuing to support Early Intervention Partnership Programs (EIPP) using Title V MCH block grant funds.

Provide an assurance that cuts in state funding will not be made to a broad array of home visiting programs in the future

The Commonwealth of Massachusetts assures that cuts in state funding will not be made to a broad array of home visiting programs in the future.