Georgia’s FY2011 Maternal, Infant and Early Childhood Home Visiting (MIECHV) Formula Grant Program

Section 1: Needs Assessment and Identification of the State’s Targeted At-Risk Communities

Georgia’s goal for MIECHV Program funding in FY 2011 remains the same as FY 2010: to strengthen the state’s capacity for improving child and family outcomes by addressing the significant barriers to the overall well-being for children and families at-risk.

As required by the FY 2010 MIECHV Program application, a comprehensive statewide needs assessment was conducted in the fall of 2010. Overall direction for this assessment was provided by epidemiologists within the Maternal and Child Health Program of the Georgia Department of Public Health and coordinated with the Georgia Title V Maternal and Child Health (MCH) Services Block Grant, Title II of the Child Abuse Prevention and Treatment Act (CAPTA), Community-Based Child Abuse Prevention Program and the Georgia Head Start Collaboration Office, as well as many other Georgia stakeholders. Counties were determined to be the unit of analysis and seven domains were assessed. These domains included (1) Healthy Start (indicators of maternal and child health), (2) Poverty, (3) Crime, (4) High School Drop Out Rate, (5) Domestic Violence Rate, (6) Substance Abuse, and (7) Child Abuse and Neglect. Indicators within each domain were standardized by assigning each county a Z-score. The Z-score formula was:

\[
\text{County-Level Indicator – Statewide Average} \\
\text{Statewide Standard Deviation}
\]

Positive Z-scores indicated values greater than the statewide average. Negative Z-scores indicated values less than the statewide average. This methodology resulted in the identification of seventy-two (72) at-risk counties. That number represents just slightly fewer than 50% of the counties in Georgia.

Narrowing the Focus: At-Risk Community Selection Process

With such a large number of counties determined to be at-risk, the next critical step for state partners comprising the Georgia MIECHV Leadership Team was to develop a process for selecting which counties could maximize the benefits from the implementation of expanded home visitation services. To accomplish this, the partners developed a menu of capacity indicators and a scoring system that could be used to rank counties according to their likelihood of success in scaling up efforts to implement home visiting services within a comprehensive, community-based early childhood system. There was agreement that successful implementation would require selecting counties that had already demonstrated a commitment to focusing on prevention efforts with an emphasis on early childhood, as well as experience with the responsibilities that accompany implementation of an evidence-based home visiting model and maintaining model fidelity. This scoring process was used on the top 25 at-risk counties identified through the needs assessment to determine a secondary ranking. Capacity indicators and rankings of the top 25 at-risk counties were included in the Updated State Plan.

Following capacity scoring, consideration was given to the county’s geographical location to assure equity across the state and learn as much as possible about urban, suburban, and rural differences. Funding estimates for FY 2010 suggested that up to six (6) counties could be selected. Using the process described above, the following counties were selected for year one implementation: Clarke (NE GA), Crisp (SW GA), DeKalb (Metro Atlanta), Glynn (SE GA), Muscogee (Central GA), and Whitfield (NW GA).
As planning began for the FY 2011 formula grant application, the Governor’s Office for Children and Families (GOCF) MIECHV Management Team utilized the same capacity indicator scoring list for the top 25 at-risk counties to select one additional county. Based on the selection process used in year 1, Houston County (Central GA) was chosen as the next demonstration site. Therefore, FY 2011 funding will support the original six counties plus one additional county, for a total of seven counties.

As each county was identified for potential funding, contact was made by the MIECHV Management Team with the Community System of Care Administrator and the Coordinator of the local Georgia Family Connection Network to begin a dialogue about how an evidence-based home visiting service strategy aligns with the community’s goals for improving outcomes for families with young children. The local System of Care Administrator provides leadership for the existing system of care grant from GOCF and the Family Connection Coordinator provides leadership for the community planning collaborative.

Following the initial contact, the MIECHV Project Manager and Director of HV Training, TA & Evaluation met with county leaders to discuss further details of the federal legislation and accompanying requirements. The local System of Care Administrator convened the System of Care Governance Group and assured representation from the following organizations: Georgia Family Connection Network, Public Health, child welfare, existing home visiting programs, Head Start, community service providers, and local funding entities like United Way. All communities participated in a process to review their status of one of Georgia’s highest risk counties based on the statewide needs assessment and determine precisely how MIECHV Program aligns with the community vision.

Each of the seven counties has significant risk conditions for children and families. Specific findings follow:

<table>
<thead>
<tr>
<th>Target County</th>
<th>Live Births, Annual # 2009</th>
<th>Children Living in Poverty % 2009</th>
<th>Low Birth Weight % 2009</th>
<th>Infant Mortality Rate (Per 1000) 2008</th>
<th>Teen Birth Rate 15-19 (Per 1000) 2009</th>
<th>Students Grad on Time % 2010</th>
<th>Babies Born to Moms with &lt;12 Yrs of Ed % 2009</th>
<th>Child Abuse Rate (Per 1000) 2008</th>
<th>Child Neglect Rate (Per 1000) 2008</th>
<th>Domestic Violence Rate (Per 10,000 households) 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke</td>
<td>1,624</td>
<td>34.3%</td>
<td>9.5%</td>
<td>6.2</td>
<td>25.6</td>
<td>70.1%</td>
<td>25.5%</td>
<td>1.5</td>
<td>9.4</td>
<td>26.7</td>
</tr>
<tr>
<td>Crisp</td>
<td>317</td>
<td>44.6%</td>
<td>13.6%</td>
<td>13.3</td>
<td>82.4</td>
<td>66.1%</td>
<td>35.7%</td>
<td>1.3</td>
<td>9.4</td>
<td>113.9</td>
</tr>
<tr>
<td>DeKalb</td>
<td>11,592</td>
<td>24.5%</td>
<td>9.8%</td>
<td>9.0</td>
<td>47.0</td>
<td>79.4%</td>
<td>22.2%</td>
<td>1.7</td>
<td>5.5</td>
<td>69.9</td>
</tr>
<tr>
<td>Glynn</td>
<td>1,085</td>
<td>26.5%</td>
<td>12.2%</td>
<td>11.3</td>
<td>75.3</td>
<td>72.5%</td>
<td>33.6%</td>
<td>1.5</td>
<td>4.2</td>
<td>108.4</td>
</tr>
<tr>
<td>Muscogee</td>
<td>3,442</td>
<td>26.3%</td>
<td>10.7%</td>
<td>12.3</td>
<td>78.3</td>
<td>82.2%</td>
<td>20.9%</td>
<td>2.9</td>
<td>8.8</td>
<td>58.4</td>
</tr>
<tr>
<td>Whitfield</td>
<td>1,580</td>
<td>32.6%</td>
<td>6.3%</td>
<td>5.3</td>
<td>70.7</td>
<td>79.6%</td>
<td>53.6%</td>
<td>1.6</td>
<td>11.4</td>
<td>122.9</td>
</tr>
<tr>
<td>Houston</td>
<td>2,036</td>
<td>19.8%</td>
<td>8.1%</td>
<td>8.8</td>
<td>48.6</td>
<td>82.6%</td>
<td>18.9%</td>
<td>2.5</td>
<td>7.3</td>
<td>68.4</td>
</tr>
<tr>
<td>Average</td>
<td>3,282</td>
<td>31.5%</td>
<td>10.4%</td>
<td>9.6</td>
<td>63.2</td>
<td>75%</td>
<td>31.9%</td>
<td>1.8</td>
<td>7.8</td>
<td>83.4</td>
</tr>
<tr>
<td>GA</td>
<td>146,603</td>
<td>22%</td>
<td>9.5%</td>
<td>8.0</td>
<td>47.5</td>
<td>80.8%</td>
<td>23%</td>
<td>2.3</td>
<td>8.5</td>
<td>59.9</td>
</tr>
<tr>
<td>US</td>
<td>4,247,694</td>
<td>20%</td>
<td>8.2%</td>
<td>6.8</td>
<td>41.0</td>
<td>75.0%</td>
<td>18%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Based on Department of Public Health Home Visiting Needs Assessment 9/10 and GA Kids Count Data 6/11.

Detailed Assessment of Needs and Existing Resources for Each Targeted Community

**Clarke County (Northeast GA)**

- **Community Strengths and Risk Factors:** The largest city in Clarke County is Athens, home of the University of Georgia. This large urban university setting with its academic culture
contrasts sharply with the high percentage of children and families living in poverty in the county. Child poverty, child neglect, and mothers under 19 years of age, and mothers with less than 12 years of education are noteworthy issues in Clarke County.

- **Characteristics and Needs of Participants**: Families targeted for home visiting services are likely to be poor; mothers are young and lack a high school education. Many of these families need services that focus on economic self-sufficiency, family and parenting support, inter-conception health, and family planning. Approximately 17% of families served through the existing Healthy Families Georgia home visiting program are Hispanic, which indicates a need for home visitors who speak Spanish and understand the Latino culture. Unemployment is also a major concern because of the jobs that brought them to the area is far fewer. Community services and supports are readily available for those with resources, but families being targeted for home visiting services often do not have the resources to access the services.

- **Home Visiting Services-Existing and Discontinued**:  

<table>
<thead>
<tr>
<th>Program</th>
<th>Type</th>
<th>Sponsor</th>
<th>#</th>
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<tbody>
<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
</tr>
<tr>
<td>Early Head Start-HBO/Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Head Start</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Families Georgia</td>
<td>EB-HV Model</td>
<td>Prevent Child Abuse Athens</td>
<td>1</td>
</tr>
<tr>
<td>SafeCare</td>
<td>National Model</td>
<td>Department of family and Children Services</td>
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No home visiting services had been discontinued since March 23, 2010.

- **Existing Mechanisms for Screening, Identifying, and Referring to HV Programs**: There are several existing methods for referring families to home visiting programs in Clarke County that are the same for many of our at-risk counties. These include:
  - First Steps Programs at local hospitals – provides universal contact and support to all families delivering at the hospital, and also identifies families for referral to other programs and services including HFG programs.
  - Children 1st and the electronic birth certificate download – operates through Public Health and provides limited home visiting services to medically at-risk infants and CAPTA referrals; provides referrals to other community home visiting programs, as appropriate.
  - Department of Family and Children Services refers to SafeCare.
  - Various community service providers - including local public health, child welfare, medical care providers, and school counselors refer families to community home visiting programs, as well.

While these existing mechanisms have had some success, they represent individual program efforts and are not organized as a coordinated central intake system for home visiting services.

- **Referral Resources/Gaps**: Clarke County has a wealth of community referral sources including a HRSA funded health center serving families with medical needs. However, some services needed by families, such as mental health treatment, including maternal and post-partum depression, and substance abuse treatment services are very limited. In addition, the families being targeted often need assistance in negotiating the service systems and learning to advocate effectively for themselves and their children.

**Crisp County (Southwest GA)**

- **Community Strengths and Risk Factors**: Crisp County is located in a very rural and agricultural area in South Georgia and is one of the most economically stressed regions in that state. Crisp County stands out among all seven counties as being the one with the most
significant problems related to child and family well-being. Two census tracts in the county are part of a federally designated Rural Empowerment Zone. In addition, the State Office of Rural Health is located in Crisp County, as Crisp represents the many issues of rural Georgia. Almost half of the children in Crisp County live in poverty, which is more than double the state percentage. The teen birth rate is almost double the state rate. One third of Crisp students do not graduate on time. Low birth weight and infant mortality are huge concerns. And, the domestic violence rate is among the highest in the state.

### Characteristics and Needs of Participants
The families targeted for home visiting services need strong programs that deal comprehensively with a broad array of maternal and child health issues. The effects of persistent poverty must be addressed by breaking the cycle, which requires beginning interventions in the pre-conception and prenatal periods to assure a healthy birth and begin the process of providing a nurturing environment in which the child can grow and learn. At the same time, parents themselves must be supported in becoming economically self-sufficient and learning to access the community services and resources that are available for them and their children. Evidence-based home visiting programs can provide that support for expectant parents and children, birth to age five, and their families.

### Home Visiting Services-Existing and Discontinued

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<tbody>
<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
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<tr>
<td>Healthy Families Georgia</td>
<td>EB-HV Model</td>
<td>Cordele Housing Authority</td>
<td>1</td>
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<tr>
<td>SafeCare</td>
<td>National Model</td>
<td>Department of Family and Children Services</td>
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A Parents As Teachers program, which operated in the county for 6 years, was discontinued in 2009 after several grant sources ended.

### Existing Mechanisms for Screening, Identifying, and Referring to HV Programs:
The current referral methods in Crisp County include:
- First Steps Program at the Crisp Regional Hospital
- Children 1st and the electronic birth certificate download - operate from the district office in Columbus and may refer a few families to HV services.
- Department of Family and Children Services refers to SafeCare.
- Various community service providers – including local public health, child welfare, medical care providers, and school counselors refer families to home visiting programs.

While these mechanisms have had some success, they represent individual program efforts and are not organized as a coordinated central intake system for home visiting services.

### Referral Resources
Community resources have always been limited in Crisp County. In recent years, those resources have become even more limited. All state and non-profit agencies have experienced staff cutbacks due to the economy, therefore, service are often harder to access. There is no domestic violence shelter in the county, yet rates are high. In addition, there are few activities to help direct teens into constructive activities. However, there is a HRSA funded community health center in the city of Cordele, which plays a significant role in providing health care to the families targeted for home visiting services.

### DeKalb County (Metropolitan Atlanta)

### Community Strengths and Risk Factors
DeKalb is a suburban county in the metropolitan Atlanta area, and is the nation’s second most affluent African-American population. It is also the most culturally diverse county in Georgia. Two particular zip codes have a high number of refugee and immigrant families that fled from countries, such as Burma, Bhutan, Burundi,
Somalia, Afghanistan, Sudan, Vietnam, and Iraq, because of war and political oppression. Approximately 30% of the individuals in Clarkston and Scottdale are foreign-born families and speak a language other than English in the home according to 2009 census data. The percentage of individuals living in poverty in 2009 was 26%, compared to 15% for the county.

- **Characteristics and Needs of Participants**: Community services are readily available in the county for those with adequate resources. However, there are significant pockets of need. Refugee and immigrant families in the targeted zip codes have entered the country legally and are receiving resettlement support from the US Government. However, these families still face enormous challenges in dealing with the significant issues that brought them to this country, and learning to live and survive in a new culture, with a new language, and new rules and laws. Major needs in these communities include economic self-sufficiency, English proficiency, cultural understanding of positive parenting/child development/child-rearing practices, school readiness for young children, and linkages and referrals to community resources. Evidence-based home visiting services, when provided by visitors that understand the culture and the language, offer an effective strategy for improving child and family outcomes. However, the current level of home visiting services does not have the capacity to enroll all immigrant families needing to be served.

- **Home Visiting Services-Existing and Discontinued**

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<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
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<tr>
<td>Doula</td>
<td>National Model</td>
<td>GA Campaign for Adolescent Pregnancy Prevention</td>
<td>1</td>
</tr>
<tr>
<td>Early Head Start-HBO/Parent As Teachers</td>
<td>EB-HV Model</td>
<td>Partnership for Community Action/Head Start</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Grandparents</td>
<td>National Model</td>
<td>Georgia State University</td>
<td>1</td>
</tr>
<tr>
<td>Parent Talk</td>
<td>Local Program</td>
<td>Catholic Charities</td>
<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Refugee Family Assistance Project</td>
<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Refugee Family Services</td>
<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Scotdale Child Development Center</td>
<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Clarkston Development Foundation</td>
<td>1</td>
</tr>
<tr>
<td>SafeCare</td>
<td>National Model</td>
<td>Department of Family and Children Services</td>
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</table>

There are four small PAT programs and an EHS-HBO program that uses the PAT curriculum currently existing in the Clarkston/Scottdale area. The other programs operate county-wide. No home visiting programs have been discontinued since March 23, 2010.

- **Existing Mechanisms for Screening, Identifying, and Referring to HV Programs**: DeKalb County has a Children 1st Program operating through Public Health, a Safe Care Program operating through Department of Family and Children Services, and other referral methods for other programs. Some of these families needing these services may live in the two targeted zip codes, however, it is very difficult for those programs to meet the multi-cultural needs of the families without staff who speak the language and understand the language. The only home visiting programs currently able to serve the majority of the refugees and immigrants are the PAT and the Early Head Start-HBO programs, the programs have recruited home visitors and staff from the same countries of origin as the families. Families are currently identified through the Refugee Resettlement Program and neighborhood service providers. The Early Head Start Program operates through the Partnership for Community Action Agency in the Clarkston
community, which serves as a hub for many family support services including food, clothing and furniture, as well as a micro-enterprise program that promotes economic self-sufficiency. Many referrals to home visiting services are generated through this center.

- **Referral Resources:** DeKalb County has many community resources to help support families. The targeted at-risk families being served through home visiting programs need support to navigate the multiple systems and access the available services. Culture and language also present barriers to taking advantage of the resources available. Home visitors are able to serve as role models, provide information, and teach families to advocate for themselves. Several HRSA funded health centers are available for medical primary care.

**Glynn County (Southeast GA)**

- **Community Strengths and Risk Factors:** Glynn County is located on the Georgia coast and includes several islands, where over the years many affluent Americans have come to vacation or retire. While Glynn has areas of great prosperity, there are also great areas of need. The data show that over one-fourth of the county’s children live in poverty, leading to other serious problems. Low birth weight and infant mortality are significant issues. The same is true for teen births and domestic violence.

- **Characteristics and Needs of Participants:** Families targeted for home visiting services in Glynn need help achieving economic self-sufficiency, building protective factors, accessing health and nutrition services, preventing teen pregnancy, increasing knowledge of child development, etc. They also need assistance in accessing the community services that are available. In 2009, community leaders, in conjunction with the University of Georgia, conducted a needs assessment that identified the lack of education as the most important issue in the county, leading to the many other concerns referenced above. The community has made a commitment to focus on the prenatal and early childhood period as the optimal time to provide services and supports to at-risk families.

- **Home Visiting Services-Existing and Discontinued:**

<table>
<thead>
<tr>
<th>Program</th>
<th>Type</th>
<th>Sponsor</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Families Georgia</td>
<td>EB-HV Model</td>
<td>Coastal Coalition for Children</td>
<td>1</td>
</tr>
</tbody>
</table>

There is a small HFG program in Glynn County that is at capacity. No home visiting programs have been discontinued since March 23, 2010.

- **Existing Mechanisms for Screening, Identifying, and Referring to HV Programs:**
  Glynn County has the following methods in place:
  - First Steps Program at Glynn County Medical Center - supported by a current System of Care grant through the Governor’s Office for Children and Families, provides universal contact and support to all families delivering at the hospital, and also identifies families for referral to the HFG program.
  - Children 1st and the electronic birth certificate download – operates through Public Health and provides limited home visiting services to medically at-risk infants and CAPTA referrals; provides referrals to other community home visiting programs, as appropriate.
  - Various community service providers - including local public health, child welfare, medical care providers, and school counselors refer families to community home visiting programs, as well.

Again, these mechanisms have had some success, but they are not organized as a coordinated central intake system for home visiting services.
Referral Resources: Glynn County leaders have worked hard to enhance and strengthen community services over the years and have had many successes. However, the recent economic decline has resulted in a greater need for services and fewer resources to address the needs. In addition, in times of economic stress fewer resources are spent on prevention and intervention services. Families in the target population who are struggling with persistent poverty issues definitely need intensive, comprehensive supports to assist in breaking the cycle. Evidence-based home visiting services can address many issues related to maternal and child health, but there is also a need for more mental health, substance abuse, and domestic violence services.

Houston County (Central GA)

Community Strengths and Risk Factors: Houston County is located in the central part of the state and has a growing population. Historically, there has been strong leadership in the county for improving outcomes for children and families through the Family Connection Community Collaborative and Community System of Care Governance Group. Like the other targeted counties, Houston County has many families that face challenges related to educational achievement, teen pregnancy, economic self-sufficiency, and health status. While Houston scores near the state rate on many indicators of well-being, it is higher in the areas of infant mortality, child abuse, and domestic violence.

Characteristics and Needs of Participants: The families eligible for home visiting services in Houston County are likely to be young and lack a high school education. They are in need of services to address the responsibilities of parenthood, such as increasing knowledge of child development, learning good parenting skills, providing school readiness activities for children, completing their educational, obtaining job skills, and seeking employment. In addition, there is a high need for inter-conception health care services for the mothers. Demographically, the county is predominately white, but there is a large African-American population, and a growing Hispanic population. Bilingual home visitors will be needed for the Latino families.

Home Visiting Services-Existing and Discontinued:

<table>
<thead>
<tr>
<th>Program</th>
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<tbody>
<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
</tr>
<tr>
<td>Nurturing Program</td>
<td>National Model</td>
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<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Even Start</td>
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</table>

Existing Home Visiting Programs

No home visiting programs have been discontinued since March 23, 2010.

Existing Mechanisms for Screening, Identifying, and Referring to HV Programs: Public Health receives referrals on families for Children 1st home visits from hospitals, service providers, and the electronic birth certificate download. A few of the families needing primarily family support services and assistance with parenting, child development, and school readiness may be referred to EHS or PAT. But, most referrals to the existing home visiting programs come from various community service providers. These mechanisms are not sufficient for looking at the entire population to identify at-risk families or providing a systematic approach for the provision of home visiting services.

Referral Resources: Houston County has many referrals sources. All support services are available in the community for those with resources. Again, accessing these services is an issue for families without resources and without the knowledge to negotiate the service systems to meet the needs of themselves and their families.
Muscogee County (West Central GA)

- **Community Strengths and Risk Factors:** Muscogee County is located in West Central Georgia on the Alabama border. It is home to Fort Benning, one of the largest military installations in the United States, which trains infantry soldiers for ground combat in many areas around the world. The installation brings much diversity to the community and provides an economic boost to the local economy. Persistent poverty is also a major concern in Muscogee; its affects can be seen in the percentage of low birth weight births, and infant mortality and teen birth rates that rise above the state rates.

- **Characteristics and Needs of Participants:** Families targeted for home visiting services in Muscogee County have many of the same needs as families in the other counties. The families are likely to be young and poor, and need services that begin prenatally, during pregnancy, and at the time of birth. Teens and young mothers often need a supportive adult to provide information and encouragement to change their lives. Pregnancy and the birth of a child provide an opportunity to tap into the desire of virtually all parents to do the right things for their child. In addition to the persistent poverty issues historically associated with families in the county, military families also have significant needs. Infantry soldiers are often deployed for long periods of time, and often bear the brunt of the casualties of combat. Their families must deal with the uncertainty of war, lack of day-to-day support of the soldier, and the issues that may accompany the soldiers return to the family.

- **Home Visiting Services-Existing and Discontinued:**

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<td>Children 1st</td>
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<tr>
<td>New Parent Support</td>
<td>Military Model</td>
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<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>County Extension Service</td>
<td>1</td>
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</table>

No home visiting programs have been discontinued since March 23, 2010.

- **Existing Mechanisms for Screening, Identifying, and Referring to HV Programs:** Muscogee County has the following methods in place:
  - There is a First Steps Program at Martin Medical Center at Fort Benning that refers families to the New Parent Support Program there. Currently, First Steps is not referring military families to home visiting program outside of the military installation.
  - Children 1<sup>st</sup> and the electronic birth certificate download operates through Public Health and provides limited home visiting services to medically at-risk infants and CAPTA referrals. The program also provides referrals to other community home visiting programs, as appropriate.
  - Various community service providers including child welfare, medical care providers, and school counselors refer families to the PAT program, as well.

- **Referral Resources:** Community services are available for families with resources; however, again, the most at-risk families often do not have the resources or knowledge to access the services. Muscogee does have good medical services for military families through Fort Benning and a HRSA funded health center in two Columbus locations for families with low incomes.

Whitfield County (Northwest GA)

- **Community Strengths and Risk Factors:** Whitfield County is located in northern Georgia near the Tennessee border. The largest city is Dalton where most of the carpet in the world is made. Whitfield County has a Hispanic population of 44%, composed of families that
immigrated to the area from Mexico to work in the carpet industry. Currently, Hispanic families represent 62% of those served through the Healthy Families Georgia program. One third of the children in the county live in poverty. Mothers without a high school education is twice the state percentage. The teen birth rate is high, but does not seem to contribute to the infant mortality and low birth weight rates. Other indicators of interest are a higher child neglect (not abuse) rate, and an unusually high rate of domestic violence.

**Characteristics and Needs of Participants:** Many of the Hispanic families have been affected by recent changes in the economy. The current economic downturn has resulted in the elimination of many jobs in carpet manufacturing due to the slowdown in the housing market. Many Hispanic families are now without employment, resulting in greater poverty than previously. Latino mothers are often very young and do not complete school. These facts do not seem to affect infant mortality and low birth weight, which are well below the state rates. However, the stress within families is evident in the high rates of child neglect and domestic violence, which are likely related to the stresses associated with poverty and the current economic environment.

**Home Visiting Service-Existing and Discontinued:**

<table>
<thead>
<tr>
<th>Program</th>
<th>Type</th>
<th>Sponsor</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 1st</td>
<td>Periodic Nurse HV</td>
<td>Public Health</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Families Georgia</td>
<td>EB-HV Model</td>
<td>Family Support Council</td>
<td>1</td>
</tr>
<tr>
<td>Parents As Teachers</td>
<td>EB-HV Model</td>
<td>Family Support Council</td>
<td>1</td>
</tr>
</tbody>
</table>

No home visiting programs have been discontinued since May 23, 2010.

**Existing Mechanisms for Screening, Identifying, and Referring to HV Programs:** There are three existing mechanisms for screening and referring to home visiting services in this county.

- A First Steps program, managed by the Family Support Council, operates at the Hamilton Medical Center. Program staff attempt to screen all new births and link families to services as needed, including home visiting services.
- Children 1st, which is managed by local or regional Public Health Departments, screens all births through an electronic download of birth certificates in order to link medically at-risk children to appropriate public health services. This program also accepts community provider referrals for children at-risk of poor health or developmental outcomes. These children and families are referred to home visiting services, as appropriate.
- Informal Referral Network: Community service providers refer families for home visiting services and families refer themselves.

**Referral Resources:** Community resources are available, although some services have been reduced due to budget cuts. Also, due to unemployment rates, families have fewer resources in which to access the services. Due to the economy, fewer resources are available to assist with economic self-sufficiency.

**Description of How Coordination among Existing Programs and Resources is Promoted and Implemented**

The MIECHV Program, beginning with FY 2010 funding, provides Georgia an opportunity to develop evidence-based home visiting services within a comprehensive, community-based early childhood system. Since planning began in the summer of 2010, the Georgia MIECHV Leadership Team developed a common vision for improving outcomes for children and families, which includes providing support for all expectant families and children, birth to five, and their families. The Leadership Team agreed that providing the support needed by families could best be accomplished through the provision of evidence-based home visiting services embedded in a
community-based Early Childhood System of Care (ECSOC). The ECSOC is grounded in the national ‘system of care’ framework, which incorporates effective, community-based services and supports that are organized into a coordinated network. The ECSOC presents a population-based approach to screening expectant parents and infants shortly after birth, and a system of referral for children up to age five to provide basic parenting support and to determine family needs and wishes. It identifies all potential resources in the community and outlines a process to assure coordination of those services and supports. A diagram outlining the system components and functions of the ECSOC was included in the Updated State Plan.

In addition, the ECSOC model is being used to promote evidence-based home visiting programs as a major service strategy within a comprehensive system of care throughout the state. The model represents Georgia’s vision of a system at the community level that provides a welcome for every child, makes available natural supports for all expectant families, children birth to five, and their families, creates a community culture of caring and encouragement for families before and after the birth of a child, and links families with more intensive services, when needed.

The ECSOC provides a blueprint for the coordination of a community outreach function, a central intake function where screening and referral to services takes place, and coordination of care through home visiting programs for eligible at-risk families and through other community service providers when other services are more appropriate. A more detailed description of home visiting program implementation and coordination with existing programs and resources is presented in Section 4.

Existing Service Gaps

Service gaps exist in all of the targeted at-risk communities. Most notably, these include:

- Mental Health Services: State mental health services are very limited in most communities and maternal depression is a significant issue among pregnant women, especially those living in poverty and other stressful situations.

- Substance Abuse Treatment: Substance abuse is an issue that affects our communities and significantly affects the ability of the home visiting program to make positive changes in the family. While there are few treatment programs, there are only a handful of treatment programs for women who need to bring their children with them.

- Domestic/Family Violence: Domestic violence has been identified as an issue for many of the targeted at-risk counties. It is also related to substance abuse and mental health concerns. Some counties have domestic violence shelters, while others do not.

- Immigration, Culture and Language: Families that come to this country for employment, education, or political oppression in their countries of origin, are often at a disadvantage because of issues related to culture, language, and the circumstance that brought them here. These factors affect the provision of services to these families. Home visiting staff must be able to understand these issues, and address them appropriately. Hiring staff who can communicate with these families in their language is a basic necessity.

- Transportation: Transportation continues to be an issue for many at-risk families in Georgia. Most communities do not have reliable and low-cost transportation, making access to services more difficult.

Addressing Existing Service Gaps

- Each community in Georgia has a Georgia Family Connection Network made up of community partners who are interested in improving the well-being of their children and
families. The Network is where many of the issues listed above are discussed and strategies developed to address the gaps in and barriers to service.

- Each of the seven targeted at-risk counties also have an existing Community System of Care Grant (SOC) from GOCF, which provides intensive needs families with care coordination and local case staffing that effectively address gaps and barriers to service for these families.
- Through the existing SOC, the evidence-based home visiting programs in the seven counties will be in a better position to address some of these services gaps through caring relationships.
  - Home visiting programs will recruit, hire, and train home visitors that understand and can communicate with immigrant, as well as, other families that may be included in the target population.
  - Home visitors will screen for maternal depression and assist in finding evaluation and treatment services. In addition, they will help families negotiate through the service system.
  - Home visitors will also address substance abuse issues as they are observed. Child welfare referrals will be made as needed. Home visitors will assist in finding evaluation and treatment services, and address safety issues.
  - In domestic violence situations, home visitors will help the family make a safety plan, assist families in accessing resources, develop a social network for support, and create a plan to become economically self-sufficient over time.
  - In addition, home visiting programs serve families in the home environment, so that transportation is not required. This is especially important for families that are isolated due to geography, mental illness, family violence issues, lack of resources, and the like.
- The MIECHV Leadership Team will continue to advocate on the state level for these needed services.

Local and State Capacity to Integrate Home Visiting Services into an Early Childhood System

As described above, the Georgia MIECHV Leadership Team, which represents all key state partners serving and supporting expectant families and those with young children, has made a commitment to develop its home visiting program within an ECSOC framework. With the buy-in from these partners and the understanding and agreement of each of our seven community partners, Georgia has the state and local capacity to integrate home visiting services into an early childhood system.

State Level

The MIECHV Leadership Team, with all appropriate state partners, has the capacity to lead the state in using evidence-based home visiting as a major service strategy within the ECSOC. Evidence-based home visiting and the ECSOC Model has received support from many GA early childhood professionals and advocates. The seven targeted at-risk counties will serve as demonstration sites for documenting the effectiveness of Georgia’s plan and will serve to inform state and community leadership for moving forward.

Local Level

The MIECHV Program state staff is providing guidance and support to all seven counties in the development of community plans for the expansion and/or addition of evidence-based home visiting programs. Communities were asked to use the ECSOC diagram to describe their community plan and provide a community level description of how all of the processes and functions of the ECSOC will occur. Communities are also required to assure the involvement of all appropriate local partners in the plan including: Community System of Care Governance Group, Family Connection Collaborative/Board, District or Local Public Health Office, County
Department of Family and Children Services, Existing Home Visiting Programs (HFG, PAT, EHS-HBO), Other Community Service Agencies/Providers or Leaders

**List of At-Risk Communities Not Selected for Implementation Due to Limited Funding**

There were seventy-two (72) counties identified as at-risk through the Home Visiting Needs Assessment conducted by the Division of Public Health, Maternal and Child Health Program. Of those, seven (7) counties were chosen to receive funding, leaving sixty-six (65) at-risk counties that were not selected for funding. They are: *(Note: Highlighted counties were selected for funding).*

1. DeKalb  
2. Bibb  
3. Muscogee  
4. Richmond  
5. Fulton  
6. Clayton  
7. Liberty  
8. Dougherty  
9. Chatham  
10. Whitfield  
11. Polk  
12. Carroll  
13. Colquitt  
14. Glynn  
15. Lumpkin  
16. Spalding  
17. Tift  
18. Clarke  
19. Coffee  
20. Ware  
21. Houston  
22. Walker  
23. Bartow  
24. Crisp  
25. Gordon  
26. Barrow  
27. Troup  
28. Lowndes  
29. Rockdale  
30. Sumter  
31. Baldwin  
32. Jackson  
33. Brantley  
34. Crawford  
35. Thomas  
36. Burke  
37. Toombs  
38. Haralson  
39. Worth  
40. Brooks  
41. Laurens  
42. Berrien  
43. Decatur  
44. Greene  
45. Floyd  
46. Cook  
47. Stephens  
48. Pulaski  
49. Bleckley  
50. Jeff Davis  
51. Ben Hill  
52. Irwin  
53. Lanier  
54. Bulloch  
55. Putnam  
56. Lamar  
57. Mitchell  
58. Jones  
59. McIntosh  
60. Telfair  
61. Dade  
62. White  
63. Butts  
64. Taylor  
65. Camden  
66. Seminole  
67. Jasper  
68. Screven  
69. Peach  
70. Elbert  
71. Dooly  
72. Macon

**Section 2: Home Visiting Program’s Goals and Objectives**

The overall goal of Georgia’s MIECHV Program is to improve child and family outcomes in Georgia by implementing evidence-based home visiting as a major service strategy within an Early Childhood System of Care. Georgia’s program is designed: (1) to improve coordination of services for children and families at the state and local levels; and (2) to provide comprehensive services to improve outcomes for families who reside in at-risk communities. Georgia plans are as follows:

- Implement Evidence-Based Home Visiting models within an Early Childhood System of Care (ECSOC) in seven demonstration counties.
- Assist counties in selecting 1 – 4 of the Evidence-Based home visiting models offered in Georgia (Early Head Start Home-Based Option, Healthy Families Georgia, Nurse Family Partnership and Parents As Teachers) for expansion or implementation based on county risks and needs.
- Develop a cohesive plan to promote program quality and effectiveness by providing ongoing training and technical assistance to counties in implementation of evidence-based home visiting programs within an ECSOC.
- Develop a coordinated data system to guide decision making and target services that will assist counties in monitoring benchmark progress and continuous quality improvement.
Georgia has developed the following objectives based on the specific child and family benchmark areas that are being tracked for the MIECHV Program.

**Objectives**

1. Improve maternal and newborn health in the targeted at-risk populations as evidenced by:
   - ↑ % of women receiving adequate prenatal care as defined by ACOG
   - ↑ % of women receiving postpartum follow-up checks within 8 weeks of birth.
   - ↑ % of mothers receiving information about contraception within 6 weeks of birth.
   - ↑ % of mothers with positive depression screens being referred for evaluation/treatment.
   - ↑ % of women enrolled prenatally who initiate breastfeeding.
   - ↑ % of children with medical home and receiving appropriate well-child visits after birth.

2. Prevent child injuries and child neglect, and reduce emergency department visits in the targeted at-risk populations as evidenced by:
   - ↑ % of families receiving injury prevention and child safety information.
   - ↓ % of children with injuries requiring treatment.
   - ↓ % of mothers/families reported for suspected maltreatment.
   - ↓ % of mother who have substantiated maltreatment reports.
   - ↓ % of mothers and children with ER visits.

3. Improve school readiness and achievement in the targeted at-risk populations as evidenced by:
   - ↑ % of mothers showing an increase in knowledge of child development.
   - ↑ % of parents showing an increase in the quality of the parent-child relationship.
   - ↑ % of parents showing decreased levels of parental stress.
   - 90% of children with positive developmental screening referred to appropriate provider.
   - 90% of parents are reading to their children (> 9 months) at least 3X weekly.

4. Reduce domestic violence in the targeted at-risk populations as evidenced by:
   - ↑ % of mothers screened for domestic violence.
   - ↑ % of mothers screening positive for domestic violence referred for services.
   - ↑ % of adults needing services who have a safety plan for themselves and their children.

5. Improve family economic-sufficiency in the targeted at-risk populations as evidenced by:
   - ↑ # of families reporting access tangible goods and services to support their families.
   - ↑ # of mothers reporting access to resources for employment assistance.

6. Improved coordination and referrals for other community resources and supports in the targeted at-risk populations as evidenced by:
   - ↑ # of community services that is available for families.
   - ↑ # of families who are screened for eligible community services.
   - ↑ # of MOUs between MIECHV Program and other community services.
   - ↑ # of agencies having identified a clear point of contact for data sharing between agencies.
   - ↑ % of families receiving services to which they have been referred.

Georgia’s logic model is included as Attachment 1 and an implementation timeline is provided as Attachment 2.

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

**Evidence-Based Home Visiting Models to be Implemented in Georgia**

For FY 2010, the Georgia MIECHV Leadership Team presented a plan to expand existing evidence-based home visiting programs in six communities to address community needs and to strengthen the foundation for evidence-based home visiting in the state. The plan for FY 2011 is
to continue to support the expanded programs in the original six communities and to further
develop Georgia’s comprehensive home visiting system. In FY 2011, an additional evidence-
based home visiting model, Nurse Family Partnership, will be implemented to strengthen
services in the area of maternal and newborn health. Also, Houston County is being added to the
original six counties, making a total of seven communities for implementation of evidence-based
home visiting.

In the first year of the Georgia MIECHV Program, the MIECHV Leadership Team selected
three evidence-based home visiting models to be expanded in the six at-risk communities. The
three models, Early Head Start-Home Based Option (EHS-HBO), Healthy Families America
(HFA) and Parents as Teachers (PAT), were selected because each of the models has:

- a history of at least ten years successful implementation in Georgia communities
- a home visiting model technical assistance infrastructure within the state
- a good fit with the Georgia Early Childhood System of Care target population of expectant
parents and families with children birth to five years
- demonstrated effectiveness in serving the types of families to be given priority for
participation in the ACA MIECHV Program
- demonstrated effectiveness in addressing needs identified in Georgia at-risk communities

The three models are a good fit for addressing the majority of needs in most of the original
six communities in the FY 2010 plan and the additional community of Houston County selected
in the FY 2011 plan. The table below summarizes the areas of need identified in those
communities according to the six federal legislation benchmark areas to be impacted by home
visiting.

### Georgia MIECHV Program Community Needs

<table>
<thead>
<tr>
<th>Community</th>
<th>Maternal/ Newborn Health</th>
<th>Child Abuse/ Neglect</th>
<th>School Readiness</th>
<th>Domestic Violence</th>
<th>Family Economic Self-Sufficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke County</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Crisp County</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>DeKalb County</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Glynn County</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Muscogee County</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Whitfield County</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Houston County</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The HFA model, which has demonstrated favorable impact in almost all areas of community
need, serves as a strong base for providing services in the at-risk communities. EHS-HBO and
PAT programs strengthen services in the areas of school readiness and family economic self-
sufficiency and provide for a more comprehensive home visiting system by broadening the range
of program entry and offering specialized early childhood services, such as school transition. The
area of need not specifically impacted by any of the FY 2010 selected models is maternal health.
In FY 2011, maternal health services in Georgia will be further strengthened by implementing
the Nurse Family Partnership (NFP) model. The following table indicates community areas of
need favorably impacted by the models selected in the FY 2010 plan and the FY 2011 plan.

<table>
<thead>
<tr>
<th>Home Visiting Program</th>
<th>Evidence-Based Home Visiting Program Model Favorable Impact Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHS</td>
<td>✓</td>
</tr>
</tbody>
</table>
To engage community leaders in assessing the fit of the selected home visiting models with their community needs, the MIECHV Management Team held two community meetings in the six FY 2010 communities. In addition, conversations have been held with Houston and Muscogee Counties to discuss the addition of NFP in those communities in FY 2011. Each of the original six communities has completed a draft plan and budget for the FY 2010 MIECHV Program and Muscogee and Houston County have each selected a model for implementation in FY 2011. The table below indicates the model selection(s) of each community and the fit of the favorable impact of the model with community needs. An x indicates an area in which a need exists and the selected program model has not been demonstrated to meet that need.

<table>
<thead>
<tr>
<th>Community (County)</th>
<th>Maternal Health</th>
<th>Newborn/Child Health</th>
<th>Child Abuse/Neglect</th>
<th>School Readiness</th>
<th>Domestic Violence</th>
<th>Family Economic Self-Sufficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke</td>
<td>x</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
</tr>
<tr>
<td>Crisp</td>
<td>x</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
</tr>
<tr>
<td>DeKalb</td>
<td>x</td>
<td>x</td>
<td>EHS/PAT</td>
<td>x</td>
<td>EHS</td>
<td></td>
</tr>
<tr>
<td>Glynn</td>
<td>x</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td>HFA</td>
<td></td>
</tr>
<tr>
<td>Muscogee</td>
<td>NFP</td>
<td>HFA/NFP</td>
<td>HFA/NFP</td>
<td>HFA/NFP</td>
<td>HFA/NFP</td>
<td></td>
</tr>
<tr>
<td>Whitfield</td>
<td>x</td>
<td>HFS</td>
<td>HFA</td>
<td>HFA/PAT</td>
<td>HFA</td>
<td></td>
</tr>
<tr>
<td>Houston</td>
<td>NFP</td>
<td>NFP</td>
<td>NFP</td>
<td>NFP</td>
<td>NFP</td>
<td>NFP</td>
</tr>
</tbody>
</table>

While the programs selected can address most community needs, there are areas in which a favorable impact of models selected by communities has not been demonstrated. There are gaps for several areas of need in DeKalb County, two of which, newborn/child health and domestic violence are expected to be addressed through implementation of the new PAT Foundational Training curriculum that specifically covers these areas. To address the gap that remains in meeting maternal health needs in communities, strategies of increasing prenatal program entry, coordinating care among ECSOC maternal health service providers and home visitors, and providing home visitor training to increase competencies in addressing maternal health factors have been developed.

For FY 2010, the Georgia MIECHV Program laid a strong foundation for home visiting by strengthening and expanding existing models and implementing strategies to address gap areas in service. By adding an additional program to address a specific need and expanding to an additional at-risk community for FY 2011, Georgia is developing a comprehensive home visiting system that can address all areas of need for first time and multiparity families entering the system during various points in pregnancy and beyond in an increasing number of Georgia communities. The protocol below developed in Muscogee County for the FY 2011 plan illustrates how this comprehensive home visiting system can provide a systematic process for decision-making, maximize the available resources, and effectively address family needs in Georgia communities.

<table>
<thead>
<tr>
<th>HV Program</th>
<th>Entry Status</th>
<th>Program End</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFP</td>
<td>1st time pregnant women, ≤ 28 weeks pregnant, Low income</td>
<td>Child’s 2nd birthday</td>
</tr>
<tr>
<td>HFG</td>
<td>Multiparous pregnant women ≤ 28 weeks pregnant</td>
<td>Child’s 5th birthday</td>
</tr>
<tr>
<td>HV Program</td>
<td>Entry Status</td>
<td>Program End</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>1st time and multiparous pregnant women &gt; 28 weeks pregnant</td>
<td>birthday</td>
</tr>
<tr>
<td></td>
<td>Birth to 2 weeks postpartum (80%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth to 3 months postpartum (20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NFP caseloads full</td>
<td></td>
</tr>
<tr>
<td>PAT</td>
<td>Infant &gt;2 weeks or &gt;3 months</td>
<td>Child’s 5th birthday</td>
</tr>
<tr>
<td></td>
<td>Child up to 3 years of age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NFP and HFG caseloads full</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At age 2 years when NFP ends</td>
<td></td>
</tr>
</tbody>
</table>

Description of State’s Current and Prior Experience with Implementing the Models Selected and Capacity to Support the Models

Three of the selected models have each been operating successfully for a minimum of ten years in the state and each has a strong base of support at the community and state level. There are currently 19 Early Head Start programs, including four EHS-HBO programs which served 228 families in 2010. Healthy Families Georgia (HFG), which currently has programs in eight counties, served 778 families in FFY 2010. There are currently 33 PAT programs in Georgia serving approximately 1600 families per year. While the state does not currently have a NFP program, a NFP Program Developer is based in Georgia and is available to work closely with developing NFP sites. All communities selected to participate in the Georgia MIECHV Program have prior experience implementing EBHV programs and have an existing home visiting program infrastructure on which to expand. The HFG programs in the Clarke, Crisp, Glynn and Whitfield Counties are among the original HFA programs in Georgia. Each has been operating continuously since 1995 or before and each has at least one HFA home visitor providing service for the program for the past 16 years. Whitfield, DeKalb and Muscogee County are all expanding existing PAT programs. PAT program experience and existing home visiting infrastructure will support the development of HFG and NFP programs in Muscogee County. In addition, the Muscogee County medical community has become a partner in implementing HFG and NFP programs. Houston County has an existing Even Start program that is blended with a PAT model and also currently delivers the home visiting Nurturing Parenting curriculum to high needs families. All the MIECHV communities have existing Systems of Care with community partners supporting the implementation of home visiting. At the state level, the Early Childhood System of Care Home Visiting (ECSOC HV) Team and the ECSOC Home Visiting Information System and Evaluation (HVISE) Team, supported by the Center for Family Research at the University of Georgia, provide a coordinated infrastructure to support the technical assistance, training, data collection and management, and quality assurance for EBHV programs. These teams are currently supporting existing HFG and PAT programs and have the capacity to coordinate training and technical assistance with EHS-HBO Program Specialists and to contract for NFP technical assistance.

State Plan for Ensuring Quality and Fidelity of the Home Visiting Models

The Center for Family Research at the University of Georgia has developed an Early Childhood System of Care Home Visiting (ECSOC HV) Team to provide a state-level centralized infrastructure to support the implementation of evidence-based home visiting models in Georgia’s MIECHV Program. The ECSOC HV Team will participate in program planning and ensure that technical assistance, training, quality assurance, data collection, and reporting on program fidelity and quality is provided to ECSOC HV Partners responsible for administration and management of the home visiting program(s). The HV Team will provide these services for
HFA/HFG and PAT sites and will communicate regularly with EHS-HBO and NFP technical assistance staff regarding the status of the EHS and NFP programs.

Each MIECHV home visiting program will commit to adhering to program model standards through affiliation with HFA or PAT national models; signing of the NFP contract; or completing the implementation and annual plans for EHS. Each of the four models selected for the MIECHV Program will base the operation of their program on the set of standards that guide program implementation: Head Start Program Performance Standards for EHS-HBO; HFA Self Assessment Tool based on twelve Critical Elements; PAT Essential Requirements; and NFP Model Elements. The HV Team and local program management will ensure that staff of each program complete the program model required core training for delivering program services. Supervision at the program level will reinforce core training concepts and, through reflective practice, support staff in developing competency in delivering services consistent with the intent of the program model. Program managers will monitor performance at the program level through implementation of quality assurance plans that include such activities as observation of staff service delivery, participant surveys, file review and data. The HV Team will monitor program performance for quality and for adherence to model standards through ongoing technical assistance calls, program data reports, and site visits. Data collected on program operation and service delivery will be reviewed regularly at the local and state level to assess program performance. The HV Team will identify and track performance indicators common to different program models and, with CQI teams, develop strategies for addressing areas that impact model fidelity. The HV Team will work with program managers, clinical supervisors, and home visiting staff to implement processes and/or training that can favorably impact service delivery and fidelity to the model.

Challenges with the models at the program level could result from changes to existing program model standards, practices or curricula by national model developers as the models are being implemented. The PAT curriculum has recently been revised, and HV Team PAT State Leader and State Coordinator have developed a plan for addressing challenges of implementing the new practices. HV Team members have been trained in the new Foundational Training and continue to clarify and obtain clear expectations for program standards and practices. All PAT staff and supervisors will attend the full 5-day Foundational Training after which the PAT HV Team will complete an onsite TA visit to review the new curriculum, the New Affiliate Plan, the PAT Essential Requirements and standards checklist. The HV Team PAT Network Team will conduct regular onsite visits to monitor adherence to the PAT standards and provide technical assistance, and will complete bi-annual file review and shadowing of Parent Educators to ensure compliance with personal visit standards. In addition, the team will review monthly and quarterly data reports, using results to guide practice; convene peer-to-peer matches to review standards and progress toward outcomes; and review the PAT Affiliate Progress Report, providing feedback on areas not meeting standards.

Challenges and Risks Associated with Home Visiting Models

Challenges may arise at the community level if expectations of community partners for use of the models are inconsistent with model design and service or if models selected by a community do not prove effective in impacting benchmark areas. The ECSOC HV Team will provide a detailed overview of each EBHV program model and on-site technical assistance from ECSOC HV Team program model staff during the Georgia ECSOC MIECHV Program planning process. The ECSOC HV Team will provide training, technical assistance and quality assurance related to impacting benchmark areas. Georgia may need technical assistance related to practices
for impacting benchmark areas found to be effective by researchers or by practitioners in other states.

Section 4: Implementation Plan for Proposed State Home Visiting Program

Description of the Process for Engaging Communities

The Georgia MIECHV Program is embedded in the Early Childhood System of Care (ECSOC) that exists within each of the seven communities selected to participate in the FY 2010 and the FY 2011 MIECHV Program. The SOC Administrator serves as the point of contact for each community. Selected communities were initially contacted by the MIECHV State Lead. To plan for the FY 2010 MIECHV Program, members of the MIECHV Management Team made two site visits to each of the original six communities between 3/4/11 and 6/2/11. They met with community leaders including System of Care Administrators, Home Visiting Program Directors, Georgia Family Connection Network staff, public health and child welfare leadership, service providers, and other community leaders and potential funders, such as United Way representatives and Community Foundation CEOs. The MIECHV Management Team has held conversations July 2011 with Houston County and Muscogee County leaders to plan for the expansion of the MIECHV Program in those counties for FY 2011. In each of the selected communities, community leaders were engaged in discussing their community needs, evaluating their interest and capacity for participating in the MIECHV program, and accessing the fit of the evidence-based home visiting models with identified community needs. The Management Team provided community partners with a profile of their community that included specific indicators of risk as well as an individual community chart indicating community areas of need in maternal and newborn health, child abuse and neglect, school readiness, domestic violence and family economic self-sufficiency. Community leaders were advised to select the evidence-based home visiting model(s) that would best meet the needs of the community. In FY 2010, six communities were given choices of expanding three program models existing in Georgia, EHS-HO, HFA and PAT. In FY 2011, the additional evidence-based home visiting model of NFP was offered as an option to Houston County, the seventh at-risk community, and to Muscogee County, one of the original six communities, to address significant maternal health needs not demonstrated by research to be impacted by the three models selected in FY 2010.

A chart indicating areas of need favorably impacted by evidence-based program models was provided to communities to assist with the model selection process. Each community selected the model(s) that community partners determined to be the best fit for addressing their community needs. Each of the six communities completed a draft plan and budget for FY 2010 implementation, and Muscogee County and Houston County have each selected programs for implementation for FY 2011. FY 2010 final community plans and budgets are expected to be approved in August 2011, contracts in place as of October 2011, and direct service implemented in January 2012. In preparation for implementation of the FY 2010 plan, members of the ECSOC Home Visiting Team and program supervisors and current staff have been trained in the new PAT Foundational Training in January, April and July 2011. Staff is expected to be hired for MIECHV program expansion after contracts are signed in October 2011. Home visiting core training, data system testing and training, and benchmark measures training for all three program models selected in the FY 2010 program will be scheduled November through December 2011. Contracts for the FY 2011 program expansion are expected to be in place as of January 2012 with service implementation tentatively scheduled to begin April 2012. Staff hiring and home
visiting trainings required for implementation of the FY 2011 program are tentatively planned for January through March/April 2012.

**Development of Policy and Standards for the State’s Home Visiting Program**

The ECSOC Management Team proposes policy and standards for the Georgia MIECHV Program with input from the seven demonstration sites. The Georgia MIECHV Leadership Team, who is key in providing input and guidance in development of the State Plan and implementation of the Georgia MIECHV Program, reviews the proposed policy and standards. The Governor’s Office for Children and Families, as the MIECHV State Lead, has responsibility for making final decisions on policy and standards.

**Plan for Working with National Model Developers**

Georgia has received approval from national model developers of four EBHV programs (EHS-HBO, HFA, PAT and NFP) to implement their models in the Georgia MIECHV FY 2010 and FY 2011 Program. The Georgia MIECHV State Lead has designated responsibility for coordinating technical assistance, training and quality assurance for programs using these models to The Center for Family Research at the University of Georgia (CFR) and their Georgia Early Childhood System of Care Home Visiting (ECSOC HV) Team. The ECSOC HV Team has developed the following plans for working with the national model developers:

- **Early Head Start (EHS)**

  The ECSOC HV Team Director of HV TA, Training and Evaluation will maintain contact with the Office of Head Start (OHS), Administration for Children and Families (ACF), Department of Health and Human Services (HSS), Georgia Head Start Collaboration Director and the Georgia ECE Specialist and State Manager to ensure that expansion/implementation of EHS Home Based Option (HBO) programs meet Head Start/Early Head State requirements. The EHS-HBO DeKalb County program selected to expand home visiting to additional families will advise the Office of Head Start of its intent to increase the number of families currently being served. The OHS is responsible for approving the EHS-HBO plan and monitoring grantee compliance with OHS regulations. The assigned federal Program Specialist will provide support and oversight, monitor fidelity to the model and examine the training and technical assistance of the regional contractors responsible for the DeKalb County program. The OHS Region IV contractors will provide training and technical assistance to the EHS-HBO program. The OHS National Centers will also support the program. The Early Childhood Learning and Knowledge Center will provide information, resources and learning opportunities. The Early Head Start National Resource Center will provide services, such as webinars, webcasts, audio conference calls and a listserv. Lastly, The ECSOC HV Team Director of HV will maintain contact with OHS Regional Office Program Specialists and Region IV Training/Technical Assistance contractors to be informed of program technical assistance and training issues and to ensure that the program participating in the Georgia MIECHV Program is operating in full compliance with Head Start Program Performance Standards and is informed of program technical assistance and training issues.

- **Healthy Families America (HFA)**

  The Georgia ECSOC HV Team includes the Healthy Families Georgia (HFG) State Coordinator, HFA Program Manager certified trainers, a HFA Family Assessment Worker (FAW) certified trainer, a HFA Family Support Worker (FSW) certified trainer, and a Growing Great Kids Curriculum certified trainer. The HFG State Coordinator and the HFA FSW Trainer, as HFA State Leaders, maintain contact with the HFA national office. They work with Clarke, Crisp, Glynn, Whitfield and Muscogee Counties to expand/develop and maintain HFA MIECHV
programs. The HFA State Leaders provide technical assistance, required training, and quality assurance for HFG programs. They ensure that HFG programs maintain fidelity to the national model and comply with HFA program affiliation and accreditation requirements. The HFA national office gives current information/upDATES to HFA State Leaders regarding the HFA national office, model requirements, and activities related to training, research and other areas. The HFA State Leaders disseminate the information to the HFG program network. The HFA national office completes the affiliation process with HFG programs at program development and annually. The national office uses peer review to complete the HFA program accreditation process with HFG programs within three years of program development and every four years thereafter. The HFA national office provides certification/recertification of HFA trainers and resources for HFG program staff.

**Parents as Teachers (PAT)**

The Georgia ECSOC HV Team includes the PAT State Leader and the PAT State Coordinator, comprising the PAT State Office. The PAT State Office works with the national office to: expand and maintain PAT programs the Georgia MIECHV counties of DeKalb, Muscogee and Whitfield; assist with site preparation of PAT implementation; ensure that PAT affiliates obtain training, guidance and resources to support services and positive outcomes; promote the value of parental involvement and early intervention in the child development/educational continuum; provide technical assistance for Georgia PAT programs; promote model fidelity; facilitate certification of parent educators; and support data collection/reporting. The PAT State Leader reviews the Georgia PAT program annual reports submitted by Georgia PAT programs. The PAT national office provides assistance to the PAT State Office in fulfilling its responsibilities related to advocacy, collaboration and networking, communication, training and technical assistance, and fidelity and quality. The national office provides materials and guidance for funding and marketing, communicates vital updates regarding PAT, and develops curricula on quality, technical assistance and evaluation.

**Nurse Family Partnership (NFP)**

The ECSOC HV Team Director of HV TA, Training and Evaluation is the Georgia MIECHV Program point of contact for the NFP National Service Office (NSO), the NFP Program Developer and NFP NSO Nurse Consultant. She ensures that the NFP NSO and NFP Georgia staff/consultants are provided with information as needed and will work collaboratively with the NFP Program Developer to ensure that the Georgia MIECHV Program Early Childhood System of Care in Muscogee County and Houston County support the development and implementation of NFP programs. The NFP NSO will provide program planning assistance, nursing education service, and continuous program support for NFP programs. Since the Georgia MIECHV State Lead has designated responsibility for coordinating technical assistance, training and quality assurance for MIECHV programs to the ECSOC HV Team, the HV Team Director will ensure that budget allocations are made for programs to cover these services and will communicate regularly with NFP NSO Georgia staff/consultants regarding the status of the Georgia NFP programs. The NFP NSO will provide NFP sites with a data collection and reporting system. The Home Visiting Information System and Evaluation Team (HVISE) at CFR, UGA will provide Georgia MIECHV Programs with a data and reporting system, Georgia Home Visiting Information System (GEOHVIS), as well. Since both systems use the same Efforts to Outcomes (ETO) software by Social Solutions Inc., the HV and HVISE Teams will explore with NFP NSO possibilities for reducing data entry burden for Georgia NFP programs.
Timeline for Obtaining Curriculum on Models

Three of the four evidence-based home visiting models being implemented in the Georgia MIECHV Program, EHS-HBO, HFA and PAT, have existed in the state for at least ten years and have infrastructure in place to provide training for staff. Contracts for EHS-HBO, HFG and PAT programs to be expanded for FY 2010 are expected to be signed October 2011. October through December 2011 will be an implementation period. Staff is expected to be hired by mid-November and trained mid-November through December. Curriculum materials will be obtained when staff attends training. With the development of new NFP programs, several steps will need to be completed before curriculum and materials can be obtained. Contracts for NFP programs to be developed for FY 2011 are expected to be signed January 2012. January through March 2012 will be an implementation period. Recruiting will begin in January and hiring is tentatively scheduled to be completed in February. The processing of the proprietary protection letter by the NFP National Service Office and the shipment of curriculum and other materials is expected to occur in March 2012.

Description of Training and Professional Development Activities

- **National Model Developer Training:** Office of Head Start (OHS) Program Specialists review EHS-HBO annual Training Technical Assistance plans to ensure they include mandatory training according to OHS Performance Standards. OHS contracts for training to be provided to grantees annually. The HFA national office will provide online training on HFA “additional required training” topics for HFA/HFG program staff. The PAT national office will be scheduled to provide PAT Foundational Training/complementary trainings at least three times per year; all PAT Parent Educators and Supervisors will receive Foundational Training prior to providing service. The NFP National Service Office (NSO) delivers initial NFP Core Education and ongoing training for home visitors and supervisors. The training includes self-study, distance learning and face-to-face learning methods. The Partners in Parenting Education (PIPE) parenting curriculum is included in the self-study and face-to-face training sessions. The NFP NSO also provides face-to-face training for NFP program Administrators. All face-to-face education sessions are held in Denver.

- **State Training:** Head Start/Early Head Start Regional Office consultants can provide mandatory training to the DeKalb County EHS-HBO program based on the site’s approved Training/Technical Assistance (TTA) plan. The Early Childhood System of Care Home Visiting (ECSOC HV) Team will schedule initial HFA training and PAT Foundational Training at least three times per year. ECSOC HV Team certified trainers will provide training for Family Assessment Workers, HFA Family Support Workers, and HFA Program Managers/Clinical Supervisors and Growing Great Kids curriculum training for HFG personnel. The ECSOC HV Team will coordinate ongoing and core competency training opportunities at least twice per year for State home visitors, including EHS-HBO, HFG, PAT and NFP.

- **Local Agency Training:** The DeKalb County EHS-HBO program will develop and submit an annual training plan to the OHS Regional Office. The program has local control over its TTA resources for obtaining required training. Local HFG and PAT programs are responsible for coordinating orientation and additional training and professional development required by national model developers and curriculum developers for specific topics and hours. NFP program supervisors may use topical education and discussion guides provided by the NFP NSO in staff team meetings. They are encouraged to identify experts from related fields in their communities to provide professional development for staff.
Plan for Recruiting, Hiring and Retaining State Level Staff

All state level GA MIECHV Program staff has been hired through subcontracts with the GA MIECHV State Lead, GOCF. The GA MIECHV Program Project Manager has experience providing health and social services, management of state level programs/projects, and more than ten years of project management related to the development of early childhood systems. She coordinates the work of the GA MIECHV project, engaging stakeholders, developing partnerships and collaborating with childhood initiatives in support of home visiting. The Center for Family Research (CFR) at the University of Georgia serves as the administrative, scientific and fiscal home for a coordinated infrastructure for the training; technical assistance and evaluation of the expanding home visiting system.

- The Associate Director, CFR, provides oversight of home visiting infrastructure, budget, contract deliverables, and development of the GA MIECHV project data system.
- The ECSOC HV Team provides leadership, program network coordination, technical assistance, training and quality assurance to local systems of care and home visiting programs. The majority of the HV Team staff held the same or very similar positions previously with several different organizations. They were recruited and hired by the MIECHV Program subcontractor, Center for Family Research at the University of Georgia, to develop a team responsible for providing coordinated services to the home visiting network in Georgia. The team consists of the following staff: (1) Director of Home Visiting Technical Assistance, Training and Evaluation, (2) ECSOC Outreach Coordinator, (3) HFG State Coordinator, (4) PAT State Coordinator, (5) HFG TTA Consultant, (6) PAT Consultant/PAT State Leader.
- The ECSOC Home Visiting Information System and Evaluation (HVISE) Team is responsible for the development of the Georgia Home Visiting Information System (GEOHVIS) that supports the implementation of EB-HV programs within the ECSOC and provides efficient tracking of process outcome data for reporting requirements. The staff for this team was recruited from other positions at the University of Georgia. They developed and maintained the Healthy Families Georgia Information System and have provided data system service and technical assistance to the HFG evidence-based home visiting program for more than ten years. The positions on the team are: (1) Information System Technical Lead, (2) Program Site Liaison/Assistant Director Georgia Home Visiting Technical Assistance, Training & Evaluation.

Retention of staff has been addressed by recruiting and hiring qualified staff, knowledgeable and experienced in the work. Retention will continue to be addressed by providing opportunities for professional growth in implementing a national home visiting initiative, opportunities to expand knowledge of the field through cross-training, increased opportunities for professional collaborative partnerships, and regular supervision and team meetings.

Plan for Community Sub-Contractor Organizations Recruiting, Hiring and Retaining Staff

Current fiscal agents for the existing systems of care in the seven targeted at-risk communities will be the subcontractor organizations, unless the current agent requests a change. The fiscal agent will be a public government entity or a 501(c)(3) non-profit organization and has oversight for the financial, program and post-award reporting requirements in cooperation with the Early Childhood System of Care (ECSOC) Governance Group. The governance group, comprised of community partners that provide policy level cross-agency governance and management of the ECSOC, will identify an ECSOC Home Visiting (HV) Partner agency. The designated HV Partner agency in each of the seven communities is responsible for ensuring that evidence-based home visiting services are coordinated in the community. The HV Partner agency administers...
one or more home visiting programs and may coordinate the provision of home visiting services with another home visiting agency in the community. HV Partners are responsible for the recruitment, hiring, and retention of staff. All of the agencies have protocols, which ensure that staff are hired and appropriately trained for the various high risk populations served. Examples of these protocols include: (1) Writing clear job descriptions; (2) Advertising position for two weeks; (3) Compliance with Equal Employment Opportunity guidelines; (4) Recruiting with cultural and linguistic needs of high risk families in mind; (5) Providing adequate supervision; (6) Providing training for position responsibilities; (7) Using an interview team; (8) Performing criminal background check for those working directly with families.

In addition, guides for recruiting and hiring staff for specific program models have been developed by model developers, such as NFP, and by the HV Team for HFG and PAT sites. Agencies in certain communities, such as DeKalb County with a large refugee population, recruit home visitors who are originally from the native countries of the refugees served by the program. Retention will be addressed by hiring well qualified staff; providing required initial and ongoing training; providing quality clinical supervision that reinforces training, guides practice and supports staff; providing regular feedback on work performance and formal performance reviews; soliciting feedback from front line staff, and offering opportunities for professional development. Programs may conduct periodic analyses of staff turnover and take action to correct identified problems with guidance from the State ECSOC HV team.

Preliminary Home Visiting Partner agencies have been identified as follows:

- Clarke County: Prevent Child Abuse Athens
- Crisp County: Cordele Housing Authority
- DeKalb County: DeKalb Board of Health
- Glynn County: Coastal Coalition for Children
- Houston County: Community Health Works
- Muscogee County: University of Georgia County Extension Service
- Whitfield County: Family Support Council

**Plan to Ensure High Quality Clinical Supervision and Reflective Practice for Home Visitors and Supervisors**

Each of the evidence-based models being implemented has requirements for clinical supervision and reflective practice. The Early Childhood System of Care Home Visiting (ECSOC HV) Team will provide technical assistance and quality assurance to support programs in hiring and supervising clinical supervisors; coordinate clinical supervisor trainings, including reflective supervision/practice; and provide supervisor opportunities for shadowing/networking to enhance supervision skills. Program managers/supervisors will ensure that the supervisor to staff ratio and the frequency of supervision meets program model requirements; clinical supervision includes reflective practices that foster the development of trusting relationships between the supervisor and home visitors; and support home visitor professional development.

**Plan for Identifying, Recruiting and Minimizing Attrition for Program Participants**

Identification and Recruitment: Participants will be recruited through Early Childhood System of Care (ECSOC) Community Outreach function. The ECSOC will collaborate with partners who identify expectant parents and children, birth to five and their families. With parental consent, referrals will be made to ECSOC Central Intake for a core screening. Families meeting the evidence-based home visiting criteria and prioritized according to the risk factors in the federal guidance will be linked to evidence-based home visiting programs.

Caseload Capacity and Timeline: It is estimated that by the end of the first year of home visiting direct service implementation, caseloads will reach a capacity of approximately 430 families for the FY 2010 programs in the original six communities and an additional 160 families for the FY2011 NFP programs, for a total of approximately 590 families. This number is based on the expected average number of cases to be served and is approximately 20% less than
maximum caseloads allowed by national model developers. Caseloads are calculated at 20% less than maximum for the following reasons (1) During Year 1 of implementation, three new programs will be developed, HFG and NFP in Muscogee County and NFP in Houston County, (2) Newly hired, inexperienced staff will be delivering services in both expanded and newly developed programs, (3) The PAT program is implementing a new curriculum that will require supervision and service delivery adjustments in existing programs, (4) Focus will be on serving the highest risk families needing intense services, which affects caseload capacity, (5) Focus on attaining benchmarks will require additional training and practice in service delivery and in administering construct measurement tools, and (6) Additional data entry will be required in a newly developed data system required for tracking MIECHV program participant information and benchmarks.

### Caseloads for FY2010 and FY 2011 MIECHV Programs

<table>
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<tr>
<th>County</th>
<th>EBHV Model</th>
<th>Total HV FTE</th>
<th>1/1/12-12/31/12 Avg. Caseload per FTE</th>
<th>1/1/12-12/31/12 Max. Caseload per FTE</th>
<th>1/1/12-12/31/12 Total Avg. Caseload</th>
<th>1/1/12-12/31/12 Total Max. Caseload</th>
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<tr>
<td>Clarke</td>
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<td>60</td>
<td>75</td>
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<tr>
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<td>HFG</td>
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<td>25</td>
<td>60</td>
<td>75</td>
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<tr>
<td></td>
<td>PAT</td>
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<td>20</td>
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<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Glynn</td>
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<tr>
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<td>25</td>
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<td>75</td>
</tr>
<tr>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
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<td>591</td>
<td>632</td>
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Plan for Minimizing Attrition: The MIECHV Program home visiting models are relationship-based. The time of entry into home visiting programs, as well as the “fit” of the parent with the program model and with their home visitor, impact the development of trusting relationships and are key factors in engaging and retaining families. The Georgia MIECHV Program will focus on program entry during pregnancy to birth, since more secure home visitor-parent relationships are established during that period when parents are open to connecting with community providers and learning how to be a good or even better parent. At program entry, a core screen and Central Intake will identify families that can best be served by home visiting and will ensure that families are linked to home visiting services most appropriate to their needs. Efforts will be made to ensure a cultural, linguistic and temperament match between the parent(s) and home visitor. After ensuring initial fit of the family with the model and home visitor, the program will ensure that home visitors have the knowledge and skills to engage and retain families in services. Understanding how to engage parents before the birth of the baby, encouraging parent input and engaging parents as partners in the parenting process, following the standards of the program model while tailoring service to individual family needs, and involving parents in leadership roles are competency areas common to the four models selected for the Georgia program. Core competency training addressing the development and enhancement of these skills will be provided for Georgia home visitors and supervisors. Supervisor training will include effective practices for strengthening staff engagement/retention skills. Reflective supervision can enhance skills as well as help retain the home visitor. Since home visiting work depends on the parent-home visitor relationship, retention of home visitors will also increase the likelihood of participant retention.
Operational Plan for Coordination among Home Visiting Programs and Other Programs and Resources in Implementation Communities

Coordination among Home Visiting Programs and other Programs will occur within an ECSOC. The ECSOC will invite service providers from all family service agencies to partner in the ECSOC. Efforts will be made to include partners providing maternal health services, such as health departments, physicians and HRSA Health Centers, which are operating in three of the seven MIECHV communities. Services available and appropriate for families will be coordinated among partners. Agreements will be established between partners so information and care can be shared and maximized. Community providers will refer families in the ECSOC target population to Central Intake and link families to appropriate internal and external services. A referral will be generated in GEOHVIS, and a staff person will be available at Central Intake to assure completion of the screening and appropriateness of the referral, notifying the system via a feedback loop. Agreements among service providers will be completed to assure communication and information sharing. The need for community services for participating families will be identified via screening in Central Intake, family assessments completed by evidence-based home visiting programs, and home visitors during family visits. Families using home visiting services that have major needs and receive ongoing services from other providers will be eligible for Family Team Service Coordination, and the family’s home visitor will initiate coordination. The Family Team includes the family, members of the family support network, the home visitor and service partners.

Data System Development to Support Continuous Quality Improvement

The Center for Family Research (CFR) at the University of Georgia is developing the web-based Georgia Home Visiting Information System (GEOHVIS) for the Georgia MIECHV Program. The system will support each step of home visiting implementation including referral, screening, linking to home visiting, tracking benchmarks, and coordinating care with community service providers. CFR has selected ETO software by Social Solutions Inc. as the data system. The ETO software designed with usability in-mind should result in better data entry outcome with fewer data entry errors and accidental missing data. ETO software includes integrated to-do lists and dashboards that provide a 360 degree view of services and prompts for next steps. In addition, it enables managers to see overdue tasks. ETO’s built-in data analytic tools provide real-time analysis through MS Excel. Fully functional Query tools enable all data fields to be queried, aggregated and exported on-demand. Data quality assessment reports show incomplete data to avoid missing data. ETO also includes reporting that demonstrates incremental progress or the connection between staff efforts and assessment results. Performance reporting specific to critical domains including staff, participants, families, sites, organizations, programs, communities and partners enable multi-dimensional views of performance analyses and support various CQI activities at the local, program and state levels.

State’s Approach to Monitoring, Assessing, and Supporting Quality and Fidelity of Models

The Governor’s Office for Children and Families has contracted with the Center for Family Research at the University of Georgia to support an Early Childhood System of Care Home Visiting (ECSOC HV) Team that ensures Georgia MIECHV Program home visiting models are implemented with model fidelity. The team is comprised of ECSOC community outreach staff, evidence-based home visitation (EBHV) model personnel, and Georgia Home Visiting Information System and Evaluation (HVISE) technical and program liaison staff. The Georgia MIECHV Leadership Team provides direct input into the development of the MIECHV Program and guides its implementation. The ECSOC HV Team provides the technical
assistance, training, and quality assurance infrastructure for implementation. The ECSOC HV Team with members of the GOCF System of Care Technical Assistance Provider Team of staff/consultants assists with development of partners’ Georgia MIECHV Program implementation plan, conducting six month and annual reviews of the ECSOC and EBHV programs.

The community ECSOC establishes partnerships and, through Community Outreach and Central Intake, identifies, refers and screens families in the ECSOC target population. Each ECSOC identifies an ECSOC HV Partner that has the experience and infrastructure to support the implementation of EBHV programs with model fidelity. Charged with linking families to models based on participation criteria and family needs, this organization is the point of contact for EBHV in the ECSOC. The ECSOC HV Partner may sponsor one or more EBHV programs and coordinate home visiting services with another EBHV provider. As appropriate, it will link families with Community Programs so the full range of services needed to achieve positive Home Visiting outcomes is provided. All data related to program implementation and MIECHV benchmark areas will be entered into the Georgia Home Visiting Information System.

During MIECHV Program planning, the ECSOC HV Team has provided information on EBHV program models to ECSOC partners to ensure targeted support and appropriate use of models. This team also ensures that outreach, program entry processes and organizational/service components meet national model standards. During program installation, the ECSOC HV Team will give program development technical assistance and coordinate required trainings for program personnel. Upon service implementation, the team will ensure that programs complete affiliation processes required by national model developers to ensure intent to adhere to national model standards and will continue to coordinate training and ongoing technical assistance. Quality assurance will be provided at the local program level by ECSOC HV Partner program managers/clinical supervisors and at the state level by the ECSOC HV Team. The team will use a CQI approach with data from GEOHVIS and program model data systems for review and supportive adjustment of program procedures to ensure model fidelity. Model fidelity will be assessed by ECSOC HV Partner program managers/clinical supervisors on an ongoing basis, by the ECSOC HV team quarterly, biannually, and annually and by national model developers for accreditation/certification.

**Challenges to Maintaining Quality and Fidelity of Models**

Program expansion/development and system changes create challenges for maintaining program quality and model fidelity. Program performance and fidelity are dependent on staff knowledge, the quality of supervision, the quality of data entry and the ability to use data reports to impact program functioning and direct service delivery. Each of these areas is impacted as the MIECHV Program is being developed. Each of these areas will be addressed at the state and local level. Consistent with state level agreements with national model developers, all sites will be expected to adhere to the core elements/standards of the program model(s) being implemented. Programs will be affiliated with the national models to confirm intent to adhere to standards. The ECSOC HV Team will ensure that training is provided for all areas of program service delivery and management that are related to model standards and MIECHV implementation: model core trainings to ensure knowledge of standards and best practice, core competency trainings to enhance quality of supervision and of service delivery, training to enhance understanding and feelings of competency in addressing MIECHV benchmark areas in the context of home visits, and training on the use of the new data system. The HV Team and local program managers/supervisors will monitor program and staff performance through
observation and the use of data reports and will participate in CQI activities to improve program performance and model fidelity.

**Collaborative Public and Private Partners on the State Level**

**Early Childhood System of Care (ECSOC) Management Team:**

- Carole Steele, Governor’s Office of Children and Families
- Carol Wilson, Sheltering Arms Training Institute
- Anita Brown, Center for Family Research, University of Georgia
- Marcia Wessels, Center for Family Research, University of Georgia.

**MIECHV Leadership Team:** (in addition to ECSOC Management Team)

- Debbie Cheatham, Georgia Division of Public Health, Maternal and Child Health Program
- Arianne Weldon, Georgia Division of Public Health, Maternal and Child Health Program
- Janice Haker, Georgia Head Start Collaboration Office
- Rebekah Hudgins, Georgia Family Connection Partnership, Inc.
- Bobby Cagle, Department of Early Care and Learning
- Rachel Carnesale, Division of Family and Children Services
- Roberta Malavenda, Voices for Georgia’s Children, Home Visiting Work Group
- Angela Monette, Department of Behavioral Health, Division of Addictive Diseases
- Kim Washington, Division of Family and Children Services

**ECSOC Advisory Group:** (in addition to ECSOC Management Team)

- Sandra Alexander, Centers for Disease Control
- Diane Bellem, Sheltering Arms Early Education and Family Centers, GA Training Institute
- Mindy Binderman, Georgia Early Education Alliance for Ready Student
- Janice Carson, Georgia Department of Community Health, Medicaid Division
- Matt Caseman, Georgia Rural Health Association
- Pat Cota, Georgia Obstetrical and Gynecological Society
- Lisa Dawson, Department of Public Health. Maternal/Child Health, Injury Prevention
- Cathi Durham, Georgia Academy of Family Physicians
- Fozia Eskew, Georgia Chapter American Academy of Pediatrics
- Yasmin Evering, Georgia Association on Young Children
- Katrina Green, Family Representative
- Duane Kavka, Georgia Association of Primary Health Care
- Sandra Mobley, Healthy Mothers Healthy Babies Coalition
- Barbara Mosacchio, Atlanta Women’s Foundation
- Charles Owens, Georgia Office of Rural Health
- Ann Pope, GA Department of Human Services, DFCS, Promoting Safe and Stable Families
- Joyce Reid, Georgia Hospital Association
- Lakeita Servance, Georgia Department of Education (Family Representative)
- Jan Stevenson, Georgia Department of Education
- Peggy Walker, Douglas County Juvenile Court
- Dan Whitaker, Birth-to-Five Work Group
- Pat Willis, Voices for Georgia’s Children

**Plan for Integrating State’s MIECHV Program into Early Childhood System**

Georgia is beginning the process of integrating the MIECHV Program into a broader early childhood system by implementing evidence-based home visiting within an Early Childhood
Systems of Care in each of Georgia’s selected at-risk communities. These community systems of care incorporate community-based services and supports into an organized network. The network of services provides a framework of support for implementation of the MIECHV Program. While the MIECHV Leadership Team guides this effort there are several agencies on the team whose state and community infrastructure is key to the development of the plan. They are the Georgia Family Connection Partnership, the Governor’s Office for Children and Families and the Department of Public Health. The Georgia Family Connection Partnership is a statewide network comprised of collaborative organizations in each of Georgia’s 159 counties. These collaboratives are committed to improving the quality of life in their communities. Those in the MIECHV communities focus on early childhood. The Governor’s Office for Children and Families has supported the development of community Systems of Care (SOC), a systematic approach to coordinating child prevention and intervention programs, and sponsors an existing system of care focused on early childhood in each of the MIECHV communities. The collaboration of the existing community SOC and the Georgia Family Connection Network brings together virtually all the community organizations that represent early childhood and creates a strong base of support for the MIECHV Program. This integration of the MIECHV program with community level partners can be strengthened by the Department of Public Health, which has an agency in each Georgia County. Public Health has an established point of entry into early childhood services in each community and has potential to support ECSOC referral and screening for the MIECHV Program. In addition, Public Health has discussed the development of a statewide single point of entry into which MIECHV Program entry could be incorporated. The collaboration among these partners has supported the first steps of the MIECHV Program’s integration into the broader early childhood system.

Assurances
- The Governor’s Office for Children and Families, along with its State partners, assures that the State home visiting program is designed to result in participant outcomes noted in the legislation.
- The Governor’s Office for Children and Families, along with its State partners, assures that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments.
- The Governor’s Office for Children and Families, along with its State partners, assures that services will be provided on a voluntary basis.
- The Governor’s Office for Children and Families assures that the State of Georgia will comply with the Maintenance of Effort Requirement.
- The Governor’s Office for Children and Families, along with its State partners, assures that priority will be given to serve eligible participants who:
  - Have low incomes;
  - Are pregnant women who have not attained age 21;
  - Have a history of child abuse and neglect or have had interactions with child welfare;
  - Have a history of substance abuse or need substance abuse treatment;
  - Are users of tobacco products in the home;
  - Have, or have children with, low student achievement;
  - Have children with developmental delays or disabilities;
  - Are in families that include individuals who are serving or who have served in the armed forces, including families with members of the armed forces who have had multiple deployments outside of the United States.
Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

Overall Approach

The Governor’s Office of Children and Families has contracted with the University of Georgia’s Center for Family Research (CFR) to implement the plan for meeting the MIECHV program benchmark requirements. The Home Visiting Information System and Evaluation (HVISE) team at CFR will design and direct the development of an information system that will be used by program staff to track all necessary demographic and service-utilization data as well as benchmark indicator measurements. The collection of benchmark data will also be used to support Continuous Quality Improvement (CQI) efforts at the local and state level.

The primary tool for benchmark tracking will be the Georgia Home Visitation Information System (GEOHVIS) which will be designed with a user-friendly interface to support case management as well as efficient entry and scoring of assessment tools. The HVISE team explored various development options with regard to GEOHVIS, but ultimately agreed to select a software development vendor rather than build our own information system. This decision was made after reviewing the software development portfolios of eight companies and meeting three vendors face-to-face to discuss the data system needs for the MIECHV program. The HVISE team is currently in discussion with Social Solutions about the use of their ETO software for the MIECHV project and a sole source agreement is being processed in accordance with the UGA procurement policies and procedures. Once the agreement is approved by the appropriate university officials, a contract with Social Solutions will be established and the HVISE team will work with them according to their Standard Implementation Methodology. Dr. Brown will serve as the Executive Sponsor. The IT Lead, Jina Tollett will be the Project Manager and ETO Administrator. The ECSOC Training and TA team, led by Marcia Wessels will serve as the subject matter experts. It is anticipated that development will get underway in August, 2011. A pilot test is scheduled for November 2011; the launch date is January 2, 2012.

With the exception of child welfare data, all information necessary to be compliant with the federally-mandated benchmark requirements will be collected in GEOHVIS. In the initial phase, this web-based system will not replace the case management systems already in place for the programs at the national or state–levels, but throughout the project period, efforts will be made to streamline systems in order to minimize data entry burden and support a cohesive, integrated home visitation system in Georgia.

The child welfare data (substantiated child abuse reports) will be obtained via a data sharing protocol with Georgia’s Department of Family and Children Services (DFCS) that has been used by Healthy Families Georgia evaluation team (also housed at CFR) since 2004. Via this protocol, the HFG evaluation staff send identified data as well as other information pertinent to the evaluation questions to the liaison at DFCS. The liaison returns the data to CFR with identifiers stripped, but all other information remaining, and attaches information about child abuse reporting status of each family. For the MIECHV program benchmark tracking effort, the HVISE is revising the informed consent document signed by participating families to allow for individually-identifiable data to be shared and integrated into GEOHVIS.

Because the system used to manage Healthy Families Georgia data was designed and is managed by the same team that will design and manage GEOHVIS, there will be a data sharing allowed between these two systems wherein case-level data that is entered in GEOHVIS and can be used to automatically populate the HFGIS system will do so. This includes participant identifying information as well as demographics and some of the benchmark tracking measures.
At this time, these are the only opportunities for coordination with other child-focused State or local data collection efforts. However, meetings are underway with lead staff and data system managers in various state agencies (Governor’s Office for Children and Families, Public Health, Vital Records, Department of Early Care and Learning) with regard to future possibilities for data coordination and sharing. It is anticipated that the use of administrative data to corroborate and supplement the data being collected via GEOHVIS will expand throughout the project period. This type of collaboration will facilitate Georgia’s plan to leverage the MIECHV funds to strengthen a comprehensive, high-quality early childhood system of care that will continue beyond the duration of these project funds.

Proposed Measures and Data Collection

Early in the planning phase, the Home Visitation Planning and Implementation Work Group agreed that the indicators and measurement of benchmark constructs would be standardized across the program models being utilized in the MIECHV program in order to capitalize on this opportunity for greater coordination and collaboration across home visitation programs in Georgia. Subsequently, a work group comprising representatives from state agencies, HV program technical assistance staff, and researchers at the University of Georgia and Georgia State University was formed to specify the identification of benchmarks and measurement selection. This group developed a set of guidelines that were used to direct their efforts in the selection of benchmarks and measurements as follows:

Benchmark Identification Guidelines:
1. Benchmarks should be SMART (specific, measureable, attainable, reasonable, and time-bound)
2. Benchmarks should be substantively aligned with the HV models (and curricula) that will be implemented in Georgia.
3. Benchmarks should be set after a review of the data that is currently available from HV data systems (e.g., HFGIS, VisitTracker, HSES) in order to measure improvements in areas that are reasonable and meaningful (e.g., avoid ceiling effects)

Measurement Selection Guidelines:
1. Minimize staff and participant burden by selecting measurements that are (a) already being administered in one or more of the HV programs, (b) reliable and valid yet able to to capture the construct with the fewest number of items, and (c) can be administered after a modest training commitment.
2. Capitalize on the unique relationship between the home visitor and participant wherein up-to-date information can be gathered on a regular basis and is more accurate, sensitive, and useful for continuous quality improvement.
3. Ensure ease of data entry and scoring
4. Choose measures that have been tested for reliability and validity with low-income and Hispanic populations.

Note that many of the constructs comprising Benchmark Areas One and Two are measured at each home visit via processes that are naturally occurring within the home visit. Regardless of the program model being implemented, home visitors begin each weekly or bi-weekly visit with a check-in about events and activities that have taken place. These conversations are targeted toward health and well-being of mother and child, and home visitors are trained to probe specifically for information related to medical appointments, child illnesses and injuries (and how the mother addressed those), and to follow-up on referrals made at screening or in previous home visits. These conversations also operate as a mechanism for repeated screening of
sensitive issues depression, substance abuse, or domestic violence. Honest disclosure of these socially-stigmatized problems may require the development of a higher-level of trust that is only possible through multiple interactions with the home visitor over time. Repeated screenings are also necessary because these are dynamic conditions that may change, e.g., an abusive boyfriend returns to live with the mother or depressive symptomatology increases in response to circumstantial stressors. For the MIECHV benchmark tracking, home visitors will be more fully trained on these informal interviewing techniques and how to record and track the valuable information obtained during these conversations in GEOVHIS. Using a newly-designed Home Visit Update form that will be piloted in two MIECHV communities in late Fall of 2011, the home visitors will systematically record information over time. The form is currently being designed by the ECSOC TA and Training team; it is an adaptation of the form that has been used by the Healthy Families Georgia Family Support Workers for the past decade. GEOHVIS will be programmed to generate these Home Visit Update forms according to the benchmark measurement administration schedule, thereby allowing it to operate as both a program model fidelity tool as well as a data recording document. Concerns about validity and reliability of the information will be addressed via continuous quality improvement strategies at the local and state levels. Detailed information about the measurement, administration schedule, and reliability/validity of the benchmark constructs is provided in the table that follows.
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<tr>
<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
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<th>Comments/Reliability/Va lidity</th>
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<tr>
<td>1. Prenatal Care</td>
<td>Increase adherence to the ACOG-recommended schedule of prenatal visits for prenatally enrolled mothers as measured by comparing cohort 1 to cohort 2.</td>
<td>Measured at each prenatal home visit. GEOHVIS will have a tickler system to remind Home Visitors of when pregnant women are due for prenatal care visits. Timing and frequency of Home Visits will be conducted according to particular program model standards. Mother Report Type of Improvement: Cohort Comparison</td>
<td>Web-based Case Management System Mother completed the following prenatal visits (Check if yes)</td>
<td>A review of HFG data collected between 2003-2010 indicates that 93% of enrolled mothers received prenatal care within the first two trimesters of pregnancy. However, the data available does not indicate how many prenatal visits were completed. For the MIECHV program, women will be assessed on their adherence to ACOG schedule of prenatal visits. Where MOUs have been established, providers will provide a confirmation that appointments have been completed. Referred to as the Provider Referral Confirmation Form; the information will be submitted directly into the web-based GEOHVIS. If a provider has not signed an MOU agreeing to submit data in this way, the information is collected via mother report to the home visitor. Home Visitors will be extensively trained on the collection of information during home visits in order to ensure valid and reliable data.</td>
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**Calculation:** # of completed prenatal visits from enrollment to delivery for each mother enrolled prenatally during year 1/# of ACOG recommended visits from time of enrollment to delivery for all mothers enrolled prenatally in years 2 & 3 (cohort 2). |

| | | | | |
| 2. Parental use of alcohol, tobacco or other drugs | Increase the rate of women who reduce the amount of smoking their child is exposed to from the time of enrollment to 6 months post-enrollment. | Assessment completed during home visit within one month of enrollment and at six months post-enrollment. Mother Report Type of | Web-based Case Management System--Items Adapted from PRAMS | Items adapted from PRAMS These items have face validity and have been used in many states to allow surveillance of tobacco-related behaviors. |

- Items adapted from PRAMS
- Items adapted from PRAMS
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- Items adapted from PRAMS
- Items adapted from PRAMS
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<tr>
<td><strong>Calculation:</strong> # of women who screened positive for smoking and/or allowing smoking in their home at enrollment and report a decrease in smoking (or allowing smoking in their home) at six months post-enrollment/# of women who screened positive for smoking or allowing smoking in their home at enrollment.</td>
<td>Improvement: Individual Comparison</td>
<td>5=21 to 40 cigarettes 4=11 to 20 cigarettes 3=6 to 10 cigarettes 2=1 to 5 cigarettes 1=Less than 1 cigarette 0=I don’t smoke now</td>
<td>Which of the following statements best describes the rules about smoking inside your home now? 0=No one is allowed to smoke anywhere inside my home 1=Smoking is allowed in some rooms or at some times 2=Smoking is permitted anywhere inside my home</td>
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3. Pre-conception care | Increase the percent of women who complete their post-partum check-up within twelve weeks of giving birth as measured by comparing cohort 1 to cohort 2. | Information collected at one time point during home visit occurring at 12 weeks post-partum. GEOHVIS will provide a tickler to remind Home Visitors to prompt mothers to schedule visit and track whether visit was completed. Mother Report | GEOHVIS – Post-natal Home Visit Update Form Mother completed postnatal visit by #/#/#/##### Y/N If applicable, reason why appointment missed: | Anecdotal data from HFG program staff suggest that this is a frequently missed appointment for HFG-enrolled mothers. Keeping this appointment would improve mothers’ access to important post-natal health information, including sound nutrition choices, reaching/maintaining a healthy BMI, and other behaviors that can potentially set them on a course of improved health over time. Although this indicator relies on the mothers’ self-report detracting somewhat from validity, the home visitors are extensively trained on how to develop a rapport with mothers to facilitate honest reporting of activities. Any concerns |
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<td>compared to – the same percentage in years 2 and 3.</td>
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<td>about data integrity will be discussed as part of CQI processes and addressed accordingly.</td>
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<td>4. Inter-birth intervals</td>
<td>Increase or maintain the percentage of mothers who receive information about maternal health risks associated with closely-spaced births (provided by home visitors) within six weeks after their child is born as measured by comparing cohort 1 to cohort 2.</td>
<td>Information collected at one time point (within seven weeks of the birth of the enrolled child) for all women enrolled prenatally or within six weeks postpartum.</td>
<td>GEOHVIS – Post-natal Home Visit Update Form</td>
<td>Anecdotal data from HFG program staff suggest that women do not have information about the health risks associated with closely spaced births. The provision of this information for new mothers within six weeks postpartum allows them to make more informed decisions regarding inter-birth intervals. Although this indicator relies on home visitors’ report, the MIECHV Training and TA team will support fidelity in education provision and data entry prior to the start of the MIECHV program visits to enhance validity and reliability.</td>
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<td>5. Maternal depression</td>
<td>Increase or maintain the percentage of Depression Screen information collected at one</td>
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<td>GEOHVIS – Edinburg Postpartum</td>
<td>The goal is universal screening for depression among mothers enrolled in</td>
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<td>mothers who are referred for further evaluation/treatment after scoring positive for depression as measured by comparing cohort 1 to cohort 2. <strong>Calculation</strong>: # women who score positive for depression (≥13 on EPDS) upon enrollment in year 1 who are referred for follow-up evaluation and/or treatment /# women enrolled in year 1 who score positive for depression - compared to same percentage in years 2 &amp; 3.</td>
<td>time point: within four weeks postpartum.</td>
<td>Depression Scale</td>
<td>Georgia’s MIECHV program. Training and TA will be extensive for this new initiative with an emphasis on obtaining valid and reliable data to inform our understanding of the extent of this problem. A second step will be a more thorough examination of community-based resources to address the issue.</td>
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<td>Target Population: Women who screen positive for depression. Mother Self-Report: Edinburgh PostNatal Depression Scale (EPDS)</td>
<td></td>
<td>The EPDS is a widely used and extensively researched depression screening tool; A recent review indicated that it may not be equally valid and reliable across all contexts; however, validity and reliability was demonstrated in a sample of low-income, rural women suggesting it is an appropriate tool for the Georgia MIECHV program.</td>
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<tr>
<td></td>
<td>Type of Improvement: Cohort Comparison</td>
<td>PROCESS MEASURE</td>
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<td>6. Breastfeeding</td>
<td>Increase the percentage of prenatally enrolled mothers who initiate breastfeeding as measured by comparing cohort 1 to cohort 2.</td>
<td>Information collected during first postnatal home visit for all women enrolled prenatally. Target Population: Women enrolled prenatally. Mother Report</td>
<td>GEOHVIS – Post-natal Home Visit Log</td>
<td>A review of HFG data collected between 2003-2010 indicates that 20% of women intended to breast feed, 20% intended to both breastfeed and bottle feed while 49% intended to bottle feed. There are no additional data around the moderators/mediators of these intentions nor of actual behaviors once the mother/baby have been discharged from the hospital. Additional data will be collected to allow greater understanding of this outcome for MIECHV program mothers. This indicator relies on the mothers’ self report which raises validity concerns. However, the home visitors will be extensively trained on how to develop a rapport with mothers to facilitate honest reporting of activities. Any concerns about data integrity will be discussed as part of CQI processes and addressed accordingly.</td>
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<td><strong>Calculation:</strong> # of prenatally enrolled women who attempt breastfeeding (see question in source column for how “initiate breastfeeding” is operationalized) and are enrolled during year 1/# of women enrolled prenatally in year 1 – compared to – this percentage in years 2 &amp; 3.</td>
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<tr>
<td>7. Well-child visits</td>
<td>Increase adherence to the AAP-recommended schedule of well-child checks for all enrolled children as measured by comparing cohort 1 to cohort 2.</td>
<td>Information collected in accordance with the AAP-defined schedule. GEOHVIS will have a tickler system to remind Home Visitors of when children are due for well-child checks. Target Population: Children enrolled during their first</td>
<td>GEOHVIS – Post-natal Home Visit Update Form</td>
<td>This indicator relies on the mothers’ self report which raises validity concerns. However, the home visitors will be extensively trained on how to develop a rapport with mothers to facilitate honest reporting of activities. Any concerns about data integrity will be discussed as part of CQI processes and addressed accordingly.</td>
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<td>well-child checks from birth of child or enrollment (whichever comes later) to child’s first birthday for all children enrolled in year 1/# of recommended well-child checks from birth of child or enrollment (whichever comes later) to one month after the first birthday in year 1 compared to the same percentage for all children enrolled in years 2 and 3.</td>
<td>year of life.</td>
<td>Mother Report</td>
<td>Type of Improvement: Cohort Comparison</td>
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<td>8. Maternal/Child health insurance status</td>
<td>Decrease the number of months that eligible, enrolled mothers and children are uninsured from the year 1 to the year 3 reporting period.</td>
<td>Collected at monthly during home visits for all eligible enrolled mothers and children.</td>
<td>GEOHVIS – Screening Form Item adapted from Pregnancy Risk Assessment Monitoring System (PRAMS) Item - Q2</td>
<td>PRAMS was developed to support the CDC’s surveillance efforts and has been utilized by many states to monitor maternal and child health indicators. The purpose is to monitor the home visitors’ success in helping mother to secure health insurance for herself and her children in the event that she doesn’t have it initially or it has lapsed. Home Visitors will update insurance status monthly with information obtained during home visits. Home Visiting staff will be provided with training and TA on the collection of this information in order to enhance validity and reliability of information gathered.</td>
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<tr>
<td>Calculation: # of months* that eligible and enrolled mothers and children are uninsured in year 1/total # of months of enrollment in year 1 compared to # of months that insurance-eligible mothers and children who</td>
<td>Monthly Status Check on Insurance: Covered: Jan ___  Feb ___  Mar ___  April ___  May ___  June ___  July ___  Aug ___  Sept ___  Oct ___  Nov ___</td>
<td>Following initial check, monthly status check: Monthly Status Check on Insurance: Covered:</td>
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<td>are receiving services in year 3 are uninsured in year 3/total # of months enrollment in years *month is defined as 16 or more days of a particular month.</td>
<td>Dec</td>
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**Benchmark 2: Child Injuries, Child Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits**

9. Child visits to the emergency department from all causes

**Calculation:** # visits to the ER by children who receive services throughout the entirety of the last six months of Year 1/# of children who are enrolled throughout the entire last six months of Year 1_compared to _ this same percentage in Year 3.

Information collected for all enrolled children at each home visit.

Target Population: Children who are enrolled for at least six months during the assessment period of each project year.

Mother Report

**Type of Improvement:** Cross-Sectional Comparison

**OUTCOME MEASURE**

Although this indicator relies on the mothers’ self-report detracting somewhat from validity, the home visitors are extensively trained on how to develop a rapport with mothers to facilitate honest reporting of activities. Any concerns about data integrity will be discussed as part of CQI processes and addressed accordingly.

10. Mother visits to the emergency department from all causes

Information collected for all mothers at each home visit.

Target Population: Mothers who are enrolled for at least six months during the assessment period of each

GEOHVIS – Post-natal Home Visit Update Form

Although this indicator relies on the mothers’ self-report detracting somewhat from validity, the home visitors are extensively trained on how to develop a rapport with mothers to facilitate honest reporting of activities. Any concerns about data integrity will be discussed as part of CQI
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<tr>
<td>Calculation: # visits to the ER by mothers who receive services throughout the entirety of the last six months of Year 1/# of mothers who are enrolled throughout the entire last six months of Year 1 compared to this same percentage in Year 3.</td>
<td>Project year. Mother Report Type of Improvement: Cross-sectional Comparison OUTCOME MEASURE</td>
<td>GEOHVIS – Post-natal Home Visit Update Form</td>
<td>Although this indicator relies on home visitors’ report, the MIECHV Training and TA team will support fidelity in education provision and data entry prior to the start of the MIECHV program visits to enhance validity and reliability.</td>
<td></td>
</tr>
<tr>
<td>11. Participant safety training</td>
<td>Increase or maintain the percentage of home visits where safety information is provided on injury prevention topics from year 1 to the year 3 benchmark reporting period. Calculation: # of home visits where safety information is provided in year 1/total # of home visits completed in year 1 compared to # of home visits where safety information is provided in years 3/total # of home visits completed in year 3.</td>
<td>Home Visitors will note whether or not they provided any safety training at each home visit. Target Population: Enrolled mothers Home Visitor Report Type of Improvement: Cross-sectional Comparison PROCESS MEASURE</td>
<td>GEOHVIS – Post-natal Home Visit Update Form</td>
<td></td>
</tr>
<tr>
<td>12. Child injuries requiring medical treatment</td>
<td>Decrease or maintain the percentage of children with injuries requiring treatment from Information collected during home visits for each enrolled family.</td>
<td>GEOHVIS – Post-natal Home Visit Update Form</td>
<td>Although this indicator</td>
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</tbody>
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39
<table>
<thead>
<tr>
<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
<th>Source</th>
<th>Comments/Reliability/Va lidity</th>
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<tbody>
<tr>
<td></td>
<td>year 1 to the year 3 benchmark reporting period.</td>
<td>Target population: Children who are enrolled for at least six months during the assessment period of each project year.</td>
<td></td>
<td>a rapport with mothers to facilitate honest reporting of activities. Any concerns about data integrity will be discussed as part of CQI processes and addressed accordingly.</td>
</tr>
<tr>
<td>Calculation: # children receiving services who require medical care for injuries or other medical issues (improper ingestions, etc.) within the last six months of year 1 who are enrolled throughout the entire last six months of year 1 compared to the same percentage in year 3.</td>
<td>Mother Report</td>
<td>Type of Improvement: Cross-sectional Change</td>
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<td>OUTCOME MEASURE</td>
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<tr>
<td>13. Reports of maltreatment for families receiving services</td>
<td>Decrease or maintain the percentage of enrolled children who are suspected victims of maltreatment from year 1 to the year 3 benchmark reporting period (separated by type of maltreatment: neglect, emotional abuse, physical abuse, sexual abuse and age: 0-12 months, 13-36 months, and 37-84 months).</td>
<td>Assessed every six months &lt;br&gt;2/25/12-8/24/12 (yr 1) &lt;br&gt;8/25/12-2/24/13 (yr2-1) &lt;br&gt;2/25/13-8/24/13 (yr2-2) &lt;br&gt;8/25/13-2/24/14 (yr3-1) &lt;br&gt;2/25/14-8/24/14 (yr3-2)</td>
<td>Department of Children and Families; Georgia SHINES Information System</td>
<td>Healthy Families Georgia evaluators at CFR have had a data sharing agreement with DFCS since 2004. The agreed upon protocol is such that identifiable participant data (including demographics, program involvement) is sent to DFCS and then returned to CFR stripped of the unique identifier but containing information related to maltreatment reports. Data is separated according to type of abuse. On 9/26/11, the MIECHV team met with the DFCS data team that manages the SHINES data system and steps are underway to secure a data sharing agreement that will allow identified data to be shared at the participant-level for this effort.</td>
</tr>
<tr>
<td>14. Substantiated or some</td>
<td>Decrease or maintain the percentage of</td>
<td>Assessed every six months</td>
<td>Department of Children and Families; Georgia SHINES Information</td>
<td>See previous information about reliability and validity of this</td>
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<tr>
<td>Construct</td>
<td>Benchmark</td>
<td>Administration Schedule/ Population Assessed</td>
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<td>Comments/Reliability/Validity</td>
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<tr>
<td>indication of maltreatment for families receiving services</td>
<td>enrolled children who have substantiated reports of maltreatment from year 1 to the year 3 benchmark reporting period (separated by type of maltreatment: neglect, emotional abuse, physical abuse, sexual abuse and age: 0-12 months, 13-36 months, and 37-84 months).</td>
<td>Target Population: Children enrolled for the entire assessment period under review (e.g., last six months of year 1 and last six months of year 3)</td>
<td>System</td>
<td>measurement strategy.</td>
</tr>
<tr>
<td>Calculation:</td>
<td>For each age group and maltreatment category listed above, # enrolled children who were reported as victims of substantiated maltreatment during the last six months of year 1/# of children who were enrolled in year 1 between 1/1/12 and 8/24/12 compared to same percentage in year 3 (include enrollees between 1/1/14 and 8/24/14).</td>
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<tr>
<td>15. First ever substantiated or some indication of maltreatment</td>
<td>Decrease or maintain the percentage of enrolled children who are first time victims of maltreatment</td>
<td>Assessed every six months</td>
<td>Department of Children and Families; Georgia SHINES Information System</td>
<td>See previous information about reliability and validity of this measurement strategy.</td>
</tr>
<tr>
<td></td>
<td>Target Population: Children enrolled for the entire assessment period</td>
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<td>Construct</td>
<td>Benchmark</td>
<td>Administration Schedule/Population Assessed</td>
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<td>Comments/Reliability/Va lidity</td>
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<tr>
<td>ent of children whose families are receiving services</td>
<td>from year 1 to the year 3 benchmark reporting period.</td>
<td>under review (e.g., last six months of year 1 and last six months of year 3)</td>
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<td><strong>Calculation:</strong></td>
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<tr>
<td><strong>Type of Improvement:</strong></td>
<td>Cross Sectional Change</td>
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<tr>
<td><strong>Outcome Measure:</strong></td>
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**Benchmark 3: Improvements in School Readiness and Achievement**

16. Parent support for child’s learning and development

- Mothers will increase their level of support for their enrolled child’s learning and development from the initial assessment to the post assessment six months later.

- **Calculation:** Average score on the Learning Materials and Involvement subscales of the HOME Inventory at 6 months

- The developers of the HOME recommend that the first administration occur when the child is a minimum of 6 months old. The measure will be completed at six month intervals; A developmentally appropriate version of HOME will be administered. Administered by Home Visitors

<table>
<thead>
<tr>
<th>Target Population:</th>
<th>GEOHVIS: Home Observation for Measurement of the Environment (HOME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 subscales:</td>
<td>Learning Materials Involvement</td>
</tr>
<tr>
<td></td>
<td>Information about the reliability and validity of this instrument are provided in the 3rd edition of the HOME Inventory Administration Manual. The Cronbach’s alpha score for the internal consistency of the measure was .84. The HOME has reasonable concurrent</td>
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<tr>
<td>17. Parent knowledge of child development and of their child’s developmental progress</td>
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<th>Benchmark</th>
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<tbody>
<tr>
<td>Mothers will increase their knowledge of child development and their child’s developmental progress from the initial assessment to the post-assessment 6 months later.</td>
</tr>
</tbody>
</table>

**Calculation:**
Average score on the organization and variety subscales of the HOME Inventory at 6 months compared to average score at 12 months.

For all enrolled women who have completed two HOME assessments (at 6 months and 12 months), compare the average score on the organization and variety subscales at six months with the average score at twelve months.

<table>
<thead>
<tr>
<th>Administration Schedule/Population Assessed</th>
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</thead>
<tbody>
<tr>
<td>Mothers enrolled for at least 12 months post-partum.</td>
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</table>

**Type of Improvement:**
Individual Comparison

**OUTCOME MEASURE**

<table>
<thead>
<tr>
<th>Source</th>
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<tbody>
<tr>
<td>GEOHVIS: Home Observation for Measurement of the Environment (HOME) 2 subscales: Organization Variety</td>
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<thead>
<tr>
<th>Comments/Reliability/Va lidity</th>
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<tbody>
<tr>
<td>validity as measured by correlations with measures such as the Sanford-Binet (.50-.71) and is a better predictor of intelligence than socioeconomic measures.</td>
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See above for validity and reliability information on the HOME with the target population.
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<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
<th>Source</th>
<th>Comments/Reliability/Validity</th>
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<tbody>
<tr>
<td>18. Parent behaviors and parent-child relationships</td>
<td>Mothers will increase the level of responsivity and acceptance for their enrolled child from the initial assessment to the post-assessment 6 months later.</td>
<td>Assessed at six month intervals; Developmentally appropriate version of HOME will be administered. Administered by Home Visitors</td>
<td>GEOHVIS: Home Observation for Measurement of the Environment (HOME) 2 subscales: Responsivity Acceptance</td>
<td>See above for validity and reliability information on the HOME with the target population.</td>
</tr>
<tr>
<td>Calculation:</td>
<td>Average score on the responsivity and acceptance subscales of the HOME Inventory at 6 months compared to average score at 12 months. For all enrolled women who have completed two HOME assessments, compare the average score on the responsivity and acceptance subscales at six months with the average score at twelve months.</td>
<td></td>
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<tr>
<td>19. Parent emotional well-being or parenting stress</td>
<td>The average level of stress experienced by mothers will decrease between the birth of their child and 10 months post-partum.</td>
<td>All mothers will be assessed within the first month postpartum visit and 10 months postpartum. For mother who enroll more than one month post-partum, the assessment will take place within the first month of enrollment and 10 months post-enrollment.</td>
<td>GEOHVIS: Parenting Stress Inventory, Short Form (PSI/SF) 1 subscale: Parental Distress</td>
<td>In a community-based, non-random sample, the PSI/SF Parental Distress subscale, Cronbach’s alpha was .87. Concurrent validity indicators of the PSI/LF are satisfactory. Psychometric properties of the PSI/SF were studied with a group of low-income, predominantly minority mothers and internal consistencies were</td>
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<tr>
<td>assessments on the parental distress subscale of the Parenting Stress Inventory. For all enrolled women who have completed two PSIs (at birth of child and 10 months post-partum), compare the score on the parental distress subscale.</td>
<td>Administered by Home Visitors Target Population: Mother who are enrolled for at least 10 months. Type of Improvement: Individual Comparison OUTCOME MEASURE</td>
<td>GEOHVIS: Ages and Stages Questionnaire (ASQ) Referral Form</td>
<td>“very good to excellent”* (Reitman et. al., 2002)</td>
<td></td>
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<tr>
<td>Increase the percentage of referrals for children whose screening indicates a developmental delay in the areas of communication, language, and emergent literacy comparing cohort 1 to cohort 2. <strong>Calculation:</strong> # of referrals within 2 months following a screening where a language delay is indicated for all children enrolled in year 1/# of screenings where language delay in</td>
<td>Upon enrollment, all children will be assessed using the developmentally-appropriate ASQ tool. Administered by Home Visitors Target Population: Children who screen positive for a language delay. Type of Improvement: Cohort Comparison PROCESS MEASURE</td>
<td>The Ages and Stages is a widely used developmental screening tool. It has been a component of the Healthy Families Georgia model for the past 10 years. Use of this instrument is consistent with the goals and efforts of Georgia’s ECCS. The Ages and Stages Questionnaire received an “A” rating on reliability and validity on the California Evidenced-Based Clearinghouse. At least one of the peer-reviewed, published studies that they reviewed included low-income parents. Benchmark was revised in March 2012 to track referrals vs. “completed” referrals. Two concerns motivated this decision: (1)</td>
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<tr>
<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
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<th>Comments/Reliability/Validity</th>
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<tbody>
<tr>
<td>indicated for all children enrolled in year 1, compared to # of referrals within 2 months following a screening where a language delay is indicated for all children enrolled in years 2 &amp; 3, # of screenings where language delay is indicated for all children enrolled in years 2 &amp; 3.</td>
<td></td>
<td></td>
<td>The initial benchmark required tracking and linking of three data points (ASQ score, referral, and completion of referral) – fairly difficult to implement at data collection, entry, and reporting phases, resulting in concerns about overall data quality, (2) there is variation among the 3 HV programs being implemented in Georgia with regard to experience in ASQ administration as well as referral procedures. Improvements in implementation of just these two components of HV will mark a significant improvement for Georgia.</td>
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<td>Construct</td>
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<td>Administration Schedule/ Population Assessed</td>
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<td>Comments/Reliability/Validity</td>
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<tr>
<td>21. Child’s general cognitive skills</td>
<td>Increase the percentage of referrals for children whose screening indicates a developmental delay in the area of general cognitive skills as measured by comparing cohort 1 to cohort 2.</td>
<td>Upon enrollment, all children will be assessed using the developmentally-appropriate ASQ tool. Administered by Home Visitors</td>
<td>GEOHVIS: Ages and Stages Questionnaire (ASQ) Referral Form</td>
<td>See previous references to information about validity and reliability of the ASQ and referral tracking.</td>
</tr>
</tbody>
</table>

**Calculation:**

# of referrals within 2 months following a screening where a cognitive delay is indicated for all children enrolled in year 1/# of screenings where cognitive delay is indicated for all children enrolled in year 1 compared to # of referrals within 2 months following a screening where a cognitive delay is indicated for all children enrolled in years 2 & 3/# of screenings where cognitive delay is indicated for all children enrolled in years 2 & 3.
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<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
<th>Source</th>
<th>Comments/Reliability/Validity</th>
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<tbody>
<tr>
<td>22. Child’s positive approaches to learning, including attention</td>
<td>Increase or maintain the percentage of home visits where brain building activities are discussed and/or practiced with mothers and children as measured by comparing Cohort 1 (year 1 enrollees) and Cohort 2 (year 3 enrollees). <strong>Calculation</strong>: # of home visits where brain building activities are discussed or practiced with mothers and children in year 1/total # of home visits completed in year 1 compared to # of home visits where brain building activities are discussed and/or practiced in year 3 for all those enrolled in year 3/ # of home visits completed for all those enrolled in year 3.</td>
<td>All mothers will be assessed on learning activities they are doing with their children at each home visit. Mother Report <strong>Type of Improvement</strong>: Cohort Comparison <strong>PROCESS MEASURE</strong> GEOHVIS: Home Visit Update Form</td>
<td>This benchmark measure was selected because reading to a child is a clear, concrete way that caregivers can support a child’s positive approach to learning – and it is addressed across curricula used by the 3 program models to be implemented in Georgia. The measure has face validity. Reliability will be checked as the Home Visitors will be collecting this information at each home visit and will note/address any significant inconsistencies in mother reports.</td>
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<tr>
<td>23. Child’s social behavior,</td>
<td>Increase the percentage of referrals for</td>
<td>Upon enrollment, all children will be assessed using the GEOHVIS: Screening: ASQ-SE</td>
<td>See previous references to information about validity and reliability of the ASQ</td>
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<td>Construct</td>
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<tr>
<td>emotion regulation, and emotional well-being</td>
<td>children whose screening indicates a developmental delay in the area of social-emotional behavior as measured by comparing Cohort 1 and 2.</td>
<td>developmentally-appropriate ASQ tool.</td>
<td>Referral Form</td>
<td>and referral completion tracking.</td>
</tr>
<tr>
<td><strong>Calculation:</strong></td>
<td># of referrals within 2 months following a screening where a social-emotional delay is indicated for all children enrolled in year 1/# of screenings where social-emotional delay is indicated for all children enrolled in year 1, compared to _# of referrals within 2 months following a screening where a social-emotional delay is indicated for all children enrolled in years 2 &amp; 3/# of screenings where social-emotional delay is indicated for all children enrolled in years 2 &amp; 3.</td>
<td>T<strong>ype of Improvement:</strong> Cohort Comparison</td>
<td>GEOHVIS: Aages and Stages Questionnaire (ASQ) Referral Form</td>
<td>See previous references to information about validity and reliability of the ASQ and referral completion tracking.</td>
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</tbody>
</table>

24. Child’s physical health and development  
Increase the percentage of referrals for children whose screening indicates a developmental delay in the area of physical health and development.  
Upon enrollment, all children will be assessed using the developmentally-appropriate ASQ tool.  
GEOHVIS: Ages and Stages Questionnaire (ASQ)  
Referral Form
<table>
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<tr>
<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
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<th>Comments/Reliability/Validity</th>
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<tr>
<td>delay in the area of physical development as measured by comparing Cohort 1 and 2.</td>
<td>Administered by Home Visitors</td>
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<tr>
<td><strong>Calculation:</strong> # of referrals within 2 months following a screening where a physical delay is indicated for all children enrolled in year 1/# of screenings where physical delay is indicated for all children enrolled in year 1 compared to # of referrals within 2 months following a screening where a physical delay is indicated for all children enrolled in years 2 &amp; 3/# of screenings where physical delay is indicated for all children enrolled in years 2 &amp; 3.</td>
<td>Target Population: Children who screen positive for physical developmental delay. Type of Improvement: Cohort Comparison</td>
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### Reduction in Domestic Violence

<p>| 25. Screening for domestic violence | Increase or maintain the percentage of mothers who are screened for domestic violence as measured by comparing Cohort 1 and 2. | All mothers screened within one month of enrollment. | GEOHVIS: Screening Upon Enrollment: For PAT and HFG Programs, DV screening questions are adapted from PRAMS Z1-Z11; This question is about things that may have happened during the past year. For each thing, indicate Y (Yes) if it | PRAMS was developed to support the CDC’s surveillance efforts and has been utilized by many states to monitor maternal and child health indicators. HFG and PAT Home Visiting staff will be provided with training and TA on screening administration in order to enhance validity and reliability of information |</p>
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<th>Construct</th>
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<th>Administration Schedule/Population Assessed</th>
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<th>Comments/Reliability/Validity</th>
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<tr>
<td>mothers who were screened for domestic violence who were enrolled in Year 1/total # of mothers who were enrolled in Year 1 compared to # of enrolled mothers who were screened for domestic violence who were enrolled in Years 2 &amp; 3/total # of mothers who were enrolled in Years 2 &amp; 3.</td>
<td>PROCESS MEASURE</td>
<td>happened to you or N (No) if it did not. In the past year— Your husband or partner threatened you or made you feel unsafe in some way You were frightened for the safety of yourself or your family because of the anger or threats of your husband or partner Your husband or partner tried to control your daily activities, for example, controlling who you could talk to or where you could go Your husband or partner forced you to take part in touching or any sexual activity when you did not want to In the past year, did an ex-husband or ex-partner push, hit, slap, kick, choke, or physically hurt you in any other way? No/Yes In the past year, did you miss any doctor appointments because you were worried about what your partner would do if you went? No/Yes Before you got pregnant, did your husband or partner ever try to keep you from using your birth control so that you would get pregnant when you didn’t want to? For example, did he hide your birth control, throw it away or do anything else to keep you from using it? No/Yes Did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way? For each time period, indicate Y (Yes) if it has happened to you or N (No) if it has not.</td>
<td>NFP nurses will be using the NFP-approved domestic violence screening via items contained in the Relationship Assessment. Both measures will offer a thorough screening to participants and allow proper referrals and follow-up to take place as needed.</td>
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<td>During the 12 months before I got pregnant</td>
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<td>During my most recent pregnancy</td>
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<td>Since my new baby was born</td>
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<td>NFP screening questions are from the Relations Assessment Pregnancy-Intake (13 items).</td>
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26. When screened with need, # of referrals made to relevant domestic violence services (shelters, food pantries)  

**Increase or maintain the percent of enrolled mothers in need of DV services who are referred for DV services as measured by comparing Cohort 1 and 2.**

**Calculation:** # of enrolled mothers who screen positive for DV and who were enrolled in Year 1 and were referred to services/total # of mothers screening positive for DV who were enrolled in Year 1 compared to # of enrolled mothers screening positive for DV who were referred for services and who were enrolled in

<table>
<thead>
<tr>
<th>Source</th>
<th>Comments/Reliability/Validity</th>
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<tbody>
<tr>
<td>GEOHVIS</td>
<td>Home Visit Update Form</td>
</tr>
<tr>
<td>All mothers screened upon enrollment</td>
<td>Home Visitors record all referrals on the Home Visit Update Form</td>
</tr>
<tr>
<td>Target Population: Mothers who screen positive for domestic violence risk</td>
<td></td>
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<tr>
<td>Home Visitor Report</td>
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<tr>
<td>Type of Improvement: Cohort Comparison</td>
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<td>PROCESS MEASURE</td>
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<td>Construct</td>
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<td></td>
<td>Years 2 &amp; 3/total # of mothers screening positive for DV and enrolled in Years 2 &amp; 3</td>
</tr>
<tr>
<td>27. Of families identified for presence of domestic violence, # of families for which safety plan was completed</td>
<td>Increase or maintain the percent of mothers who screen at risk for domestic violence who have a current safety plan as measured by comparing Cohort 1 and 2. <strong>Calculation:</strong> # of mothers enrolled in year 1 who screened positive for DV and have a completed safety plan/ # mothers enrolled in year 1 who screened positive for DV in year 1 <em>compared to</em> same percentage in years 2 &amp; 3.</td>
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**Family Economic Self-Sufficiency**

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<th>Construct</th>
<th>Benchmark</th>
<th>Administration Schedule/ Population Assessed</th>
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<th>Comments/Reliability/Validity</th>
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<td></td>
<td>Increase in the amount of monthly household income and benefits between enrollment and 12 months post-enrollment. <strong>Calculation:</strong> Compare amount of total monthly income and benefits as reported by</td>
<td>Assessment conducted for all women upon enrollment and twelve months post-enrollment. Target Population: Mothers Mother Report <strong>Type of Improvement:</strong> Individual Change <strong>OUTCOME</strong> GEOHVIS: Which of the following categories best describes your total monthly income and benefits this month? Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).</td>
<td></td>
<td>These questions were developed with feedback from the HFG and PAT program leads as well as upon consideration of NFP’s measurement design for this question. A decision was made to capture monthly income across $300 increments for two reasons: (1) TA Program Leads asserted that mothers are more likely to be able to report monthly income (vs. annual) with accuracy, and (2) Presenting options in</td>
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<td>Construct</td>
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<td>mothers within one month of enrollment with amount of total monthly income and benefits as reported by mothers at 12 months post-enrollment.</td>
<td>MEASURE</td>
<td>Less than or equal to $200 $201-$500 $501-$800 $801-$1,100 $1,101-$1,400 $1,401-$1,700 $1,701-$2,000 $2,001-$2,400 $2,401-$2,700 $2,701-$3,000 Over $3,000 Client is dependent on parent/guardian Sources of household income include (please check all that were included in your estimate) Salary/wages from employment Social Security Disability Other public benefits (such as TANF) Alimony Child Support Rent from tenants Cash Assistance for friends/relatives Unemployment Other income Sources of in-kind benefits include (please check all that were included in your estimate) SNAP/WIC Food Stamps Energy Assistance Housing Vouchers Other</td>
<td>$300 increments allows mothers a minimum of privacy and may facilitate more honest reporting of income.</td>
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<tr>
<td>Increase in educational activity over time for mothers who identify a need for education at time of enrollment.</td>
<td>Calculation: #</td>
<td>Education Assessment conducted for all women upon enrollment and twelve months post-enrollment. Target Population: Mothers</td>
<td>GEOHVIS: Upon Enrollment: Education Demographics collected At 12 Months post-enrollment: Since entering the home</td>
<td>These questions were developed with feedback from the HFG and PAT program leads as well as upon consideration of NFP’s measurement design for this question.</td>
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29. **Education of household adults**
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<td>of mothers who reply that they have continued in, enrolled in, or completed an educational program since enrolling in home visiting 12 months earlier/total number of mothers who identified a need for education at time of enrollment.</td>
<td>Mother Report</td>
<td>visiting program, have you continued in, enrolled in, or completed an educational program? Yes = 1 No=0</td>
<td></td>
<td>These questions were developed with feedback from the HFG and PAT program leads as well as upon consideration of NFP’s measurement design for this question. Georgia will be tracking this information in order to provide additional context for understanding the change in educational activity for mothers, but will not report on employment activity as a benchmark.</td>
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<td></td>
<td>Type of Improvement: Individual Change</td>
<td>If yes, please specify the type of educational program: High School GED Job-related Certification Program Vocational/Tech nical Training Associates Degree Program College Degree Program</td>
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<td>OUTCOME MEASURE</td>
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<td></td>
<td>Increase in employment over time for mothers who identify a need for employment at time of enrollment.</td>
<td>Assessment conducted for all women upon enrollment and twelve months post-enrollment. Target Population: Mothers Mother Report</td>
<td>Are you currently working? Yes Full-time: 37+ hours per week Part-time 20 – 36 hours per week 10 – 19 hours per week less than 10 hours per week No</td>
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<td></td>
<td>Calculation: # of mothers who reply that they have initiated or expanded their employment since enrolling in home visiting 12 months earlier/total number of mothers who identified a need for employment at time of enrollment.</td>
<td>Do you have a goal of getting a job (or increasing your number of work hours) during the next year? Yes = 1 No=0</td>
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<tr>
<td>30. Health insurance status</td>
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<td>OUTCOME MEASURE</td>
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<td>This construct will be tracked in the same way that the Maternal/Child Health insurance status is measured and tracked under Benchmark Area 1 (Improved Maternal and Newborn Health)</td>
<td>GEOHVIS: Adaptation of DOHVE’s Tool for the Measurement of Coordination and Referrals</td>
<td>GEOHVIS will be programmed to contain clear definitions of each enrollment and screening field in order to enhance validity and reliability of this information. The ECSOC Training and TA team will provide initial and ongoing assistance in</td>
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<td>Construct</td>
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<td>development, and domestic violence) as measured by comparing Cohort 1 to Cohort 2. Calculation: # of families who are screened for services who enrolled in year 1/# of families enrolled in year 1 compared to the same percentage in years 2 and 3.</td>
<td>of families in need of services based on these screens are tracked by the home visitors.</td>
<td></td>
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<td>these areas as well.</td>
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<tr>
<td>32. Number of families that required services and received a referral to available community resources</td>
<td>Increase or maintain the percentage of enrolled families who are referred to community resources from the year 1 to the year 3 benchmark period. Calculation: # of families who are referred to services during year 1/# of families who are identified as needing a referral during year 1 compared to # of families who are referred to services in year 3/# of families who are identified as needing services in year 3.</td>
<td>All referrals for services are entered and tracked at the local level and aggregated for state-wide analyses.</td>
<td>GEOHVIS: Home Visit Update Form Adaptation of DOHVE’s Tool for the Measurement of Coordination and Referrals</td>
<td>ECSOC Training and TA team will provide initial and ongoing assistance with strategies for referring families to appropriate services and tracking the referrals using the Home Visit Update form.</td>
</tr>
<tr>
<td>33. Number of MOUs</td>
<td>Increase in the number of</td>
<td>ECSOC Administrator will</td>
<td>GEOHVIS:</td>
<td>ECSOC Training and TA team will provide initial</td>
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| Construct                                                                 | Benchmark                                                                 | Administration Schedule/Population Assessed                                                                 | Source                                                                 | Comments/Reliability/Va
liability |
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<td>with community social service agencies</td>
<td>formal agreements with other social service agencies from the year 1 to the year 3 benchmark reporting period.</td>
<td>update this information as MOUs are established and signed.</td>
<td>Adaptation of DOHVE’s Tool for the Measurement of Coordination and Referrals</td>
<td>and ongoing assistance with strategies for establishing and tracking MOUs between HV services and other community services.</td>
</tr>
<tr>
<td><strong>Calculation:</strong> # of MOUs established by the end of Year 1 compared to # of MOUs established by the end of year 3.</td>
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<td>34. Information sharing: # of agencies with which the HV Provider has a Clear Point of Contact (POC) in the Community Agency that includes Regular Sharing of Information between Agencies</td>
<td>Increase in the number of social service agencies where a clear point of contact for those receiving home visitation services has been established from the year 1 to the year 3 benchmark reporting period.</td>
<td>ECSOC Administrator will update this information as POCs are identified.</td>
<td>GEOHVIS: Adaptation of DOHVE’s Tool for the Measurement of Coordination and Referrals</td>
<td>ECSOC Training and TA team will provide initial and ongoing assistance with clarifying the role of the Point of Contact and tracking them in GEOHVIS. The design of GEOHVIS includes preliminary ideas about how to enhance communication between service providers, using some of the features of social networking sites. As these ideas are clarified and integrated into the information system, we will make efforts to track collaboration and sharing of information beyond the POC count.</td>
</tr>
<tr>
<td><strong>Calculation:</strong> # of community agencies that have identified a clear POC for the HV Provider by the end of Year 1 compared to # of community agencies that have identified a clear POC for the HV Provider by the end of year 3.</td>
<td></td>
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<td>35. Number of completed referrals</td>
<td>Increase in percentage of families with referrals for</td>
<td>Referrals/Confirmation of Service Receipt are ongoing throughout</td>
<td>GEOHVIS: Home Visit Update Form</td>
<td>ECSOC Training and TA team will provide initial and ongoing assistance with strategies for</td>
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Data Quality Assurance Plan

The Data Quality Assurance efforts began with the careful selection of measurements. As measures were reviewed by the Benchmarks Work Group, both training requirements and ease of administration and scoring were considered. Where possible, measurement tools that were already being used by at least one of the program models were selected. Additional components of the Data Quality Assurance Plan are as follows:

1. Training: The Home Visiting Information Systems and Evaluation (HVISE) team will develop and implement trainings for Home Visitors on the measures that will be used to track benchmarks. All staff will be trained in the initial phase of implementation, even those who have already been administering the measures as part of their program model evaluation, in order to ensure fidelity to measurement administration protocols and correct “researcher drift.” Refresher trainings will be offered on an annual basis at a minimum. Newly hired staff will receive training on the measurement administration as part of the core training necessary prior to beginning home visits.

2. Technical Assistance: HVISE team staff will be available to address measurement administration concerns raised by local home visitation staff on an ongoing and as needed basis. Where necessary, the HVISE Program Site Liaison will make site visits to conduct refresher training or trouble-shoot measurement administration concerns.

3. GEOHVIS Data Entry and Scoring support: To support proper timing of administration and prevent errors in data entry and scoring, GEOHVIS will be programmed with the following features: (1) system-generated reminders to home visitors about when measurements are due, (2) system only accepts appropriate entry for each field, (3) certain fields will be mandatory, (4) automatic scoring of subscales and totals where possible, (5) Data Quality comment field...
where Home Visitors note any issues that may have affected quality of data (distractions in the home, mother fatigue, etc.)

4. Data Review: All benchmark data will be entered into GEOHVIS and reviewed regularly by the GEOVHIS Technical Lead to ensure that data is clean and stable.

5. Qualifications of Data Management and Analysis staff: The GEOHVIS technical lead has a Master’s degree in educational research and been managing the data collected via the Healthy Families Georgia Information System since 2003. This system contains data from more than 39,000 screenings and home visiting information for nearly 6000 enrolled families. She will be responsible for managing the data collected in GEOHVIS. The Center for Family Research has a data management and analysis unit directed by two doctoral-level statisticians. The lead statistician for the MIECHV program trained as a post-doctoral fellow at the University of Michigan and has extensive experience in the analysis of large-scale prevention datasets. She will be responsible for analyses necessary for the federal reporting requirements as well as additional analyses requested by the MIECHV program lead agency and state partners. At the local level, Program Managers will be provided with training and TA related to data quality assurance and how to use system-generated reports to conduct site-level quality assurance checks.

**Demographic and Service-Utilization Data**

The key to understanding progress (or lack thereof) in reaching benchmark goals lies in the collection of demographic and service-utilization information which act as modifiers of program outcomes. Again, the primary tool for collection of this type of data is GEOHVIS. A comprehensive demographic assessment, including individual (mother, child, and other household members) and family-level variables will be conducted upon enrollment and updated at regular intervals throughout the course of program implementation. Service-Utilization data is collected in accordance with the parameters that model developers have set to reflect adherence to the program model. These parameters typically include number and type of services and referrals. GEOHVIS will also collect other program-level information, including home visitor qualifications and trainings. These data will be analyzed as moderators and mediators of the benchmark outcomes at both the local and State levels.

**Data Analysis Plan**

The collection of demographic, service utilization, process indicators and outcome data will be standardized across all HV models and MIECHV sites. At the state-level, data will be exported for analysis and can be disaggregated along various dimensions to allow analyses of specific demographic subgroups or programs. Prior to analysis, the MIECHV program statistician will conduct psychometric analyses of all measurements to ensure factor structures are meaningful for the MIECHV program sample. Descriptive statistics will be conducted to allow a “snapshot” of information about enrolled families and program staff to be presented. The IT Lead and Statistician will collaborate on a strategy for coding the information contained in the multiple home visit updates per participant. Analyses will be conducted to detect improvements as specified in the proposed benchmark measurement table. Additional analyses will be conducted as requested by program managers and other stakeholders. Staff at the local level will have access to reports reflecting data entered into GEOHVIS for their site as well as other MIECHV program sites.

**Continuous Quality Improvement using Benchmark Data**

Each aspect of the benchmark tracking plan was designed with opportunities for Continuous Quality Improvement in mind. The challenge was to design an assessment administration
schedule that would generate information in a dynamic, nearly real-time way without overburdening home visitors and family participants. The solution to this problem for data related to many of the indicators was found in the “Home Visit Update Form.” This data collection tool is primarily a mechanism for standardizing a process that goes on at each home visit, regardless of program model, and allowing the wealth of information that is obtained during conversations with family members to be recorded and tracked in a systematic way. Once this information is tracked, it can become very useful at the local and state levels to either confirm what was known only anecdotally before or disrupt assumptions that turn out to not have any empirical basis. Some of the benchmark indicators are measured via a standardized assessment with time requirements that prohibit regular, repeated administration. For the indicators associated with these benchmarks, programs will enter information about program activities that are expected to be linked to those indicators. For example, subscales of the HOME will be used to assess “parent support for child’s learning and development” and will be assessed annually. On a more regular basis, staff will track their home-based interventions in this area (e.g., provision of information about brain development, introduction of games that stimulate learning for children, etc.). In this case, CQI could be used to examine barriers to providing this information or perceived resistance from families related to the interventions.

CQI-State Level: In the first year of the project, the CQI State team will be responsible for developing a familiarity with the design of GEOVHIS and ensuring that the system is designed to contain the data points necessary to supporting CQI at the state and local levels. Throughout MIECHV program implementation, the CQI State team will review the benchmark data on a regular basis and “drill down” to detect the sources of variation with the data. Next, the team will select a particular program site to work with and support them in the “Plan, Do, Study, Act” phases of CQI implementation.

CQI-Local Level: Throughout the course of MIECHV program implementation, Program Managers will be trained to review program-level data and initiate their own CQI efforts. It is anticipated that GEOHVIS will be designed to allow CQI reports to be generated (e.g., Red/Green charts, control charts) that Program Managers can use to see trends in activities or outcomes over time. Any proposed changes or adaptations to their programs must be approved by the CQI State team.

Data Safety and Monitoring Plan

The HVISE team will be responsible for ensuring that the following elements of the Data Safety and Monitoring Plan are implemented:

1. University of Georgia’s IRB approval on all data-related protocols. All aspects of this project will be subject to review and approval of UGA’s IRB. Elements will include documentation of informed consent, ethics training of staff persons interacting with families, and server security operations.

2. Staff Training. All staff at the local and state level that are responsible for data collection, entry, management, or analysis will be required to undergo an online human subjects protection training via the Collaborative Institutional Training Initiative (CITI). Additional training regarding the ethics of confidentiality, mandatory reporting of child abuse and neglect as well as protocols to follow when a member of the household is suspected to be at risk for harm to self or others will be provided. All staff persons will sign an Assurance of Confidentiality during this training.

3. Web security. The HVISE team is currently exploring possible vendors to support the development of GEOHVIS. It is possible that the vendor will operate according to the
“Software As A Service” (SAAS) business model meaning that the data collected would be stored on a server external to CFR. If this is the case, the HVISE team will specify the strictest of security measures in their collaboration with the selected vendor. When GEOVHIS data is exported to servers at CFR for purposes of data analysis, it will be secured by the same protections that are in place for all of CFR’s datasets containing information about thousands of Georgia families who participate in their research projects. CFR servers are Dell Poweredge servers running Red Hat Enterprise Linux 5. These are physically double-locked, meaning a key is needed to enter the server room as well as another key is needed to open the server rack. The servers connect to the internet via the University of Georgia's network, which implements a hardware firewall to prevent most malicious activity. In house, the servers maintain themselves by a variety of updating scripts to stay current on operating system upgrades and fixes. CFR also runs an additional software firewall to restrict access to data stored on the servers. The servers have an integrity checker installed which allows routine checking to see if any unauthorized changes have been made. The operating system has been fine-tuned to disable unnecessary services which may lead to unauthorized access.

**Anticipated Challenges in Benchmark Reporting**

The HVISE team has made all of their decisions to date in light of two related concerns about benchmark reporting: (1) Time burden of data collection and entry, and (2) Duplicate data collection and entry necessary as a result of data demands of different stakeholders. Each of these concerns as well as their proposed solutions is described here in greater detail.

1. **Time Burden:** This concern has been raised repeatedly on data-related webinars and teleconferences that have been held since the SIR was released last February. The valid point has been made that time spent in a family’s home that is focused on benchmark measurement administration is time taken away from the implementation of services intended to address these very benchmarks. Proposed Solutions: Where possible, the HVISE team has addressed this issue proactively by selecting measures with minimal administration time required or trying to capitalize on data that is collected as a natural element of the home visit. Additionally, the HVISE team will work with home visiting staff to design and develop GEOHVIS to support end user’s efforts to follow the administration schedule and enter data efficiently. The next step in addressing this issue is to work toward developing a culture of Continuous Quality Improvement, wherein data and its related tasks are not perceived as a necessary evil, but rather as a critical tool for the home visitor to enjoy more certainty and creativity in their implementation of home visitation services. Beginning with the first MIECHV program training to be held in summer 2011, the stage will be set for developing a culture of “trust and transparency” as a critical element of capitalizing on the MIECHV grant opportunity. Follow-up meetings will be held with local program staff to underscore the notion that access to data is a “carrot” for enhancing program implementation rather than a “stick” for having failed to meet expectations. Efforts toward this cultural transformation will be ongoing throughout the MIECHV program. Though it does nothing to reduce the amount of time necessary to carry out data collection activities, it can change the meaning of those activities and thereby transform the amount of stress associated with them.

2. **Duplication of Data Collection and Entry:** In a recent meeting that the HVISE team held with the program manager and a home visitor from one of the targeted MIECVH program communities, the home visitor presented a spreadsheet she used to track the unique data requirements associated with each individual participant. The requirements varied according to which funded source was used to support the work with each particular participant.
Sometimes, different assessments of the same outcome were required; other times, the data
collection tool was the same, but the information needed to be entered into multiple data
systems. Because the Georgia MIECHV program comprises three program models, this is a
fairly complex problem to address. Each program model is guided by national or state
leadership to use particular assessment tools and data systems, resulting in minimal overlap in
this area. The problem is not primarily technological; there are various mechanisms for
supporting the coordination and sharing of data between and across data systems. The issue is
primarily the time necessary for coordinating shared goals and resources across programs and
developing data sharing agreements between agencies. Proposed Solutions: To the extent that
the national program offices can work across agencies and with HRSA/ACF to support
coordination of shared goals, the entire MIECHV program network will benefit. Meanwhile,
in the upcoming months, the HVISE team will work with the state-level TA and Training team
for each of the Georgia MIECHV program models to identify points of overlap between
systems and expand ideas for coordination.

Section 6: Administration of the State Home Visiting Program

Lead Agency

The Governor’s Office for Children and Families (GOCF), a state agency, has been
designated by the Governor to act for the State in administering the funds for the implementation
of the Maternal, Infant, and Early Childhood Home Visiting Program. GOCF will serve as the
fiscal agent and ensure the accountability of funds received through this grant.

In addition to administering funds for Title V and the Office of Juvenile Justice and
Delinquency Prevention (OJJDP), GOCF is responsible for oversight of the funding received by
Georgia through Title II of the Child Abuse Prevention and Treatment Act (CAPTA - CBCAP)
In addition, GOCF is also Georgia’s Children Trust Fund and serves as the lead agency for many
statewide initiatives (including Georgia’s Strengthening Families Initiative) in addition to
fulfilling its statutory mission as the state’s primary funding mechanism for child abuse and
neglect prevention activities and programs. The agency has been instrumental in supporting and
funding evidence-based home visitation programs such as Nurse Family Partnership, Healthy
Families Georgia, Parents as Teachers, and the Nurturing Program. Further, GOCF and its
collaborative partners have designed, implemented, maintained, and funded the infrastructure
support for Healthy Families Georgia and Parents as Teachers.

Collaborative Partners in the Private and Public Sector

A list of state level collaborative partners was provided in Section 4.

Management of the State Home Visiting Plan

The administrative structure for Georgia’s MIECHV Program was developed with the bigger
early childhood system in mind. The GOCF 2011 Strategic Plan calls for the development of “a
statewide and community-level strategic response for children ages 0-5 and their families”
utilizing a system of care approach. This objective in the Strategic Plan set the stage for
developing an Early Childhood System of Care (ECSOC) that includes home visiting as a major
strategy. The state’s administrative structure to establish home visiting programs was, therefore,
designed to address both the ECSOC and home visiting implementation issues.

With regard to the state’s capacity for supporting the integration of the MIECHV Program
into a statewide coordinated early childhood system, the following structure is place:

- **Governor’s Office for Children and Families**: Has accountability for bringing together
agencies and stakeholders to develop 1) an early childhood system of care strategic response, and 2) a system of evidenced-based home visitation programs and services for young children and their families in “at risk” communities.

- **Georgia Early Childhood System of Care/MIECHV Management Team:** Comprised of key staff working with the GOCF to make decisions regarding the development and implementation of the Georgia Early Childhood System of Care Strategic Response and to manage the process.

- **Georgia Early Childhood System of Care/MIECHV Leadership Team:** Comprised of key stakeholders who are responsible for providing direct input into developing and writing 1) a strategic plan that will be used to implement early childhood systems of care in Georgia, and 2) a state plan and application for federal-funding to implement a system of evidenced-based home visitation programs in “at risk” communities, and then guiding implementation of the plan.

- **Georgia Early Childhood System of Care Advisory Group:** Represents a broad range of respected and valued leaders with great interest in developing a comprehensive system of supports and services for families with young children and with significant contributions to make in the design and implementation of such a system. Provides advice, support and consultation to the Early Childhood System of Care Management Team and the Early Childhood System of Care/MIECHV Leadership Team.

At the state level, the Early Childhood System of Care Home Visiting (ECSOC HV) Team and the ECSOC Home Visiting Information System and Evaluation (HVISE) Team, supported by the Center for Family Research at the University of Georgia, provide a coordinated infrastructure to support the technical assistance, training, data collection and management, and quality assurance for evidence-based home visitation programs.

**Plan for Coordination of Referrals, Assessments, and Intake Processes among Different Home Visiting Models**

The Early Childhood System of Care (ECSOC) provides the foundation for implementation of evidence-based home visiting in each community. Expectant parents and families with children under five are identified by ECSOC Community Outreach and, with parental consent, referred to Central Intake for screening. The ECSOC screen contains items common to screens of providers, appropriate to the system of care point of entry and prioritized for participation in federally funded home visitation. Families are linked with services as needed. Families identified for home visiting services are referred by Central Intake to the ECSOC Home Visiting Partner. This organization coordinates entry of families into the home visiting program(s); three evidence-based home visiting models were selected for implementation in the Georgia FY 2010 MIECHV Program. One additional model was selected for FY 2011. The ECSOC HV Partner matches the family with the appropriate model based on model criteria, Georgia MIECHV Program criteria for program entry, and family needs defined by the ECSOC. Family assessments are completed upon family entry into the home visiting program, as required by each program model.

**Identification of Other Related State or Local Home Visiting Evaluation Efforts**

Through a grant from the Annie E. Casey Foundation, Parents as Teachers (PAT) and Georgia State University are partnering to evaluate the combination of the PAT model and Safe Care curriculum to enhance positive health and school readiness outcomes and to prevent child maltreatment for high-risk children and families. The Georgia PAT Network and the PAT National Center are consultants on the project.
The United Way of Metropolitan Atlanta (UWMA) provides funding through an early learning initiative, Partners Advancing Childhood Education (PACE), for DeKalb County PAT programs plan to participate in the MIECHV Program. These PAT programs will participate with other PAT programs in Georgia in an evaluation conducted for UWMA.

A Promise Neighborhood grant was awarded in Clarke County; evaluation for this grant will include both the Early Head Start Home Based Option (EHS-HBO) program and the Athens Healthy Families Georgia (HFG) program. University Of Georgia’s College Of Education will conduct the EHS evaluation. The HFG evaluation will include outcomes for child well-being and substantiated abuse and neglect compared to families not participating in Athens’ HFG program.

An HFG program evaluation report is completed annually by the University of Georgia’s Center for Family Research using data from the HFG Information System. Four MIECHV Program selected communities have HFG program data included in the state HFG evaluation report.

Lastly, all GOCF-funded SOC grants are expected to participate in an annual cross-site evaluation conducted by an independent evaluator for GOCF.

**Job Descriptions of Key Positions and Resumes.** Resumes for key positions are listed below. Please refer to Attachment 4 for job descriptions for key personnel.

**Organizational Chart.** Attachment 3 includes an organizational chart of the management and administration of the State Home Visiting plan.
EXPERIENCE:
Prevention Programs Coordinator (2008 – Present)
The Governor’s Office for Children and Families (GOCF)
Conducts critical analysis research, develops policy and strategic plans, and implements, evaluates and administers GOCF- funded system of care development in prevention and intervention strategies. Leads grant review process for agency. Oversees the development and on-going management of state/federal sub-grantees. Plans, develops, implements and maintains a system designed to coordinate and provide continuous and systematic evaluations for programs and initiatives. Manages the overall direction and supervision of child abuse and neglect prevention activities for agency. Represents agency at the state, local and national level.

Interim Executive Director (2006 – 2007), Program Director (1999 – 2006)
Georgia Children’s Trust Fund Commission (CTFC), Atlanta, Georgia
Oversaw the development, implementation and evaluation of CTFC-funded programs including First Steps, Healthy Families Georgia, Parents as Teachers, Second Step and other family support programs. Managed yearly grant proposal and review. Evaluated quality of service and management of all CTFC grantees. Provided technical assistance to assure compliance with CTFC program standards and fiscal policy. Manage the Children and Elderly Preschool Children with Special Needs yearly grant proposal and review. Developed and administered all contracts, plans and budgets. Coordinated and performed legislative liaison/advocacy efforts for the Commission. Developed and maintained relationships with various national, state and local organizations.

Senior Technical Advisor (1997 – 1999)
Care Solutions, Inc., Atlanta, Georgia
Managed the federal Promoting Safe and Stable Families grant for the Department of Family and Children Services, Foster Care Unit. Provided technical assistance to grantees, created Request for Proposals and technical assistance manuals, supervised the data collection and federal reporting. Monitored grant programs and coordinated the statewide symposium.

Program Director (1986 – 1996)
Prevent Child Abuse Georgia, Inc., Atlanta, Georgia
Directed the development, implementation and evaluation of all PCA Georgia programs/initiatives including First Steps, Healthy Families Georgia, Parents Anonymous, Nurturing Program, and the statewide prevention network. Supervised evaluation/research, planning, prevention program grant proposals, trainings, and development of prevention resource materials. Provided technical assistance to organizations in public awareness activities, community collaboration, board development, fundraising, fiscal management, grant writing, and legislative advocacy. Supervised a staff of 15.

RELATED EXPERIENCES:
- Strengthening Families Georgia Leadership Team, 2006 - Present
- Early Childhood Comprehensive Systems Advisory Committee, 2006 – Present
- Child and Family Service Review Planning Committee and Citizen Review Panel Advisory Board, 2006 – Present
- Prevent Child Abuse Annual Symposium Planning Committee; Programs and Research Committee 1999 – Present
- Promoting Safe and Stable Families Grant Reviewer, 1997 – Present

EDUCATION:
Master of Arts, Clinical Concentration, 1984
University of Chicago, the School of Social Service Administration. Chicago, Illinois

Bachelor of Arts, Psychology, 1982
Vanderbilt University. Nashville, Tennessee
M. Frances Milton  
Financial Operations Specialist Advanced Level  
Governor’s Office for Children and Families

**Governor’s Office for Children and Families, Atlanta, Georgia, SFY2010 to Present - Financial Operations Specialist AL.**
Grant financial specialist for state and federal grant initiatives. Coordinate with Program staff to develop and implement grant awards agreements and grant compliance standards within agency guidelines and state and federal laws, rules and regulations. Administer and implement grant fund source distribution and oversees fund utilization within program area of assignment. Monitor grantee reporting, compliance, and accountability with established agency, state, and federal rules, regulations and grant procedures. Develops and maintains financial database within Program area of assignment. As grant financial lead, developed and implemented financial grant protocols for grant initiatives.

**Children’s Trust Fund Commission, Atlanta, Georgia, SFY1989 to SFY2009 – Administrative Operations Manager.**
Manage administrative, financial and grant/contract management functions for the Commission.
- **Administrative Operations (Budget, Procurement, HR Activities, and Records Management):** Prepare and oversee Commission operating budget and expenses. Annual operating budget 7.4 – 7.8 million. Process, record and balance all Commission operating, grant, employee travel, and Commission member travel. Oversee procurement responsibilities of the Executive Secretary in processing employee/Commission travel expenses, supply requisitions, equipment contracts and balancing VISA payments.
- **Grants/Contracts Management:** Develop and oversee financial grants management protocols and systems. Create and maintain Access database and Excel ledgers for contract management purposes including mail merges, production of contracts and reporting forms, statistical reports, recording grant expenditures and participant data. Review applications for continuation funding, review contractor financial performance and make recommendation to Commission members regarding continuation funding. Provide technical assistance to contractors.
- **Meeting Minutes, Logistics and Travel:** As Administrative Assistant planned logistics for quarterly meetings. Made travel arrangements for Commission members. Created and maintained meeting minutes.

**Office of the Governor, State Capitol, Atlanta, Georgia, 1987 to 1988**
Provide administrative support to the Assistant Legal Counsel. Provide backup reception duties. Compose correspondence for signature in response to constituent inquiries. Transcribe dictation of synopsis of House and Senate Bills during the session of General Assembly. Compose for approval routine executive orders.

**GA Department of Administrative Services, Purchasing Division, Atlanta, Georgia 1981 to 1987**
Provide administrative support to the Director. Provide for all aspects of Division administrative office support. Provide for Division budgeting, procurement, travel, personnel transaction, and maintenance of suspense file for statewide procurement contracts. Supervise secretary typist. Assist in coordination of Governor’s Small and Minority Business Development Conference.

**Department of Revenue, Field Services, Atlanta, Georgia, 1980 to 1981**
Issue FiFa legal notices that the state is filing a tax lien and a State Tax Execution to so the government to have legal right to levy or seize assets.

**Department of Revenue, Motor Vehicles, Atlanta, Georgia, 1980**
Process motor vehicle tags and titles

**Education:** Kennesaw State College, Kennesaw, Georgia
Summary
Currently working as an independent contractor, utilizing my extensive experience working at the state and local levels in Georgia to improve the health and well-being of children, families and communities. Specific knowledge and skills range from the provision of direct health and social services to children and families to state level management of programs/projects that support families with young children and promote the economic development of communities. Successful at developing partnerships to improve child and family outcomes and working collaboratively to support community-based decision-making. Major focus of work in last 15 years has been on the development of early childhood systems.

Education
1985-1987 University of Alabama at Birmingham, School of Public Health, Master of Public Health in Maternal and Child Health
1966-1970 Medical College of Georgia, School of Nursing, Bachelor of Science in Nursing

Professional Experience
2010-present Governor’s Office for Children and Families - Project Manager, Early Childhood System of Care and the Maternal, Infant, and Early Childhood Home Visiting Program – a five year initiative to develop and implement evidence-based home visiting programs as a major service strategy in an Early Childhood System of Care (ECSOC). Six counties are implementing the ECSOC, which focuses on all expectant families and children up to five years of age, and utilizing one to three evidence-based home visiting models for delivering services to families with intensive needs.

2006-2010 Children’s Trust Fund Commission and Bright from the Start: Georgia Department of Early Care and Learning - Project Director, Strengthening Families Georgia - a statewide initiative designed to embed five research-based protective factors and strategies for their achievement in all systems, programs, services and activities supporting families with young children.

Family Connection Partnership - Consultant, Early Childhood Strategy and Family Engagement- providing technical assistance to Family Connection Collaboratives wishing to plan, develop, implement or expand an early childhood community economic development strategy to address community goals, and to System of Care Communities needing assistance in engaging families and youth.

2000-2005 Family Connection Partnership - Project Director, Appalachian Early Childhood Initiative - a community-based project funded by the Appalachian Regional Commission designed to improve child and family outcomes and improve community economic development in five north Georgia counties.

1988-2000 Georgia Department of Human Resources, Division of Public Health - Responsibilities included:
• Development, implementation and management of Children 1st, Georgia’s early identification and follow-up system for children at risk for poor health and/or developmental outcomes.
• Leadership for the Center for Family Resource Development, Family Health Branch.
• Management of various grant initiatives (Carnegie Corporation Starting Points Initiative, Centers for Disease Control Disability Prevention Grant).
• Management of Family and Community Involvement, Family Health Branch.
• Nursing consultation for state’s Children’s Medical Services Program.

1971-1988 Dekalb County Board of Health - Responsibilities of various positions included:
• Management of large health centers providing direct services.
• Supervision of nursing, health education, administrative and para-professional staff.
• Provision of direct public health nursing services to families, including home visiting.

Leadership Activities
• Project Manager for the Early Childhood System of Care.
• Project Director for Georgia’s Appalachian Early Childhood Initiative, 2000-2005.
• Georgia Division of Public Health representative in Family Connection collaboration activities, 1991-2000.
• State liaison for five federally-funded Healthy Start sites in Georgia, 1999-2000.
• Project Director for Georgia’s Starting Points Initiative, 1995-1998; which created the Better Brains for Babies Initiative in GA.
• Graduate of Leadership DHR, Class of 1994.
• Chair of Georgia Model System of Contact, Support and Follow-Up at Birth Committee through Family Connection, 1992-1995.
• State Public Health Representative for bringing Hawaii Healthy Start (model for Healthy Families America) to GA, 1991.
Anita Brown, Ph.D
2229 Springwood Dr.
Decatur, GA 30033
706-255-9593
anitab@uga.edu

EDUCATION
Doctor of Philosophy: The University of Georgia, October 1998
Child and Family Development

Master of Science Degree: The University of Georgia, June, 1988
Child and Family Development

Bachelor of Arts Degree: Kent State University, May, 1986
Major: Individual/Family Studies

EMPLOYMENT HISTORY
Center for Family Research, Institute for Behavioral Research
The University of Georgia
Associate Director: January 2002-present

➢ Serve as Project Lead on the Georgia MIECHV program
➢ Collaborate with Center Directors on long-range planning for Center development
➢ Contribute to the writing of grant and contract proposals in accordance with Center goals
➢ Initiate and pursue partnerships with other investigators to further Center’s research agenda
➢ Design and monitor policies and policies for scientific and fiscal operations of the Center
➢ Continue to carry out responsibilities of the Chief Scientific Coordinator

Chief Scientific Coordinator: October 1999- December 2001

➢ Develop and monitor budgets for new grant proposals, contracts, and other Center accounts
➢ Provide long-range planning of Center activities; Direct staff efforts accordingly
➢ Develop and document data collection, data cleaning, and data management policies for multiple longitudinal research projects (current and future) at the Center for Family Research
➢ Supervise and evaluate Project Coordinators with regard to Center quality control policies and procedures
➢ Collaborate with Project Coordinators to ensure that quality standards are met at each phase of the research process

SELECTED PUBLICATIONS


Marcia H. Wessels  
8 Spring Green Place NW, Atlanta, GA 30318  
404.966.2766  
marciaw@uga.edu

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**Professional Experience**

**Center for Family Research, University of Georgia**  
Director Home Visiting TA, Training and Evaluation  
10/2010 – Present

- Provides leadership and coordination for the development, implementation, expansion, maintenance, and quality assurance of home visiting programs in Georgia
- Collaborates with the Governor’s Office for Children and Families, lead other partners, and home visiting staff to develop a coordinated system of home visiting technical assistance and training in Georgia
- Coordinates networking among evidenced-based home visiting programs in Georgia
- Supports the development and home visiting program use of the Georgia Home Visiting Information System (GEOHVIS)
- Supervises Georgia Early Childhood System of Care Home Visiting Team staff

**Lutheran Services of Georgia**  
Vice President of Operations  
2/2010 – 9/2010

- Oversaw all services programs, including Community and Placement Services, Refugee Services, Senior Services and Disaster Response
- Managed program grant and contract proposal processes
- Coordinated and/or supervised the development of policies and procedures
- Oversaw the Agency’s risk management program
- Oversaw IT functions
- Supervised statewide program directors

**Prevent Child Abuse Georgia (PCA GA)**  
Healthy Families Georgia State Coordinator  
2005 – 2010

- Provided leadership to a statewide network of Healthy Families Georgia (HFG) child abuse primary and secondary prevention programs, serving more than 20,000 families annually
- Managed a technical assistance team responsible for staff training, consultation and quality assurance
- Provided oversight for HFG use of data systems; collaborated with data system managers
- Managed technical assistance team budget; collaborated with funder on management of annual Healthy Families Georgia program network budget
- Managed grants and contracts, met deliverables, prepared and submitted reports
- Oversaw program advocacy and collaboration

**Chatham County Department of Family and Children Services**  
Social Services Supervisor  
2003 – 2005

- Administration and supervision of child welfare case managers providing foster care and adoption services and child foster home, group home and institutional placement
- Compliance with federal and state regulations; implementation of state policies/procedures
- Agency representative to community coalitions

**Prevent Child Abuse Georgia**  
Healthy Families Georgia/First Steps Associate  
2000 - 2003

- Program development, technical assistance and quality assurance for prevention programs

**Chatham County Department of Family and Children Services**  
Social Services Supervisor/Social Services Specialist  
1987-2000

- Child welfare supervision and case management

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**Professional Development**

**MPH  Master of Public Health**  
Armstrong Atlantic State University, Savannah, GA  
2000

**BA  Bachelor of Arts Psychology**  
Armstrong Atlantic State University, Savannah, GA  
1972
Plan for Meeting Legislative Requirements regarding staff, supervision, organizational capacity, referral, service networks and monitoring is detailed in Section 4.

Compliance with Model-Specific Prerequisites for Implementation is discussed in Section 3.

Modifications to the State’s Administrative Structure is not expected, however, may be made, as appropriate, upon implementation and discussion with the MIECHV Leadership and Advisory teams.

Collaborations Established with other Early Childhood Initiatives

There are a number of organizations and initiatives that are currently supporting early childhood system efforts and have the capacity and influence to promote the Early Childhood System of Care (ECSOC) and evidence-based home visiting as a significant service strategy in the ECSOC continuum of early childhood services. Some of those efforts include: Georgia Children’s Cabinet; State Advisory Council for Early Childhood Education and Care; Early Childhood Comprehensive Systems; Georgia Early Education Alliance for Ready Students; Strengthening Families Georgia; Georgia Family Connection Partnership; Georgia Birth to Five Coalition.

The Governor’s Office for Children and Families (GOCF) is directly involved with the work of most of these initiatives, providing staff to assist in collaboration around early childhood systems and making sure the Early Childhood System of Care and Evidence-Based Home Visiting work is aligned and coordinated with these activities. GOCF is the administering agent of the Georgia Children’s Cabinet. The current work of the Cabinet includes ongoing, thorough mapping and evaluation of child and family services across the state; and projects to improve the quality of services provided to children and families. In addition, GOCF provides resources to support the work of Strengthening Families Georgia, and family engagement activities for Georgia Family Connection Partnership. Staff from GOCF and Early Childhood Comprehensive Systems (ECCS) work together to support our state and communities efforts to build and integrate early childhood service systems that address the critical components of social-emotional development and mental health of young children, and parenting education and family support.

These collaborative partners assisted in the development of the Early Childhood System of Care and have been involved in decision-making related to the state Home Visiting Program.

Section 7: State Plan for Continuous Quality Improvement

- **Framework:** GOCF has contracted with the Center for Family Research at the University of Georgia to develop and monitor the state system’s CQI plan.
- **Content:** The CQI plan will address all evidence-based home visiting programs participating in Georgia’s MIECHV Program.
- **Data Collection:** The Georgia Home Visiting Information System (GEOHVIS) will be developed by the Center for Family Research at the University of Georgia. GEOHVIS will support MIECHV Program implementation by collecting and tracking data for referrals, screens, linkage to home visiting, benchmarks, and coordinated care with community service providers. The system will track process and outcome data and will generate regular reports to be used for CQI.
- **CQI State Team:** The CQI State Team will be comprised of members of the Early Childhood System of Care Home Visiting Information System and Evaluation Team, the Early Childhood System of Care Home Visiting Team, members of the Early Childhood System of Care
Management Team, an industry CQI expert as a consultant, and program managers /supervisors and home visitors representing local evidence-based home visiting programs.

- **CQI Local Program Teams:** Each evidence-based home visiting program participating in the MIECHV Program will select one or more program staff to comprise the CQI Local Program Team. Representatives to the CQI State Team will be selected from CQI local teams.

- **CQI Implementation Plan:**
  - Members of the CQI State Team will identify one or more combinations of CQI methodologies including Lean Enterprise and Six Sigma. CQI charts and tools including but not limited to Check Sheet, Cause-and-Effect Diagram, Flow Chart, Pareto Chart, Scatter Diagram, Probability Plot, Histogram or Control Charts will be used throughout the process. Some concepts of these tools and charts will be incorporated into the data system directly making them available to the local staff on-demand and in real-time.
  - To promote a positive CQI culture, the CQI State Team will provide a series of promotional speeches or workshops to home visiting state and community partners, as appropriate.
  - To support a positive CQI culture at the program level, the CQI State Team will provide CQI training and ongoing CQI technical assistance to local programs. Members of the CQI State Team will participate in MIECHV Program community level implementation planning meetings and make a CQI presentation for participants. Members of the team will provide CQI training for home visiting program staff. Prior to implementation of home visiting services, the CQI State Team will train staff on the use GEOHVIS.
  - The CQI State Team will form the CQI Local Program Teams. Each team must include one home visitor.
  - The CQI State Team will lead the CQI effort based on the Plan-Do-Check or Study-Act (PDCA or PDSA) cycle. Following steps will be taken: discovery, analysis, prioritization, clarification and charting. Specific CQI tools and procedures will be used throughout: Check Sheet, Cause-and-Effect or Fishbone Diagram, Flow Chart, Pareto Chart, Scatter Diagram, Probability Plot, Histogram, Control Charts, and Brainstorming etc.
  - Members of the CQI State Team and the CQI Local Program Teams will conduct a detailed needs assessment to identify needs, issues, problems, and processes that need improvement at the state, program and local levels. The team will also define the current status and establish targeted improvement goals in the needs assessment. Members of the CQI State Team will work closely with the CQI Local Program Teams in identifying specific situations that are unique to the community. The process will involve methods such as surveys or focus groups with home visitors and their supervisors or clients.
  - Based on the needs assessment, MIECHV benchmark requirements, program fidelity requirements and state standards, the CQI State Team will conduct a brainstorm session with appropriate stakeholders to analyze the problems or gaps using existing data, using charts and diagrams as needed. As a result of this process, the target problems and a list of possible causes will be identified. The CQI State Team will also identify areas where changes could positively impact program outcomes, select CQI strategies to implement and determine the effect of changes.
  - The team will then prioritize the problems or issues with problems that having the greatest effect being the highest priority items.
  - The CQI State Team will develop an action plan based on the analyses and prioritization with short term and long term goals. This plan will outline ways to correct the root causes of the problem, specific actions to be taken, identify who, what, when and where. The CQI State
Team will execute the action plan on the smallest and simplest scale in the first year, gradually increasing the level of complexity over time as local program staff become accustomed to the positive CQI culture.

- The action plan will be implemented at the community level by each CQI Local Program Team with guidance, support and TA from the CQI State Team, as needed.
- The CQI teams will monitor action plan results by reviewing CQI reports and charts at specified time intervals determined by the team. The GEOHVIS data team will present CQI reports along with appropriate charts and diagrams before and after the change. The CQI State Team will confirm that the problem and its root causes have decreased, and determine if the target has been met.
- CQI Local Program Team members and the ECSOC HV Team will pull program reports and monitor program performance of individual programs. CQI Local Program Team members will serve as the point of contact for the CQI State Team. In addition, they will provide CQI Plan site input and feedback to the CQI State Team.
- The teams will repeat the process with the next identified and prioritized problem or issue using the same PDCA cycle.
- The ECSOC HV Team and the CQI State Team will provide technical assistance and training, as needed, to support the implementation of strategies. Results of CQI and plans for continued improvement will be shared with MIECHV programs.

Section 8: State Technical Assistance Needs

The MIECHV Leadership Team developed the following list of technical assistance needs for Georgia: sustainability; fiscal leveraging; education on evidence-based home visiting models currently not being implemented in Georgia; peer learning from other states; special topical issues such as substance abuse, mental health, domestic violence, rural issues, cultural competence, working with fathers; data and information systems; developing training systems; collaboration and partnerships; program evaluation; continuous quality improvement/quality assurance; workforce issues; and strategic planning.

Georgia also has existing technical assistance and training resources within the state that will be helpful in implementation of MIECHV Program.

Section 9: Status of Meeting Reporting Requirements

The Governor’ Office for Children and Families assures that Georgia will comply with the legislative requirements for submission of an annual report to the Secretary of the Department of Health and Human Services regarding the MIECHV Program and its activities. The annual progress report will consist of the following:

- State Home Visiting Program Goals and Objectives
- Implementation of Home Visiting Program in Targeted At-Risk Communities
- Progress Toward Meeting Legislatively Mandated Benchmarks
- Home Visiting Program’s CQI Efforts
- Administration of State Home Visiting Program
- Technical Assistance Needs