

CERTIFICATION STANDARDS

**RHODE ISLAND DEPARTMENT OF HEALTH
Division of Community and Family Health and Equity**

**"CERTIFICATION STANDARDS"
Maternal and Child Family Visiting Program**

The Rhode Island Department of Health (HEALTH), Perinatal and Early Childhood Team within the Division of Community, Family Health and Equity has made funding available to qualified vendors to support expansion of the Maternal, Infant and Early Childhood Family Visiting Program to include evidence based Family Check-Up(FCU), Healthy Families America (HFA), and Parents As Teachers(PAT).family visiting services, which will be provided to pregnant women and children up to age 4 by community-based nonprofit agencies. The initial contract period will be for a period of 14 months (August 1, 2015 –September 30, 2016). The 14-month period enables HEALTH to align budgets on the federal fiscal year and with existing MIECHV contracts. HEALTH reserves the right to renew awards on an annual basis for up to three (3) additional 12-month periods depending on successful performance and availability of federal funding. These Certification Standards provide interested applicants with information to assist in their preparation.

Proposal Submission(s) are due at:

**The Rhode Island Department of Health
Division of Community and Family Health and Equity
Office of Maternal and Child Family Visiting Program
Three Capitol Hill, Room 302
Providence, RI 02908**

**on
Monday, June 11, 2015 by 4:00 p.m.**

All applicants submitting a proposal are encouraged to attend an informational meeting to be held on:

***Thursday, May 14, 2015 at 9:00 a.m.
In the Rhode Island Department of Health, Beck Conference Room***

3 Capitol Hill, Providence, RI 02908

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1. Introduction and Background

While significant gains have been made to improve the health and developmental trajectories of all children in Rhode Island, gaps in services still exist. Many Rhode Island children experience multiple risk factors for poor development including living in poverty, living in neighborhoods with high rates of crime, living in households headed by a single parent, and living with mothers who have low levels of education. Evidence shows that living with such risk factors also contributes to an increasing number of very young children who are at risk for abuse and neglect.

Goals of the Maternal, Infant and Early Childhood Family Visiting Program

The goals of the Maternal, Infant and Early Childhood Family Visiting Program are:

1. To strengthen and improve the programs and activities carried out under Title V.
2. To improve coordination of services for at-risk communities.
3. To identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

HEALTH receives funding to provide three-evidence based family visiting programs: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). These funds currently support family visiting services for 1100 families living in Central Falls, Cranston, Coventry East Providence, Newport Pawtucket, Providence, Woonsocket, West Warwick and surrounding communities.

New funds received in 2014 will support the expansion of

- The Expansion of Healthy Families America services for 100 families: Providence, Westerly and Woonsocket, and surrounding communities
- The Expansion of Parents As Teachers for 250 families: Central Falls, Cranston, East Providence, Providence, Pawtucket ,Westerly, Woonsocket and surrounding communities
- The implementation of Family Check-Up for 150 families: Providence

Family visiting programs funded through this opportunity will work with all other family visiting programs in identified communities, and statewide, to provide comprehensive services to families at greatest risk for negative outcomes. A rigorous evaluation will also be part of the implementation of the evidence based family visiting program in Rhode Island. Agencies will address priorities around health equity, the life course, and community engagement. A key objective of MIECHV is to build a framework for education and improved health care through networking and community empowerment. A family visitor is a frontline public health worker who is a trusted member of the community served and/or has a deep understanding of that community. Because of this relationship, the family visitor is able to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

2. Certification Process

To be eligible to provide evidence-based family visiting services through MIECHV and receive reimbursement for Family Check-Up (FCU), HFA, and PAT services, the provider must be certified by the Rhode Island Department of Health (HEALTH). HEALTH, with the national developers of FCU, HFA, and PAT has defined a set of standards for programs and agencies to provide services. These standards are both specific to the model and state requirements, to ensure compliance with specific model fidelity, federal and state regulations, and to ensure the provision of quality services to pregnant women and families with young children in the selected communities. This certification process and the issuance of these Certification Standards provide the basis for HEALTH's determination of agencies that can provide FCU, HFA, and PAT. These Certification Standards establish the procedures and requirements for the MIECHV Program, as administered by HEALTH. These Certification Standards provide potential

applicants, service providers and other interested parties with a full description of MIECHV Family Check-Up, HFA, PAT Services, including guidance related to certification requirements, methods for application, and evaluation requirements. Satisfactory compliance with these standards must be demonstrated and maintained for certification; continuing compliance is required in order to maintain full certification status.

HEALTH will certify up to four agencies to provide HFA services to 100 pregnant women and families with young children in Providence (50 families), Woonsocket and surrounding communities (25 families), and Westerly and surrounding communities (25 families). Only community-based, public or non-profit agencies in good standing with the federal government and the state of Rhode Island may submit an application for certification standards status. Applicants are allowed to submit proposals that will serve more than one community as long as a justification for doing so is provided. (HFA requires a minimum of 25 slots to become a HFA affiliate).

HEALTH will certify up to ten agencies to provide Parents As Teachers services to 240 pregnant women and families with young children in Central Falls(24), Cranston(24), East Providence,(24),Pawtucket(24) Providence (72 families), Westerly (24 families), West Warwick(24 families),and Woonsocket (24 families)and their surrounding communities. Only community-based, public or non-profit agencies in good standing with the federal government and the state of Rhode Island may submit an application for certification standards status. Applicants are allowed to submit proposals that will serve more than one community as long as a justification for doing so is provided.

HEALTH will certify up to two agencies to provide Family Check –Up services to 150 families with young children ages Birth to Five in Providence. Only community-based, public or non-profit agencies in good standing with the federal government and the state of Rhode Island may submit an application for certification standards status. If additional funding becomes available HEALTH may approve expansion of the enrollment age.

Certification Process

2.1 Submission of Certification Application

Applicants must submit applications for certification to HEALTH by 4:00 pm on Monday, June 11, 2015. Please submit one original and 5 copies of the application to:

Kristine Campagna
Office of Family Visiting
Division of Community, Family Health and Equity
Rhode Island Department of Health, Room 302
Providence, Rhode Island 02908
Phone: (401) 222-5949
Kristine.Campagna@health.ri.gov

Providers will be notified of their certification standards status when the review is complete. Applicants should anticipate a minimum of six weeks for the review process. The State reserves the right to amend the Certification Standards with reasonable notice to participating certified providers and other interested parties. Once certified, agencies will be expected to reapply for certification through HEALTH every three years. All MIECHV applicants will be evaluated on the basis of written materials submitted to HEALTH in accordance with the Certification Standards. HEALTH reserves the right to conduct on-site reviews and to seek additional clarifications prior to final scoring.

2.2 Instructions and Notifications to Applicants

This document sets forth the Certification Standards for MIECHV providers. In accepting certification from HEALTH, agencies certified through MIECHV agree to comply with these Certification Standards as presently issued and/or as amended by HEALTH, with reasonable notice to providers.

Within these Certification Standards, specific program requirements, performance standards, mandated benchmarks and expectations are identified. Applications should demonstrate the agency's understanding of the evidence based model, as well as their understanding of how they will deliver services with model fidelity, engage the communities where services are being provided, and integrate programs into an early childhood system of support for pregnant women and families within communities. Applications must include a description of the agency's capacity to carry out the program and address each required component of the standards. Applicants must describe their capacity to meet the performance standards, participate in a continuous quality improvement plan and develop, implement, and maintain a plan to improve health and developmental outcomes by meeting mandated MIECHV benchmarks. Applicants should use the proposal evaluation criteria in Appendix 1 as a guide in developing their applications; this is the criteria on which the applications will be evaluated. Applicants are required to submit a W-9 form with their applications. Applications will be scored on the basis of responses to each of the sections in these standards. Applications are limited to 70 pages excluding budgets, budget justifications, attachments and required resumes and cover letters. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to HEALTH for consideration in response to these Certification Standards may be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

2.3 Information for Interested Parties

Upon initial release of these Certification Standards, HEALTH staff will hold one public informational meeting for those pursuing certification applications on Thursday , **05/14/2015 at 9:00 a.m. in the Rhode Island Department of HEALTH , Beck Conference Room , 3 Capitol Hill, Providence, RI 02908.** Potential applicants are encouraged to attend the informational meeting.

2.4 Model Specific Certification Requirements (Additional detail in Appendix 2)

An agency that becomes certified as a provider of FCU, HFA or PAT will also have to submit a separate Application directly to the national program. In addition, certified providers of HFA must complete the HFA accreditation process, a separate process, for the first time within three years of affiliation. After the initial accreditation, providers repeat the accreditation process every four years. Once agencies are certified by HEALTH to provide HFA services, HEALTH will facilitate the Application for Affiliation with HFA. Awarded agencies must submit applications to the national HFA model within 30 days of award from HEALTH.

In addition certified PAT providers in their fourth year of implementation and beyond will go through the quality endorsement process. After the first quality endorsement this process will occur every five years. Every year it is required that all PAT affiliates submit PAT Affiliate Performance Reports

2.5 Certification

Certification as a MIECHV Family Visiting provider is required in order for HEALTH to provide reimbursement for services. Certification requires that Family Visiting providers adhere to these standards and performance expectations, as well as provide periodic reports to HEALTH, the national model or the

Office of Health and Human Services when required/necessary. These Certification Standards support the standards for implementation of each model, with fidelity.

Currently, Medicaid provides some reimbursement to agencies providing HFA services that are approved by HEALTH. As a result, all awarded HFA agencies must be able to invoice Medicaid for Medicaid allowable HFA visits in accordance with Medicaid and HEALTH requirements. Should additional funding become available through other sources, the HFA provider must be prepared to develop and implement a system to support the infrastructure required by the funding authorities, including HEALTH.

HEALTH may receive additional funds to implement MIECHV services and HEALTH may provide awarded agencies with increased funding to provide services to an increased number of pregnant women and families with young children. Should additional funding become available to expand the scope of this HFA project and/or other models implemented through MIECHV, awarded providers will be required to expand their programs to:

1. Collaborate with HEALTH to outreach and enroll specific target population(s) in the designated community and surrounding communities.
2. Work with HEALTH and the evidence-based models to provide services to additional pregnant women and families with young children and continue to meet the requirements of the model.

2.5.1 Possible Outcomes of Certification Review Process

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a quality program that complies with the requirements in these MIECHV Family Visiting Certification Standards.

Three (3) outcomes are possible as a result of the application review process. These are:

- Certification—no conditions
- Certification—with conditions
- No certification

As a result of the review, applications may be deemed in compliance with all requirements and be offered “Certification--no conditions”. Alternatively, an applicant may describe a program that meets most of the Certification Standards, but for an identified reason does not fully comply with the certification requirements at the time of application submission. In such case the applicant may be offered “Certification--with conditions”; application deficiencies will be identified by the State. The applicant will be required to address these deficiencies, within a timeframe determined by HEALTH, by submitting an amended proposal with specific dates for addressing deficient areas of compliance. The plan must be accepted and approved by HEALTH.

HEALTH reserves the right to accept or reject any or all applicants. HEALTH reserves the right to award in whole or in part, and to act in the best interest of the State of Rhode Island. Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further. Proposals that do not include all of the requirements will not be considered for the specific components they are applying to provide. The Technical Review Committee will review the proposals based on the proposal criteria outlined in Appendix 1 and present written findings, including the results of all evaluations, to the State Purchasing agent, or his/her designee, who will make the final selection. When a final decision has been made, the successful applicants will be notified.

2.6 Continued Compliance with Certification Standards

Certified MIECHV FCU, HFA, PAT providers must comply with these Certification Standards and the standards of the evidence-based model provided throughout the period of certification. Failure of HEALTH or the evidence-based model to insist on strict compliance with all Certification Standards and performance standards will not constitute a waiver of any of the provisions of these Certification Standards and shall not limit HEALTH's right to insist on such compliance. HEALTH will monitor and evaluate awarded providers for compliance with Rhode Island laws and regulations, as well as these Standards. For purposes of quality assurance reviews, certified and provisionally certified providers will provide access to appropriate personnel and written records requested by HEALTH and/or its agents at reasonable times. All supervisors and direct services staff will be required to maintain a professional development plan, to be shared with HEALTH, including any proof of certifications, trainings and course completions.

Once agencies are certified, HEALTH and the national evidence based models will monitor the performance of certified providers and their continued compliance with requirements. Certified providers are required to notify HEALTH and the model, if appropriate, of any material changes in their organization's circumstances or in program operations within 30 days of the changes. On the basis of ongoing monitoring, including review of required reports submitted by certified providers, HEALTH staff and the model may identify deficiencies in performance and/or compliance with certification requirements. Based on such review and related communications, Certification status may be modified to Certification with Conditions.

At least once every year from the original date of certification, HEALTH will complete an on-site review of currently certified providers to assure continued compliance with Certification Standards and compliance with standards of practice, data requirements, the Continuous Quality Improvement plan, and evaluation activities. The national model(s) will work with sites providing services to ensure model fidelity. Throughout the duration of the Certification Standards, agencies must maintain compliance with national evidence model requirements.

HEALTH reserves the right to apply a range of sanctions to providers that fall out of compliance for any reason. These may include:

- 1) Change of certification status to certification with conditions.
- 2) Referral of eligible pregnant women, children and their families to another similar service, including First Connections.
- 3) Referral to appropriate legal authorities.

2.6.1 Conditional Certification

As a result of its review activities, HEALTH and the evidence based models may identify deficiencies wherein a provider is not in satisfactory compliance with the certification, performance standards or model fidelity standards. In such an instance, HEALTH will notify the provider in writing of deficiencies, work with the agency to provide a corrective action plan acceptable to HEALTH and set forth a period of time within which the provider must come into compliance. The corrective action plan must include specific steps to be taken to come into compliance and defined dates for achievement of those steps. The length of the period set to come into compliance and to have a corrective action plan accepted by HEALTH will depend on the specific circumstances. Under no circumstances will the period exceed thirty (30) days from the date of notification of deficiency.

In the absence of a plan acceptable to HEALTH and/ or the national evidence models, or in the event of failure to meet the timelines in the corrective action plan, HEALTH retains the right to change the certification status of the provider to conditional. Conditional Certification will remain in effect until HEALTH determines that there is, , satisfactory resolution of deficiencies. The duration of Conditional

Certification status shall not exceed two months, at which point continued non-compliance with requirements should result in revocation of certification. The foregoing represents HEALTH's preference to engage in constructive remedial activity where deficiencies may be present, but does not limit HEALTH's rights to revoke certification of a provider in the event of non-compliance and failure to take responsive action to address deficiencies.

2.7 HEALTH Responsibilities

HEALTH has the responsibility to inform appropriate State agencies and the federal government of any instances of fraud, suspected fraud or misuse of funds, including Medicaid funds, and professional misconduct.

Rhode Island MIECHV FCU, HFA and PAT providers are obligated to comply with all applicable state and federal rules and regulations. Certified providers agree to comply with provider and specific model requirements. HEALTH reserves the right to amend MIECHV Program requirements periodically, with reasonable notice to certified providers.

3. Target Populations, Family Check Up (FCU), HFA and PAT, Model Allocation by Community, Referrals and Required Services

3.1 Priorities for Family Visiting through the Maternal, Infant and Early Childhood Family Visiting Program

Through the federal MIECHV Program, specific populations were highlighted as potential priority populations for family visiting. In Rhode Island, women under the age of 21, with low education and who have low incomes are prioritized to receive services. In addition, families who are in the Armed Forces or have prior involvement with the child welfare system are also given high priority. Low income is defined as on Medicaid/Rite Care or eligible for those services; low educational attainment is defined as a high school diploma or General Equivalency Diploma (GED), or less.

The funding available through the MIECHV expansion grant allows Rhode Island to increase the capacity of the MIECHV Program. Specifically, expansion grant funding will provide for an additional 100 HFA slots, 240 PAT slots, and 150 Family Check Up slots.

MIECHV Heathy Families America and Parents As Teachers providers may serve pregnant women and families with young children outside of the priority populations for family visiting with permission from HEALTH. Any changes to the overall priorities for MIECHV will be communicated to the awarded providers directly by HEALTH.

3.2 Estimates of family visiting slots per model by community

It is anticipated that the first year of the project will begin on August 1, 2015 and end on September 30, 2016. The initial award will be for 14 months, after that, contracts will be renewed on an annual basis for additional years, up to 3 years, on one year terms, pending the availability of Federal funding. The total amount of funding that is available for 500 families/slots is \$1,639,500.00 per year.

HEALTH designated the estimated number of FCU, HFA, PAT, "slots" that would be funded through expansion grant funds. One slot is either an eligible pregnant women or an eligible family with at least one young child as the designated recipient of Family Check-Up, HFA or PAT services. Specific amounts per model/component are detailed below

Healthy Families America	100 slots X \$4,500=\$450,000
Parents as Teachers	240 slots X \$2,800 = \$672,000

Family Check-Up

150 X \$1,015 = \$152,250

Community Specific Allocation of FCU, HFA and PAT Slots by Community Through This Funding Opportunity

<u>Evidence Based Model</u>	<u>Number of Slots per Model</u>	<u>Maximum Number of Agencies funded per Model</u>
<u>Central Falls and surrounding communities</u>		
Parents As Teachers	24	<u>1</u>
Total in Central Falls	24	<u>1</u>
<u>Cranston and surrounding communities</u>		
Parents As Teachers	24	<u>1</u>
Total in Cranston	24	<u>1</u>
<u>East Providence and surrounding communities</u>		
Parents As Teachers	24	<u>1</u>
Total in East Providence	24	<u>1</u>
<u>Pawtucket and surrounding communities</u>		
Parents As Teachers	24	<u>1</u>
Total in Pawtucket	24	<u>1</u>
<u>Evidence Based Model</u>		
<u>Providence</u>		
Family Check-Up	150	<u>1</u>
Healthy Families America	50	<u>2</u>
Parents As Teachers	72	<u>3</u>
Total in Providence	272	<u>6</u>
<u>Westerly and surrounding communities</u>		
HFA	25	<u>1</u>
Parents As Teachers	24	<u>1</u>
Total in Westerly	49	
<u>West Warwick and surrounding communities</u>		
Parents As Teachers	24	<u>1</u>
Total in West Warwick	24	<u>1</u>
<u>Woonsocket and surrounding communities</u>		
Healthy Families America	25	<u>2</u>
Parents As Teachers	24	<u>1</u>
Total in Woonsocket	49	<u>1</u>

A slot is either a pregnant woman or a parent/child dyad.

HFA requires a minimum of 25 slots to become a HFA affiliate. PAT requires a minimum of 12 slots to become a PAT site.

An agency must apply to provide at least the minimum number of slots per HFA and PAT models. However, an agency can also apply to provide the maximum per HFA and PAT models by community. There will be some economies of scale in providing a greater numbers of slots; however, HEALTH encourages smaller agencies to apply for certification status as well. Agencies may apply to provide HFA, and PAT in more than one community. An agency must provide justification for serving a community in which it is not located, including how it will meet the community needs and be connected with the community.

Once a tentative award is made, HEALTH reserves the right to negotiate with awarded agencies to ensure that all communities where MIECHV Program FCU, HFA or PAT services are to be provided are filled. It is the goal of the MIECHV Program in Rhode Island that 80% of all individuals enrolled in MIECHV Program be pregnant women.

3.3 Pregnant Women and Families Not Eligible for MIECHV services

Pregnant women and families in need of services who are not eligible to enroll in MIECHV (because they are not a targeted priority for services, the capacity of the program has been maximized, or the services will not meet the family's needs) must be provided a referral to First Connections and/ or appropriate services within their community within 48 hours and/or 2 business days after the referral has been received and assessed by the MIECHV provider.

3.4 Timeframe for Enrollment MIECHV Programs

HFA has a predetermined time period when pregnant women and families with young children may enroll. All MIECHV providers must enroll eligible pregnant women and families during approved enrollment ages approved by HEALTH. Through the MIECHV expansion grant funding, there will be no maximum age for mothers to enroll in HFA and PAT and agencies will be able to enroll children up to 3 months of age for HFA and 12 months of age for PAT. Agencies will be able to enroll children ages two through five (2-5) for Family Check-Up, however if additional funding becomes available HEALTH may approve expansion of the enrollment age. Pregnant women are a priority for MIECHV services in Rhode Island.

3.5 Referrals

Certified MIECHV HFA providers will work with HEALTH, MIECHV Local Implementation Teams, MIECHV Local Community Coalition members and other identified entities to develop and implement a referral process/system for pregnant women and families with young children. All MIECHV Program providers will coordinate with First Connections providers, MIECHV Local Implementation Teams, MIECHV Local Community Coalition members, Health Equity Zones, Family Visiting Network members, and other identified entities in each community on referrals for pregnant women and families with young children (See Section 7.3.1 and 7.3.2 Local Community Coalitions and Local Implementation Teams).

3.5.1 Capacity to accept referrals

The certified MIECHV provider must have the technological and staffing capacity to accept referrals from multiple referral sources. The agency must have a dedicated fax or secure email system for the

program to accept referrals. Capacity must include the ability for referral sources to leave confidential messages about referrals during non-business hours. The agency must also provide a phone number and clear point of contact to community referral sources and to the public. An agency must have the ability to accept phone referrals Monday through Friday during standard business hours. An agency must be able to provide family visiting services at times and dates that are convenient to the family, including nights and weekends. The schedule and hours of operation must be communicated to and approved by HEALTH. Any changes to the approved schedule and hours of operation must be communicated to HEALTH 30 days in advance, in writing. Should the capacity to make electronic referrals for pregnant women and children be developed, the certified FCU, HFA and PAT agencies will be responsible for obtaining and maintaining the technological capabilities and procedural safeguards to accept referrals electronically. The agency must be able to download these referrals daily from KIDSNET or other referral system approved by HEALTH.

3.5.2 Response to referrals

All pregnant women and families with young children referred to Family Visiting must be contacted within 48 hours and/ or two business days after the MIECHV Program provider has received the referral. As a response to referral for HFA, the model requires that the Parent Survey tool to be completed within a specified time.

3.5.3 Referral Sources

Referrals to specific programs within the MIECHV Program will come from different sources within each community. These include, but are not limited to, health care providers, including OB-GYN providers, family health and pediatric providers, health centers and hospitals, Community Health Workers, Title X clinics, housing authorities, schools, First Connections, WIC agencies, substance abuse providers, the Department of Children, Youth and Families and health insurance plans. Within two months of award, certified MIECHV Program providers will be responsible for having a designated point of contact for each referral source. Selected agencies must participate on and work with MIECHV Local Implementation Teams to develop and document these contacts and provide proof of such (i.e. memoranda of understanding) to HEALTH.

4. Health Equity and Culturally and Linguistically Appropriate Services

4.1 Commitment to Health Equity

Health Equity is defined as providing all people with fair opportunities to attain their full health potential to the extent possible (Braveman, 2006). Health inequities are a subset of health inequalities or disparities involving circumstances that may be controlled by a policy, system, or institution so that the disparity is avoidable. One of the measures of the health of a community is its social and environmental determinants of health. The wellbeing of children is an important part of human and community development. HEALTH is specifically interested in supporting the developmental milestones of children from birth to age four; the period, for which a child's physical, cognitive, social and emotional development is formed. HEALTH supports optimal early childhood development by supporting systems of health promotion, prevention and care within the context of the family and the larger community.

In Rhode Island, the Division of Community, Family Health & Equity at HEALTH is committed to providing quality services throughout an individual's life course. The Life Course Perspective suggests that a complex interplay of biological, behavioral, psychological and social protective and risk factors contributes to health outcomes across the span of a person's life. Disparities in health outcomes result from differences in protective and risk factors between groups over the course of their lives. As a result, the health and socioeconomic status of one generation directly affects the health status of the next. The Life Course Perspective integrates a focus on critical periods and early life events with an emphasis on the cumulative impacts of negative experiences over time (Contra Costa Health Services, April 2005).

4.2 Cultural Competence

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings. HEALTH is committed to ensuring that all supervisors and direct service staff providing Family Visiting services are culturally competent in the community or communities where they are providing services. Cultural competency is one of the mandatory core competencies required of staff (See Section 6.2 Core Competencies).

4.3 Culturally and Linguistically Appropriate Services

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) issued by the Federal Office of Minority Health (OMH) in 2004 outlines mandates and guidelines for the provision of language access services, culturally competent care and organizational supports for cultural competence in health care settings. In 2013 the OMH put out the 15 enhanced standards to emphasize the importance of CLAS integration throughout an organization from top-down to bottom-up and added a principle standard which frames the goal of all of the other 14 standards.

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

All agencies that contract with HEALTH for the MIECHV Program must perform the following tasks and provide documentation of such tasks upon request of a HEALTH employee:

1. The supports and services provided by a MIECHV provider shall demonstrate a commitment to linguistic and cultural competence that ensures access and meaningful participation for all eligible families. Such commitment includes acceptance and respect for cultural values, beliefs and practices of the community or communities where services are provided, as well as the ability to apply understanding of the relationships of language and culture to the delivery of supports and services through the model and curriculums. MIECHV Program providers must have an education, training and staff development plan for assuring culturally and linguistically appropriate service delivery.
2. All MIECHV providers must have a comprehensive cultural competency plan that addresses the following: 1) the identification and assessment of the cultural needs of potential and active clients where services are provided, 2) sufficient policies and procedures to reflect the agency's value and practice expectations, 3) a method of service assessment and monitoring that works in conjunction with the model fidelity requirements for HFA, 4) ongoing training to assure that staff are aware of and able to effectively implement policies.
3. MIECHV providers shall have a plan to recruit, retain and promote a diverse staff and leadership team, including Board members, representative of the demographic characteristics of the populations served.
4. MIECHV providers shall assure equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Department of Justice, *Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. MIECHV Program providers must provide language assistance services (i.e. interpretation and translation) and interpreters for the deaf and hard of hearing at no cost to the client. Applicants should submit their agency's written policies and procedures relevant to working with people of diverse cultural background and/or limited English proficiency that meet the requirements of items I – V below

and their plan for securing an interpreting service, if their agency does not already have one in place.

- I. MIECHV providers must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/ consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- II. MIECHV providers must provide to patients/ consumers in their preferred language, both verbal offers and written notices, informing them of their right to receive language assistance services.
- III. MIECHV providers must assure the competence of language assistance provided to limited English proficient patients/ consumers by interpreters and bilingual staff. Family and friends must not be used to provide interpretation services (except on request by the patient/ consumer). Children must never be used as interpreters.
- IV. MIECHV providers must make easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/ or groups represented in the service area. HEALTH and the family visiting models will work with providers to develop and distribute these materials.
- V. MIECHV providers are required to have a Memorandum of Agreement or contract with a minimum of one interpreting and translating service within 30 days of award.

MIECHV providers must indicate how culturally and linguistically appropriate services will be delivered to racial and ethnic minority populations. Per federal standards released in November 2011, Office of Management & Budget (OMB) Directive 15 identifies racial and ethnic minority populations: Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, Another Hispanic, Latino/a, or Spanish Origin, Not Hispanic, Latino/a, or Spanish Origin (Ethnicity) and White, Black or African American, American Indian or Alaska Native, Asian- Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian or Other Pacific Islander- Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander. HEALTH will support agencies in providing cultural competency training through the Family Visiting Network and other identified opportunities to achieve the level of competency required by CLAS Standards through Technical Assistance and training. FCU, HFA and PAT may also require cultural competency trainings and a demonstration of their model specific commitment to providing culturally appropriate services through model delivery.

5. Maternal, Infant and Early Childhood Family Visiting Program Personnel

5.1 General Qualifications

The MIECHV provider shall have policies and procedures in place for all employees consistent with HEALTH certification. This requires that:

Licensed and certified professionals conform to continuing education requirements specified by their respective credentialing bodies

- 1) Educational backgrounds and experience align with position qualifications
- 2) Appropriate competency training, agency orientation sessions and specific model and curriculum trainings are completed.
- 3) Recent employment experience is relevant for target population
- 4) Employment background checks, Background Criminal Investigations (BCIs) and Child Abuse Notification and Tracking System (CANTS) are performed for all potential employees.

5.2 Specific Staff Qualifications by Evidence Based Program Model

All qualified professionals providing MIECHV services, whether employed on a full-time or part-time basis for which certificates, licenses, or registrations are required by state law and regulations, must hold

current certificates, licenses, or registrations. Only those professionals that hold such certificates, licenses, or registrations and meet the highest requirements in the State applicable to a specific profession or discipline may be considered qualified professionals. This documentation may be checked during site reviews by HEALTH.

5.3 Supervision

MIECHV Family Visiting providers must demonstrate the capacity to provide and document the specific supervision requirements of FCU, HFA and PAT. All program supervisors must use reflective supervision practices. Supervisors and program managers (if applicable) must attend all required model and curriculum specific trainings. Supervisors and/ or program managers are required to attend monthly Local Implementation Team meetings, Local Community Coalition meetings, and other meetings related to MIECHV as well as participate in the Family Visiting Network.

5.4 Additional Staffing Structure

The work of all certified MIECHV staff must be systematically organized with clear roles, reporting relationships, and supervision. **If the agency is a multi-service organization, the applicant must illustrate how MIECHV services and the model fit into the organization as a whole.** HEALTH will work with certified providers to provide job descriptions specific to each position within the model

Job descriptions must address the following areas:

1. Functional tasks and responsibilities
2. Required skills, training, and experience
3. Licensure or certification qualifications, when applicable
4. Reporting relationships
5. Percentage of time dedicated to program

It is the responsibility of a certified MIECHV provider to conform to certification requirements regarding staff credentials, training, personnel management and guidelines. Certified MIECHV providers must demonstrate acceptable staffing ratios per the national model. Additionally, documentation of relevant education, qualifications and experience of staff and contracted providers must be maintained at certified provider sites for review by HEALTH and/ or national model.

6. Provider Orientation and Training

All certified MIECHV staff is required to participate in the mandatory model training and curriculum requirements for FCU, HFA, and PAT.

6.1 Family Visiting Network

HEALTH will maintain a Family Visiting Network. All staff providing family visiting services to pregnant women or families with young children, regardless of their program affiliation, will be invited to participate in the Family Visiting Network. All direct service staff and supervisors providing MIECHV services will be required to participate in the Family Visiting Network. HEALTH and its partners will support multi-disciplinary training for family visitors through the Family Visiting Network. See Section 7.3.3.

6.2 Core Competencies for all Family Visitors

All family visitors in programs supported through HEALTH will be required to meet core competencies in subject areas identified by HEALTH and its partners. Some subject areas are covered in individual model trainings and will be supported by HEALTH and the agencies providing services. All family visitors providing MIECHV services must receive training and be competent in the following subject areas:

- Maternal prenatal and postpartum care
- Infant care
- Healthy homes
- Child development
- Family and Community Engagement
- Breastfeeding/Nutrition/WIC
- HIPAA, ethics and confidentiality
- Training in behavioral health, inclusive of mental health and substance abuse, domestic abuse and interpersonal violence, with comprehensive training in the current screening tools for depression and substance abuse
- Referrals and linkages to programs at statewide and community levels that will support families in reaching the goals they have set for themselves and mitigating their risk for poor outcomes
- Identification of risk factors for child abuse and neglect, mandatory reporting laws for children, elders and those with disabilities
- Motivational interviewing
- Toxic Stress
- Using a Life Course approach and health equity
- Providing culturally appropriate services that reflect the demographics of the State and the specific communities where services are provided
- Culturally and Linguistically Appropriate Services (CLAS) standards
- Reflective supervision (Supervisors)

If national models do not provide training within their requirements, HEALTH will ensure that family visitors can access training. Should the need for additional core competencies arise, family visitors will be required to become competent in the identified subject areas.

6.3 Professional Development

All MIECHV providers must complete professional development plans and/ or number of hours of training required by the national models. Family visitors and supervisors will be required to maintain a detailed professional development plan, including dates of completed training and professional development hours, and provide copies of the plans to HEALTH as requested.

7. Maternal, Infant and Early Childhood Family Visiting Program Requirements

Family Check Up, HFA and PAT are distinct evidence-based family visiting models that strive to improve maternal and child health outcomes. Models have their own prescribed method of providing services and all models must be implemented with fidelity.

7.1 Model fidelity

Model fidelity in evidence-based family visiting refers to the prescribed replication of services. National models and related curricula are to be implemented with strict conformity to the standards established by the national models and curriculum. MIECHV providers will be required to participate in regular fidelity team meetings with HEALTH staff to ensure that the model being implemented by an agency is implemented with fidelity.

7.2 Maternal, Infant and Early Childhood Family Visiting Program Required Assessment Tools

Through the MIECHV Program, certified providers will be required to use specific standardized tools to assess and provide data for program evaluation, continuous quality improvement, health-related data, and mandated benchmarks. All certified MIECHV Program providers are required to use these tools, in addition to other model specific tools that may be required at specific time periods as mandated by

HEALTH and/ or the specific models. HEALTH will work with certified providers to provide these tools directly to agencies. Any changes in the use of these tools or additional tools will be communicated with certified MIECHV providers.

Required tools include:

- Ages and Stages Questionnaire (ASQ-3)
- Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST-10)
- Patient Health Questionnaire-9 (PHQ-9)
- HOME Observation for Measurement of the Environment Inventory (HOME)

Additional details on the above listed tools can be found in Appendix 3. HFA may use additional required tools that are not mentioned above.

7.3 Required Components of Maternal and Child Family Visiting Program

Through the MIECHV Program, an infrastructure for evidence-based maternal and child family visiting programs has been developed. This infrastructure has been developed to ensure that there is a comprehensive and coordinated system of family visiting services along a continuum of need for all families. All certified MIECHV providers will be required to participate in specific parts of the MIECHV Program infrastructure.

In communities there are local coalitions/groups that meet, the following are examples of these, and agencies are expected to describe how they will participate in each of these groups

7.3.1 Health Equity Zones. Agencies certified to provide home visiting will also be expected to coordinate and collaborate with Health Equity Zones if these are being funded in a specific community. <http://www.health.ri.gov/projects/healthequityzones/>

7.3.2 Local Implementation Teams (LITs): LITs were established to create a standardized, centralized identification and referral system that can be used by each community to identify and refer pregnant women and families with young children to MIECHV services and/or other programs in the community designed to meet their needs.

7.3.3 Family Visiting Network (HVN): The HVN was established to create cross-model culturally competent program standards and core competencies to ensure that all family visitors and supervisors (not just those that are MIECHV-funded) have adequate training, education, and support.

7.3.4 Family Visiting Managers Team: The Family Visiting Managers Team (FVMT) addresses the administrative and policy processes involved with the development of a system of family visiting services, which describes services by their anticipated outcomes, service strategy (intensity and level of professional) and eligibility criteria (most appropriate fit), that is supported by policies and programs that are coordinated and consistent.

7.3.4 Model Teams: Model Teams were established to ensure that Rhode Island's MIECHV evidence based -funded implementing agencies are meeting evidence-based model requirements. The Teams are made up of representatives of HEALTH, supervisors, and when appropriate, family visitors.

7.4 Community Collaboration

The MIECHV Program seeks to provide services to eligible pregnant women and families with young children in the previously noted designated and surrounding communities . MIECHV recognizes that enhanced service coordination in surrounding communities in each community's region, as well as program linkages, are critical to meeting the needs of participants. All certified MIECHV providers must demonstrate the capacity to serve both the specific community or communities and form partnerships and opportunities for collaboration in the surrounding region. All MIECHV providers will be required to have Memoranda of Understanding with specific service provider types in their communities and/ or region with clear points of contact and provide proof of such to HEALTH.

Specific provider types include, but are not limited to:

- Primary health care providers
- Obstetricians and gynecologists
- Pediatricians
- Early Intervention providers
- Domestic violence service providers
- Alcohol and illicit drug treatment providers
- Tobacco cessation providers
- Mental health service providers
- Education providers
- Health insurance plans
- Local Department of Human Services office
- Local WIC sites
- Local housing authorities
- Other family visiting programs, including First Connections

Applications must provide evidence of existing Memoranda of Understanding. MIECHV providers will be expected to increase the number of Memoranda of Understanding as a mandated MIECHV benchmark.

Building community networks often involves interacting with other community agencies or organizations around community issues, ideas, or projects that are not directly related to an individual child and thus are not directly billable. As participation in such interactions ultimately benefits pregnant women and families with young children, MIECHV providers have a responsibility to engage in community activities. Certified MIECHV Program providers are responsible for developing and maintaining knowledge of community supports and assisting families in accessing them. Evidence of community coordination with other local agencies will be expected and will be favorably factored into the scoring process. Successful applicants will describe current community partnerships and collaborations as well as how these collaborations support families and how the applicant currently integrates its services with other agencies that serve children and families.

7.5 Outreach and Engagement

Outreach should be local, systematic, family-centered, community-based, and be coordinated with other MIECHV provider outreach efforts. The applicant must be prepared to conduct integrated outreach activities that offer eligible families with information on all family visiting programs (NFP, HFA, PAT, Family Check-Up First Connections, Youth Success, etc.) and allow the family to choose the program that best fits its needs. Outreach and engagement includes communication with the general population, primary referral sources, pregnant women, and families with young children for the purpose of raising their understanding of the community supports and services available to all eligible families. The goal of outreach and engagement is to increase awareness of the Rhode Island's family visiting programs, increase community engagement in Rhode Island's family visiting programs, and develop referral pathways for children and families that would potentially benefit from evidence-based family visiting programs.

7.5.1 Outreach Plan

The agencies awarded contracts for MIECHV will be expected to submit a detailed outreach plan, within 60 days of notification of certification. All activities need to be developed and coordinated within the parameters of the evidence-based model's service delivery plan. The plan should include:

- A protocol for contacting a family for the first time, including the type of professional who will make the initial contact, consistent with each evidence based model's standards and fidelity requirements.
- How the agency plans to meet the needs of families from different cultural backgrounds.
- How the certified provider plans to locate and meet the needs of pregnant women and families with multiple risk factors (for example, how they would contact a family without a telephone, or one that speaks a language other than English or Spanish).
- How the certified provider will work with the HEALTH and other MIECHV providers to provide effective, targeted and appropriate outreach.
- How the agency will participate in community activities. Agencies must provide documentation that they have participated in local community events.
- How the agency will provide information in appropriate languages regarding the specific evidence-based models and/ or MIECHV programs. See Section 11, Marketing Promotions and Forms for additional details.
- How the agency will incorporate use of technology such as social media and texting to engage and retain families.

8. Data Systems and Entering Data

All certified MIECHV providers will be required to input program and visit data into an electronic data system approved by HEALTH, within specified timeframes. Providers must demonstrate that they have the current technology and capability to support the required data entry and describe their infrastructure and information technology support within their organization.

8.1 Efforts to Outcomes (ETO™)

Certified MIECHV providers will be expected to record data collected at every family visit and at specific times per HEALTH and the evidence-based models. FCU, HFA, and PAT agencies must demonstrate the capacity to enter this data directly into the designated MIECHV Program database module of Efforts to Outcomes (ETO™) in the timeframe prescribed by HEALTH and the models. Documentation of family visits must be entered within 24 to 48 hours or two business days after the family visit. HFA agencies must demonstrate capacity to enter data into the ETO™ system in a timely manner.

8.2 KIDSNET

Agencies will be expected to have the capacity to use KIDSNET to track outcomes not captured in ETO™.

KIDSNET is an integrated child health data system at HEALTH. KIDSNET has several components including:

- 1) An electronic automated, real-time tracking and follow-up system which links several HEALTH programs (Universal Newborn Metabolic, Hearing, Developmental Screening; First Connections; Immunization; Lead; Poisoning Screening; Early Intervention; and WIC);
- 2) Access for physicians and other authorized public health programs to screening test results, program enrollment, and other selected public health information such as immunization records;
- 3) Systematic coordination of follow-up response for all children in need of health services.

KIDSNET creates a child profile allowing HEALTH programs and primary care providers and other approved users to obtain information about preventive public health services received by the family.

HEALTH will train staff at the certified MIECHV agencies to use KIDSNET. As HEALTH moves toward electronic data exchange, certified MIECHV providers will be expected to participate in this electronic data exchange and show capacity to enhance their technology to meet the needs of the MIECHV program.

The MIECHV Program uses data to inform the performance, stability, and quality of services provided to pregnant women and families with young children. Agencies applying to provide services must demonstrate the capacity to:

- 1) Utilize the most current version of the data system as prescribed by HEALTH.
- 2) Maintain a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.
- 3) Ensure that its information management systems are protected from unauthorized outside access and meet all applicable HIPAA regulatory requirements.
- 4) Plan and design information management processes to meet the organization's internal and external reporting and tracking needs that are appropriate to its size and complexity. Mechanisms must exist to share and disseminate information both internally and externally.
- 5) The organization has written policies and procedures regarding confidentiality, informed consent, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure. The agency should demonstrate:
 - i. It maintains signed releases for confidentiality and sharing of information.
 - ii. It maintains signed informed consent for services.
 - iii. It maintains Memorandum of Agreement where necessary.
 - iv. It has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.
 - v. Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.

HEALTH may request additional reports, documentation, and site visits as necessary to monitor compliance with these certification standards and services provided by the certified MIECHV provider.

9. Performance Measures

The MIECHV Program includes a detailed Continuous Quality Improvement Plan (CQI), strong performance measures (including legislatively mandated benchmarks) and a comprehensive evaluation. In addition, FCU, HFA and PAT have distinct performance measures that must be achieved by each implementing agency. See Appendix 5 for a list of Rhode Island's approved MIECHV benchmarks.

9.1 Continuous Quality Improvement Plan

Rhode Island will use CQI methods in the MIECHV Program. Incorporating CQI into the family visiting infrastructure will result in more effective program implementation and improve outcomes. Through the collection and regular use of data, Rhode Island's family visiting programs can identify and address impediments to effective performance, as well as document changes and improvements.

Applicants must submit a description of their proposed, agency-specific, CQI Plan with their application. All certified MIECHV providers will also be required to participate in the HEALTH CQI Program. Successful applicants must demonstrate their ability and their experience to affect change using CQI in their programs and services. Applicants should describe their experience with monitoring performance using program data to assess and enhance program quality and management and how they support staff to use program data to improve practice results. Through training and monitoring, HEALTH will ensure data safety, monitor the privacy of data and utilize administrative procedures that do not place individuals at risk of harm and comply with applicable regulations related to the Institutional Review Board (IRB), the Health Insurance Portability and Accountability Act (HIPPA) and the Family Education Rights & Privacy Act (FERPA). Training related to data privacy, using data appropriately, HIPPA and FERPA will be required as a core competency for all MIECHV Program staff.

9.2 Mandated benchmarks

In the MIECHV Program included in the Affordable Care Act, 38 constructs among six distinct benchmark areas were identified for states to develop related process and outcome measures that they will use to demonstrate progress toward improving outcomes. HEALTH and its partners have developed Rhode Island specific constructs within each of the six benchmark areas. The Health Resources and Services Administration (HRSA), the federal funding agency, requires that data be collected across all benchmark areas.

The six benchmark areas are:

- Maternal and Newborn Health
- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
- School Readiness and Achievement
- Domestic Violence
- Family Economic Self-Sufficiency
- Coordination and Referrals for Other Community Resources and Supports

The measures proposed are developmentally appropriate measures for the corresponding constructs and appropriate for use with the populations served by the MIECHV Program. To measure progress towards intended outcomes, information to assess every construct will be collected at time of enrollment, during enrollment, at one year post enrollment and/ or at time of discharge from Family Check-Up, HFA and PAT, as well as other specific time points as designated by HEALTH. Benchmark related data will be reported using specific forms required by HEALTH and/ or Family Check-Up, HFA and PAT. MIECHV programs are required to demonstrate improvement in at least 4 of the 6 areas. A report demonstrating these improvements must be submitted to the Secretary of Health and Human Services (HHS) no later than 30 days after the 3rd year of the program.

In addition to the data collected for the benchmarks, certified providers must collect individual-level demographic and service utilization data on the participants in their program to analyze and understand progress made by children and families. Certified MIECHV agencies are required to use the current standards for federal reporting on language and disability status and the data collection standards for race, ethnicity, sex, language, and disability status. This data includes, but is not limited to:

- Family's participation rate in the family visiting model
- Demographic information for participant children, pregnant women, expectant father, parents, or primary caregivers receiving family visiting services, including child's age and gender, age of all at each data collection point and racial and ethnic background of all participants in the family
- Participant child's exposure to language other than English

- Family socioeconomic indicators

All data will be entered and stored in the designated data systems for the program. Certified agencies must demonstrate the capacity to enter data directly into the designated MIECHV Program database module in the timeframe prescribed by the national models and HEALTH.

9.3 Model Specific Performance Measures

FCU, HFA, and PAT have specific model measures that must be adhered to by the agencies implementing the model. All MIECHV providers will be required to meet the specific performance measurement requirements of the model they are implementing per model fidelity requirements.

10. Qualified Entity

All MIECHV providers must be able to demonstrate capacity regarding organizational and administrative structure to support the program. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance measures and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision. These requirements are in addition to the standards and requirements of the national model.

10.1 Administration

Specific standards regarding administration are as follows:

- 1) The Executive Officer, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.
- 2) A current organizational chart, which clearly defines lines of authority within the organization, is maintained and provided as part of the certification application. These charts are also necessary for FCU, HFA and PAT.
- 3) The management of the organization is involved in the planning process for performance improvement and the evaluation and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement and Continuous Quality Improvement plans.

10.2 Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to pregnant women and families with young children. Fiscal management is conducted in a way that supports the organization's mission, values, goals and objectives in accordance with responsible business practices and regulatory requirements. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, Medicaid and commercial insurance billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes.

10.2.1 Reporting and Billing

HEALTH must meet its obligation to monitor and assure that the requirements of the contracts to be awarded under these standards are met. The following reporting and billing criteria have been established:

- Agency will bill monthly (bills must be received by the 10th day of the month for services provided the prior month) for services rendered in accordance with HEALTH requirements.
- Agency must comply with federal and state standards to safeguard the use of funds. Documentation and records of all income and expenditures must be maintained as required.
- Agency must request approval, in writing, from HEALTH for any changes in the agency's approved budget.
- Agency will document all activities related to this initiative and make them available to HEALTH when requested, for purposes of monitoring or quality assurance.
- HFA agencies must demonstrate ability to bill Medicaid for services and maximize Medicaid collection and reconcile Medicaid billings.
- Provide documentation of general liability insurance covering the services provided annually and/or upon request.

10.3 Budgets

10.3.1 Budgets (FCU, HFA, and PAT)

The applicant is required to submit a complete a 14-month program budget with a justification narrative which will cover all estimated financial needs for the model that the applicant is proposing to provide, see Appendix 1, 2 or 3, for model specific budget templates. The total program budget should be itemized and include personnel costs (salary and fringe benefits), travel, equipment, supplies, consultants, other costs, and, for agencies with a federally approved indirect cost rate, indirect costs. Subcontracts are prohibited. A 10% verifiable match from non-federal sources is required and agencies that can demonstrate additional funding and services will be given priority. The budget narrative should be as detailed as possible. If the proposed budget and/or proposed budget narrative is not acceptable, HEALTH reserves the right to request a revised proposed budget and narrative.

10.3.4 Definitions of costs for all budget narratives

- **Personnel costs:** Personnel costs must be explained by listing each staff member who will be supported with MIECHV funds, name (if possible), position title, total number of hours budgeted, times hourly rate,. This must include the Program Manager and Supervisor as appropriate.
- **Fringe benefits:** List the components that comprise the fringe benefit rate and percent per item. For example, health insurance, taxes, unemployment insurance, life insurance, and retirement plan.. The fringe benefits must be directly proportional to that portion of personnel costs that are allocated to the project.
- **Consultants:** List any individuals who are paid consultants, their position title, and their hourly rate. All consultant hours/rates must be billed in accordance with the purchase order. Applicants must provide a clear explanation as to the purpose of any consultant, how the costs were estimated, and the specific consultant deliverables.
- **Travel:** List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel must be outlined. The local mileage rate must not exceed the current State local travel mileage rate (\$0.575 per mile). The budget must also reflect any out-of-state travel expenses associated with participating in HFA meetings that address family visiting efforts and other proposed trainings or workshops. These must be broken out by airfare, hotel, registration, parking, ground travel, mandatory baggage fees, and food/drink.
- **Equipment:** List equipment costs and provide justification for the need for the equipment to carry out project goals. Extensive justification is required when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years). The budget may include the cost of desk top computers, laptops or notebooks, and cell phones for all HFA staff. The budget must also include the cost of a color printer/copier (or

professional printing costs) to ensure that printed informational materials provided to families are high quality.

- **Supplies:** List the items that the project will use. In this category, separate office supplies from educational purchases. Office supplies include pencils, pens, paper, etc. Educational supplies include pamphlets, educational videos, and HFA-specific supplies – such as family support materials – that are essential to ensuring model fidelity.
- **Printing/Copying:** List any printing/copying costs, especially printing/copying costs associated with ensuring that families served have access to high quality printed informational materials.
- **Telephone/Internet/Fax:** List any costs associated with telephone, internet and fax services.
- **Postage:** List any costs associated with postage, especially postage costs associated with mailings to referrals sources and families served by the program.
- **Training/Professional Development:** List any training/professional development costs for staff, including consultants if applicable.
- **Other:** Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. Applicants may include the cost of access accommodations as part of their project’s budget, including sign interpreters, plain language and health literate print materials in alternate formats and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings.
- **Subcontracts:** Subcontracts are not an allowed expense under the MIECHV Program.

Indirect costs: Indirect cost calculations can only be included if the agency has a federally approved indirect cost rate. The indirect cost rate must be up to date and attached to the application as part of the budget. If an agency does not have a federally approved indirect cost rate, they can use the “de minimis” flat rate of 10% or break out costs as individual line item expenses for the administration of the program. The costs must be accompanied by a description of the methodology used to arrive at each itemized administrative cost. All non-federally approved calculations and rates can be negotiated by Health.

10.4 Human Resources and Staffing

The organization must demonstrate that it provides clear information to staff about job requirements and performance expectations, and supports continuing education, relevant to the job requirements of the individual. It must also demonstrate that it assists staff in maintaining and documenting required professional development.

Specific standards regarding Human Resources and Staffing are as follows, and must be explained in the application to become certified:

- 1) The organization’s personnel practices must contribute to the effective performance of staff by maintaining sufficient staffing ratios through direct hiring of qualified individuals and agencies that are culturally and linguistically competent to perform clearly defined jobs and address MIECHV Program needs. The organization’s personnel practices must be maintained to meet the specific staffing requirements, including but not limited to staff to supervisor ratios and caseload limits per evidence-based model requirements.
- 2) Personnel records are kept that contain a checklist to track appropriate training, credentialing and other activities. A copy of all required current staff licenses and certifications must be kept on file. A professional development plan must also be kept on file for each staff member. HEALTH is permitted to view these files upon request.
- 3) Certified MIECHV providers must perform annual written performance appraisals of staff based on input from families and supervisors, as appropriate. These must be available in the personnel

files for review by HEALTH upon request. National models may have additional requests and/ or requirements that certified agencies must adhere to.

- 4) Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
- 5) Staff is hired with skills, credentials, education and experience that match the requirements set forth in both the appropriate job description and in the policies and procedures per each specific evidence based model(s) provided by the agency. Any position for which at least 25% of the position is supported with MIECHV funds must be approved by HEALTH prior to the agency's offering a position to an individual. As appropriate, HEALTH may participate in the interview process with awarded agencies.
- 6) Each staff's personnel file contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. All job descriptions include standards of expected performance and personnel development plans. Each direct service staff's personnel file must contain documented answers to specific interview questions provided by the model and HEALTH. As appropriate, HEALTH may require awarded agencies to ask specific interview questions.
- 7) The organization provides a clear supervisory structure that includes delineated responsibilities and caseloads as appropriate per the requirements of FCU, HFA and PAT services provided by the certified MIECHV agency. The roles of staff are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching from national models to develop their capacities to function as experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision. This includes:
 - a) Protocols for communication and coordination with all interested parties.
 - b) Clear procedures for addressing unmet education or licensure requirements will be stated. Credentialing records will be maintained annually to document compliance. All staff are required to maintain professional development plans.
- 8) Credentials of qualified personnel are in accordance with Rhode Island's licensing requirements and shall be contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, as appropriate, and records maintained in the staff's personnel file.
- 9) Staff is required to participate in orientation and training activities on an ongoing basis, as specified by HEALTH, the model, the provider agency, and individual job descriptions.
- 10) Staff is required to undergo and pass a Criminal Background Check as a condition of their hire and before providing any services. Staff already employed by an agency that has not already had a Criminal Background Check must complete one. Criminal Background Check documentation for all staff must be kept in the personnel records.

10.5 Health and Safety, Risk Management

The certified MIECHV provider supports an environment that promotes optimal safety and reduces unnecessary risk for pregnant women, families with young children, family members and staff. The service delivery models of the MIECHV Family Visiting Program call for specific policies and

procedures to assure that services are provided in a safe and effective manner for both the family and the staff.

Standards regarding Health, Safety, and Risk Management are as follows and must be explained in the application to become certified:

- 1) The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement Program Committee.
- 2) The organization has protocols for identification and monitoring of safety risks, staff and family communication, family crises, medical emergencies and difficult situations.
- 3) The organization has health and safety policies and procedures that are clearly communicated to agency staff, visitors, and infants and toddlers and their families.
- 4) The organization has an effective incident review process.
- 5) The organization follows OSHA guidelines.
- 6) The organization follows all Federal and State mandates.
- 7) The organization will follow any health, safety and risk management policies required by the national model.

11. Marketing, Promotion, and Forms

Any information disseminated about family visiting reflects on HEALTH and must be approved by HEALTH prior to dissemination. Public health messages produced should communicate the MIECHV Program goals, values, and priorities. Within HEALTH, the Center for Public Health Communication (CPHC) provides strategic guidance and assistance in developing program communications and helps ensure that messages and tone are aligned with HEALTH priorities and communication guidelines.

Examples of materials that should follow these guidelines include, but are not limited to: flyers, posters, brochures, data books, invitations, banners, postcards, reports, forms, newsletters, advisories, advertisements (print, radio, and TV), letters for the public requiring the Director of HEALTH's signature, public health campaign materials, press releases, legislative materials, interviews, articles, and all materials and content posted on HEALTH's website. All communications bearing HEALTH's logo that will be disseminated via outside partners or networks, including certified MIECHV Program providers, are also included in these policies and procedures. Anything with HEALTH's logo must be approved by HEALTH before printing. The source of funding should be listed on materials.

11.1 Agency website content, brochures and promotional materials

All certified MIECHV Program providers are to maintain information about the MIECHV Program and the specific model provided by the agency on the agency's website. HEALTH will provide all related content to agencies to post on their website and all content must be approved by HEALTH prior to being posted on the website.

11.2 Translating Materials

Certified MIECHV providers must work with HEALTH and the CPHC to coordinate all translations of materials. A translation coordinator within CPHC will act as the liaison between the MIECHV Program and translators/reviewers.

11.3 Evidence based model requirements

National models have policies for use of their name and logos that are to be followed by all approved HFA providers. Federal copyright laws apply to all copyrighted materials.

11.4 Outreach Materials

All certified MIECHV providers are required to have an outreach plan in the communities where services are provided. Agencies may use outreach materials, such as door hangers, magnets and related items to support outreach efforts. Before outreach materials are purchased, approval from HEALTH is required.

11.5 Transportation for families

In the event that pregnant women and families participating in family visiting require transportation for services of a time sensitive nature (outside of medical emergency services), such as Newborn Bloodspot Repeat Specimen testing, certified MIECHV providers must have a plan in place to provide transportation services through a cab company or similar service. Funds to provide transportation to pregnant women and families must be used as payer-of-last resort funds. A payer-of-last resort is an entity that pays for services after other programs have been paid. For instance, RIt Care provides its members with transportation to routine medical appointments. As a result, MIECHV funds should not be used to provide RIt Care members with transportation to routine medical appointments.

11.6 Forms used in the Maternal, Infant and Early Childhood Family Visiting Program

HEALTH and/ or the national models will provide the necessary data forms for the implementation of the MIECHV Program. These forms may not be changed without the prior written approval of HEALTH and/ or national models.

11.6.1 HEALTH's Distribution Center

Some materials and forms that support the implementation of the MIECHV Program will be available through the Distribution Center at HEALTH. MIECHV providers may order materials from the HEALTH website at no cost (www.health.ri.gov).

12. Assurances

HEALTH, as the lead agency for the MIECHV Program in Rhode Island, is responsible for the implementation, fiscal reporting and overall operation of the MIECHV program in Rhode Island. Awards made from these Certification Standards are conditional based on approval from the evidence-based HFA model. Certified MIECHV providers will be required to work with HEALTH and its designated partners on MIECHV and the specific models within the program.

Scoring for Family Visiting through the Maternal, Infant and Early Childhood Family Visiting Program (Section 3.1)

Criterion	Points possible	Points given
Agency has clearly described which family visiting model(s) they are applying to provide, which community (ies) they are applying to provide services in and has applied to provide an appropriate number of slots per model.	4	
Agency is located within the community(ies) it is proposing to serve	2	
Agency has demonstrated experience working with the priorities populations for family visiting through the Maternal, Infant and Early Childhood Family Visiting Program	1	
Agency has demonstrated active relationships with primary care providers/ medical homes and other child serving agencies in their communities that the Maternal, Infant and Early Childhood Family Visiting Program prioritize for services.	3	
Total	10	

Cultural Competence and Culturally and Linguistically Appropriate Services (Section 4.3)

Criterion	Points possible	Points given
The policies and procedures provided by the agency adequately address Section 4.3, items i – v.	4	
Agency has a Memorandum of Understanding or contract with an interpreting and translating service or has provided a plan for securing such services.	<i>Required</i>	
Agency demonstrates evidence of Agency and Program Orientation		
Agency demonstrates a system for ongoing Professional Development and Training both within the organization and outside of the organization		
Total	4	

Capacity to accept referrals (Section 3.5)

Criterion	Points possible	Points given
Quality of evidence provided by agency regarding the capacity to accept referrals via phone and fax during standard business hours and to ensure that families have immediate access to information about enrollment in languages that meet their needs.	<i>Required</i>	
Agency has demonstrated the capacity to respond to referrals within 48 hours and/ or two business days upon receipt of referral.	<i>Required</i>	
Agency has demonstrated engagement rates of greater than 60% when implementing <u>previous home visiting programs</u>		
Total		

Model Fidelity (Section 7.1, Appendices 2-4)

Criterion	Points possible	Points given
Quality of evidence provided by agency regarding their understanding and/ or experience they have with the model they are applying to provide.	4	
Agency has described how the model they are applying to provide complements agency's mission.	2	
Plan for hiring appropriate staff for each model and the community (ies) they are applying to serve.	4	

Agency has previously demonstrated staff retention rates of greater than 50% for supervisors and staff Agency has previously demonstrated retention rates of 50-60% for families when they have implemented home visiting programs		
Total	10	

Community Collaboration (Section 7.4)

Criterion	Points possible	Points given
Quality of current community partnerships and collaborations and how agencies currently integrate their services within their agency and within other agencies that serve children and families. Agency has signed MOA's with a wide array of local community partners Agency has demonstrated participation in Local Implementation Teams, Home Visiting Network or other community collaborations.	5	
Total	5	

Data Systems and Entering Data (Section 8)

Criterion	Points possible	Points given
Quality and depth of infrastructure and information technology support within agency to support required data system(s).	4	
Demonstrated ability of agency to enter data within specified timeframes for each model.	2	
Agency has provided an adequate, detailed written plan for information management.	5	
Agency maintains signed releases for sharing of information.	<i>required</i>	
Quality of written policies and procedures regarding confidentiality, security and integrity of information. Agency has mechanisms to safeguard records and information.	5	
Total	16	

Continuous Quality Improvement Plan (Section 9.0)

Criterion	Points possible	Points given
Comprehensiveness of agency's Continuous Quality Improvement Plan related to MIECHV and the agency as a whole.	4	
Agency can demonstrate the ongoing use of data for Continuous Quality Improvement	3	
Total	7	

Qualified Entity (Section 10.0)

Criterion	Points possible	Points given
Agency has provided a description of their current organizational structure, including an organizational chart. Demonstrates how MIECHV is integrated within overall organizational structure.	2	
Agency has clearly demonstrated that it has the financial ability to integrate data from all necessary client and financial accounting systems	4	

Total	6	
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Cost Proposal and Budget (Section 10.3 and Appendix 2)

Criterion	Points possible	Points given
Agency submitted a W-9 form with their application.	1	
Agency has provided a budget using the template provided by HEALTH for each model they are applying to provide.	6	
Agency has submitted a detailed budget narrative explaining each line item in detail.	6	
The cost per model for each model an agency is applying to provide is close to the average cost per family for each model.	6	
Agency has committed to providing additional funding, with a minimum of a 10% verifiable agency match to support its agency's implementation of the Maternal, Infant and Early Childhood Family Visiting Program.	6	
Total	25	

Human Resources, Staffing (Section 10.4)

Criterion	Points possible	Points given
Agency has demonstrated ability to provide clear information to staff related to job performance and expectations, professional development plans and training.	3	
Agency provides an annual written performance appraisal of staff and maintains copies of all current staff license and certifications.	3	
Agency has a clear programmatic management and supervisory structure and has demonstrated the commitment to dedicated program staff.	4	
Total	10	

Health and Safety, Risk Management (Section 10.5)

Criterion	Points possible	Points given
Agency has described their written policies and procedures for health and safety policies, the incident review process, and protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.	7	
Total	7	

_____ **Total Score** (out of 100)

Appendix 2: Family Check Up

Program Model Overview

Theoretical Model

The Family Check-Up (FCU) model is the cornerstone of a more general intervention framework referred to as an Ecological Approach to Family Intervention and Treatment (EcoFIT). FCU is designed to address a range of needs of families from prevention to treatment for children ranging in age from 0 to 17 years old. In contrast to traditional clinical models, FCU utilizes a health maintenance model involving regular periodic contact between client and provider to prevent problems proactively. In Rhode Island, Family Check Up will provide services until a child turns five.

Program Model Components

FCU is comprised of three sessions that typically occur within the home. Following these three sessions, the Everyday Parenting curriculum provides a basis for more intensive parenting support. The FCU model involves yearly “check-ups,” which provide clinicians with the opportunity to track family and child behavior over time and continue to motivate families to change persistent areas of difficulty.

Target Population

The target population for this model is families with risk factors including socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use.

Where to find out more

The Child and Family Center Family Check-Up Institute
195 West 12th
Eugene, OR 97401-3408
Phone: (541) 346-4805
Fax: (541) 346-4858

Budget Template- Family Check Up

CATEGORY			
Total number of slots requested			
Community to be served	Providence		
PERSONNEL	Hourly Rate	Total # of hours	Total
	\$		\$
	\$		\$
	\$		\$
FRINGE BENEFITS	Fringe % rate	Total (\$)	
	%	\$	
	%	\$	
	%	\$	
CONSULTANTS	\$		
IN-STATE TRAVEL	\$ (\$0.575 per mile @ # of miles)		
OUT-OF-STATE TRAVEL			
TRAINING/PROFESSIONAL DEVELOPMENT	\$		
TELEPHONE/FAX/INTERNET SERVICE -	\$		
PRINTING/COPYING	\$		
POSTAGE	\$		
EQUIPMENT	\$		
SUPPLIES – OFFICE	\$		
SUPPLIES – EDUCATIONAL	\$		
OTHER/SPECIFY	\$ (TOTAL)		
OTHER: Family Check Up COSTS			
INDIRECT COSTS/ADMIN COSTS			
TOTAL REQUEST	\$		

Appendix 3: Healthy Families America

Compiled from <http://homvee.acf.hhs.gov/>

Program Model Overview

Theoretical Model

HFA is based upon a set of critical elements that serve as the framework for program development and implementation. HFA program model components are theoretically rooted in a strength-based approach. The strength-based approach recognizes that all families have strengths and that programs should build on these strengths rather than focus on correcting weaknesses. Family Support Workers (FSWs) help families build their own abilities to manage life's challenges. FSWs are HFA family visitors.

Program Model Components

HFA includes: 1) screenings and assessments, and 2) family visiting services. In addition, many HFA programs offer services such as parent support groups and father involvement programs. HFA allows local sites to formulate program services and activities that correspond to the specific needs of their communities.

Target Population

HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve.

HFA requires that families be enrolled prenatally or within the first three months after a child's birth. Once enrolled, HFA programs provide services to families until the child enters kindergarten. In Rhode Island, HFA will provide services until a child turns four .

Where to Find Out More

Healthy Families America National Office
228 S. Wabash, 10th Floor
Chicago, IL 60604
Phone: (312) 663-3520
Fax: (312) 939-8962
Website: <http://www.healthyfamiliesamerica.org/home/index.shtml>

Specific Requirements of Healthy Families America in Rhode Island

1. Specific Staff Qualifications

Healthy Families America uses two positions to provide direct services to families: a Family Assessment Worker (FAW) and a Family Support Worker (FSW). These positions are supported by a Supervisor and a Program Manager. Direct service staff for HFA should be hired because of their personal characteristics that support their education and experience, per the Critical Elements requirements of HFA.

HFA agencies must support at least one Supervisor, one Program Manager, one Family Assessment Worker and two Family Support Workers. The number of families served by each agency will determine if one full time person may serve as both the Supervisor and the Program Manager.

Program Manager

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. The Program Manager is responsible for the overall operation of the HFA program within the agency, as well as funding/ budgets, quality assurance activities, evaluation and assist in developing and maintaining community.

Supervisor

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. Discipline specific supervision should be provided in accordance with HEALTH practice acts. HFA supervisors are responsible for providing weekly supervision to all direct service staff and completing some quality assurance activities and will assist in developing and maintaining community contacts.

Family Assessment Worker

Must have a minimum of an Associate Degree in Human Services, Child Developments or related field, with a minimum of two (2) years' experience providing services to and/ or engaging families with infants and toddlers in services. Must have experience working with families with multiple needs.

Family Support Worker

Must have a minimum of a Bachelor's Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience. Must have experience in working with families with multiple needs. Caseloads will not exceed 15 families per FSW if the caseload is all expectant mothers and families with infants. As the HFA program progresses and FSWs have combined caseload of expectant mothers, families with infants and toddlers and the frequency of visits decreases for some families, FSWs may have a caseload up to 25 families. Part time FSWs with a pro-rated caseload are permitted based upon the percentage of a full time employee they are working.

2. Healthy Families America Supervision

There should be one Supervisor for every five staff persons. A ratio of 1:6 is permissible, but 1:5 is optimal. If the Supervisor and Program Manager roles are staffed by the same person, adequate time to support each role must be provided for in a supervision plan. The HFA agency must demonstrate a commitment to adequate staffing to provide the level of supervision for direct service staff required by HFA standards. Supervisors provide a minimum of 1.5 hours of direct supervision to each FAW and FSW each week. Supervisors must also receive regular supervision at a minimum of once per month.

3. Additional Staffing Structure for Healthy Families America

All Certified MIECHV providers are required to enter extensive data into the required web based database. HFA providers are permitted to use additional support staff outside of the positions listed in above to support data entry, billing, community outreach and other activities and these staff must be identified with hourly allocations in the proposal.

4. Provider Orientation and Training

HFA Program Managers, Supervisors, FAWs and FSWs are required to attend training to be held in Rhode Island or the Northeast region. Healthy Families America provides separate training sessions for

the FAW and the FSW. Supervisors are required to attend both. In addition to the specific HFA training, staff is required to attend Growing Great Kids training. Growing Great Kids is the curriculum utilized in the delivery of HFA services in Rhode Island. Training will be held in Rhode Island or the Northeast region. Staff is required to attend both the HFA model training and the Growing Great Kids curriculum training before direct services may be provided to families. HEALTH requires HFA FAWs to participate in HFA FSW training and HFA FSWs to participate in HFA FAW training.

5. Enrollment in Healthy Families America

Pregnant women may enroll in HFA at any time in their pregnancy. Families with young children may enroll in HFA up until the child is three months of age. Pregnant women and families may have more than one child. All agencies providing HFA are strongly encouraged to enroll women parentally, before the birth of their child. There will be performance measures in HEALTH's MIECHV Program associated with the percentage of women enrolled prenatally that certified providers are required to achieve. It is a goal of Rhode Island's MIECHV Program for 80% of the individuals enrolled in MIECHV to be pregnant women.

6. Healthy Families America Model Requirements

HFA is designed to work with pregnant women and families until a child is three years of age. Pregnant women and families with young children, through three months of age, may enroll. Direct services are provided by a FAW and a FSW. Services are initially provided weekly; the frequency of visits decreases as the child ages. All services are provided under the framework of the 12 Critical Elements of HFA. Per HFA, "all affiliated and credentialed HFA programs adhere to these critical elements, which provide the framework for program development and implementation. Staff is trained on the critical elements. Programs are credentialed based on adherence to the critical elements."

6.1 Growing Great Kids Curriculum

Certified MIECHV providers that are providing HFA in Rhode Island must use the Growing Great Kids curriculum. This is the curriculum for all HFA sites in Rhode Island. Agencies selected to provide HFA will need to attend a separate Growing Great Kids training.

Please submit budgets and budget narratives in accordance with the instructions in Section 10.3 based on the following template that does not go over the total amount for which you are applying. A budget must be submitted that includes the total number of slots requested. A detailed budget narrative must accompany each proposed budget. Applicants are free to include additional rows on the template.

Budget Template- Healthy Families America

CATEGORY	
Total number of slots requested	
Community(ies) to be served	
PERSONNEL	Hourly Rate Total # of hours Total
Program Manager	\$ \$
Supervisor	\$ \$
Family Assessment Worker(s)	\$ \$
Family Support Worker(s)	\$ \$
FRINGE BENEFITS	Fringe % rate Total (\$)
Program Manager	% \$
Supervisor	% \$
Family Assessment Worker(s)	% \$
Family Support Worker(s)	% \$
CONSULTANTS	\$
IN-STATE TRAVEL	\$ (\$.575per mile @ # of miles)
OUT-OF-STATE TRAVEL	
TRAINING/PROFESSIONAL DEVELOPMENT	\$
TELEPHONE/FAX/INTERNET SERVICE	\$
PRINTING/COPYING	\$
POSTAGE	\$
EQUIPMENT	\$
SUPPLIES – OFFICE	\$
SUPPLIES – EDUCATIONAL	\$
OTHER/SPECIFY	\$ (TOTAL)
OTHER: HFA COSTS	\$4,000.00 (TOTAL)
HFA Application fee at Affiliation	\$500.00
HFA annual fee	\$3,500.00
INDIRECT COSTS/ADMIN COSTS	
TOTAL REQUEST	\$

Appendix 4: Parents as Teachers

Program Model Overview

Theoretical Model

The PAT model is a voluntary, evidence-based home visiting model designed to ensure young children are healthy, safe, and ready to learn.

Program Model Components

The PAT model has four components, each closely related and integrated: personal visits, group connections, child screenings, and resource network. Together, these four components create a cohesive package of services with four primary goals:

- a. Increase parent knowledge of early childhood development and improve parenting practices.
- b. Provide early detection of developmental delays and health issues.
- c. Prevent child abuse and neglect.
- d. Increase children's school readiness and school success.

Target Population

PAT does not have eligibility requirements for participants. Individual programs select the specific characteristics of the target population they plan to serve.

PAT programs can serve children and their families from pregnancy through kindergarten entry. Through MIECHV funding in Rhode Island, PAT will enroll pregnant women and families with infants through 12 months of age and provide services until a child turns four.

Where to Find Out More

Parents as Teachers National Center, Inc.
Attn: Public Information Specialist
2228 Ball Drive
St. Louis, Mo. 63146
Telephone: 314-432-4330
Toll-free telephone: 1-866-728-4968
Fax: 314-432-8963
Website: www.parentsasteachers.org

Specific Requirements of Parents as Teachers in Rhode Island

PAT requires a minimum of 12 slots to become a PAT affiliate.

1. Specific Staff Qualifications

PAT utilizes Parent Educators to provide direct home visiting services to pregnant women and families. Parent Educators are supported by a Supervisor, who may supervise no more than 12 Parent Educators at any time.

Supervisor

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. Discipline specific supervision should be provided in accordance with HEALTH practice acts.

Parent Educators

Must have a minimum of a Bachelors Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience working with young children and/ or parents. Part time Parent Educators with a pro-rated caseload are permitted based upon what percentage of a full time employee they are working.

2. Parents as Teachers Supervision

PAT supervisors must provide a minimum of two hours of individual reflective supervision each month, in addition to a minimum of two hours of staff meetings each month. HEALTH recommends providing a minimum of four hours of individual reflective supervision each month and four hours of staff meetings and case management each month.

3. Additional Staffing Structure for Parents as Teachers

All certified MIECHV providers are required to enter extensive data into the required web based database. PAT providers are permitted to use additional support staff outside of the positions listed above to support data entry, billing, community outreach and other activities and these staff must be identified with hourly allocations in the proposal.

4. Provider Orientation and Training

Supervisors and Parent Educators must attend PAT Foundational and Model Implementation trainings. In addition to the specific PAT trainings, staff is required to attend Life Skills Progression (LSP) training and HEALTH's MIECHV Orientation Training. LSP is the curriculum utilized in the delivery of PAT services in Rhode Island. Trainings will be held in Rhode Island or the Northeast region. Staff is required to attend the PAT model trainings, the LSP curriculum training, and HEALTH's MIECHV orientation training before any direct services may be provided to families.

5. Enrollment in Parents as Teachers

Pregnant women may enroll in PAT at any time in their pregnancy. Families with young children may enroll in PAT up until the child is six months of age. Pregnant women and families may have more than one child. All agencies providing PAT are strongly encouraged to enroll women parentally, before the birth of their child. There will be performance measures in HEALTH's MIECHV Program associated with the percentage of women enrolled prenatally that certified providers are required to achieve.

6. Parents as Teachers Model Requirements

Through the MIECHV Program funding, pregnant women and families with young children, through six months of age, may enroll in PAT in designated communities. Services are provided by Parent Educators and home visits will be provided weekly during pregnancy and early in the child's life, then decrease in

frequency as the child ages. Through MIECHV Program funding, PAT services will be provided until the child is three years of age. All certified MIECHV Program providers that are providing PAT must implement the program per the PAT Essential Requirements and curriculum.

Please submit a one year budget based on the following template in Excel format that does not go over the total amount for which you are applying. A budget must be submitted for each model and the total number of slots per model must be described. A detailed budget narrative must accompany each budget for each model. Food/drink is not an allowed cost.

Budget Template- Parents as Teachers

CATEGORY			
Total Number of Slots			
Community			
PERSONNEL	Hourly Rate	Total # of Hrs	Total
Supervisor	\$		\$
Parent Educator(s) (List-Individually. There must be one parent educator for every 12 families)	\$		\$
FRINGE BENEFITS	Fringe % Rate		
Supervisor		\$	
Parent Educators(s) (List individually)		\$	
IN-STATE TRAVEL (\$.575 per mile X ___ miles)	\$		
OUT-OF-STATE TRAVEL	\$		
OFFICE SUPPLIES	\$		
TELEPHONE/INTERNET/FAX	\$		
EDUCATIONAL MATERIALS	\$		
PRINTING/COPYING	\$		
EQUIPMENT	\$		
POSTAGE	\$		
OTHER/SPECIFY (See Below)			
OTHER/FIXED PAT Program Support Fees (\$3,500)	\$3,500.00		
OTHER/Staff Professional Development Costs	\$		
Other/Group Connections	\$		
	\$		
INDIRECT COSTS/ADMIN COSTS (___ %)			
TOTAL REQUEST			

Appendix 6: Standardized tools for use in the Maternal, Infant and Early Childhood Family Visiting Program

All certified Maternal, Infant and Early Childhood Family Visiting Program providers are required to use these tools, in addition to other model specific tools that may be required as specific time periods as mandated by HEALTH and/ or the specific models. HEALTH will work with certified providers to provide these tools directly to agencies. The individual evidence based models may use additional required tools that are not mentioned below.

Ages and Stages Questionnaire (ASQ-3)

The Ages and Stages Questionnaire is a tool that measures a child's performance in five developmental subscales. It is based on parent report.

Ages and Stages Questionnaire: Social Emotional (ASQ:SE)

The Ages and Stages Questionnaire: Social Emotional measures a child's social behavior, emotion regulation and emotional well-being. It is based on parent report.

Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test screens for hazardous/ risky drinking, harmful drinking or alcohol dependence. It is a ten item self-report screening questionnaire.

Drug Abuse Screening Test (DAST-10)

The Drug Abuse Screening Test screens for use/ abuse of illicit drugs. The self-report screening questionnaire identifies individuals who are abusing drugs and the degree of problems related to drug use and misuse.

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 measures depressive symptomology and is based on mother/ caregiver's self report.

HOME Observation for Measurement of the Environment Inventory (HOME)

The HOME Observation for Measurement of the Environment Inventory measures the quality and quantity of stimulation and support available to a child in the family environment. It is composed of 45 items among six subscales.

**RI Department of Health- MIECHV Benchmark Plan
Revised December 27, 2013**

Proposed Indicator

Indicator Type

Benchmark I. Improved Maternal and Newborn Health			
1.1	Prenatal Care	Percentage of pregnant women enrolled in the program that received an “adequate” or “adequate plus” number of prenatal care visits from entry into the program to delivery of child as measured by the Kotelchuck index	Outcome measure
1.2	Pre and post natal use of tobacco*	Percentage of mothers enrolled in the program who smoke/ use tobacco products that receive a brief tobacco cessation intervention and/ or who receive referrals (HEALTH will report on this construct)	Process measure
1.3	Preconception Care	Percentage of women enrolled in the program that discussed preconception health with a health care worker during a health care visit within 6 months postpartum	Outcome measure
1.4	Inter-birth Interval	Percentage of women who enroll in the program prenatally through one month postpartum that are using an appropriate form of birth control at 6 months postpartum	Outcome measure
1.5	Screening for Maternal Depression	Percentage of women enrolled in the program that have been screened for maternal depressive symptoms within 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9)	Process measure
1.6	Breastfeeding	Percentage of women enrolled who report exclusively breastfeeding their index child at 12 weeks of age	Outcome measure
1.7	Adequacy of well-child visits	Percentage of index children who are up-to-date on a schedule of age-appropriate preventative and primary health care according to RI’s Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule for well child care visits for children 6	Outcome measure
1.8	Maternal and Child Health Insurance Coverage	Percentage of mothers and index children who obtain and/ or maintain health insurance	Outcome measure
1.9	Maternal Health Insurance Coverage*	Percentage of enrolled women (mothers) with health insurance (HEALTH will collect this data and report its outcome as part of a larger construct that includes child health insurance)	Outcome measure
1.10	Child Health Insurance Coverage*	Percentage of index children with health insurance (HEALTH will collect this data and report its outcome as part of a larger construct that includes maternal health insurance)	Outcome measure
1.11	Pre and post natal use of alcohol*	Percentage of mothers enrolled in the program who score positive on the Alcohol Use Disorders Identification Test (AUDIT) that receive a brief intervention and/ or who receive referrals (HEALTH will collect data for this construct, but report on tobacco use)	Process measure
1.12	Pre and post natal use of illicit drugs*	Percentage of mothers enrolled in the program who score positive on the Drug Abuse Screening Test (DAST-10) that receive a brief intervention and/ or who receive referrals (HEALTH will collect data for this construct, but report on tobacco use)	Process measure
Benchmark II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits			

2.1	Decrease in visits for children to the emergency department from all causes	Percentage of visits by children enrolled in the program to the emergency department from all causes	Outcome measure
2.2	Decrease in visits for mothers to the emergency department from all causes	Visits by mothers enrolled in the program to the emergency department from all causes	Outcome measure
2.3	Increase in information provided or training of participants on prevention of child injuries	Percentage of mothers/caregivers provided information and/or trained on specific topics such as safe sleep, shaken baby syndrome, passenger safety, etc. while enrolled	Outcome measure
2.4	Decrease in incidence of child injuries requiring medical treatment	Percentage of index children enrolled in the program that required medical care outside of the index child's primary medical home for preventable and/ or avoidable injuries	Outcome measure
2.5	Decrease in reported suspected maltreatment of children in the program (screened but not necessarily substantiated)	Percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for suspected maltreatment *Amended August 2013	Outcome measure
2.6	Decrease in reported substantiated, indicated maltreatment of children in the program (substantiated/ indicated/ alternative response victim)	Percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for substantiated, indicated maltreatment of children in the program (substantiated/ indicated/ alternative response victim) *Amended August 2013	Outcome measure
2.7	Decrease in first time victims of maltreatment for children in the program	Percentage of index children enrolled in the programs that were first time victims of maltreatment *Amended August 2013	Outcome measure
Benchmark III. Improvements in School Readiness and Achievement			
3.1	Parent support for children's learning and development	(1) Parent's support for children's learning and development as measured by the HOME. (2) Percentage of enrolled families whose HOME scores for both children's learning and development improve or remain the same from index child is 6 months of age to 18 months of age. *Amended August 2013	Outcome measure
3.2	Parent knowledge of child development and their child's development progress	(1) Parent knowledge of child development and their child's developmental progress as measured by the HOME. (2) Percentage of enrolled families whose HOME scores improve or remain the same from index child is 6 months of age to 18 months of age. *Amended August 2013	Outcome measure
3.3	Parenting behaviors and parent child relationship	(1) Parenting behaviors and parent-child relationship, (e.g., discipline strategies and play interactions) as measured by the HOME. (2) Percentage of enrolled families whose HOME scores on both parenting behaviors and parent-child relationship improve or remain the same from index child 6 months of age to 18 months of age. *Amended August 2013	Outcome measure
3.4	Parent emotional well-being or parenting stress	Percentage of women enrolled in the program that have been screened for maternal depressive symptoms within 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9)	Outcome measure
3.5	Child communication, language and emergent literacy	Index children screened in Communication as measured by the Ages and Stages Questionnaire and referred and evaluated as appropriate	Process measure
3.6	Child's general cognitive skills	Index children screened in Problem Solving as measured by the Ages and Stages Questionnaire and referred and evaluated as appropriate *Amended August 2013	Process measure

3.7	Child's positive approach to learning, including attention	Index children screened in child's positive approach to learning, including attention as measured by the Ages and Stages Questionnaire: SE and referred and evaluated as appropriate *Amended August 2013	Process measure
3.8	Child's social behavior, emotion regulation and emotional well-being	Index children screened in social behavior, emotion regulation, and emotional well being as measured by the Ages and Stages Questionnaire: SE and referred and evaluated as appropriate *Amended August 2013	Process measure
3.9	Child's physical health and development	Index children screened in Gross Motor and Fine Motor skills as measured by the Ages and Stages Questionnaire and referred as appropriate *Amended August 2013	Process measure
<i>Benchmark IV. Domestic Violence</i>			
4.1	Screening for domestic violence	Percent of families that have been screened for domestic violence during the enrollment period	Process measure
4.2	Of families identified for presence of domestic violence, number of referrals made to relevant domestic violence services (shelters, food pantries)	Percent of families enrolled in the program identified with a presence of domestic violence that have been referred to relevant domestic violence services	Process measure
4.3	Of families identified for presence of domestic violence, number of families with a safety plan completed	Percent of families enrolled in the program identified with a presence of domestic violence that have a safety plan completed	Outcome measure
<i>Benchmark V. Family Economic Self-Sufficiency</i>			
5.1	Household income and/or benefits	Percentage of enrolled families who increase their total amount of income from employment, income from public systems and/ or the value of in-kind benefits the family receives	Outcome measure
5.2	Employment or education of adult members of the household	Percentage of mothers enrolled in the program that are not employed that participate in an educational program	Outcome measure
5.3	Health Insurance Status	Percentage of mothers and index children who obtain and/ or maintain health insurance within three months of program enrollment.	Outcome measure
<i>Benchmark VI. Coordination and Referrals for Other Community Resources and Supports</i>			
6.1	Number of families identified for necessary services	Percent of families screened for necessary services. Necessary services include: ___ Domestic Violence/ IPV ___ Tobacco Cessation ___ Mental Health Services ___ Maternal Depression ___ Developmental Delays ___ Income and Benefits ___ Health Insurance Status ___ Education/ Employment	Outcome measure
6.2	Number of families that required services and received referral to available community resources	Percent of families identified with an identified need that received an appropriate referral, when there were services available in the community	Outcome measure
6.3	Number of Completed Referrals	Percent of families enrolled in the program with referrals where receipt of referrals can be confirmed	Outcome measure

6.4	Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community	Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community.	Outcome measure
6.5	Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Number of social service agencies that have a regular communication with home visitor provider, with clear point of contact and regular sharing of information between agencies.	Outcome measure