

State of Kansas

**Updated State Plan for the Maternal, Infant and Early
Childhood Home Visiting Program**

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Section 1: Identification of the State's Target At-Risk Communities.

From the communities identified as being at highest risk in the State of Kansas Needs Assessment for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program submitted September 2010, the targeted communities selected for initial implementation will be Wyandotte County, which includes urban Kansas City, KS, and Montgomery County, one of a cluster of primarily rural high risk counties in southeast Kansas.

Other communities that were identified as being at highest risk in the Kansas needs assessment but are not selected for initial implementation due to limited FY 2010 MIECHV funding are:

- A cluster of counties in rural southeast Kansas in addition to Montgomery County - Bourbon, Cherokee, Crawford, and Labette (while it is the intent of the state plan to take a multi-county approach in southeast Kansas, due to current availability of federal funds and to build a foundation of success, Montgomery County will be the focus for implementation in the first year)
- Sedgwick County (including Wichita)
- Shawnee County (including Topeka)

Montgomery County

Assessment of needs and existing resources

Montgomery County is in the far southeast corner of Kansas and borders Oklahoma. The population of Montgomery County is estimated to be 34,282 (U.S. Census Bureau, 2005-2009 American Community Survey) composed of 83.7% White Non-Hispanic, 5.4% Black Non-Hispanic, 2.2% American Indian Non-Hispanic, 0.6% Asian, and 3.4% Hispanic (any race). About 2% of the population is not proficient in English. Approximately 42% of population lives in rural areas and population centers include Coffeyville (10,244) and Independence (9,245). Children under 5 years of age compose 7% (2,326) of the county population. For the five-year period 2005-2009, the Kansas Department of Health and Environment (KDHE) recorded an annual average of 499 births to Montgomery County residents.

The southeast Kansas region including Montgomery County has a high rate of individuals and families living below the poverty level, near poverty, and who are considered as "working poor". Compared to the state average, the county has remarkably high rates of families with children under five living in poverty and unemployment, and a median household income that is only 78% of the state median. Montgomery County, as well as other counties in the southeast region, has been noted for having some of the worst health outcomes (i.e. mortality, morbidity) and health factors (i.e., health behaviors, clinical care, socio-economic factors, physical environment) in the state. Additional risk factors include high rates of births to teens and unmarried women, high child maltreatment, and low completion of immunizations for infants and toddlers. Furthermore, pregnant women in Montgomery County have a greater likelihood of preterm births and low birth weight, and of using tobacco or abuse other substances. Children under age 18 are more likely have mental health concerns.

Table 1 contains a summary of risk factors affecting children and families in Montgomery County compared to the rest of Kansas.

Table 1. High Risk/Need Indicators

Risk Indicator	Montgomery Co.	Wyandotte Co.	Kansas	Data Source
Inadequate or no prenatal care	15.7%	22.8%	15%	KDHE, 2005-2009
Preterm births (live births < 37 weeks)	11.3%	9.3%	9.4%	KS Certificate of Live Birth Data, KDHE, 2005-2008
Low birth weight	9.1%	8.2%	7.2%	KS Certificate of Live Birth Data, KDHE, 2004-2008
Infant Mortality rate per 1,000 live births	7.6	9.5	7.5	KDHE, 2004-2008
Smoking during pregnancy	30.2	14.3	16	KDHE, 2005-2009
Substance abuse by pregnant women, rate per 1,000 women ages 15-44	8.8	7.0	6.3	Substance Abuse Admission Program Data, 2003-2009, KS Dept. of Social and Rehabilitation Services (SRS)
Teen births (ages 10-19)	14.9%	15.9%	10.3%	KDHE, 2005-2009
Births to unmarried women	46.3%	58.7%	36.2%	KDHE, 2005-2009
Births to mothers without a high school diploma	21.09%	33.4%	18.8%	KDHE, 2004-2008
Arrests per 1,000 adult population (ages 18-64)	7.9	8.2	6.3	Adult Arrests by Agency, 2004-2008, KS Bureau of Investigation (KBI)
Domestic violence incidence rate per 1,000 population (ages 5-60)	7.2	7.9	9.5	Domestic Violence and Rape Statistics, 2003-2008, KBI
Child maltreatment incidence rate per 1,000 children (ages 0-17)	8.0	4.6	3.6	Family and Child Tracking System, Dept. of SRS, Children and Family Services Data Unit, 2005-2008
Health outcomes (mortality & morbidity)	97th	96th	-----	County Health Rankings, 2011, Kansas Health Institute
Health factors (health behaviors, clinical care, socio-economic factors, physical environment)	90th of 98 counties	98th of 98 counties		
Children < age 18 hospitalized for mental health, rate per 1,000 children	9.5	3.36	3.36	KS Hospital Association and KDHE, 2004-2008
Immunizations by age 2 years	62.1%	50%	75.0%	KDHE, 2004-2008
High school (grades 7-12) dropout rate per 1,000 high school enrollees	17.5	31.9	15.7	Kansas K-12 Reports, KS State Dept. of Education, school years 2004/05 - 2008/09
Unemployment	10.4%	10.4%	7.0%	Annual Unemployment by County, 2010, KS Dept. of Labor
Poverty level - families with children < 5 years	29.8%	28.3%	17.5%	U.S. Census Bureau, 2005-2009
Children living in single-parent households	34%	43%	27%	KS Health Institute, 2011
Median household income	\$37,927	\$36,973	\$48,394	U.S. Census Bureau, 2005-2009

Established home visiting services focused on pregnant women and families with young children operating in Montgomery County are:

- *Early Head Start - Home-based*: Administered by the Southeast Kansas Community Action Program in 12 counties. Presently serves 28 pregnant women and families with children 0-3 in Montgomery County.
- *Parents as Teachers*: Two separate programs are administered by (1) Southeast Kansas Education Service Center - Greenbush for Unified School Districts (USD) 436 Caney Valley, 446 Independence, and 447 Cherryvale, and (2) USD 445 Coffeyville. Each of these programs presently serves about 100 families expecting or with children 0-3.
- *Birth to Three*: The Southeast Kansas Education Service Center – Greenbush provides Part C Infant Toddler Services, an early intervention program to help families whose children have developmental delays or disabilities. Services may include family training, counseling and home visits, screening and assessment, speech-language and audiology, occupational therapy, physical therapy, psychological and health services, and more. Currently, 30 children are being served.
- *Healthy Start Home Visitor Services*: As part of the Maternal and Child Health program of the county health department, a paraprofessional under the supervision of a professional registered public health nurse provides one or more outreach visits to pregnant women and families with newborns. In 2010, 157 pregnant women or mothers with infants were visited, approximately 30% of births in the county.
- *Project Before*: The Four County Mental Health agency provides case managers to visit and assist families with children from birth to age 5 and additionally have been identified with mental health, substance use, or other at-risk factors. The program is based on a SAMSHA promising practice model. In 2010, 95 families were served in a four county area, the majority in Montgomery County.

A Healthy Families America program does not serve Montgomery County. However, Kansas Children's Service League (KCSL) has established services in the nearby southeast region in Bourbon, Cherokee, and Crawford counties.

As of the writing of this updated state plan, we are unaware of any Montgomery County home visiting services discontinued since March 23, 2010.

Many challenges to the effective provision of services to pregnant women and families with young children in Montgomery County exist including:

- A coordinated outreach and referral process across home visiting programs and other maternal and early childhood services is nonexistent. There is no central access point for home visiting programs. Each program conducts its own procedures with some referrals being made between programs as well as other community services. Various program waitlists, eligibility and service enrollment procedures create coordination challenges. Families have to coordinate accessing services mostly on their own. Mechanisms to support follow-up on referrals are lacking.
- All home visiting programs operate at caseload capacity and some have long waitlists. As a result:
 - most families cannot receive full services immediately upon referral or application
 - the intensity and frequency of services does not always match the needs of families

- families who do not meet certain eligibility guidelines may not receive services
 - differences between children in poverty under the age of five and the number of available home visiting slots indicates that Montgomery Counties is meeting approximately half the need (54%) for that population
 - with the exception of home-based services offered for families with children in Head Start home visiting programs have limited ability to serve families after their child reaches age three years, thus there is a gap in serving families with children between ages 3-5
- Engaging and retaining families in programs & services, including fathers, is difficult. The at-risk population can be hard to find. Identifying and engaging women who are not receiving any services is difficult. Families are highly mobile and move across state/county lines, yet there is no way to link with or track them. Families perceive stigma or fear of services (i.e., removal of children, punitive action; lack of comfort or trust).
 - Programs lack bilingual staff to serve primarily Spanish-speaking families.
 - Home visitors have inadequate training to address the issues of families experiencing substance use disorders, domestic violence, or mental health concerns.
 - Substance use treatment providers and domestic violence service providers lack awareness and understanding of home visiting services and vice versa.
 - There is a lack of comprehensive, wrap-around services/programs for substance-using pregnant women and mothers of young children. Treatment services for substance abuse are lacking and do not meet the demand. There are few residential treatment options for pregnant women and women with small children.
 - Mental health services for infants and toddlers are limited.
 - Availability of and transportation to needed services by at-risk clients, including medical care, is limited. Many clients must travel across counties or even state lines to access available services. Families just above poverty line (i.e., “working poor”) and who cannot afford services may not qualify for services and be underserved.
 - There are a considerable number of families who are homeless or live in substandard housing conditions.
 - Quality child care is limited and there are many children who do not attend any early childhood programs.

Coordination among existing programs and resources, and capacity to integrate home visiting services into an early childhood system

To address this complex array of risks and challenges, Montgomery County has a number of strengths on which to build the MIECHV Program. Multiple services for pregnant women and families with small children are centered and offered in this county including public health, mental health and other social services. There is a substantial level of collaboration and linkages across services at the community, county and multi-county regional levels. A number of service providers serve various configurations of multi-county catchment areas.

Also, there are a number of existing agencies, collaborative groups and initiatives that focus on comprehensive early childhood system improvements in Montgomery County and the multi-county southeast Kansas region. Representatives from all of the presently offered home visiting programs and/or their parent organizations have been integral partners and even leaders in these efforts. These include a demonstration learning community initiative in the Coffeyville public

schools that has integrated preschool, Head Start/Early Head Start, Parents as Teachers, Part C Infant Toddler Services, and other support services in one location. Also, state Kansas Early Learning Collaborative and Smart Start grants have been received multiple years to enhance a broad array of systems and program development. Early Childhood Collaborative groups for both Coffeyville and Montgomery County regularly meet and are attended by many local and regional agencies and programs representing health and mental health services, education, child care, parenting education as well as community advocates and others. The Montgomery County Early Childhood Collaborative group members were engaged in the needs assessment and planning processes for the MIECHV Program.

From these processes, top priorities have been identified to address the existing coordination and service gaps in Montgomery County. One priority is to expand the caseload capacity of the Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs to serve additional Montgomery County families. An additional home visitor will be hired for each program. Some programs will emphasize recruiting and hiring individuals who are bilingual in English and Spanish.

Second, is to develop a coordinated, centralized system for community awareness, outreach, referral, screening, and intake, and other cross-program functions (e.g., staff training, parent groups, coordination with other services). This will include all existing home visiting programs and other related community services for families with pregnant women and young children. A program coordinator will be hired and employed by the nonprofit Four County Mental Health agency. The coordinator will be based at the Community Access Center (CAC). The CAC, a 501(c)3 organization working under the Community Foundation for Independence, KS, provides a centralized location to assist individuals in determining their needs and identifying the wide variety of services available within their community to meet those needs. Assistance and programs include referrals to other community resources, short-term financial assistance with rent, utilities, medications and transportation, food, disaster aid, and more. The center is an ongoing "one-stop shop" where residents can access a variety of services and be assisted in initial contact with numerous agencies, more effectively and to prevent duplication of services. The CAC also partners with the United Way of the Plains, 211 Information and Referral Service for Kansas, to gather referral and resource information to be included in this system. Recently, similar plans have been made to locate an early childhood mental health coordinator at the CAC. Adding the function of a home visiting coordinated and centralized system meets the objectives of all parties involved. The intent is to develop policies, procedures, and agreements for implementation across Montgomery County that then may be expanded to include other counties in the southeast region.

A third priority is to enhance capacity of the evidence-based programs to serve families experiencing substance abuse, domestic violence, and mental health concerns. This includes increasing the ability of staff to identify, engage, serve, and refer families with such concerns by providing additional training and consultation. Specific steps will be taken to increase collaboration and referrals between the home visiting programs and substance use treatment, domestic violence, and mental health providers.

Wyandotte County

Assessment of needs and existing resources

Primarily urban, Wyandotte County contains part of the Kansas City metropolitan area which is split along the Kansas and Missouri state line. The county population is 155,085, while the Kansas City, KS population is 145,786, and is composed of 48% White Non-Hispanic, 26% Black Non-Hispanic, 22% Hispanic (any race), 0.5% American Indian Non-Hispanic, and 2% Asian (U.S. Census Bureau, 2005-2009). About 11% of the population speaks English less than “very well”. The county’s annual number of births over the five-year period of 2005-2009 averaged 2,864 (KDHE) and 13,662 children (9% are under 5 years of age (U.S. Census, 2005-2009).

Table 1 contains a summary of risk factors impacting Wyandotte County families and children. Wyandotte County ranks lowest in the state on health outcomes (i.e. mortality, morbidity) and health factors (i.e., health behaviors, clinical care, socio-economic factors, physical environment). Compared to the state average, the county has substantially high rates of families with children under five living in poverty and unemployment, and a median household income that is only 76% of the state median. Additional risk factors include high rates of births to teens, births to unmarried women, and births to mothers without a high school diploma. Pregnant women and their infants have a greater likelihood of inadequate or no prenatal care, low birth weight, infant mortality and substance abuse. The rate of immunizations for infants and toddlers is low. Further analysis of county zip codes indicates the highest risk populations are particularly concentrated in the Kansas City, KS inner city area (66101-66106).

Existing home visiting services currently operating in Wyandotte County are:

- *Early Head Start - Home-based:* Administered by Project EAGLE Community Programs affiliated with the University of Kansas Medical Center. Presently, 145 pregnant women and families with children 0-3 are served.
- *Healthy Families America:* Two program sites are administered by (1) Kansas Children’s Service League (KCSL) serving 60 families, and (2) the Public Health Department of the Unified Government of Wyandotte County and Kansas City, KS serving 36 families. Additionally, a Family Support Worker is based at Project EAGLE who serves approximately 15 families.
- *Parents as Teachers:* Two separate programs are administered by (1) USD 445 Kansas City, KS, and (2) USD 202 Turner, a school district also located in Kansas City, KS. In the past year, these programs served 609 families and 100 families, expecting a baby or with children 0-3, respectively.
- *Healthy Start Home Visitor Services:* As part of the Maternal and Child Health program of the county health department, paraprofessionals under the supervision of a professional registered public health nurse provides educational information, referrals, and one or more outreach visits to pregnant women and families with newborns. On average, the program annually provides services to 56 prenatal women and 456 postpartum women; of the latter, approximately 94 receive services in home or the office.
- *Healthy Start:* One of a network of federal Maternal and Child Health programs to reduce infant mortality, this site is administered by Project EAGLE in collaboration with the Mother and Child Health Coalition covering the bi-state Kansas City metropolitan

area. Home-based prenatal education and case management services is offered to pregnant women and mothers until their child is 2 years of age. Sixty (60) mothers are served annually.

- *Infant-Toddler Services:* The Children's Therapeutic Learning Center (TLC) provides Part C early intervention services to children birth to 36 months and their families. Children with developmental delays or disabilities are eligible. Services may include family service coordination, home visits, screening and assessment, speech-language and audiology, occupational therapy, physical therapy, psychological and health services, and more. Currently, 277 children are served.

As of the writing of this updated state plan, we are unaware of any Wyandotte County home visiting services discontinued since March 23, 2010.

A coordinated screening and referral system is present in Wyandotte County. Since 2003, Project EAGLE Community Programs has offered the *Connections Centralized Screening and Referral System* to families with pregnant women and/or children ages birth to five who reside in Wyandotte County. Connections was developed as an approach to address several concerns: some programs in the community had long waiting lists and children would age out before services were available while other programs were under enrolled; families were not able to access the services they needed at critical times; and many parents do not adequately self-identify their needs. The program aimed to connect children and families with appropriate services in the community, and to improve utilization of community resources.

The purpose of Connections is to screen for multiple risks in families with young children from birth to five years of age and to provide timely referrals to address their needs. Connections is currently staffed by 3 full-time employees (Intake Specialists) - 2 who work in the field and conduct screening visits and one who does phone triage. During a 90 minute home or office visit, the Intake Specialist works in partnership with the family to complete a series of brief, formal screening measures with established sensitivity that provide unique information about self-sufficiency, basic child development and social-emotional development, depression, anxiety, trauma, parent and child interaction, domestic partner abuse, and substance abuse. Based on the results of all of these tools, families receive referrals to agencies that can best meet their individual needs. Referrals are made to more than 60 agencies/programs providing services in the following domains: self sufficiency, parent health and mental health, parenting, child health and development. A 10-minute follow-up phone call is made to the family to collect data on the family's access to and satisfaction with services.

The Connections program is currently supported by integrating several federal, state, and local funding sources and is responsible for keeping the Healthy Families, Early Head Start, and the Healthy Start (Project EAGLE) programs fully enrolled. Referrals are also made to Parents as Teachers, Wyandotte County Infant Toddler Services (Part C), Part B preschools (USD 500 & Turner), 4 year-old preschool, and Economic Opportunity Foundation Head Start. Connections has an advisory board composed of many of the referral partners that meets several times per year. The program has been nationally recognized as a model for centralized screening and referral and recently received its second Healthy Tomorrows Partnership for Children Project grant through DHHS/HRSA/MCHB.

Incoming referral sources include the local health department (WIC, Family Planning, Healthy Start, and Healthy Families programs), hospitals, health care practitioners and clinics, social service and mental health agencies, early childhood education programs, early intervention programs, domestic violence shelters, legal system, family and friends, as well as flyers posted throughout community. Annually, the Connections Program serves approximately 600 high-risk families. On average, per month, over 80 referrals and 112 phone calls are received, and an average of 48 comprehensive screening and referral visits and 25 follow-up phone calls are completed. Primarily low-income families are served; during the Connections' history, 76.6% of families have reported incomes below \$15,000 with 51.5% reporting incomes below \$5,000. Program data from the period of February 2008-August 2010, indicates that families received an average 7.5 referrals to medical and behavioral health, parenting, early intervention, child care, food, shelter, housing, utilities, job training/adult education, and transportation services. Phone screenings and full assessments, respectively, revealed the following: domestic partner abuse (5.5%, 22.9%), depression/anxiety (41.4%, 38.7-47%), substance abuse (2%, 8%; more recently, approximately 13% of families screened indicate substance abuse). Also, 44% of parents reported having experienced a traumatic event. Of children receiving a developmental screening, 11.5% were referred for further evaluation and of children receiving a social-emotional screening, 9.7% were referred for further evaluation.

While this array of services exists in Wyandotte County, many challenges to the effective provision of services to pregnant women and families with young children emerged from the needs assessment and planning processes:

- Existing home visiting programs operate at caseload capacity and some have waiting lists. As a result, most families cannot receive full services immediately upon referral or application and some families are not matched with the most appropriate service for their needs. Families who are on the brink of eligibility may not receive services. It is estimated that the available home visiting slots meet only 30% of the need in serving children in poverty under the age of five.
- Home visiting programs have limited ability to serve families after their child reaches age three years, thus there is a gap in serving families with children between ages 3-5.
- Difficulties with engaging families in services after referrals are made are common. Some families in the screening/assessment process are lost. Receiving referrals is not enough to ensure that families are engaged. Mechanisms to support follow-up are lacking. Various program wait lists, eligibility and service enrollment limits create referral coordination problems.
- Certain populations of at-risk families may not be reached. Engagement of some families is limited by misconceptions of agencies and fear of punitive action.
- Retaining families/parents in programs & services, including fathers, is challenging. Mobility of the population, including across county and state lines, and lack of consistent phone availability create struggles for service delivery.
- There is a growing population of families from diverse cultures and languages. Existing staff are unfamiliar with serving the variety of cultures. There is a lack of bilingual/multilingual staff.
- Home visiting programs have inadequate capacity to identify, engage, and address the issues of families experiencing substance use disorders or mental health concerns.

- Substance use treatment providers and domestic violence intervention services lack awareness and understanding of home visiting services, and vice versa.
- Assessment and treatment services for substance abuse are lacking and do not meet the demand. There are few residential treatment options for pregnant women and women with small children.
- Access to mental health services for many segments of the population is limited. Mental health services for birth-3 are minimally available. Screening and support for maternal mental health (i.e., depression, anxiety) is inconsistent.
- Parents are so overwhelmed they don't follow up on referrals or engage with needed services. After referrals are made, there is not communication back about what happens with the family.
- Common challenges confronting families include stable housing, food, finding jobs, child care while going to school/work, and transportation to community services and appointments.
- Part C Infant Toddler services need to be expanded to serve more children.
- Many families with young children are unaware of and not participating in any early childhood programs. Accessibility to quality child care needs expanded.

Coordination among existing programs and resources, and capacity to integrate home visiting services into an early childhood system

Wyandotte County has a strong network and history of collaborative partnerships and leadership that bolster the area's comprehensive early childhood system. A number of collaborative groups and initiatives focus on comprehensive early childhood system improvements including the Interagency Coordinating Council for Early Intervention, Smart Start, and the Wyandotte Kansas Early Learning Collaborative (WELC). Smart Start and WELC have overseen state grants multiple years focused on a broad array of systems and program enhancements. Representatives from all of the presently offered home visiting programs and/or their parent organizations are integral partners and leaders in these efforts. There have been coordinated efforts around strengthening the various home visiting services and the existing programs collaboratively engage in regular communication, meetings, and sharing referrals and information. Additional local initiatives have relevance and potential for linking the MIECHV Program objectives. These include the Mother and Child Health Coalition covering the bi-state Kansas City metropolitan area which has focus areas such as infant mortality, the Kansas City, KS Mayor's Healthy Communities Wyandotte Initiative which includes early childhood and other family strengthening components, a Custody Prevention Initiative of the county child protection agency (Social and Rehabilitation Services), and the KC Substance Abuse Task Force, and the Kansas City Task Force on Families Affected by Substance Abuse, a bi-state group.

The WELC group has been engaged in the community planning for the Kansas MIECHV Program. From the state and local needs assessment and planning processes, the top priority for Wyandotte County is to enhance the capacity of the system of home visiting programs to serve families experiencing substance abuse and mental health concerns. This will be addressed by expanding the caseload capacity of the Early Head Start, Healthy Families America, and Parents as Teachers evidence-based home visiting programs to serve additional families. In the first year, an additional home visitor will be hired for each program site. Families to be served will have been identified as having substance abuse and/or mental health risk factors. Furthermore, a

promising approach home visiting program to specifically serve pregnant and postpartum women affected by alcohol or other drugs and/or HIV, the Team for Infants Endangered by Substance Abuse (TIES) Program, will be added to the delivery system. To further build the home visiting programs' capacity to appropriately address mental health and substance abuse concerns, additional training and consultation will be provided to help staff identify, engage, serve, and refer families with such concerns. Also, specific steps will be taken to increase awareness, referrals, and collaboration between the home visiting programs and substance use treatment and mental health providers.

Section 2: State Home Visiting Program Goals and Objectives.

The Kansas MIECHV Program Logic Model is attached. In order to contribute to the development of a comprehensive, high quality early childhood system that promotes maternal, infant and early childhood health, safety and development and strong parent-child relationships, the Kansas Home Visiting Program (KHVP) goals and objectives are to:

Goal 1: Deliver a coordinated, integrated system of evidence-based home visiting programs with high model fidelity and quality to families with pregnant women and children (0-5) in at-risk communities.

Objective 1: Increase the number of families with identified risks served in targeted communities by evidence-based home visiting programs (i.e., Early Head Start, Healthy Families America, and Parents as Teachers) and a promising home visiting approach (TIES).

Objective 2: Ensure program services are aligned with local and individual family needs so that families receive services that best fit their needs.

Objective 3: Improve coordination and referrals between home visiting programs and other community resources.

Objective 4: Build capacity for locally coordinated, centralized outreach, referral and intake processes

Objective 5: Ensure accountability, model fidelity, and quality through coordinated cross-program training, technical assistance and monitoring.

Goal 2: Effectively engage and retain underserved, hard-to-reach populations in home visiting services.

Objective 1: Build home visiting programs' capacity to effectively engage and retain families in services.

Objective 2: Build home visiting programs' capacity to involve fathers in services.

Objective 3: Build home visiting programs' capacity to appropriately address mental health and substance abuse concerns of referred and enrolled families.

Objective 4: Implement a promising home visiting approach to serve pregnant women/ mothers with substance use problems and their families.

Goal 3: Utilize a coordinated, integrated system to determine outcomes and quality of home visitation programs.

Objective 1: Select common indicators and measures across home visiting programs.

Objective 2: Develop and utilize a common data collection and reporting system across home visitation programs.

Objective 3: Assess program outcomes (i.e., MIECHV Program benchmarks and constructs) and implementation quality.

Objective 4: Utilize data for continuous quality improvement.

Objective 5: Evaluate a promising home visiting approach to serve pregnant women and mothers with substance use problems.

Throughout the planning process, the KHVP has established strategies to develop close connection with the local and statewide early childhood programs, plans and initiatives which will facilitate integration of the planned project. The KHVP partners have been and will continue to be active partners in the development, implementation and coordination of all Kansas early childhood plans and initiatives including: the Kansas Early Childhood Comprehensive Systems Plan (KECCS); Kansas Strengthening Families (KSF); the Kansas Early Childhood Advisory Council (ECAC); the Kansas Early Learning Collaborative (KELC) and the Kansas School Readiness Data Task Force. The KHVP enhances these efforts as well as strengthens and creates partnerships between early childhood and prevention professionals to deepen the quality and reach of home visitation services. KHVP partners and the early childhood and child welfare systems have demonstrated commitment to cross-agency partnerships. This coordination has informed the development of the KHVP and the identified need to support and expand home visiting programs as part of the KECCS plan and ultimate goal of a statewide comprehensive, integrated early childhood system.

The KHVP includes planned strategies to operationalize the recommendations of the plans and initiatives in Kansas listed above most clearly through the identified need for expanded home visitation as well as data and service coordination among early childhood systems. The KHVP is well coordinated with the KECCS Plan and the developing ECAC. Goals of the KECCS Plan are to: (1) ensure that all Kansas children have health insurance and access to medical providers; (2) fully integrate mental health and social-emotional development into the early childhood system in Kansas; (3) develop a comprehensive and coordinated early childhood care and education system in Kansas birth-5; (4) educate and mentor parents about childhood health, development, and education; and (5) promote a system that helps families develop and utilize both intellectual and material resources to prepare their children for school and life. The KECCS Plan utilizes School Readiness as a bridging framework to create a statewide, unified effort for investing in Kansas through investing in our children. KELC, a collaborative among six statewide early childhood organizations (including home visiting) which focuses on a seamless and family-friendly continuum of services, and the Kansas School Readiness Data Task Force work to support the KECCS plan and will further support the KHVP and assist in coordination efforts as described below.

The KECCS Plan has resulted in significant collaboration and cross-agency initiatives at the state and local level. While silos have been broken down on the service delivery side, evaluation silos have prevented the assessment of the effectiveness of home visitation on the State and community level. The KHVP will inform spending decisions in early childhood by providing evidence of a community-based home visitation model of coordinated services that is non-duplicative, conserves resources by reducing program attrition, and ensures early, intensive

investment in families to prevent higher costs to the system later. In addition, two policy implications for the early childhood system would occur. First, Kansas currently invests in a statewide home visitation training system that is administered through the Kansas Head Start Association (KHSA). The KHVP would provide direction about how to best invest professional development resources for home visitors to achieve positive outcomes for children in Kansas. Second, research informing the evidence-based policy framework for home visitation programs would encourage data-driven decision making to build effective local service delivery systems. The coordinated intake processes are planned to lead to coordinated professional development on family recruitment and retention.

The KHVP also incorporates the KSF Plan which provides a framework for a coordinated effort that promotes protective factors and minimizes risk factors for all children and families by bridging a variety of disciplines, agencies, services, and prevention approaches. The KSF Plan was developed by both state and local stakeholders to unify efforts, coordinate resources, and strengthen and support families. The KSF Plan builds on existing systems in Kansas and reframes child abuse and neglect to embed prevention strategies. These efforts not only work to prevent child abuse and neglect, but also have a global focus of strengthening support for all families in Kansas.

Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of how the Model(s) meets the needs of the targeted communities.

A. Selection of Approved Evidence-Based Home Visiting Models

Three evidence-based home visitation models will be implemented: (1) Early Head Start; (2) Healthy Families America; and (3) Parents as Teachers. All currently have widespread availability in Kansas and are established in the identified at-risk communities (with the exception of Healthy Families America in Montgomery County). These three models will be utilized as a continuum of services in the targeted communities and to address the identified needs.

The targeted communities were engaged in the needs assessment and planning processes. For the state needs assessment in 2010, service providers and parents from the areas participated in key informant interviews and focus groups. In recent months (March-May 2011), the Kansas Home Visiting Program Manager conducted a series of individual meetings with home visiting and related early childhood system service providers and coalition leaders who cover the targeted communities. Subsequently, it was determined that the Montgomery County Early Childhood Coalition and the Wyandotte County Early Learning Collaborative would serve as the lead groups in their respective communities for further planning and implementation steps. In-depth planning sessions were facilitated by the Kansas Home Visiting Program Manager with each group incorporating information on community needs, capacity, readiness, and fit of the models to address the needs.

State and local partners determined that the best approach for a coordinated, comprehensive state plan is to build on the strong foundation of programs already in place given the existing commitment to support these programs and their likelihood to yield more geographical coverage with a higher level of fidelity. These established programs and their experienced, trained staff will facilitate timely and cost-effective implementation for the MIECHV Program. Furthermore, given the current budgetary constraints in Kansas and the rest of the nation, it is prudent to enhance the quality and coordination of the present infrastructure services rather than adopt an entirely new program that may not be fully implemented or sustained for the long-term.

By including the continuum of three programs, this approach reaches families at various risk levels. The community intake process and referral agreements among the partners will help ensure that families are matched to the appropriate service to meet their needs.

Specifically, all of the models meet numerous needs of the targeted communities. All are voluntary and work with pregnant women and families with children from birth to age three, with some up to age five.

- Early Head Start particularly serves families who meet the Federal Income Guidelines, have an infant or toddler with a disability, or other stressors. Targeted outcomes include promoting healthy prenatal outcomes for pregnant women, enhancing the development of infants and toddlers, healthy family functioning, and preparing children to enter school ready to learn. The EHS model has demonstrated favorable impacts in the domains of child development and school readiness, positive parenting practices, and family economic self-sufficiency.
- Healthy Families America particularly serves families identified with risk factors for child abuse or neglect such as childhood history of abuse, substance use, mental health concerns, lack of social support, family stressors, and lack of parenting and child development knowledge. Targeted outcomes include reducing child maltreatment, increasing utilization of prenatal care, positive parenting and parent-child interactions, healthy child development and school readiness, family self-sufficiency, and access to primary care medical services. The HFA model has demonstrated favorable impacts in the domains of child health, child development and school readiness, reductions in child maltreatment, positive parenting practices, family economic self-sufficiency, reductions in juvenile crime and family violence, and in linkages and referrals.
- Parents as Teachers has no income or other eligibility guidelines although priority is given to first time parents, teen parents, and families with at-risk indicators such as low income, single parent and foster or adoptive families. Targeted outcomes include improving parent knowledge of early childhood development and parenting practices, providing early detection of developmental delays and health issues, preventing child abuse and neglect, and increasing children's school readiness and school success. The PAT model has demonstrated favorable impacts in child development and school readiness and positive parenting practices.

The state level partners for the three selected models have worked together on multiple projects, have been involved with all stages of the KHVP planning, and are committed to the state plan. All of the programs have experience with rigorous program evaluation and accountability processes through existing funding streams and as part of fidelity to their models. The partners

will also utilize existing agency resources to support the plan. The KHVP builds on the experience and existing structures of partner agencies. Following is a description of the state's current and prior experience with implementing each of the three selected models and the current capacity to support the models.

Early Head Start (EHS) - Kansas Early Head Start Programs are administered by the Kansas State Department of Social and Rehabilitation Services (SRS) under the Economic and Employment Support Services Division. This division also administers Head Start programs and the State Head Start Collaboration Program. Carrie Hastings is the Division's Acting Services and Access Manager.

Fifteen Kansas-administered grant-funded EHS programs serve 48 Kansas counties and 1,177 enrolled slots for pregnant women and young children, including the targeted at-risk communities. Some local program agencies also receive federal funds. At least 55% of those served must be at or below 100% of the federal poverty level; 35% may be up to 130% FPL; and at least 10% are children with special needs. The 15 KEHS programs are required to partner with existing child care providers to provide center-based services to families who are working or attending school. In addition, over 2,000 more children are affected by the quality improvements provided to the partnering child care providers.

Programs are monitored by the state and through the federal EHS program to assure compliance with Federal EHS Performance Standards. The federal regulations as indicated in the Head Start Performance Standards and the Head Start Act as Amended December 2007 for hiring staff are followed. SRS also contracts with the Kansas Head Start Association to provide training and technical assistance to local programs. Over the past ten years, KEHS has collected outcomes on children and families enrolled in the program which provide evidence of program success.

Healthy Families America (HFA) – Kansas programs are based upon the national initiative, Healthy Families America, sponsored by Prevent Child Abuse America and are administered by the Kansas Children's Service League (KCSL). A statewide not-for-profit agency, KCSL has a 118 year history with the mission of strengthening the quality of family life through the provision of prevention, early intervention, treatment, advocacy, and placement services (adoption). KCSL has 250 employees, serves about 40,000 children and families annually; is a charter member of the Child Welfare League of America; serves as the Kansas Chapter of Prevent Child Abuse America; has achieved national accreditation from the Council on Accreditation and Healthy Families America; is a member of the Alliance for Children and 15 United Way agencies across the state.

KCSL has demonstrated experience in the area of early childhood services with more than 30 years of experience administering Head Start and Early Head Start services in 14 Kansas counties as well as 14 years experience administering HFA. Currently, HFA services are provided in 17 counties of Kansas: Barton, Bourbon, Chase, Cherokee, Crawford, Dickinson, Douglas, Ellis, Finney, Johnson, Leavenworth, Lyon, Miami, Reno, Sedgwick, Shawnee, and Wyandotte. To ensure Continuous Quality Improvement and model fidelity, KCSL is a HFA Multi-Site System and programs are currently affiliated with the HFA National Office. HFA

accreditation is current through March 2013 and any new programs will be incorporated into this process.

KCSL has office locations, referral sources and community support in each of the targeted geographic areas. While HFA services are not currently provided in Montgomery County, services are established in nearby counties. The KCSL HFA program expertise will be utilized to provide new HFA services to Montgomery County. KCSL HFA has a centralized quality assurance manager and technical assistance staff available to ensure appropriate support is available and all HFA standards and critical elements are met. Tracie Lansing is the KCSL Healthy Families Policy Director. Also, KCSL maintains three nationally certified HFA trainers and facilitates a centralized training program for Family Support Worker/Specialists, Assessment Coordinators, and Supervisors to ensure all training requirements are met according to HFA standards. KCSL maintains a comprehensive database to collect HFA program data for reporting, evaluation, and quality assurance purposes.

Parents as Teachers (PAT) - The Kansas State Department of Education (KSDE) has administered the state's PAT program since implementation in Kansas in 1990. The KSDE Early Learning Services Unit, which includes Parents as Teachers staff, through leadership and partnership advances the provision of high quality early childhood and family services that result in the ability of all young children to succeed in school and life.

KSDE is the state office affiliated with the PAT National Office and provides grant funding to local school districts, or consortiums of school districts, statewide to implement PAT with fidelity to the national model. This includes the targeted at-risk communities. KSDE currently funds PAT programs prenatal to age 3. Local school districts match \$0.65 for every state \$1.00. All PAT programs write an implementation plan that is approved by KSDE and PAT National Center prior to beginning a program. This plan reflects funding, program design, services, and staffing. This plan is updated each time a parent educator is hired. Parent educators and programs also sign letters of agreement for family service, use of curriculum and professional development to ensure fidelity to the model. Programs also submit required data and annual program performance reports.

The KSDE PAT State Office coordinates implementation of the national model in Kansas providing leadership, technical assistance and training on PAT Foundational Curriculum and Model Implementation, program implementation with fidelity, Continuous Quality Improvement, reporting and evaluation. Janet Newton, PAT Program Consultant at the KSDE PAT State Office serves as a liaison with both the PAT National Office and local programs. Janet and other individuals in Kansas are certified PAT trainers. In recent months, the trainers have been providing trainings statewide in accordance with new PAT standards.

The KHVP will incorporate the quality assurance procedures and support of model fidelity from the selected home visiting program models. The Home Visiting Program Manager will closely collaborate with the three state program leaders to ensure all program sites implement the models with fidelity and comply with quality assurance procedures. Memorandums of Understanding and contracts will be developed to ensure all state and local partners understand the expectations and procedures. Joint procedures for coordinated training, technical support, and a system of

monitoring will be developed. A schedule of in-person and phone meetings will be planned to consistently address quality and fidelity assurance steps. Data will be collected from all program sites regarding such factors as staff qualifications, supervision, provision of program components and services, participant engagement, retention, and attrition, and program adaptations. This data will also be incorporated into the Continuous Quality Improvement (CQI) plans.

Given the established infrastructure and experience of the selected programs, at the state and local levels, major challenges to maintaining quality and fidelity are not anticipated. The primary challenge may be how to efficiently coordinate these efforts across all three programs as an integrated system. It will be critical to jointly finalize procedures early on and all parties are committed to doing so. Further technical assistance on how to manage this type of integration is requested.

B. Promising Approach

Description

The *Team for Infants Endangered by Substance Abuse* (TIES) Program will be implemented and evaluated in Wyandotte County as a promising approach. The TIES Program was selected to specifically address the need to expand effective services for pregnant women and mothers of young children impacted by substance use. The TIES Program, initiated in 1990, is a project of The Children's Mercy Hospital in Kansas City, Missouri. The TIES Program model has been developed as a project of the Abandoned Infants Assistance program of the Children's Bureau of the U. S. Department of Health and Human Services. The TIES model has been refined and reviewed over the past 20 years within this Bureau. The Institute for Human Development, a University Affiliated Program of the University of Missouri-Kansas City, has functioned as the TIES Program independent evaluator since its inception in 1990. The Institute collects data from the project staff, conducts some client level survey and infant assessment, and synthesizes and analyzes data from all sources. The Institute has also served for a number of years as the cross-site evaluator for all the Abandoned Infants Assistance projects, and brings that expertise to its evaluation role with the TIES Program.

The TIES Program Logic Model is attached. The TIES program provides intensive, comprehensive home-based services to pregnant and postpartum women and their families affected by alcohol or other drugs and/or HIV. Program goals are: (1) substance use reduction; (2) improved parenting; (3) accessing appropriate health and mental health needs for the family and child; (4) gaining economic stability; and (5) maintaining adequate housing. Using a community-oriented approach, this project provides individualized, culturally appropriate services including crisis intervention, support for substance abuse treatment, supportive counseling, child health and development, parenting education, and connection to other community services. The TIES Program aims to: enhance continuing community collaboration in providing services to this population of families; identify and address challenges and resources in partnership with enrolled families; enhance a multi-agency system of care providing services to families; and promote the safety, health and well-being for each child in enrolled families.

The TIES Program accepts referrals of adult pregnant or postpartum women, 18 years of age and older, and their families affected by substance abuse and/or HIV from health care, alcohol and

other drug treatment, and child protection providers, as well as emergency assistance, shelters, other social service programs, and self-referrals. Referrals are accepted up to six months postpartum, and families are served until the identified child is two years old. TIES is entirely voluntary, and relative caregivers (e.g., fathers, grandparent) can be served, as well, with parental consent. All family members, as identified by the pregnant or postpartum woman, will be served including all the children in enrolled families. Families served in the current Kansas City, MO program are typically low income, live in a limited urban catchment area with approximately 60% of families African American, 30% non-Hispanic Caucasian, and less than 10% other.

Family support specialists are master's level social workers and serve as the lead contact for the family. Each can serve 10-12 families at a time. A parent resource specialist, trained in early childhood or parent education, provides assessment and consultation for all families and direct, home-based parenting services for up to 12-15 selected families at a time. Home visits are provided at least weekly. At first, some families are seen more frequently. In addition to intensive case management and support, various parenting education curricula and resource materials are used (e.g., Florida State University *Partners for a Healthy Baby*, Parents as Teachers *Born to Learn*).

The TIES model involves assessment of family resources and needs, engagement of families in a problem solving relationship, and development of a home-based intervention plan. Support Specialists build a unique rapport with families by providing direct services, coordinating services from other providers, and helping families meet their own identified needs. Within six weeks of enrollment, the Support Specialist creates a written plan with the family. Many services have already been provided by this time. Support Specialists provide connection to alcohol and other drug treatment and transportation to medical and other appointments. They assist families in making application for all available public assistance (i.e. WIC, Medicaid, TANF). They provide parenting information, modeling, and supportive counseling from the first encounter.

The TIES model dictates a strengths-based approach, not only to make good use of the families' resources but to build their own esteem and sense of efficacy in doing so. One of the tenets of the TIES Program design is the Individualized Family Service Plan (IFSP) which the family creates in partnership with the support specialist and defines the roles of all other involved agencies. Within three months of enrollment, the support specialist convenes the identified service team for a conference with the family. The family, with support from the team, identifies resources and needs pertaining to such areas as substance abuse, parenting, physical and mental health, housing, and financial stability. The family support specialist, parent specialist, and other partners review and revise the IFSP as needed, with another full team conference held at 9 and 18 months. The support specialists provide families with support, information, goal setting assistance, and linkage to other community agencies. Direct services are provided by the program staff in the areas of supportive counseling, transportation, emergency assistance, child care, and relative caregiver support. Parenting education, skill building, and modeling are also provided to each family by both family support and parent resource specialists. The *Waiting to Exhale* Women's Support Group functions as an educational, social, and recreational group for TIES participants and alumni. The group, which is led by the members, develops its own rules and plans its own calendar.

Ongoing home-based intervention is provided for support. The Support Specialist assists the family in obtaining services and dealing with crises. These crises may take the form of utility or housing disruption, domestic violence, legal problems, or a host of other potential emergencies. Support Specialists both provide direct services and coordinate others. They assist families to advocate for themselves, and they encourage them to follow through on their commitments. Families are empowered as they address their own identified needs. The context of services is constantly evaluated in terms of ethnic and cultural values.

TIES Support Specialists have been successful in encouraging parents to participate in substance abuse treatment. The Support Specialists work closely with these treatment providers to coordinate related services and ensure appropriate aftercare. Upon enrollment, women will be referred to drug treatment appropriate for women with children. Because the Support Specialists work closely with treatment programs, they can provide specific, relevant information to families about what to expect upon entering treatment. They enhance one another's efforts to keep mothers engaged in treatment. Treatment staff are important participants in the IFSP process with the TIES Program, and TIES Support Specialists participate at times in treatment staffings as well. When women complete treatment, the Support Specialist will be at the graduation, helping recognize accomplishments and continue work with the family in next steps. If women are discharged unsuccessfully, the TIES Support Specialist will assist them in re-entering treatment when possible, advocating for other services, and addressing those barriers to successful completion.

In addition to formal treatment, TIES staff will support participation in recovery support groups. The staff will be familiar with 12 Step programs in the area, including AA, NA, CA, and Alcoholics Victorious, as well as Footprints, Access to Recovery providers, and other community and faith based groups. Women will be encouraged to consider their own support networks and try different kinds of community recovery groups, both as a supplement to treatment and as an ongoing support.

The extent of the need for specialized services for pregnant and postpartum women affected by substance abuse and/or HIV is well documented, and research has demonstrated that women are motivated to change their behavior during pregnancy to promote healthy birth outcomes. While the pregnant and postpartum period is an effective time for intervention, the services provided must be appropriate. The TIES model incorporates these elements:

- inter-agency, multi-disciplinary collaboration forged at administrative and service levels;
- social work professionals engaging families with a focus on the families' holistic challenges and resources including substance abuse;
- development of a trusting, intensive, home-based relationship with parents that is respectful and honest with a willingness to learn from each other;
- comprehensive and ongoing strengths-based assessment with each family;
- concentration on child development, child physical and mental health, including provision of home-based services by an early childhood specialist for families as needed;
- partnership with families to create an individualized, comprehensive, culturally competent, problem-solving plan to address families' goals with both their own resources and those of community partners;

- flexibility in addressing newly identified issues and plan review and revision;
- staff recruitment, orientation, professional development and supervision to promote adherence to the above core components

Because the TIES Program currently operates in Kansas City, Missouri which is part of a bi-state metropolitan area, a number of agencies in the service area relate/have related to the TIES Program over its long existence. State and local agencies participate on the Kansas City Task Force on Families Affected by Substance Abuse, which is a bi-state group addressing the issues of high-risk families. Wyandotte County Social and Rehabilitation Services (SRS) children's services, Wyandotte County Juvenile Court, Kansas City, Kansas Police Department (KCPD), and University of Kansas Medical Center (KUMC) are all represented on the task force. The TIES Program Manager, Oneta Templeton, facilitates the Task Force, and the TIES model and philosophy are well-known in the group. Additionally, there is a subcommittee involving SRS, KCPD, Wyandotte Juvenile Court and their Missouri counterparts addressing child protection, child custody, jurisdiction, transport, and other issues when children are identified in one state and live in the other. Information exchange and policy development are promoting a bi-state approach to these issues, particularly with drug affected families.

The TIES Program also has ongoing contact with the Kansas SRS Addiction and Prevention Services. A member of their staff is on the KC Task Force on Families Affected by Substance Abuse, consultation has been provided to them by the TIES Program and TIES Consortium members upon development of the Health in Pregnancy (HIP) initiative, and Oneta Templeton presented at a statewide conference in Wichita, KS, last year on Prevention of Substance Use During Pregnancy.

In the Kansas City, KS metro area, the TIES Program staff have particularly collaborated with SRS and KUMC on numerous occasions and are aware of one another's practices. On the medical care level, representatives from multiple metropolitan hospitals, including KUMC and Olathe Medical Center, have met to address identification, tracking, and support of drug-exposed infants and their families. Policies and procedures were shared and reviewed, incidence and identification were compared in the aggregate, and advocacy for both identification and support of families was made with hospital administrations. Children's Mercy West primary care clinic is also located in Wyandotte County. Outreach to other potential Wyandotte County partners has been promoted through priori planning processes as well.

Fidelity to the TIES model will be accomplished by the TIES manager monitoring and assessing compliance with the practice standards that will be formalized in the implementation development. The manager will meet with program staff both individually and as a group, accompany staff in home visits, review program documentation, and receive feedback regarding consumer satisfaction from the evaluator. The individualized nature of intervention and field-based decision making are both challenges to quality and fidelity. However, the manager will observe staff regularly interacting with families and will discuss quality improvement efforts on an ongoing basis. This observation and regular supervision coupled with record review will promote model adherence. Furthermore, the TIES Program will be included in the state level integrated procedures for quality assurance and model fidelity as described in the last section. Assessing implementation and fidelity will also be a critical feature of the TIES evaluation.

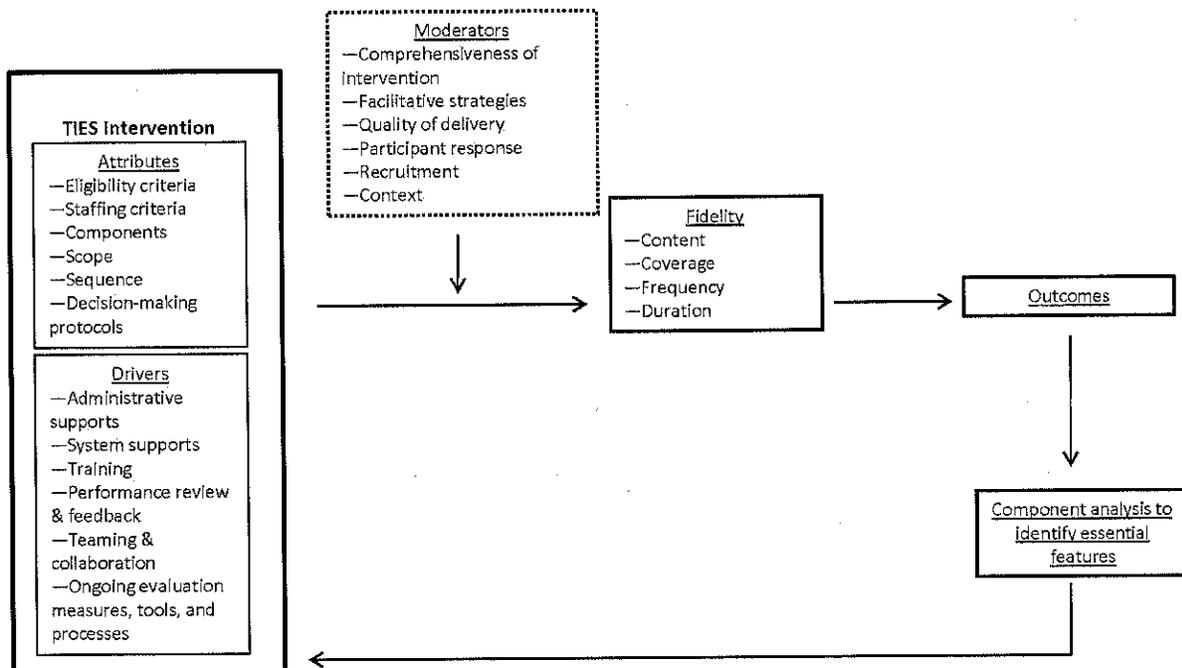
Promising Approach Evaluation Plan

Conducting a rigorous evaluation of implementation processes and fidelity is essential for fully identifying the mechanisms and factors contributing to resulting outcomes. Home visiting programs often utilize multi-faceted interventions in response to individualized needs. As a comprehensive multi-faceted intervention for women and their drug-exposed infants, TIES is designed with flexibility to address immediate and changing needs of participating women and their children through the infant's age of 24 months. The TIES model builds upon a foundation of trusting relationships established through home visitation, supplemented by an integrated network of community supports for individualized. The first three years of the five-year study of this promising approach will be devoted to conducting the implementation evaluation. After completing the implementation evaluation, a rigorous experimental study will be conducted over the remaining two years. The following detailed plan and timeline describes the methodologies for both the implementation and experimental studies.

Evaluation of Implementation Processes and Fidelity

Recently, a number of researchers studying the science of implementation have theorized frameworks identifying the key components to evaluating processes and fidelity (Hasson, 2010; Carroll et al., 2007; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Each framework cited illustrates the relationships between intervention, potential moderators, fidelity, and outcomes. This plan for evaluating the implementation of the TIES program model uses a framework adapted from mentioned researchers to fit the TIES model. Figure 1 displays the framework for conducting the implementation evaluation of the TIES program model.

Figure 1. Implementation Evaluation of the TIES Program Model



Adapted from Hasson (2010).

This figure shows the intersection of moderators and fidelity in the path from intervention to outcomes. Fidelity refers to the variables assessing the degree to which the intervention was implemented as intended. Moderators are variables that have potential to affect the manner in which the intervention is delivered, i.e., the degree of fidelity (Hasson, 2010; Carroll et al, 2007). By evaluating fidelity with consideration for potential moderators, the defining relationship between outcomes and the intervention is more definitive. Additionally, the most critical components of the intervention necessary for intended effects may be identified through this analysis, which in turn ideally inform the content and delivery of the intervention (Carroll et al., 2007).

Within the initial six months of the project, the TIES evaluation team will work with the TIES program staff to compile and document all aspects of the intervention. This includes the specific attributes of the intervention describing what the service recipients receive, as well as the specific supports that facilitate and organize the process of providing the intervention (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The resulting package will include all instructions, protocols, materials, and measures necessary for implementing the intervention with high fidelity. Also during this time, the additional measures necessary for this comprehensive evaluation of the moderators and fidelity variables will be developed. Table 2 lists the variables, evaluation questions, and the method of measurement.

Table 2. Implementation Variables, Evaluation Questions, and Method

Variables	Questions	Method
Fidelity to the TIES Model		
Content	To what extent was each component of the TIES intervention model implemented as planned?	Observation of home visits Intervention logs Interviews with staff Fidelity measure
Frequency/Duration (Dosage, Dose delivery)	To what extent was the TIES intervention provided as often and as long as planned?	
Coverage (Reach)	What were the characteristics of the clients served and of the potential clients who did not want to participate? What proportion of the participants received the full intervention?	
Moderators		
Participant responsiveness	To what extent did participants engage in services? To what extent did participants use materials or recommendations from the intervention? How satisfied were the participants with the intervention services?	Intervention logs Interviews with staff Participant questionnaire
Comprehensiveness of intervention description	To what extent are the components and processes of the intervention clear and succinct?	External reviewers rubric
Strategies to facilitate implementation	How is implementation of the intervention supported? How are these supportive strategies perceived by the staff involved in providing the intervention?	Interview with staff
Quality of delivery	To what extent is the quality of the delivery of the intervention high and consistent?	Observation of home visits Interview with staff
Recruitment	Who recruited the participants and how? What information was given at recruitment? What characterizes persons who did not want to participate? Were there barriers regarding maintaining	Recruitment records Intervention logs

Variables	Questions	Method
	continued involvement?	
Context	How do social supports outside the provision of the intervention affect implementation? How do community and administrative systems affect implementation?	Intervention logs Social support measures TIES Coalition minutes Interviews with staff

(Adapted from Hasson, 2010)

Fidelity will be established through documentation of the consistency of the implementation of the TIES Program across multiple employees. If different employees follow different processes, then there is no fidelity to a single plan. Fidelity also requires completeness of documentation and consistency between what is documented and what is actually done.

The longitudinal measurements of outcome will establish fidelity. If there is not a measurable impact on individual trends in the outcome measures, then the TIES Program model cannot hope to demonstrate effectiveness. An improved trend over time is not definitive proof of effectiveness, but rather an attempt to establish that this program has the potential to change meaningful measures of family function.

Measuring Success of the Fidelity Assessment

The instruments used to assess maternal and child outcomes of the TIES intervention are described in Figure 2. The implementation and effectiveness study will also be informed by longitudinal data collection with these instruments for approximately 40 Missouri participants over the course of 2 years from October 2009 to September 2011. These data will assist in determining benchmarks, identifying gaps and inconsistencies in implementation, and determining anticipated trends. The longitudinal data will require the use of linear and nonlinear mixed models. All analyses will be conducted using R software and the nlme library (Pinheiro and Bates, 2009).

Figure 2. TIES Outcome Evaluation Instrumentation

- **Adult-Adolescent Parenting Inventory-2 (AAPI-2)** (Bavolek & Keene, 2001): This inventory consists of 40 Likert scale items that assesses 5 parenting constructs: inappropriate expectations of children, empathy towards children, corporal punishment, parent-child role reversal, and oppression of children's power and independence. Cronbach's alpha reliabilities of the constructs for Forms A and B range from .82 to .92. Analysis of variance tests confirm the instrument's criterion related validity to distinguish between abusive/neglecting populations and those that are not ($p < .001$ for each construct). The AAPI-2 was added to assess more fully the parenting constructs due to the addition of new parenting interventions.
- **Bayley Infant Neurodevelopmental Screener (BINS)** (Aylward, 1995): This instrument, comprised of a subset of items from the Bayley Scales of Infant Development (2nd Ed.) (BSID-II) and additional items assessing muscle tone and movement quality, was selected for its capacity to screen children for the need for additional diagnostic testing for developmental delay or neurological impairments. Since the interventions of the TIES Program do not directly focus on early intervention for infants, but rather, on the supports needed for the family, it was determined that the screening instrument was more appropriate than the full diagnostic assessment. Internal consistency reliability is documented with Cronbach's alpha coefficients that range from .73 to .85. Group classification consistency ranged from 68% to 78% for 3-, 9-, and 18-month old infants. Inter-rater reliabilities were .79, .91, and .96 for infants aged 6, 12, and 24 months, respectively. In a sample of 3-, 6-, 18-, and 24-month-old infants, Pearson correlation coefficients of the BINS with the BSID-II Mental Developmental Index ranged from .43 to .82; they ranged from .39 to .58 with the BSID-II Psychomotor Developmental Index.

- **Brief Symptom Inventory (BSI) 4th Ed.** (Derogatis, 1993): In this scale respondents indicate the degree to which they experience 53 symptoms. Symptoms are coded according to these dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Cronbach's alpha coefficients for the 9 dimensions ranged from .71 to .85 for 719 psychiatric patients, demonstrating very good internal consistency. Comparison of the BSI dimensions with the MMPI scales for symptomatic volunteers revealed coefficients at or above .30. Correlations above .90 document the equivalence of the SCL-90-R with the BSI. The instrument has been used in HIV research and in clinical studies with drug-abusing populations.
- **Consumer Satisfaction Survey** (UMKC Institute for Human Development, 1991): A survey was developed for the TIES Program to determine the women's perception of various features of the program. In this instrument, participants rate how fair, caring, capable, knowledgeable, helpful, and easy to reach the Family Support Specialists are. They also give an overall rating of satisfaction with the TIES Program. At 18 months, additional items explore the degree to which services have successfully addressed their needs and the degree to which families continue to have unmet needs.
- **Family Support Specialist Survey** (Fuger, McMann, 1997): A survey was designed to gather the perspectives of the TIES Support Specialists concerning activities within their job descriptions, characteristics of the program, the effectiveness of their strategies with families, their training needs, and their linkage with the community. This instrument provides helpful information from the persons closest to the families served.
- **Individualized Family Service Plan (IFSP) Goal Attainment Scale** (McMann, 1992): A goal attainment scale was developed for the five goals most universally present in the participants of the TIES Program: (1) becoming drug-free; (2) improving parenting skills and practices; (3) securing adequate housing; (4) achieving economic stability; and (5) maintaining adequate health care. This instrument operationalizes the goal achievement in each area, providing an objective supplement to the Individualized Family Service Planning process.
- **Keys to Interactive Parenting Scale (KIPS)** (Comfort & Gordon, 2006): This video assessment is a structured observation tool administered during free play of a parent with a child at age 2-71 months. These 12 items are rated on a 5-point scale to describe the quality of parenting behaviors: sensitivity of responses, response to emotions, encouragement, promotion of exploration and curiosity, involvement in child activities, language experiences, touch and physical interaction, limits and consequences, openness to the child's agenda, reasonable expectations, adaptation of strategies to the child, and supportive directions. Factor analysis was used to derive the research scale, and field testing resulted in confirmation of validity, inter-rater agreement of 92.4-96.9%, and internal consistency of alpha at .96. Previously the *Child-Parent Interaction Rating Scales* was administered and rated by the evaluators; it is now replaced by this tool which is considered better suited for TIES personnel to administer in conjunction with their parenting interventions.
- **North Carolina Family Assessment Scale (NCFAS)** (Kirk & Ashcraft, 1998): To meet needs of both practitioners and researchers, the NCFAS is designed to describe the ecological structure of family functioning, address safety concerns, assess both strengths and deficits, and detect small changes in family functioning while being administered in a limited time with personnel requiring minimal training. Preliminary field-testing with 126 families resulted in the inclusion of these 5 domains: environment, family interactions, family safety, and child well-being, with coefficient alpha scores ranging from .71 to .93. An additional domain of parental capabilities has not yet been empirically tested. Construct validity with two other family assessment tools was found for all 5 domains, with Pearson's R correlations of .26 to .71. This instrument replaces the previously used *Family Risk Scales*, due to its breadth and strengths-based focus.
- **Supplement to the HOME for Impoverished Infants (SHIF)** (Ertem, Avni-Singer, & Forsyth, 1996): This is a 20-item scale developed at the Yale Child Study Center to complement the Home Observation for Measurement of the Environment (HOME) developed by Bettye Caldwell. The SHIF is designed for use with low-income families, since the HOME has been found to be more appropriate for middle-class families; the SHIF is recommended for children aged 0-3 years. Items are rated as yes or no (present or absent) by trained observers in the child's home environment.

The outcomes measures are administered at critical junctures in the intervention thus giving indication of gradual changes. The measures of implementation will occur over the course of participation (through infant age of 24 months); however, particular attention will be paid to the critical junctures in order to align the implementation data with the outcome data.

At the mid-point of Year 1, the implementation evaluation will begin and proceed for 24 months. Because TIES continuously enrolls women for the program, the number of participants will vary over the 24-month time period of the implementation evaluation. It is estimated that 18 families will be served during this time period and 12 will complete the full program during this time period. The TIES evaluation team will work with the TIES program staff to implement the evaluation with fidelity. Table 3 specifies the data collection schedule for the outcome evaluation. This schedule will occur concurrently for the TIES enrollees during the implementation evaluation study.

Table 3. TIES Assessment Schedule

Assessment Instruments	Completed By	Assessment Times					
		Intake	Child's Age				
			Birth	3-7 Mo	9-13 Mo	18 Mo	24 Mo
TIES Intake	TIES Family Support Specialist	X					
Infant Birth Information	TIES Family Support Specialist		X				
North Carolina Family Assessment Scale (NCFAS)	TIES Family Support Specialist	X					X
Supplement to the HOME Assessment for Impoverished Families (SHIF)	TIES Family Support Specialist	X		X	X	X	X
Keys to Interactive Parenting Scale (KIPS)	TIES Family Support & Parenting Resource Specialists			X	X	X	
Bayley Infant Neurodevelopmental Screener (BINS)	Evaluation Team			X	X	X	
Adult/Adolescent Parenting Inventory (AAPI)	Evaluation Team			X	X	X	
Brief Symptom Inventory	Evaluation Team			X	X	X	
Consumer Satisfaction Survey	Evaluation Team			X	X	X	X
IFSP Goal Attainment Scale	TIES Participant & Family Support Specialist	X		X	X	X	X

Moderator, fidelity, and outcome data will be analyzed and the essential features of the program will be identified during Year 3 of the Kansas Home Visiting Program. Using a method of collective inquiry, the TIES evaluation team and the TIES program staff will discuss results and modify the attributes and drivers of the TIES intervention accordingly, with a goal of improving the effectiveness of the intervention. This modified version of the intervention will be tested during Years 4 and 5 using a rigorous experimental design, as described in the next section of this proposal.

Proposed Effectiveness Study of the TIES Program Model as a Promising Approach

If the implementation study reveals problems requiring a second iteration, then years 4 and 5 of the grant will be spent on additional review of the attributes, drivers, and moderators of the TIES Program. A successful result in the first three years, however, will provide the bonus of assessing the effectiveness of the the TIES Program in a rigorous and evidence based fashion. The detailed

structure of this effectiveness review will depend largely on the findings of the implementation study, but here are some broad details.

The one absolute pre-requisite for an evidence-based evaluation is the use of a concurrent control group. Historical controls have far too many limitations and cannot provide definitive evidence of effectiveness. The control group intervention would be the current standard of care. By necessity, the current standard of care would be beyond the control of the researchers, and would produce a wide degree of heterogeneity in the control group. This is actually an advantage in one way: comparison to a broad range of heterogeneous interventions rather than a single narrowly defined intervention provides a more realistic assessment of the overall added value of the TIES Program. The intervention of the TIES Program is significantly different than the standard of care provided by any of the potential interventions in its individualized, comprehensive, long-term, and home based relationship model.

A second pre-requisite for an evidence-based evaluation is the careful matching of subjects in the treatment and control groups. The subjects being studied are widely diverse across multiple dimensions. Matching is the simplest way to insure that there is an equal mix of subjects in the treatment and control groups. It is difficult to provide all the details of matching, as it depends largely on what information is available at the time of recruitment. There are several critical matching variables that will certainly be available: race/ethnicity of the mother, maternal age, source of referral (health care providers, emergency and women's shelters, hospital, drug treatment source, child protective services, family drug court), reason for referral (alcohol abuse, marijuana use, cocaine use, use/abuse of multiple drugs, and HIV positive status), and time of referral (prenatal, less than 15 days post partum, 15 days to 6 months post partum). We will also consider matching by zip code, or at minimum matching by residence in the catchment area, as there are only eight zip codes in the catchment area.

An evidence based evaluation of effectiveness would ideally use randomization and we will carefully evaluate this option. Randomization, however, is problematic in this area for several reasons. First, randomization presents difficult logistical issues. Randomization would have to be performed by an independent and disinterested party, because there might be a tendency to recruit families with the greatest needs into the more resource intensive TIES Program. This would create a biased sample, with the TIES Program skewed towards the higher risk families compared to the control group. Second, ethical review of a randomized study would require a careful examination of the standard of care received in the control group. Given the difficulty in standardizing the care in the control group, this may lead to the rejection of the entire project. Third, randomization may decrease the number of subjects agreeing to participate in the study. Even if there is equipoise between the treatment and control arms, research subjects may dislike the prospect of having a random number select the type of care and support that they will be getting. Informed consent would still be needed in a non-randomized experiment, of course, but an accurate description of the non-randomized experiment would be less likely to raise objections from the research subjects.

A tightly matched cohort of control patients is a viable alternative to randomization. Key variables needed for matching are readily identifiable at baseline and matching will produce a fair and even mix of families in the two groups. Even if we are able to adopt randomization,

matching pairs of subjects and randomizing within that pair will be a necessary tool to assure a balanced and comparable control group, given the wide range of heterogeneity among families.

The choice of outcome measures will depend, in part with lessons learned during the implementation phase of the research. There are several outcome measures that will be evaluated for possible inclusion in the effectiveness phase of the research: referral to child protective services, child placement, parental drug use, and housing. For prenatal enrollees, outcomes measures will include infant gestational age and birth weight as well. If practical, household income and parenting skills, as measured by the AAPI, will be evaluated.

A limitation of this study, with or without randomization, is the inability to use blinding. This is typical for studies of this type of intervention. Partial blinding, by keeping the evaluators blinded as to treatment status while they are interviewing the families, is an option that can prevent some of the biases associated with unblinded studies.

Dropouts are a serious concern in any study of effectiveness, but especially here because families who drop out do so for a variety of reasons. Some families are doing poorly (i.e. lose custody of their children) and contact is lost: some are doing well (i.e. child protective service case is closed) and chose to withdraw; and some dislike the perceived intrusiveness and withdraw or move out of the area whether doing well or poorly. While some of these reasons will lead to biases in opposite directions, it is highly unlikely that the biases produced will cancel out overall. All efforts will be made to stay in contact with families in the control and treatment groups, and even if families refuse to cooperate with the research team, some outcomes can still be obtained from public records. Multiple imputation will be used to estimate missing outcome measures (McKnight et al., 2007).

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Anticipated Challenges and Technical Assistance Needs for the Promising Approach

Challenges to implementation will involve identifying and engaging community partners across the human service continuum in Wyandotte County. TIES Program staff will need to become familiar with all treatment and other resources in order to build the effective consortium that is necessary for program consultation and service provision and coordination. They must become intimately familiar with alcohol and other drug treatment and health care provider systems, scope of services, service delivery and other aspects in order to provide accurate, timely information to

families to encourage participation in services. They will also need to learn about the informal networks in the community from participants and others. Effective linkages will need to be built at service and administrative levels with agencies not entirely familiar with the model or the program. Education, open communication, flexibility, role clarification and other issues will be undertaken.

The TIES Program model is intensive and will be able to serve a limited number of families. The frustration that may result from small capacity will have to be addressed. The TIES model will have to, jointly with community stakeholders, define its place on the continuum of home based services for high risk families particularly the three selected evidence-based models (EHS, HFA, and PAT). Technical assistance is requested on how to clearly articulate criteria and referral procedures among the three evidence-based programs and the TIES Program, as well as with the Connections Centralized Screening and Referral System.

Section 4: Implementation Plan for Proposed State Home Visiting Program

Engaging the at-risk communities around the proposed State Home Visiting Plan

The targeted at-risk communities were engaged in the development of this state plan. In recent months (March-May 2011), the Kansas Home Visiting Program Manager conducted a series of individual meetings with home visiting and related early childhood system service providers and coalition leaders who cover the targeted communities. Subsequently, it was determined that the Montgomery County Early Childhood Coalition and the Wyandotte County Early Learning Collaborative would serve as the lead groups in their respective communities for further planning and implementation steps. In-depth planning sessions were facilitated by the Kansas Home Visiting Program Manager with each group. A summary of common themes from the 2010 needs assessment and the individual meetings was utilized as a springboard to eventually identify the top priorities for action.

Local representatives from the following organizations participated in the individual and/or group meetings:

Montgomery County

Coffeyville USD 445 – School Superintendent and Parents as Teachers program

Coffeyville Early Childhood Coalition

Community Access Center, Independence

Crawford County Health Dept. – Family Connections

Family Resource Center, Pittsburg

Four County Mental Health – Children and Family Services/Early Childhood Mental Health

Kansas Children's Service League - Healthy Families program (Crawford County)

Montgomery County Health Dept. – Administrator and Healthy Start Home Visitor program

Southeast Kansas Community Action Program - Early Head Start/Early Childhood program

Southeast Kansas Education Service Center, Greenbush – Parents as Teachers program and Birth to 3 (Part C Early Intervention)

Wyandotte County

Family Conservancy

Infant Toddler Services (Part C Early Intervention)

Kansas Children's Service League – Healthy Families

Kansas City, KS USD 445 – Parents as Teachers

Kansas Association of Infant Mental Health

KU Juniper Gardens Children's Project

KU Medical Center – Labor, Delivery, NICU services social worker

Mother and Child Coalition of Greater Kansas City – Healthy Start

Project EAGLE - Early Head Start, Connections Centralized Screening & Referral System

Turner USD 202 – Parents as Teachers

Unified Government of Wyandotte Co. & Kansas City, KS Public Health Department – Healthy Families

United Way – Smart Start

Wyandotte County Social and Rehabilitation Services – Children's Services social worker

State's approach to development of policy and to setting standards for the State Home Visiting Program

A State Home Visiting Work Group was convened and has met regularly since the announcement of the federal MIECHV Program. The work group members (listed in Section 6) have been instrumental in providing input and guidance to the needs assessment process as well as all aspects of the Kansas State Plan. Furthermore, these representatives have been able to integrate the MIECHV Program development and objectives within the context of current and evolving policy and standards for various agencies, initiatives and programs. This work group will continue to meet throughout the implementation stages as an advisory body.

As the lead agency, the Kansas Department of Health and Environment (KDHE), Bureau of Family Health will develop specific policies and standards for the Kansas Home Visiting Program (KHVP) implementation. The Home Visiting Program Manager will be responsible for constructing the policies and standards. This will be done in coordination with state program leaders for the selected home visiting models – EHS, HFA, and PAT – as well as the TIES program in order to develop policy and standards that will be appropriate across programs. Policies and standards will be communicated to all involved state and local agencies/programs as well as other stakeholders and administrators.

Working with national model developers and technical assistance and support to be provided

The Home Visiting Program Manager will facilitate communication with the EHS, HFA, and PAT national offices to ensure fidelity to the models during implementation and to obtain any necessary technical assistance and support. Given the strong infrastructures and liaisons in Kansas for each of these models, this communication and consultation will be coordinated with the related state program leader.

The Kansas EHS programs (under SRS) are monitored through the ACF Office of Head Start to assure compliance with Federal EHS Performance Standards. EHS receives ongoing support through a regional contract with Caliber and ICF International for training and technical assistance.

KCSL has had 14 years experience working with the HFA and utilizing available technical assistance and support and has existing relationships with national HFA program staff. KCSL HFA employs four staff credentialed by the national model developer to provide local technical assistance and support to ensure programs meet all national program model standards and expectations. As an HFA accredited program, KCSL HFA receives the following technical assistance from Healthy Families America:

- Provide a complete overview of the process from preparation of the Self-Assessment through the accreditation decision;
- Answer any questions about the completion of the self-study, standards interpretation, and/or the process;
- Assist with program implementation and/or policies and procedures development;
- Provide guidance with site visit preparation;
- Connect programs with local experts; and
- Handle the logistics of the site visit for reaccreditation.

Kansas PAT has worked closely with the PAT National Center. The KSDE is the recognized State Office for Parents as Teachers via Covenantal Agreement with the Parents as Teachers National Office. Technical assistance to programs is coordinated between state and national office.

Since all of the selected programs are established in Kansas and the targeted community areas, technical assistance and support will not be needed for start-up or basic implementation issues. It is likely that any needed technical assistance may revolve around the specific issues we are planning to address as outlined in this plan. At this time, no specific or additional technical assistance requests have been made to any of the national model offices. The Home Visiting Program Manager will provide information regarding the KHVP that the national program offices may request or need.

A timeline for obtaining the curriculum or other materials needed;

As all of the involved programs are currently established in the state and targeted areas, primary curricula and resource materials are already available. However, newly hired staff must complete required core and curricula training which will be completed within 3 months from their start date. As needed, new or additional sets of curriculum and resource materials will be obtained for them within this timeframe.

Initial and ongoing training and professional development activities

Local programs/agencies will be responsible for ensuring program staff receive necessary training and professional development in accordance with their program model and agency requirements.

EHS staff members are trained in accordance with Head Start Program Performance Standards. Kansas programs receive support from the Office of Head Start for their professional development activities. Each staff member has an individual professional development plan and local EHS agencies assess and monitor individual staff needs.

The training for HFA staff follows HFA standards. It is an ongoing process and based on three levels:

- Orientation – Training required before beginning work with families which includes 30 hours of instructional training with the program supervisor and an additional 15 to 30 hours shadowing experienced KCSL HF staff.
- Required Training – A minimum of 40 hours of training acquired in the first 6 months and first 12 months of employment.
- On-going Training – Training acquired each year after the first year of employment. Each employee should receive 20 hours of training each year which usually comes from formal training, conferences, and in-service training.

All PAT staff will follow the 2011 Essential Requirements for Affiliates. Affiliated programs must complete the PAT Foundational Training and Model Implementation Training. Regular 5 day training is available on-going through the PAT National Office with state training available 2 to 3 times per year through the recognized Kansas State Training Team consisting of nationally approved trainers. This training also has a follow up day, 20 hours of professional development the first year, 15 hours the 2nd year, and 10 hours every year after. Supervisors are also required to attend 2 day training, encouraged to attend advanced supervisors training, and 10 hours of professional development annually. Program staff must be successfully certified as a PAT Parent Educator.

The initial training for new TIES program staff will include modules on: women and substance abuse; safety in home visitation; prenatal drug use effects on pregnancy and infant development; rapport building and engagement strategies; building cultural competence; and intervention planning. This training is created with use of the expertise of community partners, program and hospital resources, and online resources. Training will be provided by Program Manager on program policies and procedures as well as all documentation instruments and tools.

Additionally, each new staff member will shadow peers in the Missouri program to observe staff interaction with current families. Ongoing staff development will be coordinated with each staff member in development of a skill building plan that takes into account previous professional training and experience, challenges being encountered in the field, areas of interest, and emerging trends. These plans will be reviewed annually.

In addition to the above, as part of the KHVP plan specific training will be provided to all participating programs on the following topics. Some of these trainings may be provided through local sources and some may be provided from the state level:

- Reflective practice and supervision
- Mental health – may include infant mental health, communication with families/parents with mental health issues, supporting families/individuals who choose not to access formal mental health care, screening tools, making appropriate referrals, trauma
- Client retention/engagement – such as high-risk parents, diverse cultures, fathers
- Substance use – may include substance use disorders (gender specific and home visiting), screening and identification, referral coordination, assessment and treatment resources
- Domestic violence – may include screening tools, safety plans, referral resources and coordination

- Child injury prevention
- Parent health literacy – may include training parents on what to do when their child is sick or injured and accessing health care
- Home visitor safety
- Evaluation/data collection procedures

Recruiting, hiring, and retaining appropriate staff

In year one, programs in the targeted communities will hire new home visitors. Local program agencies will be responsible for recruiting and hiring staff in accordance with their established program model and agency procedures (available upon request).

EHS follows Head Start Program Performance Standards for hiring staff. Prefer AA/BA/BS in early childhood education or related field.

KCSL HFA programs follow the guidelines for staff/volunteer recruitment outlined in the *Healthy Families America Program Development Guide*. In addition to educational background, KCSL HFA direct service staff candidates are selected:

- based upon personal characteristics--non-judgmental, compassionate, ability to establish a trusting relationship, etc.;
- willingness to work with a culturally diverse population;
- skills to do job;
- understand the community in which they will work;
- willingness to work with all family members, not just the mother and her baby; and
- have the ability to advocate for positive, nurturing, nonviolent discipline of children

Selection of program supervisors includes additional requirements:

- Masters degree in social services, family studies or family therapy, counseling, psychology, or a related degree; and
- A minimum of 2 years experience working with families and children from a prevention framework and/or with populations with special needs.

Existing PAT programs will hire staff via their local policies and practices. PAT programs follow Best Practice with National Quality Standards and require parent educators to hold a bachelor's degree or beyond in early childhood education or a related field and have supervised experience working in the early childhood field. Parent educators must have effective interpersonal skills and possess the knowledge, skills, and sensitivity to respond effectively to families' community, cultural, and language backgrounds. Parent educators receive annual written reviews of their performance and progress toward their professional goals. Quarterly reviews of each parent educators' files are completed by the program coordinator for accuracy, completeness, and overall quality.

The TIES Program will recruit, hire, orient, and train three new staff positions: 2 Family Support Specialists (1.6 FTE) and 1 Parent Resource Specialist (.6 FTE). Candidates will be sought who have MSWs with home-based experience and background in either child welfare or substance abuse for the Family Support Specialist position and a qualified early childhood educator with home-based experience for the Parent Resource Specialist position. Candidates

with work experience in Wyandotte County will be sought. The plan for recruitment will be to publicize positions and qualifications in the substantial TIES Program network including the current TIES Consortium and Advisory Council and the Metropolitan Task Force on Families Affected by Substance Abuse; local online social services websites, and local media outlets, including Spanish language. The positions will also be posted with Wyandotte County home visiting partners and referral sources. Staff will be employees of Children's Mercy Hospital and retention strategies include competitive salary and benefit package, comprehensive wellness program onsite, training, orientation, and appropriate supervision/consultation, and a collegial, supportive peer environment.

Subcontractor organizations

To implement the KHVP plan in year one, KDHE will establish specific contractual agreements with each of the following once approval of the state plan and confirmation of federal funding is received. These organizations were identified in the targeted at-risk communities through the planning process previously described. In year one, each of the EHS, HFA, and PAT programs listed below will hire a 1.0 FTE home visitor.

Montgomery County

Coffeyville USD 445 – PAT

Kansas Children's Service League (KCSL) – HFA

Southeast Kansas Community Action Program (SEK-CAP) - EHS

Southeast Kansas Education Service Center (SKESC), Greenbush (USDs 436, 446, 447) – PAT

Four County Mental Health – 1.0 FTE Central Outreach/Referral Coordinator

Wyandotte County

KCSL – HFA

Project EAGLE – EHS; also support for Connections Centralized Screening & Referral System Public Health Dept., Unified Government of Wyandotte Co. & Kansas City, KS – HFA

Kansas City, KS USD 445 – PAT

Turner USD 202 – PAT

Family Conservancy – Training/professional development and consultation on mental health

And the Promising Approach:

Children's Mercy Hospital – TIES Program; includes 2 Family Support Specialists (1.6 FTE), 1 Parent Resource Specialist (.6 FTE), evaluation subcontract with University of Missouri–Kansas City

High quality clinical supervision and reflective practice for all home visitors and supervisors
This will be addressed and ensured across all programs.

With EHS, supervision is provided by the Early Childhood Manager or Assistant Manager of each EHS Program. Reflective supervision occurs on a monthly basis with each Family Educator. Individual professional development plans also address supervision, training, and other support needed by staff members.

All KCSL HFA home visiting staff members receive weekly supervision with a Master's level supervisor who has a degree in social work or a related discipline and at least two years experience working with the service population. Family support workers/specialists will receive a minimum of 1½-2 hours of scheduled individual supervision per week depending upon the worker's experience level. All family support workers should have access to the program supervisor throughout the week for emergencies that may arise while working with families in their homes. In addition, all KCSL HFA staff participate in group supervision for an average of 2 hours twice per month. The supervision ratio of staff to program supervisor is 6 family support workers or assessment workers per one program supervisor.

Supervision for all family support worker staff will include:

- A review of the progress of families they are serving;
- Review of new or updated IFSP;
- Problem-solving in difficult cases;
- Support, if needed in completion of reporting requirements;
- Individualized staff development as appropriate;
- Assistance in coordination of services and determining appropriate roles when more than one agency is involved;
- Reflective supervision; and
- Monitoring of services provided: confirmation that services have been initiated as scheduled; verification that services are appropriate and satisfactory and follow up to any complaint or problems which develop in the delivery of service or with the person receiving services.

HFA supervision also includes case management for all the clients served by these persons, with specific tasks for service coordination assigned by the supervisor. In addition to regularly scheduled supervision, family support workers have access to a program supervisor or KCSL management staff during all hours for case consultation as needed.

Existing local PAT programs will provide 2 hours monthly reflective supervision to staff and 2 hours of monthly staff meetings with staff, the minimum required for affiliated PAT programs. Parent educators participate in relationship-based supervision (RS) monthly with the PAT program coordinator. RS focuses on the parent educators' reflections on their work and relationship building efforts with families, through home visits, group meetings, and playgroups.

For TIES, all staff will be supervised by the TIES Program Manager. One-to-one supervision will be available weekly to each staff member involving reflection on practice, identification of personal challenges and resources, remediation of experiences of secondary trauma, and other skill building activities. Additionally, staff will meet monthly with all other home-based staff in a group setting and with the current TIES staff an additional time monthly.

Estimated number of families served

For year one of this state plan, funding per the potential contracts listed above will allow serving the approximately 209 families as follows. These are numbers for full caseloads per 1.0 FTE home visitor and actual numbers may vary based on hiring and training of new staff, individual family needs, and attrition of enrolled families.

<u>Montgomery County</u>	<u># families per caseload</u>
Coffeyville USD 445 PAT	30
KCSL HFA	15
SEK-CAP EHS	12
SKESC - USDs 436, 446, 447 PAT	30
<u>Wyandotte County</u>	
KCSL – HFA	15
Project EAGLE EHS	12
Public Health Dept. HFA	15
Kansas City, KS USD 445 – PAT	30
Turner USD 202 – PAT	30
TIES	20

Identifying and recruiting participants

Families will be recruited from a number of sources. All programs conduct intensive outreach in their respective communities. Referral sources include various social service agencies, hospitals, health clinics, health care providers, shelter providers, emergency assistance agencies, schools, and other community organizations. Many other forms of outreach are used to personally reach the target populations.

In Wyandotte County the Connections Centralized Screening & Referral System, as previously described, will be utilized to recruit, identify and refer families. The focus of recruitment in Wyandotte County will be pregnant women and families with infants and young children that are impacted by substance use and/or mental health concerns. Outreach efforts will also be concentrated with the local alcohol and drug treatment providers, KU Medical Center, the public hospital in Kansas City, KS, and the Wyandotte County SRS child protection agency. In addition to the existing outreach efforts and referral sources in Montgomery County, a new centralized screening and referral system will be developed to enhance the coordinated identification and recruitment of participants.

A plan for minimizing the attrition rates for participants enrolled in the program

The retention rate is the number of families that remain active in the KCSL HFA program after having completed the initial home visit. Each year it is calculated to determine how many families have been enrolled 5 years or more, 4 years or more, 3 years or more, 2 years or more, 1 year or more, and 6 months or more. This information is reported in each programs annual report. KCSL HFA will utilize the program database reporting (“Closed Cases” and “Open Cases” Report) to calculate retention rates based upon the HFA method.

Responding to the decision on the part of a parent to discontinue KCSL HFA services requires an individual response to address the presenting issue. KCSL HFA services are voluntary and decisions of each parents are respected and honored. Gentle probing, offering of additional services or referrals support, willingness to meet with extended family members, addressing the individual’s safety needs or formulating general service plan goals are some appropriate responses to such issues. Attempts are made to allow families to determine the frequency and

intensity of KCSL HFA services as long as there is some degree of consistency and regularity of contact, so that program liability issues are addressed.

The KCSL HFA program defines, measures, analyzes and addresses how it might increase the retention rate and decrease the attrition rate of families in the program in a consistent manner and on a regular basis. KCSL HFA programs analyze at least once every two years (e.g., both formally through data collection and informally, through discussions with staff and others involved in program services) which individuals dropped out of the program, at what point in services, and reasons why. A plan is developed and implemented based upon this information to increase retention rates and this plan addresses programmatic, demographic, social and other factors.

Existing local PAT programs track attrition for all families enrolled in the program. Relationship building is key to family retention and reflective supervision and training for new staff provide supports for parent educator skill and knowledge development.

For the TIES Program, attrition will be minimized by the program model and the expertise of staff and manager. At screening, families will understand clearly that the decision to participate is theirs alone. The TIES model stresses rapport building and early engagement. Its strengths-based assessment and family-centered goal setting encourage participation. The limited caseload allows responsive, frequent contact with a single staff person who is able to communicate positive personal regard for the family. Over time, a trusting relationship is built that involves family and worker initiated contact. When families miss appointments or fail to respond to the worker, various avenues will be pursued to reach the family including contact with family members and other providers for whom a release will have been secured early on. Families with whom contact cannot be established for three months will be discharged, but only after multiple attempts with various methods have been employed. Even after discharge, families who contact the program will be re-admitted if caseload allows. In its most recent four year period, the TIES Program had 65% of enrolled families complete the program even with this very high risk population.

An estimated timeline to reach maximum caseload in each location;

For all of the EHS, HFA, PAT, TIES programs, it is estimated that a minimum of 6 months and a maximum of 12 months from this project's start date is needed to reach maximum caseload in each location. This takes into account time to formalize contracts, for local programs to recruit, hire, train and prepare all new staff, and recruit and enroll new families. Given TIES addition to the Wyandotte County area, implementation preparation will be undertaken for about 6 months of Year 1, so enrollment of the first cohort of families should be complete by the middle of year 2. Enrollment will be slower at first as referring agencies gain experience with the process. Referrals will likely be more frequent as the program progresses but the time-intensive intervention, especially in the first few weeks of involvement, will still necessitate enrollment of 1-2 families per week as a maximum.

An operational plan for the coordination between the proposed home visiting program(s) and other existing programs and resources in those communities, especially regarding health,

mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services; Given the involved home visiting programs, some coordination between many of the local programs and other community resources already exists. In Wyandotte County, further work will particularly focus on integrating TIES into the network of services in the county and Kansas City, KS, area, clarifying and enhancing referral criteria and procedures between the home visiting programs (including the Connections system), and increasing linkages with substance use and mental health treatment providers. In Montgomery County, there will be intensive efforts to create processes and procedures for a centralized outreach, intake and referral system.

Obtaining or modifying data systems for ongoing continuous quality improvement (CQI); All of the involved programs collectively support the philosophy of CQI for program processes and services. CQI has two components: monitoring quality and quality enhancement. Both components work best when they are used systematically and routinely. CQI will be incorporated throughout the benchmark/construct data measurement as well as fidelity, quality, and other implementation components. The Home Visiting Program Manager will work collectively with the program leaders of the involved programs and evaluators to build formalize common, specific areas of interest and improvement, tracking, monitoring, and communication loops for all levels of program implementation. Following are examples of existing CQI efforts on which the broader CQI plans will build.

KCSL HFA has a well-established, web-based management information system (database) developed and customized over the past 10 years and in coordination with HFA. This management information system is available to all KCSL HFA staff with quality controls in place to ensure data integrity and technical assistance. For monitoring quality, programs follow a system of procedures designed to monitor the outcomes of program activities and to elicit client feedback on program services. The methods used to monitor quality include:

Peer Audit File Reviews	Quarterly
Supervisory File Reviews	Weekly during supervision
Home Visit Observations	1 spontaneous HVO/6 mo/worker
Observations of Assessment Visits	1 spontaneous AVO/6 mo/worker
Tracking Intensity of Services	Monthly/Annually
Participant's Satisfaction Surveys	Annually
Program Reports	Monthly
Outcome Reports by program	Quarterly
Outcome Reports by worker	Annually

Quality enhancement, the phase of CQI where staff members give and receive feedback, set annual performance goals, and engage in activities to improve and maintain skill levels. Issues requiring corrective action are addressed immediately. The quality enhancement methods used by KCSL HFA programs include:

Positive Reinforcement & Recognition	Weekly/Annually
Skill Enhancement/Training	Monthly
Performance Goals/Employee Evaluations	Annually

The HFA Program Supervisor, Quality Assurance Manager and Policy Director monitor and evaluate the progress toward program goals by addressing the results of chart reviews, outcomes reports, client suggestions and satisfaction survey at least annually. The Program Supervisor and staff plan programmatic changes and /or development based upon this evaluation.

Existing local PAT programs primarily use the Visit Tracker data system endorsed by the PAT National Office or have developed similar data tracking. Data is collected and analyzed annually for the State Parents as Teachers Continuation Grant process including goal setting and reporting via Continuous Quality Improvement plans developed using the PAT National Self-Assessment process.

Kansas EHS programs also collect and report similar information.

State's approach to monitoring, assessing, and supporting implementation with fidelity to the chosen models and maintaining quality assurance

The KHVP will incorporate the quality assurance procedures and support of model fidelity from the selected home visiting program models. The Home Visiting Program Manager will closely collaborate with the three state program leaders to ensure all program sites implement the models with fidelity and comply with quality assurance procedures. Memorandums of Understanding and contracts will be developed to ensure all state and local partners understand the expectations and procedures. Joint procedures for coordinated training, technical support, and a system of monitoring will be developed. A schedule of in-person and phone meetings will be planned to consistently address quality and fidelity assurance steps. Data will be collected from all program sites regarding such factors as staff qualifications, supervision, provision of program components and services, participant engagement, retention, and attrition, and program adaptations. This data will also be incorporated into the CQI plans.

Currently, EHS staff are monitored by Risk Management Specialists to determine if files and records are complete and up-to-date, referrals are current, children have an individualized learning plan, and parents are working towards self sufficiency goals. Monitoring is completed monthly and assists the supervisor is addressing concerns. Supervisors assist home visitors to complete corrective action plans when needed. Family educators receive an annual evaluation on their job performance, their professional goals and their strengths and areas for improvement and development. In addition, the program does an annual self assessment that includes family and community.

Once every four years, HFA sends a team of at least two external, trained peer reviewers to conduct a site visit. The purpose of this visit is to provide a comprehensive and objective review and validate a program's self-assessment and adherence to the HFA critical elements. Based on their findings, the peer review team prepares a Site Visit Report which is sent first to PCA America and then to the applicant program. The program has 45 days to respond to the report in writing. This response is then discussed by the HFA Advisory Panel. Depending on the outcome of the Self-Assessment, the peer reviewer site visit, the program response and the deliberations of the Panel, the evidence will be used to determine whether to grant accreditation.

The KSDE PAT programs are required to go through the PAT Standards and Self-Assessment with a Quality Consultant to maintain fidelity to the PAT model. Each program develops a CQI Plan which is reviewed and revised annually and is part of the KSDE PAT Continuation Grant process. The PAT state office reviews and approves annual program reports, data analyses required via the PAT Continuation Grant process including goal setting and reporting via the CQI plans. Telephone and email technical assistance is provided. On-site review of model fidelity is conducted every 4 years as part of the Quality Standards process.

Fidelity to the TIES model will be accomplished by TIES program manager monitoring and assessing compliance with the practice standards that will be formalized in the implementation development. The manager will meet with program staff both individually and as a group with other TIES and program staff. She will also accompany staff in home visits, review program documentation, and receive feedback regarding consumer satisfaction from evaluator. The individualized nature of intervention and field-based decision making are both challenges to quality and fidelity. However, the program manager will observe staff regularly interacting with families and will discuss quality improvement efforts on an ongoing basis. This observation and regular supervision coupled with record review will promote model adherence.

A discussion of anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified;

Local PAT programs are implementing increased essential requirement standards set by the National office which will require policy and practice changes. In addition, new Foundational Curriculum changes will require practice and continuous feedback as Parent Educators implement new practices.

Assurances

The KHVP assures the following:

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

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

For each of the six benchmark areas, data will be collected for eligible families that have been enrolled in the program who receive services funded with the MIECHV Program funds. A chart listing all benchmarks, constructs, measurable indicators, measures, collection schedule and scoring for analysis is attached in the Appendix. For most data, program staff will be responsible for collecting the fidelity and outcome data for their respective programs and providing the data.

Not all existing home visitation programs across the State collected the same type and level of data on existing clients and services. There is no centralized data system or common outcomes across home visiting programs. This impacts the extent to which it is possible to comprehensively analyze across all programs in communities. Standardized data collection across all home visiting programs will assist in assessing the success of coordinated home visiting programs to meet the needs in each community. To address these challenges, the University of Kansas Institute for Educational Research and Public Service will be contracted to develop a data collection and reporting system for the KHVP as follows.

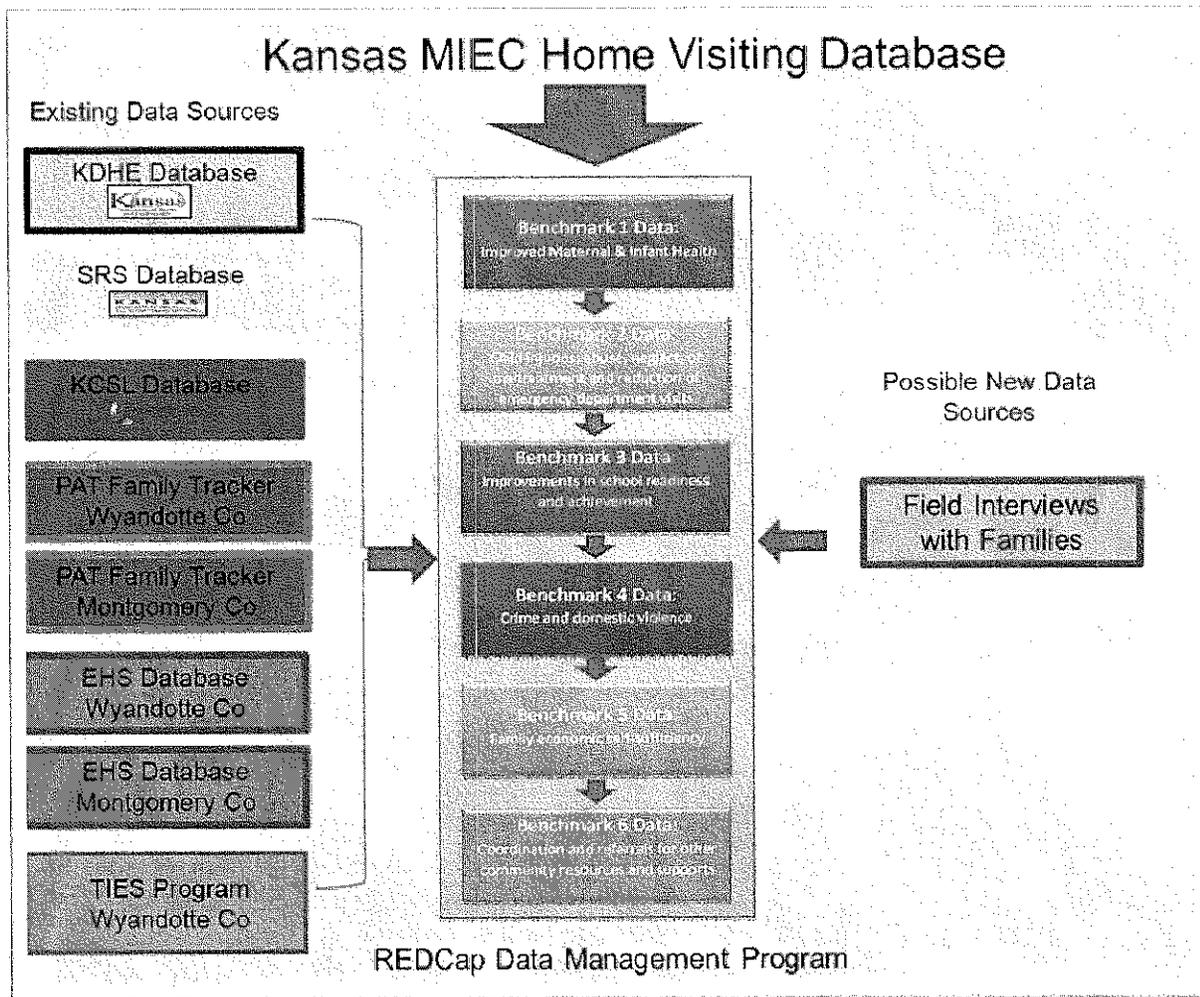
MEICHV Data System and Management Plan

The Kansas MIECHV team will develop a comprehensive data management system and plan that includes continuous data quality monitoring and appropriate training of data management staff and other personnel responsible for collecting and entering data. This plan will ensure that internal and external procedures for data integrity monitoring are in place for all required data elements – from the initial point of collection, transfer into each home visiting agency data system, and import into a larger, integrated home visiting database.

In response to federal requirements, the Kansas Department of Health and Environment will establish the Kansas Maternal Infant and Early Childhood Home Visiting Database. This comprehensive HIPAA/FERPA-compliant database and management system will become a robust and secure repository of client-level data on those served in the federally funded home visiting programs. This will be accomplished by using Research Electronic Data Capture (REDCap) to create one database that integrates and stores linked client-level data across existing State databases (e.g., KDHE, SRS, KSDE), the agency-level Management Information System, and any data collected in the field by home visiting program staff. The Kansas Maternal Infant and Early Childhood Home Visiting Database will allow the State to collect, monitor, analyze, store, and report on the required MEICH home visiting individual constructs and benchmark areas (e.g., Maternal and Newborn Health, Child Injuries and Abuse/Neglect/Maltreatment, School Readiness, Crime and Domestic Violence, Economic Self-Sufficiency, and Coordination and Referrals).

Additionally, REDCap database and management system is flexible and dynamic; it can handle future add-ons such as incorporating data on child care, Head Start, or other early childhood program data. Cross-system referrals and service receipt may also be captured by this system. This will allow the State to collect, monitor, store, and analyze a wide variety of client-level data on the outcomes associated with clients receiving different State or private services. Such a system will provide the State with easy access to program and client data to inform administrators, program staff, legislators, federal funders, or other key parties on child and family outcomes associated with these programs.

The following graphic outlines the proposed data collection and reporting system:



Continuous Data Quality Monitoring: A two-tiered approach will be taken on a quarterly basis in alignment with CQI reporting. The first-tier is targeted at ensuring accurate data collection methodology, instrument scoring, and data entry at the home visiting agency level. On a quarterly basis, a random sample of 5% of the clients served in each agency in that quarter through this funding stream will be selected. All intake forms, screening assessments, construct instruments, and program records will be reviewed for those clients. Data monitoring will ensure that all hard copy records match electronic agency data management information system files. Additionally, the electronic files of a random sample of 10% of the clients served in that quarter will be reviewed for data entry completeness. All data errors or missing data will be identified by a home visitor or information specialist and targeted refresher training will be offered individually or as a program, depending on the specificity or scope of the errors.

The second-tier is targeted at ensuring system-level data quality across home visiting agency programs, outside agency databases, and the MIECHV REDCap database. Specifically, data

management staff will conduct quarterly reviews of the data element mapping within each agency's electronic data management information system. This procedure is designed to check the file and query structures of all exported agency electronic records against the required construct elements and the REDCap MIECHV data dictionary. Data management staff will also work with State-level data management personnel in external and internal agencies (e.g., SRS, KDHE) on ensuring accurate and reliable record matching procedures are taken to link home visiting clients and clients within their databases. Data management staff will work with State-level data personnel to utilize secure, up-to-date record linking software (e.g., *Data Match 2011*, *The Link King*) if the State agencies have no existing record matching procedures in place. This will ensure the accuracy and reliability of identifying home visiting clients and their data in outside agency data systems.

Staff Training and Qualifications: The data collection and analysis plan for the Kansas MIECHV program will involve multiple agencies and organizations collaborating together on both the day-to-day administration of programs and data collection and on the technical database management of cross-system data integration. As a result, the State will develop a coordinated training and communication protocol to ensure that all staff and associated personnel understand their roles and responsibilities with regard to the data collection and reporting requirements for the MIECHV funding. This will include a 'data kickoff' meeting focused on an overview of the State's plan with regard to all data collection procedures, benchmark constructs, the MIECHV REDCap database, data security and confidentiality, and an outline of the roles and responsibilities of each individual across and within programs. Subsequent training sessions will be targeted to and delivered in same staff group-level sessions (e.g., home visitors, supervisors, information specialists/agency database manager, state-level administrators). If feasible, all home visiting program staff will be combined in the sessions. Home visitors and supervisors will be trained to administer each newly selected MEICHV instrument according to the developer or manual guidelines. If home visitors are required to enter data into their agency electronic management information system, they will receive initial and ongoing training support on how to correctly enter this data. If home visitors or their supervisors are required to interface with REDCap for data collection, training sessions on this will also occur. Information specialists or agency data managers will receive targeted training on identifying the necessary data elements in their system and building queries to retrieve and export this client-level data. These individuals will also be trained on how to interface with REDCap as needed. Finally, State-level MIECHV staff and home visiting agency directors will be trained on using REDCap to generate outcome or CQI reports or other functions as needed/requested. Refresher trainings will occur on an annual basis and for all new key personnel hired.

Additionally, the State will ensure that the right staff are identified and qualified to carry out their responsibilities. In Table 4, the State has outlined the following staff qualifications, responsibilities, and estimated level of effort required for data collection:

Table 4. Staff Training and Qualifications for Data Collection and Analysis

Staff Type	Qualifications	Data Responsibilities	Level of Effort for Data Responsibilities (12 month)
Home Visitors	National, state and local home visiting program qualifications	Administer all screening tools, enter existing program data requirements and any new data collection instruments directly into agency database or REDCap	10-15%
Information Specialists/Agency Database Manager	B.A. / B.S./ M.A./M.S.W. – experience working with agency management information systems and building data queries	Identify required data elements within existing agency data management system, build queries to extract client-level screening and outcome data, build queries to extract program and QA data, data quality monitoring at the agency level	10-25%
MIECHV Database Manager	Ph.D., MSW – experience using REDCap, interfacing with agency-level management information systems	Coordinating all data mapping and linking across home visiting programs, data sources, and data collection methods, building REDCap database, generating reports, training on database and data entry issues, data quality monitoring	50-75%
MIECHV Data Analyst	Ph.D., MSW – experience analyzing client-level data, calculating instrument scores, aggregating data across programs or other variables, experience with SPSS or other analysis software	Analyzing all program specific client-level data, analyzing aggregate outcomes by program and across programs, generate CQI and outcome reports, training on instrument administration as needed	25-30%
MIECHV Program Manager	Ph.D.	Providing overall management and oversight of the MEICHV program and data reporting requirements, monitoring CQI and outcome reports	10-15%

Data Analysis Plan: In alignment with the data collection plan, the State has developed an analysis plan to analyze each benchmark construct, assess progress towards benchmark improvement, and develop CQI reports. The following section will begin with a technical description of the database structure from which data can be drawn for subsequent analyses. This will highlight the capability of the system to produce useable, formatted data needed for multiple purposes. Next, an overview of the State plan is given with particular attention to how it will impact and inform the analysis plan. This section will also outline the general analysis approach taken at the local, State, and promising approach level to address program impact and performance monitoring. Finally, a brief overview of CQI analyses will be given as it relates to the proposed CQI Plan.

Database Structure: As previously described, the MIECHV REDCap database system collects and stores client-level data from each home visiting agency. This database will include program data (e.g., home visiting program enrolled in, home visitor, number of home visits, etc), demographic information, all screening and assessment instrument data, and any other process benchmark construct data. Depending upon the construct and/or instrument selected to measure that construct, cross-sectional (point in time) and longitudinal (repeated measures over time) data will be available for analysis at the client level. This data may then be aggregated within and across home visiting programs, communities, or other demographic variables of interest. Analysis and outcome reporting will be done by construct, with additional variables such as program dosage and collaboration data included to better assess performance and impact of services.

One of the strengths of the proposed MIECHV REDCap database is that all data in the system can be easily exported in multiple formats for analysis purposes. Data can be exported into many common statistical software formats such as SPSS, SAS, Stata, as well as Excel. Specific variables can be selected as needed for each analysis and the structure of the data (client-level flat file) can be easily aggregated by any desired grouping variable (e.g., home visiting program, zip code, demographic variable, etc). Thus, the MIECHV REDCap database structure is well suited to enable easy and flexible data export for targeted analyses.

Analysis Overview: As previously described, two communities in Kansas are targeted for initial home visiting services. Wyandotte County will look to expand existing home visiting services within a community with a coordinated intake program and introduce a promising approach focused on home visiting services for women with substance use disorders. Additionally, concurrent mental health services delivered within the home visiting system in Wyandotte County is also the focus of the State's efforts. In Montgomery County and southeast Kansas, few home visiting services exist in the multi-county semi-urban and rural area and there is not currently a coordinated system of referrals to home visiting services. The state plan includes building capacity to serve families in that region expanding home visiting services as well as developing a coordinated multi-county intake and referral system.

Given those two contexts and the focus of the State's efforts in those communities to address different needs, local level analysis will be particularly informative for measuring progress in the benchmark areas and examining the impact of the system-level expansion efforts and coordination of services in those communities. Additionally, because Kansas is proposing funding multiple home visiting programs within each community, the State needs the ability to monitor program performance and assess the impact of expansion and coordinated referrals on each of the home visiting programs. The State is also implementing a promising approach in one community that will require additional analyses given the proposed design. To supplement each home visiting program's internal quality assurance and CQI plan, the State will also have the capability of analyzing and producing CQI reports focused on quality indicators and program performance.

State Level Analyses: In order to monitor progress on benchmark outcomes across all funded home visiting program clients under the MIECHV program for federal reporting, analyses at the State level will focus on aggregate data. In other words, the primary focus of analyses at the

State level will be to assess performance on all benchmark constructs across all programs and all clients served under this funding. For some constructs, data will be consistently measured in the same way with the same kind of data across home visiting programs. The State can then aggregate this data to show overall progress on meeting benchmark goals. This will also involve, in some cases, standardizing scores if multiple measures are used for the same construct by different home visiting programs. Depending upon the operational definition of a construct and its improvement, change over time from intake to follow-up to discharge from services will be analyzed and an aggregated change score will be calculated. Finally, the State may choose to analyze overall impact of home visiting services for families served under this funding if comparison or historical data exists on families not receiving home visiting services on key indicators measured under this initiative.

Local Level Analyses: To that end, the State will aggregate client-level data at the home visiting program level in each community. In other words, for each benchmark construct, data from all clients served by the home visitor(s) funded under MIECHV in Parents as Teachers, Healthy Families, and Early Head Start will be combined. Within Wyandotte and Montgomery County, the State will use this aggregated data to assess progress of each home visiting program on the benchmark constructs. Both within and across home visiting programs, analyses will be broken down by key demographics in order to assess how well services are meeting the identified needs of each community.

Wyandotte County: As noted in the State's home visiting needs assessment and in this State Plan, Wyandotte County had identified a need for more and effective services for women with substance use disorders and mental health services. In order to assess how well home visiting services and coordinated system referrals within this community are meeting these needs and having an impact on families served, supplemental analyses will focus on indicators aligned with these goals. Specifically, the Benchmark 1 constructs of parental use of alcohol, tobacco, or illicit drugs and screening and referrals for maternal depression will be analyzed by key demographic variables and home visiting program. Over time, the State will expect that substance use will decrease for families receiving home visiting services and concurrent referrals to treatment as needed. It will be particularly important to track client-level trajectories of substance use screening, treatment referrals, and treatment service receipt for these families to ensure that home visiting services within a coordinated community system helps families move effectively through that system and achieve better outcomes. Similarly, for women screened for maternal depression, the treatment referral and service receipt trajectories are also critical in assessing how well the State has coordinated mental health services for these families. Thus, in Wyandotte County, the State will be able to not only assess progress toward all benchmark outcomes, but also analyze the impact of services designed to meet the unique community needs identified for these families.

Montgomery County: As previously described, families in Southeast Kansas and Montgomery County have the least number of concrete personal and community resources available and their health outcomes are poorer compared to the rest of the state. To assess how well expanding home visiting services in this area helps meet those needs, supplemental analyses will be performed on all Benchmark 1, 2, 5, & 6 constructs.

Specifically, improvements over time in these indicators over time will help the State assess whether expanded home visiting services are a factor in these families. When possible, the State will obtain historical health indicator and self-sufficiency data on a matched comparison sample of families in the area. This data will be compared to outcomes achieved by families receiving services funded under this program. Additionally, like Wyandotte County, analyzing client-level service trajectories over the course of funding will be critical in demonstrating how expanded services work within a newly developed coordinated referral system. Over time as the State expands services in Southeast Kansas to multiple counties, it will be critical to analyze multi-county collaboration, referral, and service delivery for families receiving home visiting services. This may mean additional evaluation activities and data not currently collected.

Finally, at the local level and at the State level, with the data collected for this initiative, it will be possible to begin to analyze whole-family service and outcome trajectories. In other words, with sufficient sample size across programs or within communities, the State will be able to do more sophisticated modeling of program dosage (e.g., what home visiting services provided and in what quantity) on all construct outcomes. Additionally, the data will be available to analyze how achievements in one benchmark area or construct are related to or predict achievements in other benchmark areas within a family. For example, it will be possible to test whether improvements in maternal and child health indicators leads to concurrent or additive improvements in school readiness indicators. Similarly, the data will allow the State to test whether improvements in maternal depression screening, reduction in substance use, and treatment referral and service receipt leads to reductions in child maltreatment or injuries. While planning for these kinds of analyses are preliminary at this point, the data collected as a result of this funding initiative and the MIECHV REDCap database are critical components that will be in place to assist the State and federal partners better assess impact of these services and this funding.

Promising Approach Analyses: While a comprehensive evaluation plan for TIES is included in Section 3, it is important to emphasize here that TIES will be included in the state data plan, collection of benchmark data, and the CQI plan.

CQI Analyses: To align with the State's CQI Plan, the MIECHV REDCap database will be used to analyze and produce reports on quality indicators. As previously noted, the data collected in this database will include program specific, home visitor-level data on visits, intensity level, referrals, services, and other identified quality-assurance measures. The State will be able to generate these CQI analysis reports on a regular basis and work with home visiting agencies to understand the data and use it for continuous quality improvement. Analyses may be broken down by demographic variables of interest (e.g., Number of newborn referrals to Tiny-K programs for teenagers compared to women over 25 served in Parents as Teachers; Percent of home visits completed by home visitor based on race, ethnicity, and SES status of client). Additionally, the State will systematically be collecting model fidelity data and this may be used to analyze percentage of home visitors who received training within a given timeframe or other similar reports that can be used to provide quality checks on services by program.

Data Security Plan. As noted above, the State will employ REDCap data management system to integrate existing and new data. REDCap is and will be maintained on a secure,

HIPAA/FERPA-compliant server within the Center for Research Methods and Data Analysis at the University of Kansas. This server is certified HIPAA compliant by the University of Kansas Information Security unit. As such, REDCap is maintained on a server that must address three areas in the HIPAA Security Standards Matrix to protect covered entities using or storing protected health information (PHI). The University of Kansas REDCap server has the necessary safeguards in place for administrative, technical, and physical security of data to ensure the proper handling, access, storage, and recovery of PHI. REDCap can be configured to restrict access to users to protected information residing in the database. Also, data will be de-identified prior to any subsequent data exports for analysis or report generation so that no identifying information is ever allowed outside of the REDCap server system. Thus, all data stored on the MIECHV database will have the necessary security and privacy safeguards in place.

The MIECHV Database Manager and agency information specialists/database managers will also work to ensure that all data exported from individual agency management information systems is transferred securely within the server framework. All client data obtained from each agency will be identified only by an alphanumeric client ID, ensuring that no identifying information such as names or addresses, are queried for data transfer. While individual agency database managers and home visitors will have client contact information (e.g., name, addresses, DOB), this information will never be stored in the MIECHV REDCap database itself. If client identifying information is required to match records to an outside agency database (e.g., KDHE, SRS), an encrypted file stored on the REDCap server will be used for the linking software analysis. This encrypted file will also contain the client ID assigned by the home visiting agency – after record matching occurs with the outside agency database, all identifying information will be stripped from this file and new data will be linked by client ID only for integration into the MIECHV REDCap database.

In addition to utilizing REDCap as the comprehensive MIECHV database, the State will also work with individual home visiting agencies and staff to ensure that existing agency policy regarding client privacy is maintained at the program level. This will be done through on-going supervision and training. Additionally, each program will be required to have protocols in place to reduce risk to clients if any screening or measurement instrument is used to obtain data that may place a person at risk (e.g., domestic violence, child maltreatment). This will include procedures for assessing client and home visitor safety as well as identifying and responding to clients displaying immediate distress. On-going supervision and training will ensure that these procedures are in place and followed.

Finally, in collaboration with the University of Kansas Institute for Educational Research and Public Service, the State will apply for the necessary IRB approvals to ensure protection of human participants and analysis of protected health information. This IRB will include data sharing agreements between all home visiting agencies, KDHE, and the University of Kansas. All staff who will be directly working with the MIECHV REDCap server and data will complete the required IRB training modules on protection of human participants and on handling HIPAA protected data.

Anticipated barriers or challenges in the benchmark reporting process (including the data collection and analysis plan) and possible strategies for addressing these challenges

Even with the detailed data system development plan, there may be barriers with coordinating all of the various local and state level data systems and staff. The KU expertise and support will be helpful in navigating these issues yet further technical assistance may be needed. Also, some of the required constructs have been challenging in terms of determining the best or most appropriate definitions to measure change and measurement tools. Further technical assistance would be helpful.

Section 6: Plan for Administration of State Home Visiting Program

The lead agency for the MIECHV Program, as designated by the Governor of Kansas, is the Kansas Department of Health and Environment. The Home Visiting Program Manager, based in the Bureau of Family Health, is responsible for day-to-day operations, providing leadership and direction for planning and implementation of the plan, completing activities in support of the program goals and objectives, managing contractual procedures and agreements, providing project oversight, monitoring and preparing program reports and setting priorities.

Each of the three evidence-based program state leaders – EHS, HFA, and PAT – as well as the TIES Program Manager will provide support to respective local agencies to coordinate expansion of the evidence-based programs in targeted communities. All have extensive experience working with their home visitation program and knowledge of the selected communities. These program leaders will work with the Home Visiting Program Manager to provide support to prepare for expansion of services, monitor fidelity issues, finalize common outcome measures, implement the data collection system and CQI plan, identify technical assistance needs related to adherence to the selected models, and coordinate community resources to support the KHVP. Each of the involved local programs, as listed in Section 4, will have responsibility for managing and supervising day-to-day program operations and delivery of services.

Job descriptions for key positions, including resumes are included in the Appendix.

An organization chart for the Kansas MIECHV Program is attached.

The state Home Visiting Advisory Workgroup includes leadership from each of the partner programs. The workgroup will meet at least quarterly to provide guidance on planning and implementation, and evaluation of the program. Workgroup members are:

Charles Bartlett	Addiction and Prevention Services Kansas Dept. of Social and Rehabilitation Services
Mary Baskett	Kansas Head Start Association
Karin Chang-Rios	Institute for Educational Research and Public Service University of Kansas
Susan Gile	Children and Family Services Kansas Dept. of Social and Rehabilitation Services

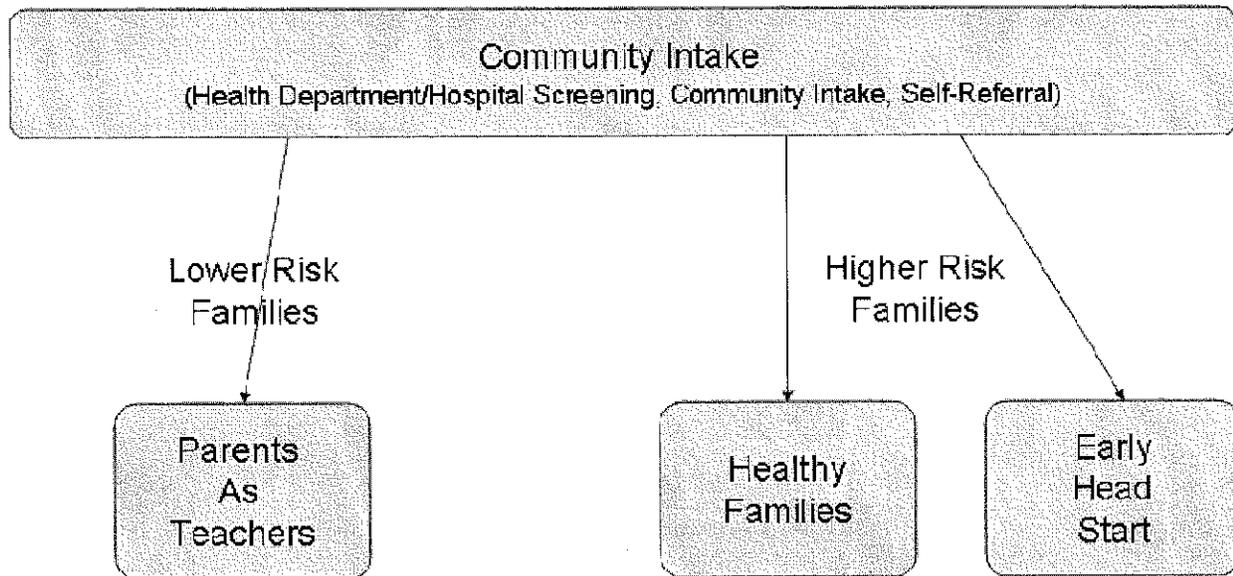
Carrie Hastings	Head Start/Early Head Start, Economic & Employment Support Kansas Dept. of Social and Rehabilitation Services
Sharon Homan	Kansas Health Institute
Linda Kenney	Bureau of Family Health Kansas Dept of Health and Environment
Chrisy Khatib	Addiction and Prevention Services Kansas Dept. of Social and Rehabilitation Services
Tracie Lansing	Healthy Families Kansas Children's Service League
Janet Newton	Parents as Teachers Kansas State Dept. of Education
Jim Redmon	Kansas Children's Cabinet and Trust Fund Kansas Dept. of Social and Rehabilitation Services
Sabra Shirrell	Part C Infant-Toddler Services Kansas Dept. of Health and Environment

Coordination of referrals, assessment, and intake processes across the different models

As previously noted, Wyandotte County has the established Connections Centralized Screening and Referral System. In Montgomery County, a goal of this plan is to develop such a centralized system with eventual expansion to other southeast counties.

The KHVP will use a comprehensive approach to expand evidence-based home visitation services to meet the needs of all families by matching risk level to the appropriate program. Figure 3 gives an overview of the planned project design.

Figure 3: Kansas Home Visitation Program Screening and Referral System.



The state home visiting program plan development and implementation has and will coordinate with several early childhood initiatives. The KHVP partners are active participants in the development, implementation and coordination of all Kansas early childhood plans and initiatives including: the Kansas Early Childhood Comprehensive Systems Plan (KECCS); Kansas Strengthening Families (KSF); the Kansas Early Childhood Advisory Council (ECAC); the Kansas Early Learning Collaborative (KELC) and the Kansas School Readiness Data Task Force. The KHVP enhances these efforts as well as strengthens and creates partnerships between early childhood and prevention professionals to deepen the quality and reach of home visitation services. KHVP partners and the early childhood and child welfare systems have demonstrated commitment to cross-agency partnerships. This coordination has informed the development of the KHVP and the identified need to support and expand home visiting programs as part of the KECCS plan and ultimate goal of a statewide comprehensive, integrated early childhood system.

Throughout the planning process of the KHVP, the local and other state early childhood initiatives have been included and incorporated into this plan as described fully in Section 2. The inclusion and cooperation with these initiatives is a great strength of the plan to ensure success and long term sustainability.

Section 7: Plan for Continuous Quality Improvement.

See Sections 4 and 5

Section 8: Technical Assistance Needs

Anticipated and requested TA needs not previously noted are:

Wyandotte County

Mental Health - Incorporating mental health among the EHS, HF, and PAT programs (i.e., how other states and local programs done so effectively and remaining true to the models). This objective is to enhance the HV programs' capacity to address mental health concerns of families, both adults and young children. Potential ideas include:

- Contracting with mental health specialists to provide consultation and provide in-home counseling across programs
- Individual programs hire a staff member with mental health expertise to provide consultation to home visiting staff, serve as a home visitor with a caseload of families with such concerns and/or to provide in-home counseling

Substance Use – How to build better collaboration and referrals between home visiting/early childhood programs and the substance use assessment and treatment providers. How to increase the competence of the program staff to communicate with families regarding substance use issues, identify and make appropriate referrals, etc.?

Diverse Cultures - Serving a diverse community with multiple cultures and languages beyond Spanish-speaking. For example, one of the PAT programs is aware of Somali families, Burmese families, etc. The Part C Birth-3 program reports that they are serving up to 12 different languages. What are effective ways that programs can serve such diverse populations with their limited staff capacity and beyond just trying to find an interpreter (which are not always available, especially on an ongoing basis)? Also, what might be allowable incentives to recruit and hire bilingual staff (e.g., Spanish) with required credentials? Programs have experienced difficulty finding such candidates.

SE Kansas/Montgomery County

Coordinated Outreach & Central Intake – How to effectively develop such a system in a rural area that would start in one county with future expansion across multiple rural counties? This may include coordinated outreach and marketing to hard-to-reach populations, referrals, assessment, intake, linkages with other wraparound services, staff cross-training, parent groups, etc.

Diverse Cultures – While there appears to be much less diversity than Wyandotte Co., this community wants to better serve the Spanish-speaking population. While having bilingual home visitors is one solution, as mentioned above it is very difficult to locate, recruit and hire bilingual staff (e.g., Spanish) with required qualifications. What might be some solutions? Programs have tried to use interpreters but that is not a consistent, cost-effective, or effective approach for ongoing services to the families. Would it be feasible to hire an interpreter who does not have the required qualifications that would accompany the other home visitors? What might be some further strategies to enhance the capacity of the existing staff to better serve families of different cultures and languages?

Substance Use – How to build better collaboration and referrals between home visiting/early childhood programs and the substance use assessment and treatment providers. How to increase the competence of the program staff to communicate with families regarding substance use issues, identify and make appropriate referrals, etc.?

Section 9: Reporting Requirements

Assurance that the State will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program, including information specified in the February 8, 2011 Supplemental Information Request.

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		Total (g)
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	
1. KS Home Visiting Pr	93.505	\$	\$	\$ 936,464.00	\$	936,464.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		\$ 0.00	\$ 0.00	\$ 936,464.00	\$ 0.00	936,464.00

SECTION B - BUDGET CATEGORIES						
Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY					
	(1)	(2)	(3)	(4)	(5)	Total (5)
a. Personnel	\$ 61,838.00	\$	\$		\$	61,838.00
b. Fringe Benefits	18,057.00					18,057.00
c. Travel	5,000.00					5,000.00
d. Equipment	0.00					0.00
e. Supplies	3,009.00					3,009.00
f. Contractual	818,211.00					818,211.00
g. Construction	0.00					0.00
h. Other	4,746.00					4,746.00
i. Total Direct Charges (sum of 6a-6h)	910,861.00		0.00	0.00	0.00	910,861.00
j. Indirect Charges	25,603.00					25,603.00
k. TOTALS (sum of 6i and 6j)	\$ 936,464.00	\$	0.00	0.00	\$	936,464.00
7. Program Income	\$	0.00	\$	\$	\$	0.00

SECTION C - NON-FEDERAL RESOURCES					
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS	
8. KS Home Visiting Program	\$	\$	\$	\$	0.00
9.					0.00
10.					0.00
11.					0.00
12. TOTAL (sum of lines 8-11)	\$	0.00 \$	0.00 \$	0.00 \$	0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 936,464.00	\$ 234,116.00	\$ 234,116.00	\$ 234,116.00	\$ 234,116.00
14. Non-Federal	0.00				
15. TOTAL (sum of lines 13 and 14)	\$ 936,464.00	\$ 234,116.00	\$ 234,116.00	\$ 234,116.00	\$ 234,116.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16KS Home Visiting Program	\$ 936,464.00	\$ 936,464.00	\$ 936,464.00	\$ 936,464.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16-19)	\$ 936,464.00	\$ 936,464.00	\$ 936,464.00	\$ 936,464.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges: 818,211.00	22. Indirect Charges: 25,603.00

23. Remarks: Approved Indirect rate 18.6%

Budget Justification Narrative
Kansas MIEC Home Visiting Program – 7/15/2010 – 9/30/2012

Maintenance of Effort Baseline Expenditure as of March 23, 2010

Program	State General Funds
Early Head Start	\$0
Healthy Families	\$461,530
Parents as Teachers	\$0
Healthy Start Home Visitors	\$501,444
Infant Toddler Services – Part C	\$0
TOTAL	\$962,974

Personnel

Debbie Richardson, Home Visiting Program Manager, 1.0 FTE @ 12 mo. 61,838
 Fringe benefits (29.2%) – includes health insurance, taxes, unemployment 18,057
 insurance, life insurance, retirement. \$79,895

Travel

Local/In-state – includes mileage, lodging, per diem, registration fees, 1,700
 miscellaneous costs for visits to targeted high-risk communities, meetings with
 state & community partners, state and community collaborative meetings,
 conferences & training events

Out-of-state – includes mileage, airfare, hotel, per diem, conference fees, 3,300
 miscellaneous costs for 2 trips to Washington, D.C., 1 individual x 2 nights
5,000

Equipment \$0

Supplies

Laptop computer docking station, monitor, & software for Program Mgr. 2,009
 Miscellaneous consumable office supplies 500
 Program/educational/evaluation resources 500
 \$3,009

Other

Data and fax line – 1 x 12 mo. x \$65 780
 Blackberry service – 1 x 12 mo. x \$78 936
 Long distance – 1 x 12 mo. x \$40 480
 Postage – 12 mo. x \$25 300
 Fed Ex – 12 units x \$25 300
 Printing and advertising 700
 Repairs, servicing, maintenance 500
 Meeting costs including food (50 persons x \$15) 750
 \$4,746

Other Contractual Services

KU Institute for Educational Research	
Needs assessment, key informant interviews, & focus groups	20,000
Developing data collection and reporting system	49,255
Evidence-based home visiting program services & related support (for 9 mo.)	
<i>Montgomery Co.</i>	
Southeast KS Community Action Program - Early Head Start	46,555
Kansas Children's Service League – Healthy Families	60,000
Coffeyville USD 445 – Parents as Teachers	33,638
Southeast KS Education Service Center, Greenbush – Parents as Teachers	33,638
Four County Mental Health – Central Outreach/Referral Coordinator	59,987
To be determined – training/professional development on substance use and mental health issues	1,000
<i>Wyandotte Co.</i>	
Project EAGLE –	
Early Head Start	54,970
Connections Centralized Screening & Referral System	12,000
Kansas Children's Service League – Healthy Families	60,000
Public Health Dept., Unified Government of Wyandotte Co. & Kansas City, KS – Healthy Families	62,899
Kansas City, KS USD 445 – Parents as Teachers	46,555
Turner USD 202 – Parents as Teachers	48,300
Family Conservancy – training/professional development on mental health	4,500
To be determined – training/professional development on substance use issues	400
<i>Promising Approach in Wyandotte Co. (for 12 mo.)</i>	
Children's Mercy Hospital – TIES Program	233,514
Includes evaluation subcontract with University of Missouri–Kansas City	
	<hr/>
	\$818,211
Indirect costs @ 18.6%	\$25,603
Total Proposed Project	\$936,464

Memorandum of Concurrence

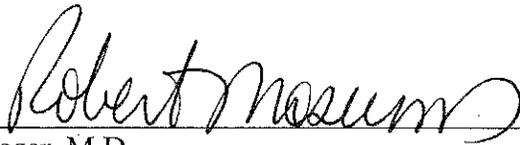
Kansas Updated State Plan for the Maternal, Infant and Early Childhood Home Visiting Program

This memorandum serves as our concurrence with the Kansas Updated State Plan for the Maternal, Infant and Early Childhood Home Visiting Program.

We are in agreement with the implementation of the Home Visiting Program as proposed in this document.

We support the development and enhancement of quality, coordinated home visiting services in the identified high-risk communities that will meet the needs of vulnerable families.

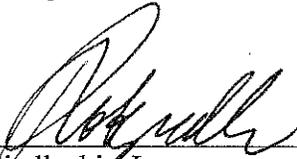
Our agencies are committed to collaboration and support home visiting as part of the continuum of early childhood services within the State of Kansas.



Robert Moser, M.D.
Secretary, Kansas Department of Health and Environment
Representing the State Maternal and Child Health agency

6/2/2011

Date



Robert Siedlecki, Jr.
Secretary, Kansas Department of Social and Rehabilitation Services
Representing the:
State Child Welfare Agency, Title IV-E and IV-B
Single State Agency for Substance Abuse Services
State Child Care and Development Fund (CCDF)
State Head Start Collaboration Office

6/2/11

Date

The Kansas Updated State Plan for the Maternal, Infant and Early Childhood Home Visiting Program proposes providing intensive home visiting services, and enhancing coordination of those services, in Montgomery County and Wyandotte County.

Kansas MIECHV Home Visiting Program Logic Model

Identified Population

Pregnant women and families with children birth to 5 years in identified high need communities

Assumptions

Multiple HV programs have evidence of positively impacting pregnant women and families with infants and young children

HV services are child-focused, family-centered, culturally appropriate, and strengths-based

Ensuring families receive HV services that best fit their needs can effectively reduce risks to, and enhance the health, development and well-being of, infants and young children

HV is a service within a broader set of systems including health care, education, child care and early education, and social services

State and local organizations must operate in a collaborative and coordinated manner, share resources, use data to drive decisions, and engage parents as partners

Theoretical Frameworks

- Life course development
- Socio-ecological

Contextual Factors

- Family risks and protective factors
- Community characteristics and demographics
- State and local policies and supports
- State and local infrastructures

Inputs

Comprehensive needs/readiness assessment

State & community commitment to improve the well-being of young children and their families

Established evidence-based and promising approach HV programs:

- Early Head Start
- Healthy Families America
- Parents as Teachers
- TIES

Parents and families

State-level agencies/organizations:

- Education – Parents as Teachers
- Head Start Association
- Health & Environment – Family Health Health Institute
- Children's Cabinet & Trust Fund
- Children's Service League – Healthy Families
- Social & Rehabilitation Services
 - Addiction & Prevention Services
 - Children & Family Services
 - Economic & Employment Support - Head Start/ Early Head Start
- Academic/research partners – KU, UMKC

Local-level agencies/organizations:

- Home visiting program providers
- Early childhood collaborative groups
- County health departments
- Nonprofit social service agencies
- Public schools/education agencies

KS Early Childhood Comprehensive System Plan

Federal MIECHV Program funds & technical asst.

Training and evaluation resources

National program model developers

Outputs

Evidence-based HV programs are locally delivered with high model fidelity and quality, and are aligned with local needs

Build HV programs' capacity to:

- operate as a coordinated system of HV services
- utilize locally coordinated, centralized outreach, referral and intake processes
- serve families according to model standards
- effectively engage and retain families in services
- support healthy relationships and involve fathers
- appropriately address mental health and substance abuse concerns of families served

Implement and evaluate a promising HV approach to serve pregnant women and mothers with substance use problems

Utilize common measures and data system:

- to collect and analyze data across HV programs
- to assess program impact and effectiveness
- for continuous quality improvement

Provide needed training/technical assistance to HV programs and collaborative partners

Monitor program activities to ensure accountability, fidelity, and quality

Convene state/local advisory and work groups

Facilitate ongoing, open communication among state and local stakeholders



Short-Term Outcomes

Improved coordination and referrals between HV programs and other community resources & supports

HV programs delivered with high model fidelity and quality

Increased number of families with identified risks served in high need communities

Improved engagement and retention of families in services

Increased involvement of fathers in services

Enrolled families with mental health and substance abuse concerns receive services that meet their needs

Local and state-level stakeholders actively and collaboratively participate in planning, implementation, and assessment

Intermediate Outcomes

Maternal and newborn health

- Increased use of prenatal care
- Reduced parental alcohol, tobacco, or illicit drug use
- Improved preconception care
- Increased inter-birth intervals
- Increased maternal depression screenings
- Increased breastfeeding
- Increased well-child visits
- Improved maternal & child insurance status

Child injuries, maltreatment, and emergency room visits

- Decreased child & maternal ER visits
- Increased child injury prevention & safety information or training
- Reduced child injuries requiring medical treatment
- Improved rates of reported and substantiated child maltreatment

Parenting and child development

- Improved parental:
 - support for children's learning and development
 - knowledge of child development and child's developmental progress
 - behaviors and parent-child relationship
 - emotional well-being or parenting stress
- Improved child's:
 - communication, language and emergent literacy
 - general cognitive skills and positive approaches to learning
 - social behavior, emotion regulation, and emotional well-being
 - physical health and development

Domestic violence

- Improved domestic violence screenings, referrals, and safety plans

Family economic self-sufficiency

- Improved household income and benefits
- Improved adult employment & education

Coordination and referrals for community resources & supports

- Increased # of families identified as requiring services & receiving referrals
- Increased MOUs or other formal agreements with community social services
- Improved information sharing between HV providers & community agencies
- Increased # of completed referrals

Long-Term Outcomes

High quality, effective home visiting programs

Improved maternal and newborn health

Reduced child injuries, child abuse, neglect, or maltreatment, and emergency room visits

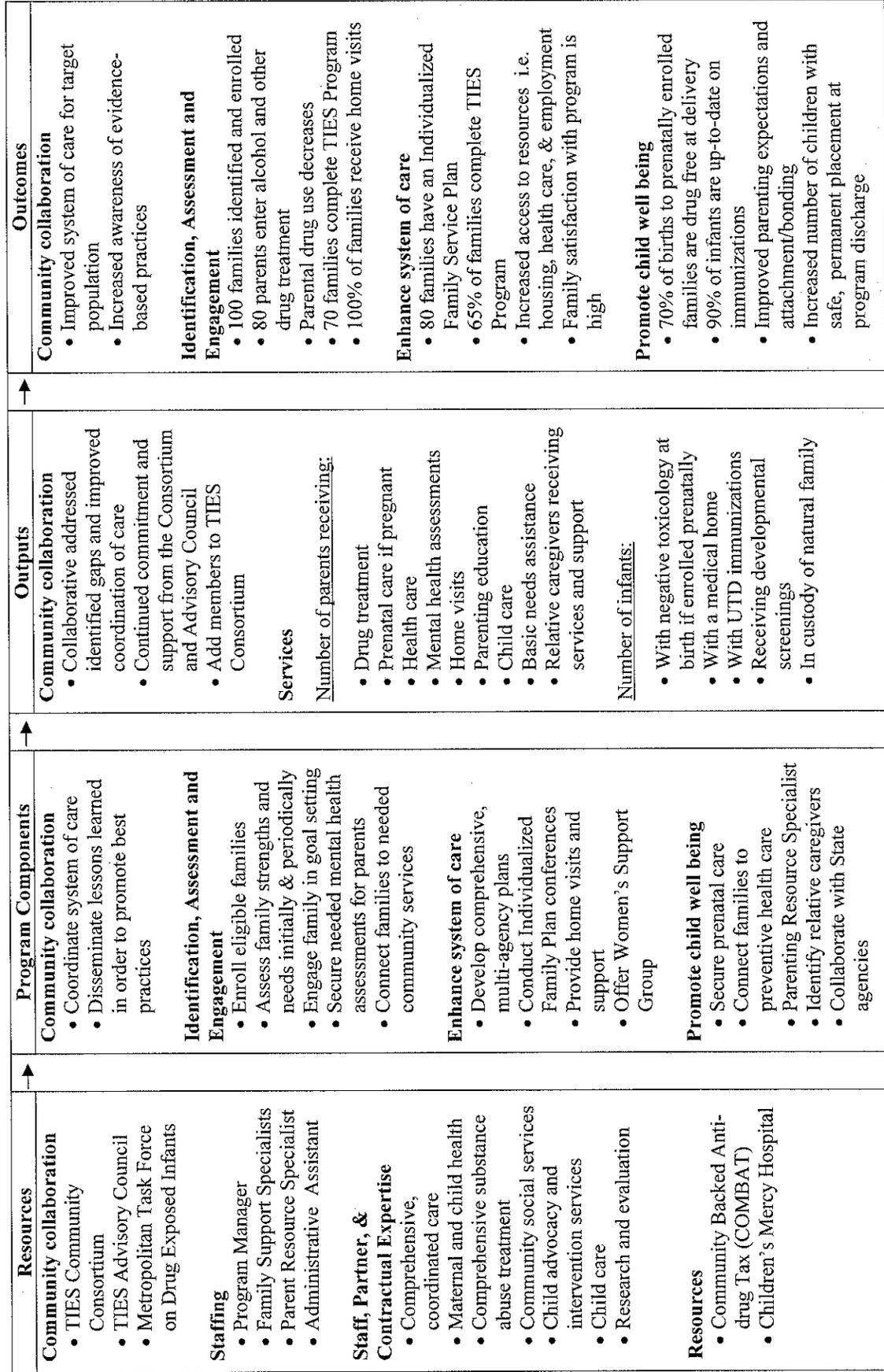
Improved school readiness and achievement

Reduced domestic violence

Improved family economic self-sufficiency

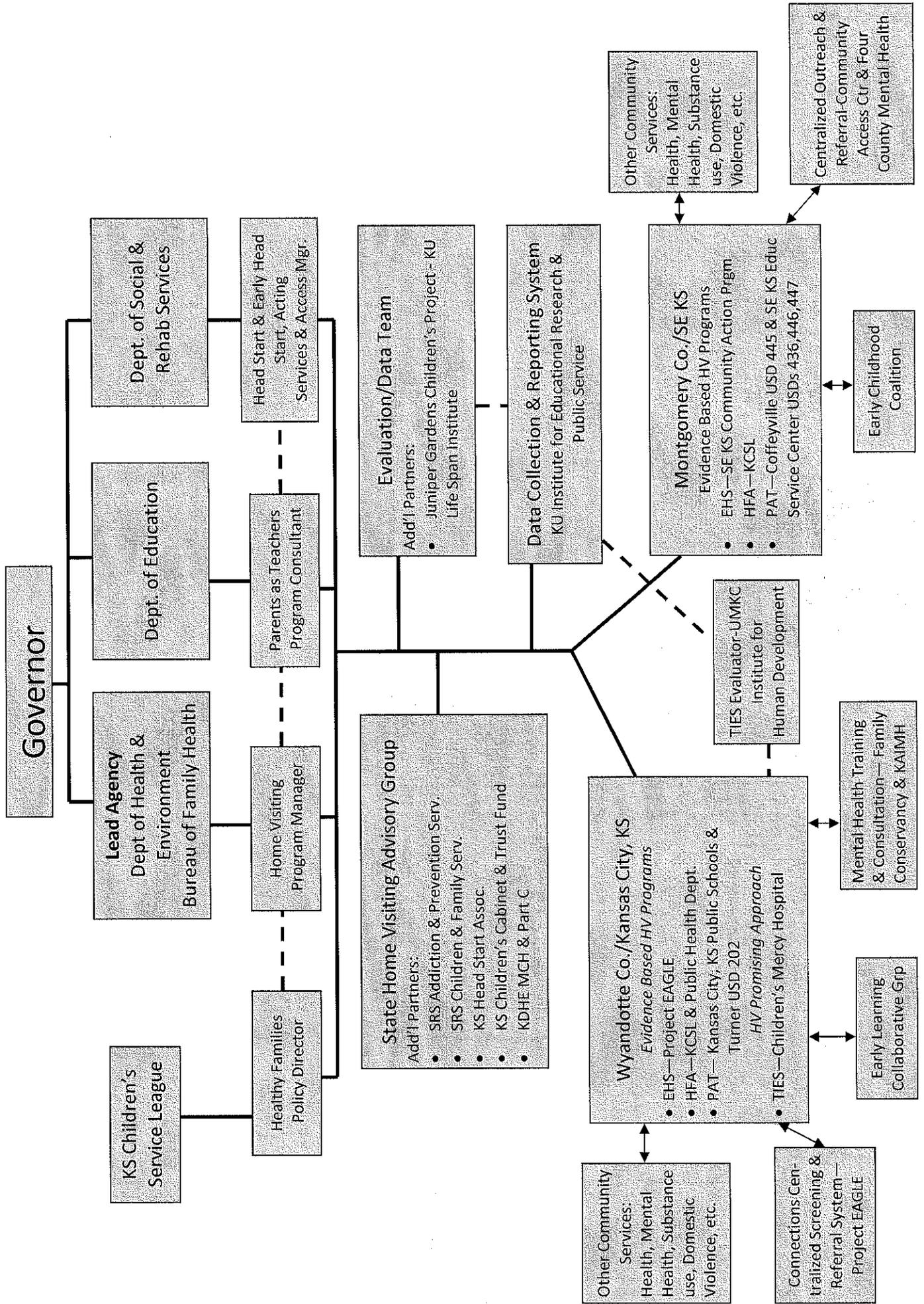
Improved coordination and referrals for community resources & supports

TIES Program Logic Model



Kansas Maternal, Infant & Early Childhood Home Visiting Program

Organizational Chart



Benchmark 1: Improved Maternal and Newborn Health			
Construct	Definition of Improvement	Measure/Source	Data Collection & Analysis
1) Prenatal care	Increase the mean number of prenatal health care visits pregnant women attend after their enrollment in the program, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	Timing: Intake and after completion of each trimester Analysis: Sum of prenatal health care visits attended by enrolled pregnant women after enrollment in program divided by sum of all enrolled pregnant women
2) Parental use of alcohol, tobacco, or illicit drugs	Increase in the percentage of pregnant women, mothers and fathers enrolled in the program who are screened for alcohol, tobacco, and illicit drug use using a standardized instrument, from year 1 baseline to the 3-year benchmark reporting period	<i>Alcohol, Smoking and Substance Involvement Screening Test</i> (ASSIST 3.0; World Health Organization) - 8 items covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives, hallucinogens, opioids, and 'other drugs', that can be answered by most subjects in around 10 minutes. Available in English and 10 other languages. Proven a valid screening instrument for identifying psychoactive substance use in individuals who use a number of substances and have varying degrees of substance use. Concurrent validity: significant correlations between ASSIST scores and scores from the ASI-Lite ($r = 0.76-0.88$), SDS ($r = 0.59$), AUDIT ($r = 0.82$) and RTQ ($r = 0.78$); and significantly greater ASSIST scores for those with MINI-Plus diagnoses of abuse or dependence ($P < 0.001$); Construct validity: significant correlations between ASSIST scores and measures of risk factors for the development of drug and alcohol problems ($r = 0.48-0.76$); Discriminative validity: established by the capacity of the ASSIST to discriminate between substance use, abuse and dependence (Humeniuk et al., 2008).	Timing: Intake and annually post enrollment Analysis: Sum of enrolled pregnant women, mothers and fathers screened for alcohol, tobacco, and drug use divided by sum of all enrolled pregnant women, mothers and fathers
3) Preconception care	Increase in the percentage of mothers in the program who receive one or more routine	HV program records Self-reports	Timing: Intake and every 6 months post enrollment

	primary care visits after the birth of the index infant and before a subsequent pregnancy, from year 1 baseline to the 3-year benchmark reporting period		Analysis: Sum of enrolled mothers receiving one or more routine primary care visits after index child's birth and prior to subsequent pregnancies divided by the sum of all enrolled mothers
4) Inter-birth intervals	Reduction in the percentage of mothers enrolled in the program who have a subsequent pregnancy in less than 18 months after the index infant's birth, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	Timing: Intake and every 6 months post enrollment Analysis: Sum of enrolled mothers who become pregnant < 18 months after the index infant's birth divided by the sum of all enrolled mothers
5) Screening for maternal depressive symptoms	Increase in the percentage of women enrolled in the program who are screened for depression during pregnancy through one year postpartum using a standardized instrument, from year 1 baseline to the 3-year benchmark reporting period	(EHS, HFA, PAT will use) <i>Edinburgh Postnatal Depression Scale</i> - 10 item non-standardized self-report used to measure and assess maternal postnatal and postpartum depression. Good user acceptability (92% response rate) and sensitive and specific (79% and 85% respectively) to measure postnatal depression in adult women (Cox et al., 1996). Internal consistency reliability for 149 adolescents .88 (Logsdon et al., 2009). (TIES will use) <i>Brief Symptom Inventory</i> (BSI; Derogatis, 1993) - Total scale and depression subscale that identifies level of clinical depression and other psychiatric symptoms. Total scale and depression subscale: Cronbach's alpha coefficients for 9 dimensions ranged from .71 to .85 for 719 psychiatric patients, demonstrating very good internal consistency. Correlations above .90 document equivalence of SCK-90-R with the BSI.	Timing: At intake and every 3 months through one year postpartum Analysis: Sum of enrolled women screened for depression prenatally or within 1 year postpartum divided by the sum of all enrolled women who are pregnant or within 1 year postpartum

6) Breastfeeding	Increase in the mean length of time mothers enrolled in the program breastfeed the index infant during first six months, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	<p>Timing: Monthly for first 6 months postpartum</p> <p>Analysis: Sum length of time enrolled mothers breastfeed 6 months postpartum divided by sum of all enrolled mothers under 6 months postpartum</p>
7) Well-child visits	Increase in the percentage of index children of families enrolled in the program who are current on well-child visits according to AAP Recommendations for Preventive Pediatric Health Care, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	<p>Timing: Intake and every 6 months post enrollment</p> <p>Analysis: Sum of enrolled index children current on recommended well-child visits divided by sum of all enrolled index children</p>
8) Maternal and child health insurance status	Increase in the percentage of women and index children enrolled in the program who are covered by health insurance, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	<p>Timing: Intake and annually post enrollment</p> <p>Analysis: Sum of enrolled women and index children covered by health insurance divided by sum of all enrolled women and index children</p>
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits			
Construct		Measure/Source	Data Collection & Analysis
9) Visits for children to the emergency department from all causes	Decrease in the mean number of visits to the emergency department from all causes for index children of enrolled families, from year 1 baseline to the 3-year benchmark reporting period	HV program records Self-reports	<p>Timing: One month after index infants' birth and every 6 months</p> <p>Analysis: Sum of ED visits for enrolled index children for divided by sum of all enrolled index children</p>

<p>10) Visits for mothers to the emergency department from all causes</p>	<p>Decrease in the mean number of visits to emergency department from all causes for women enrolled in program, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records Self-reports</p>	<p><u>Timing:</u> Intake and every 6 months post enrollment <u>Analysis:</u> Sum of ED visits for enrolled women divided by sum of all enrolled women</p>
<p>11) Information provided or training of participants on prevention of child injuries</p>	<p>Increase in the mean number of child injury prevention lessons provided to families enrolled in the program during home visits and/or parent group meetings using planned curriculum materials, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records Home visitor reports and parent group agendas</p>	<p><u>Timing:</u> Annually after enrollment <u>Analysis:</u> Sum of child injury prevention specific lessons to enrolled families divided by sum of all enrolled families</p>
<p>12) Incidence of child injuries requiring medical treatment</p>	<p>Decrease in the mean number of injury incidents requiring medical treatment (i.e., primary care, ambulatory care, emergency room visits, hospitalization, other medical intervention) for the index children of families enrolled in the program, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records Self-reports</p>	<p><u>Timing:</u> One month after index infants' birth and every 6 months <u>Analysis:</u> Sum of injury incidents requiring medical treatment for enrolled index children divided by sum of enrolled index children</p>
<p>13) Reported suspected maltreatment for children in the program (allegations screened in but not necessarily substantiated)</p>	<p>Decrease in the percentage of index children of families enrolled in the program for whom suspected maltreatment has been received and screened in by child protective services (CPS), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>SRS administrative data HV program records</p>	<p><u>Timing:</u> Intake and annually post enrollment <u>Analysis:</u> Sum of enrolled index children with screened in CPS reports due to suspected maltreatment divided by sum of all enrolled index children</p>

<p>14) Reported substantiated maltreatment (substantiated/indicated /alternative response victim) for children in the program</p>	<p>Decrease in the percentage of index children of families enrolled in program for whom CPS has substantiated reports of maltreatment (i.e., disposition as victim, substantiated or indicated), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>SRS administrative data HV program records</p>	<p><u>Timing:</u> Intake and annually post enrollment <u>Analysis:</u> Sum of enrolled index children with substantiated reports of maltreatment divided by sum of all enrolled index children</p>
<p>15) First-time victims of maltreatment</p>	<p>Decrease in the percentage of index children of families enrolled in the program for whom child maltreatment is substantiated by CPS for the first time in their lives, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>SRS administrative data HV program records</p>	<p><u>Timing:</u> Intake and annually post enrollment <u>Analysis:</u> Sum of enrolled index children with first-time child maltreatment cases substantiated divided by sum of all enrolled index children with substantiated reports of maltreatment</p>
<p>Benchmark 3: Improvements in School Readiness and Achievement</p>			
<p>Construct</p>			
<p>16) Parent support for children's learning and development</p>	<p>For families enrolled in the program, increase in the mean scores of parents' support of index children's learning and development (i.e., learning materials, parental involvement in learning) in the home environment, from year 1 baseline to the 3-year benchmark reporting period</p>	<p><i>Home Observation for Measurement of the Environment – Infant/Toddler Inventory</i> 3rd Ed. (HOME; Caldwell & Bradley, 2001): Learning Materials and Parental Involvement subscales - Intended to identify environments that do not stimulate the cognitive development of children and to assist in the development of interventions that benefit both the caregiver and the child. Comprised of 45 items organized into 6 subscales: (1) responsiveness to parent, (2) avoidance of the restriction and punishment, (3) organization of the environment, (4) appropriate play materials, (5) parental involvement, and (6) variety in daily stimulation. The information is collected from observations, supplemented by parent interview, during home visits that are scheduled when the</p>	<p>Data Collection & Analysis <u>Timing:</u> Index child ages 6 months, 12 months, 18 months, 24 months, 36 months (within window of 3 months) <u>Analysis:</u> HOME Learning Materials and Parental Involvement subscales scores</p>

<p>17) Parent knowledge of child development and of their child's developmental progress</p>	<p>For families enrolled in the program, increase in the mean scores of parents' appropriate expectations of children (i.e., understanding of growth and development, developmental capabilities, self-concept as a caregiver, and parental support), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>child is awake and engaged in activities typical for that time of the day. Internal consistency reliability: Cronbach's alphas were .84 for the HOME inventory and .49-.78 for the 6 subscales. Kuder-Richardson coefficients: .89 for the inventory and ranged from .44 to .89 for the subscales. Intraclass correlation coefficients: .57 for the inventory and .23-.57 for the sub-scales when administered at ages 6 and 12 months, .58 for the inventory and ranged from .25 to .58 for the subscales at ages 6 and 24 months, and .76 for the inventory and .30 to .76 at ages 12 and 24 months. Validity comparison with the Stanford-Binet: The correlations between the HOME inventory score at 6 months and the Stanford-Binet at 36 and 54 months were .50 (subscales ranged from .24 to .41) and .44 (sub-scales ranged from .10 to .44), respectively. The correlation between the HOME at 12 months and the Stanford-Binet at 36 months was .58 (sub-scales .24 -.56); between the HOME at 24 months and the Stanford-Binet at 36 and 54 months .71 (subscales .41-.64) and .57 (subscales ranged from .28 to .56), respectively.</p>	<p>Timing: At intake, at index child ages 6 months, 12 months, then annually (within window of 3 months)</p> <p>Analysis: AAPI-2 Expectations of Children construct scores</p>
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	Forms A and B for pretest and posttest. Takes an average 10-15 minutes to complete; 5 th grade reading level. Available in Spanish; normed for Spanish-speaking families. Cronbach's alpha reliabilities of the constructs for Forms A & B range from .82 to .92. Analysis of variance tests confirm the instrument's criterion related validity to distinguish between abusive/ neglecting populations and those that are not ($p < .001$ for each construct).		
<p>18) Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)</p>	<p>For families enrolled in the program, increase in the mean scores of parents' appropriate responses to child's behavior (i.e., reinforcement, communication, acceptance, corporal punishment, empathy), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HOME Infant/Toddler Inventory: Responsivity and Acceptance subscales OR AAPI-2: Use of Corporal Punishment, Parental Empathy toward Child's Needs, & Children's Power and Independence constructs</p>	<p>Timing: Index child ages 6 months, 12 months, 18 months, 24 months, 36 months Analysis: Scores from HOME Responsivity and Acceptance subscales or AAPI-2 Use of Corporal Punishment, Parental Empathy toward Child's Needs, & Children's Power and Independence constructs</p>
<p>19) Parent emotional well-being or parenting stress</p>	<p>For families enrolled in the program, increase in the mean scores of parents' protective factors (i.e., family functioning/resiliency, social support, concrete support, knowledge of parenting/child development, nurturing and attachment), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>Protective Factors Survey (Institute for Educational Research and Public Service at the University of Kansas) - Self-report instrument aimed at caregivers receiving child abuse prevention services. Examines 5 domains: family functioning/ resiliency, social emotional support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Only available in English. Internal consistency: Subscales .76 to .89. The PFS negatively predicts risk factors for child abuse and neglect (stress and depression) and positively predicts caregiver health.</p>	<p>Timing: At intake, index child ages 6 months, 12 months then annually Analysis: Reverse score specific items and then sum the subscales</p>

<p>20) Child's communication, language and emergent literacy</p>	<p>Increase in the percentage of index children of families enrolled in the program who demonstrate developmentally-appropriate communication skills, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>(EHS, HFA, PAT will use) <i>Early Communication Indicator (ECI)</i>; Juniper Gardens Children's Project) – Checks growth of children birth-3 toward being able to express themselves through their gestures, vocalizations, words, and sentences. Standardized play-based progress monitoring measure intended for use by early interventionists, service providers and home visitors in intervention decision making. Uses video for observation assessment and checklist. Can be utilized in different languages. The ECI is sensitive to short-term growth, well suited for planning and modifying interventions for individuals as well as an entire program and can be used for children who have English as a second language and for children with disabilities. Criterion validity with the Preschool Language Scale is $r = .62$; reliability is $.90$.</p> <p>(TIES will use) Bayley Infant Neurodevelopmental Screener (BINS): Verbal Expressive Functions For ages 3-24 months. Four areas of abilities measuring reduction of developmental risk associated with developmental delay or neurological impairments. Internal consistency reliability - Cronbach's alpha coefficients .73 to .85. Group classification consistency 68% to 78% for 3-, 9-, and 18-month old infants. Inter-rater reliabilities: .79, .91, and .96 for infants aged 6, 12, and 24 months, respectively. In a sample of 3-, 6-, 18-, and 24-month-old infants, Pearson correlation coefficients of the BINS with the BSID-II Mental Developmental Index ranged from .43 to .82; ranged from .39 to .58 with the BSID-II Psychomotor Developmental Index.</p>	<p><u>Timing:</u> ECI - quarterly BINS - index child ages 3-7 months, 9-13 months, and 18 months Analysis: Sum of enrolled index children demonstrating developmentally-appropriate communication skills per ECI scores or BINS Verbal Expressive Functions scores divided by sum of all enrolled index children</p>
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<p>21) Child's general cognitive skills</p>	<p>Increase in the percentage of index children of families enrolled in the program who demonstrate developmentally-appropriate cognitive skills, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>(EHS, HFA, PAT) ASQ-3: Problem-solving area (TIES) BINS: Basic Neurological Functions and Cognitive Processes</p>	<p><u>Timing:</u> ASQ-3 is conducted at interval ages at the following months of age: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60</p> <p>BINS - ages 3-7 months, 9-13 months, and 18 months</p> <p><u>Analysis:</u> Sum of enrolled index children demonstrating developmentally-appropriate cognitive skills per ASQ-3 Problem-Solving Area scores or BINS Neurological Functions and Cognitive Processes scores divided by sum of all enrolled index children</p>
<p>22) Child's positive approaches to learning including attention</p>	<p>Increase in the percentage of index children of families enrolled in the program who demonstrate positive approaches to learning including attention, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>Note: An appropriate measure has not been determined. Further technical assistance is requested.</p>	<p><u>Timing:</u> <u>Analysis:</u> Sum of enrolled index children demonstrating positive approaches to learning including attention divided by sum of all enrolled index children</p>
<p>23) Child's social behavior, emotion regulation, and emotional well-being</p>	<p>Increase in the percentage of index children of families enrolled in the program who demonstrate developmentally-appropriate social and emotional behavior and emotional well-being, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>(EHS, HFA, PAT will use) <i>Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)</i> - A series of 8 questionnaires and Analysis sheets each taking 15 to 20 minutes to complete. Appropriate for use with children ages 1 month to 66 months. Areas screened include self-regulation, compliance, communication,</p>	<p><u>Timing:</u> ASQ-SE is conducted at interval ages at the following months of age: 6, 12, 18, 24, 30, 36, 48, 60 NCFAS -- At Intake and at child age of 24 months</p>

		<p>adaptive behaviors, autonomy, affect, and interaction with people. Parents or caregivers complete the questionnaires and paraprofessionals, professionals, or clerical staff score them. Validity is 75-89%. Reliability is 94%. Specificity is 95% and overall sensitivity is 78%.</p> <p>(TIES will use) <i>NCFAS for Intensive Family Preservation Services (IFPS) Programs</i> (Kirk & Ashcroft, 1998): Child Well-Being subscale - Designed to describe the ecological structure of family functioning, address safety concerns, assess both strengths and deficits, and detect small changes in family functioning while being administered in a limited time with personnel requiring minimal training. Preliminary field-testing with 126 families resulted in the inclusion of 5 domains: environment, family interactions, family safety, and child well-being, with coefficient alpha scores ranging from .71 to .93. Construct validity found with two other family assessment tools for all 5 domains, with Pearson's R correlations of .26 to .71.</p> <p>(EHS, HFA, PAT will use) ASQ-3: Gross Motor and Fine Motor areas</p> <p>(TIES will use) BINS: Motor Expressive Functions</p>	<p><u>Analysis:</u> Sum of enrolled index children demonstrating developmentally-appropriate social and emotional behavior and emotional well-being per ASQ-SE scores or NCFAS Child Well-Being subscale scores divided by sum of all enrolled index children</p>
<p>24) Child's physical health and development</p>	<p>Increase in the percentage of index children of families enrolled in the program who demonstrate developmentally-appropriate motor skills, from year 1 baseline to the 3-year benchmark reporting period</p>		<p><u>Timing:</u> ASQ-3 is conducted at interval ages at the following months of age: 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, 60 BINS - index child ages 3-7 months, 9-13 months, and 18 months</p> <p><u>Analysis:</u> Sum of enrolled index children demonstrating</p>

<p>29) Of families identified for the presence of domestic violence, number of families for which a safety plan was completed</p>	<p>Increase in the percentage of families enrolled in the program and identified with the presence of domestic violence who have a completed safety plan, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records (safety plan can be completed by home visitor or referral service)</p>	<p><u>Timing:</u> Intake and annually post enrollment <u>Analysis:</u> Sum of identified enrolled families with a completed safety plan divided sum of enrolled families with identified presence of DV</p>
<p>Benchmark 5: Family Economic Self-Sufficiency</p>			
<p>Construct</p>			
<p>30) Household income and benefits</p>	<p>Increase in the mean total amount of income and benefits (earnings and cash support) from all sources received by the household of families enrolled in the program (i.e., all individuals who regularly live in the home who contribute to the support of the enrolled pregnant woman, mother and/or child), from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records</p>	<p><u>Data Collection & Analysis</u> <u>Timing:</u> At intake and annually post enrollment <u>Analysis:</u> Sum of total amount of income and benefits from all sources of enrolled families divided by sum of enrolled families</p>
<p>31) Education of adult members of the household</p>	<p>Increase in the percentage of households of families enrolled in the program (i.e., all adults who regularly live in the home who contribute to the support of the enrolled pregnant woman, mother and/or child) who have improved levels of educational attainment (i.e., high school diploma, GED, post-secondary coursework/degrees, vocational training/certification), from year 1 baseline to 3-year benchmark reporting period</p>	<p>HV program records</p>	<p><u>Timing:</u> At intake and annually post enrollment <u>Analysis:</u> Sum of enrolled family households with improved levels of educational attainment divided by sum of enrolled family households</p>
<p>32) Health insurance status</p>	<p>Increase in the percentage of household members of families enrolled in the program (i.e., all individuals who regularly live in the home) who are covered by health insurance, from year 1 baseline to the 3-year benchmark reporting period</p>	<p>HV program records</p>	<p><u>Timing:</u> At intake and annually post enrollment <u>Analysis:</u> Sum of household members covered by health insurance divided by sum of all household members</p>

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports		
Constraint	Definition of Improvement	Measure/Source
33) Number of families identified for necessary services	For families enrolled in the program, increase in the mean number of completed screenings to determine the families' needs for other services, from year 1 baseline to the 3-year benchmark reporting period	HV program records <u>Timing:</u> At intake and annually post enrollment <u>Analysis:</u> Sum of screenings completed to determine enrolled families' needs divided by sum of all enrolled families
34) Number of families that required services and received a referral to available community resources	Increase in the mean number of appropriate referrals to available community resources made to enrolled families identified as needing other services, from year 1 baseline to the 3-year benchmark reporting period	HV program records <u>Timing:</u> At intake and annually post enrollment <u>Analysis:</u> Sum of appropriate referrals made to enrolled families with identified needs divided by sum of families who have an identified need through screenings
35) Number of Memoranda of Understanding (MOU) or other formal agreements with other social service agencies in the community	Increased number of MOUs or other formal agreements established between HV programs and other social service agencies in the community, from year 1 baseline to the 3-year benchmark reporting period	Documented MOUs or other formal agreements <u>Timing:</u> At start of program implementation then annually <u>Analysis:</u> Count the number of MOUs or other formal agreements between HV programs and other social service agencies
36) 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	Increase in the number of collaborating community agencies with which the HV program has a clear point of contact in the agency that includes regular sharing of information between agencies	HV program records – survey of community partners <u>Timing:</u> At start of program implementation then annually <u>Analysis:</u> Count the number of collaborating community agencies with which the HV program has a clear point of contact in the agency that includes regular sharing of

<p>between agencies</p> <p>37) Number of completed referrals</p>	<p>Increase in the percentage of community resource referrals provided to families enrolled in the program with identified needs for whom receipt of services can be confirmed</p>	<p>HV program records – documentation of individual family referrals assessed for completion</p>	<p>information between agencies</p> <p><u>Timing:</u> At intake and annually post enrollment</p> <p><u>Analysis:</u> Sum of confirmed service receipt divided by sum of all referrals made to enrolled families with identified needs</p>
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POSITION DESCRIPTION

Part I: POSITION INFORMATION

Read each heading carefully before proceeding. Make statements simple, brief, and complete. Be certain the form is signed. Send the original to Human Resources. Supervisors and incumbents are responsible for completion of this form.

Unclassified	Temporary	Full-Time	New	100%	Other %
Position Number: K0221106	Current Class Title:		For Use by Human Resources		
Employee Name: <i>Deborah Richardson</i>	Proposed Class Title: (reallocations or new positions only) Program Manager (Home Visiting)		Allocation:	Program Manager	
Direct Supervisor	Name: Linda Kenney	Position Number: K0076002	Effective Date:	9/7/2010	
	Title: Director, Bureau of Family Health		FLSA Status:	Nonexempt	
			Approved By:	Patti Woodcock	
			Pay Grade:	29	
Location:	Topeka/Shawnee	Other Location:	8:00am - 5:00pm	Other Hours:	
Division:	Division of Health, Bureau of Family Health		Budget Program Number:	65101	

Part II: ORGANIZATIONAL INFORMATION

1. If this is a request to reallocate the position, briefly describe the reorganization, reassignment of work, new function added by law or other factors which changed the duties and responsibilities of the position.

2. How much latitude is allowed incumbent in completing work? Significant

3. What kinds of instructions, methods and guidelines are given to the incumbent in this position to help do the work?
Meets with supervisor to obtain general information and direction and discuss problems relating to administration of services or program content and objectives.

4. Which statement best describes the results of error in action or decision of this incumbent?
Major program failure, major property loss, or serious injury or incapacitation.

5. Describe the work of this position. Use the following format for describing the duties: What is the action being done (use action verb); to whom or what is the action directed (object of action); why is the action being done (describe the result or outcome expected); how is the action expected to be performed (describe the manner, methods, techniques or procedures in which the task is currently performed).

Number Each Task, Indicate Percent of Time and Identify each function as Essential or Marginal by placing an "E" or "M" next to the % of time for each task. No duty shall exceed 50% nor be less than 5%.

Essential functions are primary job duties for which the position was created and that an employee must be able to perform, with or without a reasonable accommodation.

Marginal functions are peripheral, incidental or minimal parts of the position.

Note: The description of how the work is to be performed does not preclude the consideration of reasonable accommodation(s) for qualified persons with a disability.

Number	% of Time	E or M	Description of Duties
1.	20%	E	Program management that includes coordinating the information from state needs assessments of multiple agencies and from federally-specified indicators that are used to derive state-specific strategies to deliver services for high-risk populations. Involves work with multiple agencies at the state and local levels, with private contractors, research entities, and academia. Work activities are framed by the U.S. Department of Health and Human Services Funding Opportunity Announcement for Maternal, Infant, and Early Childhood Home Visiting Program that provides funding to the State to develop a service system of evidence-based practice.
2.	20%	E	Provides support for the state needs assessment by tailoring methodology to reflect project needs. Assists state and local agencies to be fully engaged in the process by providing communications and other support. Evaluates local agency project plans for compliance with federal guidance and technical assistance regarding state needs. Consults with partners across state and local agencies and programs regarding plans and progress of the project and local programs.
3.	20%	E	Provides project oversight to agency managers for compliance with project planning guidelines, standards, policies and methodologies. Coordinates and provides reporting on project plan and coordinates the work group activities and convenes the public input or stakeholder group at appropriate intervals. Manages the project plan and coordinates the work of multiple managers from multiple agencies working on the project.
4.	20%	E	Participates in recommendations for home visiting model acquisition by identifying budgetary and other impacts. Tracks program progress against established timeline and budget. Identifies and reports on program deficiencies and advises of measures to correct. Provides project management support for local agencies who are implementing evidence-based practice in home visiting.
5.	15%	E	Represents the program at local, state, regional or national conferences and meetings. Gives presentations and briefings as requested.
6.	5%	M	Perform other duties as assigned including serving as a member of the KDHE Disaster Response Team as needed to assure the agency's public and environmental health response is adequately staffed during and immediately following natural and/or manmade disasters, infectious disease outbreaks, and/or acts of terrorism.

6. Click on the button if this position directly supervises agency employees: Supervisor Non-Supervisor

7. List the class titles and position numbers of all agency employees directly supervised by this position:

Class Title	Position #	Class Title	Position #

8. For what purpose, with whom and how frequently are contacts made with the public, officials or other employees?

	Frequency	Purpose	Other Purpose:
<input checked="" type="checkbox"/> Local Government Officials	Daily	carry out duties	
<input checked="" type="checkbox"/> State Government Officials	Daily	carry out duties	
<input checked="" type="checkbox"/> Federal Government Officials	Frequently	carry out duties	
<input checked="" type="checkbox"/> Community Contacts	Daily	carry out duties	
<input type="checkbox"/> Private Consultants	Frequency:	Purpose:	
<input type="checkbox"/> Owners	Frequency:	Purpose:	
<input type="checkbox"/> Operators	Frequency:	Purpose:	
<input checked="" type="checkbox"/> Legislature	Occasionally	provide program information	
<input checked="" type="checkbox"/> KDIIE Program Staff	Daily	carry out duties	
<input type="checkbox"/> Other	Frequency:	Purpose:	
<input type="checkbox"/> Other	Frequency:	Purpose:	
<input type="checkbox"/> Other	Frequency:	Purpose:	

9. What hazards, risks or discomforts exist on the job or in the work environment?

Normal Office Environment
 Other (please explain)

10. Describe any methods, techniques or procedures that must be used to ensure safety for equipment, employees, clients and others. (Check all that apply.)

- Standard industry health and safety protocol is used at sites to ensure the safety of all on-site personnel and the general public.
- Contact with corrosive, toxic, ignitable, and/or reactive materials during fieldwork including hazardous or solid waste site visits, sampling activities, and related work may occur.
- Pursuant to 29 CFR, Part 1910.120, employee will be required to successfully complete the 40-hour Hazardous Waste Site Operations training and the annual eight-hour update training.
- Personal protective equipment is provided as necessary.
- The use of electrical audiovisual equipment necessitates knowledge and safety measures while using and securing equipment cords to prevent self and others from electrical shock or trip/fall injuries.
- Normal driving and road hazards may occur while traveling Kansas roads.
- Use of proper lifting techniques is necessary when lifting and moving material, equipment, etc.
- Requires the use of computer, copier, calculator, fax, and other electrical office machines.
- Incumbent is encouraged to follow office safety practices to ensure safety for self and others in the office.
- Other:

11. Performance of the duties of this position could be reasonably anticipated to cause exposure to blood, blood products and/or other potentially infectious materials.
 Yes No

12. Check all machines regularly used in the work of this position and indicate frequency with which they are used.

Equipment:	Frequency Used:	Equipment:	Frequency Used:	Other:
<input checked="" type="checkbox"/> Computer	Daily	<input checked="" type="checkbox"/> Other (describe)	Occasionally	projector
<input checked="" type="checkbox"/> Telephone	Daily	<input type="checkbox"/> Other (describe)	Frequency:	
<input checked="" type="checkbox"/> Copier	Daily	<input type="checkbox"/> Other (describe)	Frequency:	
<input checked="" type="checkbox"/> Fax machine	Frequently	<input type="checkbox"/> Other (describe)	Frequency:	
<input checked="" type="checkbox"/> Scanner	Occasionally			
<input type="checkbox"/> Scientific equipment	Frequency:			
<input type="checkbox"/> Sampling equipment	Frequency:			
<input checked="" type="checkbox"/> Vehicle	Frequently			

Part III: EDUCATION, EXPERIENCE AND SAFETY INFORMATION

13. Minimum Requirements (MR) as stated in the State of Kansas Class Specification. Note: Do not include substitution statement indicated on class specification. However, if substitution is desired, specifically describe substitution.

Two years of experience in planning, organizing and directing the work of a department, program or agency.

14. Special Requirements: Additional qualifications for this position that are necessary to perform the Essential Functions of the position (i.e. license, registration or certification).

- License's Required
- Valid Driver's License - Incumbent is required to have and maintain a valid driver's license when operating a state vehicle, a private vehicle, or a rental vehicle for the benefit of the State.
 - Professional Environmental Engineer - Incumbent is required to maintain a professional environmental engineer license while in the position.
 - Professional Geologist - Incumbent is required to maintain a professional geology license while in this position.

Other License

15. Preferred education, experience or skills. (These items will be used to screen applicants when recruiting to fill the position.)

Preferred Education	Degree Area	Preferred Skills	
<input checked="" type="checkbox"/> High School/GED		<input checked="" type="checkbox"/> Computer Skills	Word, Excel, PowerPoint, Access
<input type="checkbox"/> Bachelors Degree		<input checked="" type="checkbox"/> Grammar	Proofreading, editing, attention to detail
<input checked="" type="checkbox"/> Masters Degree	Health, Social Services, Education	<input checked="" type="checkbox"/> Other	Public speaking
<input type="checkbox"/> Ph.D.		<input type="checkbox"/> Other	
<input type="checkbox"/> M.D.		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	

Preferred Experience:
 Two years of experience managing a health or social service related program at the state or local level. Demonstrated experience in working with a large group of diverse stakeholders to achieve a common goal. Project management experience. Federal grants management experience. Experience in health, social service or early childhood programs. Program guidelines development experience. Professional standards development experience. Annual plans/reports development experience. Performance measures development experience. Experience working with diverse professional groups.

Part IV: SIGNATURES

Deborah L. Richardson 2/7/11
 Signature of Employee Date

Patti Woodcock 9/7/2010
 Signature of Human Resources Official Date

Approved:

Linda Kenney 9/7/2010
 Signature of Supervisor Date

Robert J. Brady 9/7/2010
 Signature of Agency Head or Appointing Authority Date

DEBORAH L. RICHARDSON
618 S. Willis Street Stillwater, OK 74074
405-743-8364 (home) 405-245-3725 (cell) 405-744-9932 (office)
dlr405@sbcglobal.net

EDUCATION

Oklahoma State University (OSU) – Stillwater, OK

- Ph.D. 2009 Human Environmental Sciences - Human Development & Family Science
Dissertation title: *Evaluation of interpersonal problem-solving skills program for preschool and elementary school children*
- M.S. 1984 Applied Behavioral Studies in Education - Community Counseling
- B.S. 1982 Psychology with Honors

PROFESSIONAL EXPERIENCE

Home Visiting Program Manager, Bureau of Family Health Feb 2011 - present
Kansas Department of Health and Environment Topeka, KS

- Coordinate and administer the planning and implementation of the federal Maternal, Infant and Early Childhood Home Visiting Program.

Parenting/Child Development Assistant State Specialist Mar 2001 – Feb 2011
Oklahoma Cooperative Extension Service, OSU Stillwater, OK

- Administered funding contracts for multiple child abuse prevention home visitation programs and other projects totaling up to \$650,000 per year.
- Coordinated and provided training, technical support, site and staff development, curriculum, resource materials, and monitoring for county Extension staff as well as contracting agencies.
- Led and evaluated targeted impact programs with teams of field staff and other faculty, particularly to strengthen family resilience and prevent risk behaviors in children and youth.
- Prepared and disseminated research-based information for professional and public audiences.

Senior Planner, Office of Planning and Coordination Apr 1999 – Mar 2001
Oklahoma Commission on Children and Youth Oklahoma City

- Facilitated joint planning and coordination among state and local agencies to improve services for children and youth including community and state needs assessment and planning processes.
- Provided staff support, technical assistance, and training to a state council, a network of community partnership boards, and post-adjudication citizen review boards statewide.
- Revised structure and guidelines for community partnership boards to enhance functioning.
- Liaison with other organizations, task forces, initiatives and provided training, communication, and leadership on child and family issues.

Executive Director June 1990 – Apr 1999
Oklahoma Committee to Prevent Child Abuse (now Prevent Child Abuse OK) Oklahoma City

- Implemented state chapter's mission and goals as the first employed director.
- Supported and collaborated with nonprofit board of directors, advisory and project committees.
- Managed administrative and financial functions, developed budget, personnel and volunteers.
- Developed and coordinated public awareness, education, advocacy, and community-based programs.
- Generated and coordinated grants and other resource development activities.
- Provided consultation, training, and information resources to professionals, policy-makers, and media.
- Built and sustained collaborative partnerships with national, state, and local organizations and initiatives.

Program Coordinator**Oct 1989 – June 1990****Mother to Mother of Oklahoma County****Oklahoma City**

- Initiated goals, policies, procedures, and program services as the first employed coordinator.
- Developed community awareness through media and networking with organizations and churches.
- Collaborated with nonprofit board of directors and recruited, trained, and supervised volunteers.
- Facilitated fundraising activities and grant writing.
- Assessed referrals and conducted home visits with low-income mothers.

Teen Family Life Program Director, The Infant Center**Aug 1986 – June 1989****Department of Family Medicine, University of Oklahoma Health Sciences Center****Oklahoma City**

- Developed and provided services for pregnant and parenting adolescents including parent support and education groups, childbirth classes, and parent aide home visitation.
- Administered state and federal child abuse prevention grants and submitted reports.
- Recruited, trained, and supervised volunteers. Provided training and consultation to professionals.
- Co-authored group curriculum and implemented project evaluation.
- Coordinated community outreach, interagency collaboration, and public awareness.

Counselor**Nov 1984 – Aug 1986****Mid-Del Youth and Family Center****Del City, OK**

- Provided individual, marriage, and family counseling and crisis intervention.
- Conducted parenting skills classes, presentations in schools, and community public awareness.

PROFESSIONAL AFFILIATIONS, INVOLVEMENT, AND SERVICE

Society for Research in Child Development - Member, 2009-present

National Council on Family Relations - Member, 2002-present

Oklahoma Home Visitation State Leaders Coalition - Member, 2004-present; Facilitator, 2004-2007

Healthy Families America State Leaders Advisory Committee - Member, 2001-2004; Co-chair, 2002-2004;
Research sub-group co-facilitator, 2002-2004Oklahoma Council on Family Relations - Board Member, 2003-2007; President-Elect, 2004-2005; President,
2005-2006Oklahoma Institute for Child Advocacy, Annual Fall Forum - Child Abuse Prevention Issue Workgroup Convener
and Facilitator, 2002-2004, 2006-2007, 2009

Interagency Evaluation Team, Oklahoma Child Abuse Prevention High Risk Population Pilot Project - 2003-2005

American Association of Family and Consumer Sciences, Council for Accreditation - Member, 2000-2002;
Secretary, 2002

Oklahoma Child Abuse Prevention State Plan Committee - 2001

Oklahoma Interagency Child Abuse Prevention Task Force - 1997-2001

Oklahoma County Child Welfare Citizen's Advisory Board – 1991-93

District VII (Oklahoma County) Child Abuse Prevention Task Force – 1986-92

Teen Pregnancy Coalition of Oklahoma County - Chairperson, Member-at-Large, and Treasurer, 1986-95

SPECIALIZED TRAINING & CERTIFICATIONS

Certified Family Life Educator (CFLE), National Council on Family Relations, 2010

Healthy Families America Certified Trainer, Prevent Child Abuse America, 2003

Group Facilitation Methods & Participatory Strategic Planning, Institute for Cultural Affairs, 2000

HONORS & RECOGNITIONOutstanding Group Award, Team Leader for Outstanding Educational Program, Healthy Families, Oklahoma
Cooperative Extension Service, January 2008

Outstanding New Professional Award, Oklahoma Council on Family Relations, 2005

Marion Jacewitz Award for Outstanding Service to Oklahoma, Oklahoma Interagency Child Abuse Prevention
Task Force, 1998

Position Description

Part I.		
1. Agency Name Kansas Department of Education (KSDE)	2. Position # K0145829	3. Current Classification Job Title Education Program Consultant <input checked="" type="checkbox"/> Classified <input type="checkbox"/> Unclassified
4. Division Learning and Innovative Services		5. Proposed Job Title (if reallocation)
6. Team Special Education Services		Date Position Description Updated 4/15/08
8. Name of Incumbent Janet Newton		7. Approved Classification
10. Work Station Location City: Topeka County: Shawnee		9. Reallocation Effective Date
13. <input checked="" type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> %		11. Classified Pay Grade
		12. FLSA Status <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt
		14. Approved By
18. Regular hours of work From: 8:00 AM to 5:00 PM Days of Week: M-F Other (please circle): Su M Tu W Th F Sa		Additional notes:
Part II.		
19. Describe the purpose of this position. Why does it exist?		
<p>The purpose of the position is to implement the Parents as Teachers Programs (PAT) throughout the state of Kansas. The person in this program provides oversight to local programs that access funding in order to provide early childhood supports and services in their communities for Parents as Teachers.</p>		
20. Who supervises this position?		
Incumbent	Title	Position #
Colleen Riley	Director	K0069308
21. a) How much latitude is allowed employees in completing the work? b) What kinds of instructions, methods, and guidelines are given to the employee in this position to help do the work? c) State how and in what detail assignments are made? d) Who reviews the work, how often, and what is the level of review?		
<p>The operational procedure for employees will include integrated team work as well as area specific work. In addition to team responsibilities, the individual will have specific, unique assignments. Individual work will be validated as it relates to the team mission, goals and assignments. Team members will be assigned to agency work groups to accomplish a specific outcome. Team members will continually develop and update a team action plan outlining work assignments and detailing team functions and responsibilities. The overall process will be guided by the strategic directions of the State Board of Education, and state and federal legislation.</p>		
22. Check the statement that best describes the leadership, supervisory, or management responsibilities of this position.		
<input checked="" type="checkbox"/> None Lead worker: Plans and coordinates the work of co-workers, guiding and training them while performing the same kind and level of work a majority of the time.		
<input type="checkbox"/> Supervisor: Assigns, directs, reviews, and evaluates the job performance; has significant input into decisions related to hires, transfers, promotions, demotions, dismissals, and discipline of employees under his or her supervision. The majority of the work is different from that of subordinates.		
<input type="checkbox"/> Manager: Integrates and coordinates the activities of several organizational functions or programs and initiates changes through subordinate supervisors or integrates and coordinates the activities of one or more programs having Department wide impact.		
23. Positions supervised directly by this position.		
Incumbent	Title	Position #
1. What hazards, risks, or discomforts exist on the job or in the work environment? Frequency of exposure?		
<p>The job requires frequent and extensive travel, therefore, exposing the Education Program Consultant to hazards of the road. Lifting and carrying boxes of workshop materials is necessary.</p>		

25. Number Each Task and Indicate Percent of Time an Incumbent Spends or Would Spend Performing each Task.		Describe the work of this position using this page. Duties may be continued on the next page if more space is needed. Use the following format for describing duties: What is the action being done (use an action verb)? To whom or what is the action directed (object of the action)? Why is the action being done? How is the action being done?
Essential Functions ADA Codes	% Of time	ADA Coding A: Essential function, position exists to perform the function. B: Essential function, number of employees available to perform this function is limited. C: Essential function, requires specialized expertise to perform this function. D: Non-essential function

Performance expectations will be established at the beginning of each performance review period that include, at a minimum, the following categories: dependability, agency values, job proficiency, communication, customer service, initiative, and teamwork

- A 40% Early Childhood Education – birth through age 3 interagency collaboration; home visits; develop and implement integrated programs with other agencies providing early childhood services; liaison with Part C Early Childhood and Early Childhood Mental Health through Kansas Dept. of Health & Environment
- C 45% Coordinate the Parents as Teachers Program
 1. Collect and report on parent education data
 2. Serve as KSDE liaison with the National Parents as Teachers Center (NPTC)
 3. Provide technical assistance in the local application process for parent education state grant funds
 4. Review and approve continuation and expansion applications and establish grant reading committees for new applications.
 5. Provide or contract for the required staff development hours
 6. Assess needs and progress toward meeting program goals and outcomes
 7. Disseminate materials and provide technical assistance related to assessment, model programs, and effective practices
 8. Act as liaison between NPTC, KSDE and local PAT programs
 9. Monitor implementation of PAT grants
- B 15%
 1. Prepare grant applications for local programs
 2. Review and award grants to local programs
 3. Serve on agency work groups and committees

Part III

26. State Required Minimum Qualifications	Advanced degree from an accredited university or college in relevant degree field(s) as determined by the agency.
27. Preferred Skills and/or Qualifications	An awareness of teaching and learning technology issues related to the area of information management, educational restructuring issues, and broad knowledge of education issues.
28. Preferred Experience	At least one year of experience in early childhood instruction, coordination, or administration of early childhood education and/or community learning services.
29. Necessary Special Qualifications, Licenses, Certifications, and/or Registrations	Communication skills: The candidate must be able to organize, write, and speak clearly and effectively. Social skills: The candidate must be able to meet with the general public and be able to work well with others in team tasks. Content knowledge: Knowledge of early childhood and adult education.

Position Description (EP)

Read each heading carefully before proceeding. Make statements simple, brief, and complete. Be certain the form is signed. Send the original to SRS Personnel Services. Supervisors and incumbents are responsible for the completion of this form.

CHECK ONE: () NEW POSITION (X) EXISTING POSITION

PART I - Position Description

1. Agency Name Dept. of Social and Rehabilitation Services		9. Position Number K0142760	10. Budget Program Number
2. Employee Name (leave blank if position vacant) Carrie Hastings		11. Present Class Title (if existing position) Public Service Executive II	
3. Division Economic and Employment Support (EES)		12. Proposed Class Title	
4. Section Benefits and Services		13. Allocation	
5. Unit Services and Access Section		14 (a). Effective Date	14 (b). FLSA Code
6. Location (address where employee works) City: Topeka County: Shawnee		15. By: _____ Approved	
7. (Circle appropriate time) Acting Assignment Effective 05-02-10		16. Audit	
Full Time X Part Time	Perm : Temp	Inter : %	Date: _____ By: _____ Date: _____ By: _____
8. Regular Hours (circle appropriate time) From: 8:00 AM To: 5:00 PM		17. Position Review Date: _____ By: _____	

PART II - Organizational Information

Area for use by Personnel Office

18 (a). Briefly describe why this position exists. (What is the purpose, goal, or mission of the position)

This team leader position is responsible for Head Start Collaboration; Early Head Start; Child Care Development Fund (CCDF) Child Care targeted and quality funds planning and oversight of related contracts, grants and initiatives; oversight of the commodities programs; and other Economic and Employment Support (EES) initiatives.

18 (b). If this is a request to reallocate a position, briefly describe the reorganization, reassignment of work, new functionality added by law or other factors which changed the duties and responsibilities of the position.

19. Who is the supervisor of this position? (Who assigns work, gives directions, answers questions and is directly in charge.)

Name: Karen Beckerman Title: Public Service Executive III Position Number: K0047316

Who evaluates the work of an incumbent in this position.

Name: Karen Beckerman Title: Public Service Executive III Position Number: K0047316

20. a) How much latitude is allowed employee in completing the work? b) What kinds of instructions, methods and guidelines are given to the employee in this position to help do the work? c) State how and in what detail assignments are made

Work is performed independently, with considerable latitude for making independent decisions based upon general direction developed within EES leadership and federal and state laws.

- d) Which statement best describes the result of error in action or decision of this employee.
- () Minimal property damage, minor injury, minor disruption of the work flow.
 - () Moderate loss of time, injury, damage, or adverse impact on health and welfare of others.
 - (X) Major program failure, major property loss, or serious injury of incapacitation.
 - () Loss of life, disruption of operations of a major agency.

21. Describe the work of this position using this page or one additional page only. (Use the following format for describing job duties:)

What is the action being done (use an action verb); to whom or what is the action directed (object of action); why is the action being done (describe the result or outcome expected); *How is the action expected to be performed (describe the manner, methods, techniques or procedures in which the task is currently performed). For each task state: Who reviews it? How often? What is reviewed for?

Number Each Task and Indicate Percent of Time and Identity of each function as essential or marginal by placing an E or M next to the % of time for each task. Essential functions are the primary job duties for which the position was created and that an employee must be able to perform, with or without reasonable accommodation. A marginal function is a peripheral, incident or minimal part of the position

No.	%	FORM	
1	25%	E	Provides direct supervision and leadership to subordinate managers and other staff by establishing goals, direction and trainings necessary to accomplish duties assigned and goals of the unit, consisting of Head Start Collaboration, Early Head Start, CCDF targeted and quality fund planning, partnership and collaboration development, and the Commodity Food programs. Recruits, selects, evaluates and disciplines staff. Provides direct supervision of Program Managers including Early Head Start, Head Start Collaboration staff, Commodity staff and other Section staff.
2	20%	E	Oversight and management of Head Start Collaboration Office functions. Participates in and represents Kansas in national, regional, state, and local meetings concerning young children and families. Analyzes federal legislation and regulations to assess ramifications for the State regarding early childhood care and education systems, Commodity Food programs, and other program areas. Responsible for development and design of strategies to implement federal policies in Kansas and for the oversight of budget and program reports. Participates on committees to evaluate the results relative to desired outcomes and determine whether further policy refinements are needed.
3	20%	E	Oversight, development and management of policy and initiatives for statewide Child Care Development Fund (CCDF) activities designed to address accessibility and quality of child care. Oversight of the Child Care Development Fund state child care and early education state planning process. Responsible for development and design of strategies to implement federal policies in Kansas and for the oversight of budget and program reports. Participates on committees to evaluate the results relative to desired outcomes and determine whether further policy refinements are needed.
4	20%	E	Responsible for oversight and management of the Food Distribution Unit, which manages five diverse USDA Food Distribution programs including: TEFAP, NSIP, Commodity Supplemental Food Program (CSFP), Soup Kitchen Food Bank Program, and Charitable Institution Commodity Program. Plans, organizes and provides leadership for the work of Food Distribution Unit staff ensuring successful program administration of USDA Commodity Foods Programs.
5	15%	E	Develops and plans for methods of establishing new partnerships to enhance access and promote outreach including faith based organizations. Oversees coordination of EES program contract activity and TANF Work Program initiatives related to community partnerships (i.e., OARS, EITC promotion, etc.) in collaboration with TANF Work Program Manager.

*The description of how the work is to be performed does not preclude the consideration of reasonable accommodation(s) for qualified persons with a disability.

22. List the consequences of not performing the essential functions of this position as identified in Section 21.

The implementation of new programs is often dependent on the planning and design of the implementation strategy and could result in program failure. Policy changes could negatively impact numerous consumers and costs millions of dollars.

23. a. If work involves leadership, supervisory, or management responsibilities, check the statement which best describes the position

- () Lead worker assigns, trains, schedules, oversees, or reviews work of others.
(X) Plans, staffs, evaluates, and directs work of employees of a work unit.
(X) Delegates authority to carry out work of a unit to subordinate supervisors or managers.

b. List the class titles and position numbers of all persons who are supervised directly by employee in this position.

Class Title	Position/KIPPS Number
PSEI	K0068778
PSEI	K0210207
PSEI	K0132769
PCII	K0132767
MSAI	K0048649
MSAI	K0163618
PSAI	K0046811
Administrative Specialist	K0212122

24. For what purpose, with whom and how frequently are contacts made with the public, other employees or officials?

Contacts are made regularly with EES staff, SRS Regional and Central Office agency staff, federal officials in both the national and regional offices, officials in KDHE Child Care Licensing, KSDE, Kansas Head Start Association, Head Start Programs, and others in various state and local agencies. Public speaking and group facilitation as required.

25. What hazards, risks or discomforts exist on the job or in the work environment?

Must be able to carry 25 lbs. (material, booklets, etc. as needed for presentations)

Position requires in state and out of state travel.

26. List machines or equipment which are currently used to complete the tasks or production standards for this position. Indicate the frequency with which they are used.

Personal computer- daily
Power Point software/projector as needed
Fax Machine
Copier

PART III - Education, Experience and Physical Requirements Information

27. Minimum Qualifications as stated in the State of Kansas Class Specifications.

Two years of experience in planning, organizing, and directing the work of a department, program or agency. Education may be substituted for experience as determined relevant by the agency.

28. SPECIAL REQUIREMENTS

A. State any additional qualifications for this position that are necessary to perform the essential functions of this position. (License, registration or certification).

B. List any skill codes or selective certification required for this position. Selective certification must first be approved by the State Division of Personnel Services.

C. List preferred education or experience that may be used to screen applicants.

Bachelor's degree

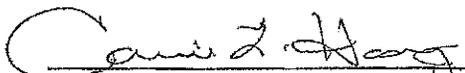
Leadership ability at the administrative level including demonstrated skills and experience in facilitation, team building, conflict resolution, and problem solving.

29. Describe the physical characteristics of the job as they relate to essential functions (focus on results, not methods of obtaining results).

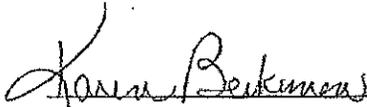
Will require periodic travel.

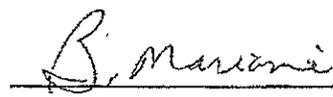
30. Describe any methods, techniques or procedures that must be used to insure safety for equipment, employees, clients and others.

PART IV - Signatures

 4/20/10
Signature of Employee Date

 4-20-10
Signature of Personnel Officer Date

 4-20-10
Signature of Supervisor Date

 4/20/10
Signature of Agency Head or Appointing Authority Date

Carrie L. Hastings
14175 123rd Lane, Hoyt, KS
(785) 986-6781home
(785) 250-7503 cell
Carrie.hastings@srs.ks.gov

RELEVANT EXPERIENCE & ACCOMPLISHMENTS

- Appointed by Governor Parkinson to the Kansas Early Childhood Advisory Council in August 2010.
- Successfully wrote program and special project grants.
- Organized and coordinated spring and fall Health Fairs, providing physical and developmental screens to children ages 0-5 years of age.
- Counseled families and staff on defining Family Partnership Agreement goals and objectives.
- Served as Tribal Representative on the Kansas Early Learning Guidelines Committee.
- Developed Request for Proposals application for Child Care ARRA grants.
- Designed a Community Resource Guide.
- Worked with program management team to formulate, write and implement program work plans to meet Head Start Performance Standards.
- Worked with State Partners to create State Inter-agency Memorandum of Agreement between Kansas Department of Education (Part B, PAT), the Kansas Department of Health & Environment (Part C) and Kansas Department of Social and Rehabilitative Services (Head Start State Collaboration Office, Kansas Early Head Start).
- Supervised and coordinated services in Head Start, Early Head Start and Part C tiny-k Infant Toddler Program.
- Trained, supervised and evaluated staff.
- Trained and supervised program volunteers.
- Successfully completed four Federal Head Start Reviews.
- Presented in-service training sessions at the P.B.P Annual Pathways to Our Future Early Childhood Education Conference and the Kansas State Department of Education Nutrition Services CACFP Fall Workshop.
- Completed coursework in Vision Services to serve blind and vision impaired children.
- Trained to provide Infant Massage classes.
- Coordinated with State partners to present workshops on Collaboration and Memorandums of Agreement throughout Kansas at Regional Part C meetings.
- Facilitated quarterly Kansas Early Head Start meetings.

EMPLOYMENT

Public Service Executive II, State of Kansas Department of Social & Rehabilitative Services, Topeka, KS
2010-present

- Promoted from the Head Start State Collaboration position.
- Provides direct supervision and leadership to subordinate managers and other staff by establishing goals, direction and trainings to accomplish duties assigned and goals of the unit, consisting of Head Start State Collaboration, Early Head Start, Child Care Development Funds targeted and quality fund planning, partnership and collaboration development, and the Commodity Food programs.

- Recruits, selects and evaluates staff.
- Participates in and represent Kansas in national, regional, state, and local meetings concerning young children and families.
- Analyzes federal legislation and regulations to assess ramifications for the State regarding early childhood care and education systems.
- Responsible for development and design of strategies to implement federal policies in Kansas and for the oversight of budget and program reports.
- Participates in committees to evaluate the results relative to desired outcomes and determine whether further policy refinements are needed.
- Responsible for the oversight and management of the Food Distribution Unit, which manages five diverse USDA Food Distribution programs.
- Oversees coordination of Employment and Economic Services program contract activity and TANF Work Program Initiatives related to community partnerships (.i.e., OARS, EITC promotion, etc.)
- Manages the Kansas Early Head Start contracts.

Head Start State Collaboration Director, State of Kansas Department of Social & Rehabilitative Services, Topeka, KS

2008-2010

- Served as the Head Start Collaboration Director for the agency. Reports on collaboration projects. Serves as a liaison between ACF, state agencies, Head Start agencies, Kansas Head Start Association, education agencies, and others providing services to low income children and families and early childhood professionals.
- Served as the main contact for the State Head Start Collaboration projects in the sharing of information.
- Participated in and represents Kansas in national, regional, state and local meetings concerning children and families.
- Analyzed federal legislation and regulations to assess ramifications for the State regarding early childhood care and education systems and Head Start agencies.
- Responsible for development and design of strategies to implement federal policies in Kansas and for the oversight of all Head Start Collaboration Grant budget and program reports.
- Worked in partnership with the Kansas Head Start Association, Head Start Directors, KDHE Child Care Licensing, the Interagency Coordinating Council (ICC), Part C (IDEA), the Kansas Department of Education Early Childhood Services, SRS Child Care Assistance, child care initiatives, Foster Care, Mental Health, KHPA, and other early care and education programs to develop system-wide plans and goals to enrich the lives of children and families.
- Participated on committees to evaluate the results relative to desired outcomes and determine whether further policy refinements are needed.
- Collaborates with managers of other state agencies such as Department of Health and Environment and Kansas Department of Education, as well as other programs and divisions within SRS. This ensures proper management of joint initiatives, to review and develop policies of mutual concern, and to achieve the goals and objectives of the department.
- Provides direct supervision and leadership to subordinate staff by establishing goals, direction and training necessary to accomplish duties assigned and goals of the unit, consisting of Head Start Collaboration.

Early Head Start/ Head Start Program Manager / Part C Infant Toddler Service Coordinator, Prairie Band Potawatomi Early Childhood Education Center, Mayetta, KS 1998-2008

- Coordinated and provided therapy services for special needs infant-toddlers and their families.
- Responsible for supervision, organization and documentation of daily activities in the Head Start, Early Head Start and Part C Infant Toddler programs.
- Responsibilities include family partnership agreements, transportation, health, dental, nutrition, in-kind tracking, and home visiting.
- Supported the Program Director with budgets, purchasing, time-keeping, grant applications, community relations and staff supervision.
- Coordinated the meeting, records and activities of the PBP Interagency Coordinating Council / Health Advisory Board.
- Trained to provide OAE Hearing screens, vision screens and infant massage classes.
- Originally hired to be the Lead Head Start teacher and co-teach in the Early Childhood Special Education Classroom, then promoted to management.

Head Start Lead Teacher/ Center Director, ECKAN Head Start, Carbondale, KS 1995-1998

- Oversaw the daily operation of the Osage County Head Start program.
- Directed transportation, nutrition, health services, education plans, staff supervision, classroom lesson plans, parent policy council, disabilities services, home visits and health tracking.

Teen Parent Educator, USD 501, Topeka, KS 1994-1995

- Counseled and educated expectant teens and teen parents attending Topeka High, Highland Park and Topeka West high schools.
- Worked with school counselors, administration and teachers to support teens school attendance.

COMMITTEES, COUNCILS & COMMUNITY INVOLVEMENT

- Royal Valley Middle School Site Council, former President
- Jackson County Communities That Care
- Jackson County 4-H – Hoyt Livewires 4-H Club Community Leader, Project Leader, County 4-H Council Member, Club Community Service Project Leader, Club Arts & Crafts leader, Shooting Sports assistant and scorer
- Jackson County Community Assistance Team
- Prairie Band Potawatomi Youth Action Team
- Kansas Head Start Association board
- Region VII Head Start Association board
- Expanding Opportunities
- Home Visitation Taskforce
- CACFP/SRS/Childcare Licensing Coordination
- State Interagency Coordinating Council

- Healthy Homes Advisory Council
- Child Care Aware of Kansas ex-officio board member (formerly KACCRRRA)
- Region VII Partnership Leadership Team
- School Readiness Taskforce
- Homevisiting Taskforce

Janet R Newton, MS

EDUCATION:

Emporia State University, Emporia, KS
Master of Science, Master Teacher Early Childhood Education – 1994

Emporia State University, Emporia, KS
BGS – 1992; Graduated Cum Laude

Certified Public Manager, Topeka, KS
State of Kansas and the University of Kansas - 2002

Kansas Health Foundation, Leadership Institute, Wichita - 2000

WORK EXPERIENCE:

August 2008 to Present: Education Program Consultant, Parents as Teachers

Kansas Department of Education, Special Education Services Team, 120 SE 10th Ave., Topeka, KS 66612-1182

Provide leadership and coordination for the state's Parents as Teachers Program including collection and reporting on parent education data, state liaison with Parents as Teachers National office, technical assistance to local programs, assess needs and progress toward state program goals and outcomes, disseminate materials related to assessment, model programs and effective practices, monitor PAT grants, and liaison with Birth to Five early childhood and home visiting programs, particularly other Birth to 3 programs including Part C Infant Toddler Early Intervention and Early Head Start.

May 1999 to August 2008: Public Service Executive II

Kansas Department of Health and Environment, Division of Health, Bureau of Child Care and Health Facilities, Child Care Licensing and Registration, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1274

Manage, direct and oversee the state wide regulatory activities of the Early Care and Youth Programs section. Plan, organize and direct professional and administrative staff. Develop and implement policy and management strategies to provide internal quality control and evaluate program effectiveness. Prepare statistical and special reports. Coordination of services with other agencies and local child care regulatory contractors through the local public health departments. Represent department as leader and expert. Prepare department testimony, monitor legislative activity, initiate and develop proposed legislation, analyze proposed legislation and prepare bill briefs. Provide technical assistance and research. Interpret regulations and procedures to administrative staff, the public and the regulated community.

April 1998 to May 1999: Executive Director

Kansas Head Start Association, Meriden, KS

Manage KHSA office, budget and procedures. Grant writing. Participated in collaboration opportunities and Professional Development Initiatives in Early Childhood Education.

April 1996 to April 1998: Coordinator of Children's Services

Kansas Department of Health and Environment, Division of Health, Bureau of Child Care and Health Facilities, Child Care Licensing and Registration, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1274

Responsible for child care facility regulation within a region of Kansas; decision-making for licensure and enforcement action on child care facilities; testify in hearings; correspond with public and child care facilities; conduct training and participate in policy and regulatory development.

July 1995 to April 1996: School Food Service Consultant

Kansas Department of Education, 120 SE 10th, Topeka, KS 66612

Monitor administration of the Child and Adult Care Food Program in child care centers for assigned region of the state; conduct on-site reviews of facilities; assist in developing policies and procedures; provide leadership; coordinate and provide training opportunities; promote public relations.

1994 Parents as Teachers Coordinator

Flint Hills Educational Research Development Association (FHERDA)

Implemented and directed the Parents as Teachers program for FHERDA for initial year prior to the closure of FHERDA.

1984 through 1994: Operation of licensed child care facilities.

Emporia, KS

Program Director of Licensed Child Care Center; and owner/provider in a Licensed Child Care Home to enhance and nurture the growth and development of young children in coordination with parents.

PROFESSIONAL - SPECIAL PROJECTS AND ASSOCIATIONS:

Kansas School Readiness Initiative including work on the addition of early childhood education programs beginning at birth into the state's Longitudinal Data System, 2010 to present

Kansas Core Team for the state's Home Visiting Grant Application, July 2010 to present

Kansas State Interagency Early Childhood Team, 2008 to present

Kansas Strengthening Families Leadership Team August 2008 to present

Kansas Statewide Professional Development Planning, Core Team, December 2007 to present

Kansas Early Learning Guidelines Advisory Committee, 2004. Document revision completed 2009.

Investing in the Child Care Industry; an Economic Development Strategy for Kansas, advisory committee, project completed 2003.

Kansas Core Competencies for Early Care and Education Professionals Document, participating member of the Professional Development Initiative, project completed 2001.

Kansas Quality Standards for Early Childhood Education for Children Birth through Eight Document, participating member of the Kansas Stakeholders Advisory Committee, project completed 1996

American Academy of Certified Public Managers

Kansas and National Associations for the Education of Young Children

PRESENTATIONS/EDUCATIONAL TRAINING CONDUCTED:

Numerous presentations and educational training events conducted over the years including

**Aligning State and Local Collaboration*, Presentation at the National Parents as Teachers Conference, St Louis, MO, Nov 2010 and the National Division for Early Childhood (DEC) Conference in Kansas City, Oct 2010 highlighting State Interagency work among partner programs

*state and local presentations to the public, legislative committees, professional organizations and partners regarding Parents as Teachers. Previous work included presentations on regulatory practices including investigations, documentation, compliance, and enforcement.

*Adjunct Instructor at Emporia State University, Early Childhood Division in the areas of Program Management of Early Childhood Facilities; Curriculum Development

*national, regional, state and local conferences for early childhood professionals with topics including regulatory compliance, administration, child development, behavior and guidance, curriculum development, health and safety

East Region Director

Title: East Region Director
Reports To: Vice President of Program Services
Department: Program Services
Classification: Exempt
Date: October 2006

Job Summary:

This is a critical leadership position. Leadership is required within all essential job functions and is demonstrated through positive and appropriate communication, community collaborations, excellent customer service, business and professional integrity. The Regional Director will have passion and respect for the mission and vision of the organization.

The Regional Director will routinely assess service needs and develop and implement local programs at the community level appropriate with the agency mission, vision, and values. This leadership position will demonstrate the ideals of the organization to the public and to staff at all times. The position will ensure an exceptional quality of services delivered by the organization through continuous evaluation and performance improvement strategies that enhance outcomes to children and families and the overall public image of the organization.

Although this position directly reports to the Vice President of Program Services, the incumbent will also take direction from and support all members of the organizations Senior Staff.

ESSENTIAL JOB FUNCTIONS

Customer Service 20 % of Time

As a leader in excellent customer service, set the example of excellence that is expected by all employees in the management region.

Whether working with internal or external customers establishes effective customer service response systems which:

- Provide appropriate supports to ensure that customer needs and expectations are addressed timely and appropriately to prevent a situation from escalating into a crisis.
- Assess concerns and take action oriented approach to prevent a situation from deteriorating to a degree that a child or family become at increased risk of harm.
- Use listening skills to assess needs and apply a strengths based approach in working with the customer on possible solutions.
- Initiate follow up to ensure the situation was successfully resolved.
- Treat all customers with dignity and respect and promote customer choice and family centered decision-making processes.
- A 2007 Priority Staff Development goal identified a creation of a positive learning environment in the East Region. This would be partially accomplished through implementation of all office and all region staff meetings.

- Support the Vice President of Corporate Services in identifying appropriate physical office space and equipment, maintenance of a positive and professional work environment, and reporting and notifying appropriate service professionals to address maintenance issues.

Community Collaborations 25% of Time

Capacity building requires successful internal and external relationships with professionals and individuals vested in the agency mission and vision. Job duties will include as a priority that you:

- Develop successful collaborative partnerships and business relationships both with internal communities and external communities. A 2007 Priority Program Development goal agreed upon was to find financial support to stabilize Healthy Families programs in the East Region. Seek out and establish positive relationships with traditional and non-traditional partners who share in the agency mission, vision and values.
- Promote inclusion through teamwork and in team assignments. Be available and represent KCSL as a leader and decision-maker in public interactions.
- Assess and identify needed services and create opportunities for new business development at the community level.
- Participate in work groups, community committee's, and task forces to represent the agency's interests and support community needs.
- Participate in grant writing activities that support collaborative ventures. Coordinate grant writing activities with the Vice President of Education and Awareness and the Chief Financial Officer.
- Work with the Vice President of Education and Awareness on planning and development when new business initiatives are identified.
- Work directly with Community Councils for feedback and assessment of agency work and service needs at a local level.

Program Management 25% of Time

The core business of program services is to:

- Monitor the quality and effectiveness of all agency programs and services outcomes through effective data management and evaluation.
- Work with the Vice President of Corporate Services to develop or effectively use technology as an efficient means to gathering data for program monitoring.
- Be creative in service delivery design. Use a continuous performance improvement philosophy in recommending needed changes to programs and services to ensure accreditation, contracts, and grants remain viable.
- Lead and coordinate activities involved in internal and external program and agency audits or reviews, including federal and State audits. Coordinate activities directly with policy directors and the Vice President of Corporate Services.
- Establish and monitor clear goals and expectations for staff in achieving program outcomes.
- Manage programs and services within allotted budget and seek new resources for funding as required.

- In 2007 a new priority management responsibility was added to this position description. Statewide agency policy direction for Healthy Families as well as Parent Education.
- In partnership with Policy Directors, develop materials and coordinate the delivery of staff or community training as needed to ensure program integrity.
- Provide opportunities for staff development and training in leadership and program expertise.

Communication

15 % of Time

In all activities and job functions identified, appropriate and timely communication is required. Therefore:

- Use of verbal and written (both paper and electronic) will be expected in sharing information internally and externally as necessary to meet needs.
- Assess need, audience and appropriate mode for each communication.
- Communications will be delivered in a clear and positive format.
- Respect the confidential nature of the organization's business and child/family information.
- Communicate with community councils, Board members, and Foundation Trustee's to ensure program services information is shared.
- Include the Chief Financial Officer and finance staff regarding program services budget, grant and resource procurement efforts.
- Serve as an agency liaison to federal and state government, contract agencies' task forces, partnering agencies, consortiums/networks and committees as assigned, as they relate to program services.

Supervision

15% of Time

Our employees are our most valued resource. Establish professional boundaries and promote a healthy work environment:

- Provide the day-to-day direct supervision of all program services supervisors within the Region of responsibility.
- Establish and lead routine meetings, at least monthly, of all program services managers within the Region, to share information across programs, teams and set priorities and evaluate progress towards outcomes and agency goals.
- Establish routine weekly meetings with each program supervisor to monitor individual unit or team progress towards outcomes, performance expectations, and communicate on personnel issues.
- Recruit and hire a high quality and diverse workforce to deliver programs and services and represent the agency's desired image.
- Evaluate employees timely and according to agency policy. Take appropriate disciplinary action when required.
- Identify training needs on an individual and regional basis. Provide opportunities to address needs and develop a highly skilled and diverse workforce.

PHYSICAL REQUIREMENTS:

Work Environment Offices
Lifting Requirement 25 Pounds
Travel Requirements Travel as necessary, up to 25% of time
Valid drivers license
Transportation
Auto Insurance
Pass KBI check
Pass CANIS
Ability to be available for a rotating on-call cycle.

The physical requirements described here are a representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

SCOPE:

Total Staff: 30
Direct Exempt 6
Indirect Exempt 16
Direct Non-exempt 1
Indirect Non-exempt 7

BUDGETARY RESPONSIBILITY:

Direct Budget \$2,500,000
Indirect Budget \$0

MAJOR SYSTEM (MIS) OR PROCESS RESPONSIBILITY:

Child Pro
CAPS
Multiple data collection systems

EDUCATION AND EXPERIENCE REQUIREMENTS:

Required

- Master's Degree in Human Services, licensed in the state of Kansas as required by specific program or licensing body
- 3 years minimum experience, social service regulatory functions and knowledge of Statewide social service systems.
- Supervisory and Management experience.
- Solid written and oral communication skills.
- Self-motivated, highly organized
- Ability to verbally, and through professional work, articulate KCSL's mission and values.

MANDATED REPORTER:

As a staff member of KCSL you are a mandated reporter of child abuse and neglect as outlined in the employee handbook. Failure to properly report to SRS and your supervisor can result in disciplinary actions up to and including termination. See Mandated Reporter Policy in the Employee handbook for specific details.

The duties and responsibilities of this job are subject to change without prior notice.

Tracie Lansing, LMSW

25815 155th Street, Leavenworth, KS 66048
913-306-4018 * JayhawkSW@yahoo.com

Summary

Energetic Administrative Professional with 6 years experience in not-for-profit administration and 14 years experience in social services.

Specialties

Financial Management * Grant Writing * Non-Profit Accreditation * Policy Development
Program Administration and Development * Quality Assurance * Staff Development

Experience

Healthy Families Policy Director at the Kansas Children's Service League (KCSL)

June 2004 to Present (6 years)

- Supervision, development and program management of 5 direct reports and 40 indirect report service professionals managing priority programs among 16 Kansas counties.
- Statewide policy advocacy, leadership, strategic planning and management of Healthy Families program and the Kansas Early Learning Collaborative that has created a national model for early childhood partners to work successfully together to create effective means of funding and distribution of early childhood programs in Kansas.
- Budget development and management responsibility for approximately \$3.1 million in salaries and expenses and \$4.5 million in revenue.
- Grant writing, development and renewal expertise and responsibility for at least ten annual grants and ten annual contracts (Federal, State and local) generating \$4.5 million in revenue for KCSL.
- Represents organization at all local social service meetings in Leavenworth County and the surrounding area currently serving as Vice President of the Leavenworth County Child Abuse Prevention Council and Chair of the Leavenworth County Early Learning Collaborative.
- Successfully implemented and completed a plan that created a Healthy Families specific statewide management information system (database) meeting all COA, HFA, and grant reporting requirements.
- Responsibly manages the facility issues for five office locations that provide work space for 31 employees.

Part-Time Practitioner at The Family Conservancy

2002 - 2004 (2 years)

Research Assistant at the University of Kansas School of Social Welfare

2000 - 2004 (4 years)

Case Manager/Volunteer Coordinator at the Alliance Against Family Violence

1998-2002 (4 years)

Business Coach at the University of Kansas School of Social Welfare

1999-2000 (1 year)

Mentor at The Farm, Inc. (TFI) (employment-based internship)

1999-2000 (1 year)

Family Support Worker at Kaw Valley Center (KVC)

1998-1999 (1.5 years)

Legal Secretary at Neil E. Fowles Law Office

1997-1998 (1.5 years)

Education

University of Kansas

Master of Social Work, 2000 – 2004

University of Kansas

Bachelor of Social Work, 1991 - 2000

Honors and Awards

- Direct Service to Children, Hall of Fame Award, Kansas Children's Service League
- Margo Schutz Gordon Award, University of Kansas School of Social Welfare
- Scholar Athlete Award, University of Kansas, 1993-1994

Interests & Other Qualifications

- Accomplished technical writer
- Enjoy reading, running, softball and volleyball
- Excellent communication skills with extensive public speaking experience

Children's Mercy Hospital
Kansas City, Missouri

Job Description
Job Title: **TIES Program Manager**
Job Code: 24490

Job Summary Program Manger will provide overall supervision of the TIES Program, including its financial management. She will provide clinical and administrative supervision to all staff, act as liaison to the community, staff the Consortium and Advisory Council. She will manage the relationship with funders and the local community and prepare all statistical and other reports.

Supervision Exercised: Family Support Specialists
Parent Resource Specialists
Administrative Assistant

Supervision Received:
Social Work & Community
Services Department Director

Job Duties and Responsibilities (any one position may not include all of the duties listed nor do the listed examples include all tasks which may need to be performed)

1. Provide clinical and administrative supervision to Family Support and Parent Resource Specialists.
2. Supervise Administrative Assistant.
3. Act as liaison to community regarding the TIES Program, outreach, and community education.
4. Staff TIES Consortium.
5. Staff TIES Advisory Council.
6. Prepare all statistical and funding reports.
7. Oversee program budget.
8. Serve on Metropolitan Task Force on Drug Exposed Infants.
9. Provide program feedback to management team of Social Work Department as needed.
10. Carry pager 24 hours per day to provide consultation as needed.
11. And other related duties as assigned.

Minimum Job Qualification: Masters degree in social work or related discipline
Applicant will have experience in management and supervision of home based programs and in child welfare, substance abuse or other work with high risk families.

Managed budget totaling \$2.8 million and over 70 employees
Previously Family Services Coordinator managing emergency
assistance

operation and providing office and home-based counseling
to families and individuals

1978 - 1980 Medical social worker in two acute care and rehabilitation settings

Select Publications and Presentations

McMann, O. T., Coon, L., Wells, K., Otero, C. (June 2007) *Using Collaboratives to Affect Policy, Program & Practice Change*. Community = Common Unity for Children & Families Meeting of US DHHS Children's Bureau Abandoned Infants Assistance & Substance Exposed Projects, Berkeley, CA.

McMann, O. T. & Price, Amy (February 2007) *Building Community and Client-Level Relationships to Support Substance Affected Families with Infants or Young Children*. Putting the Pieces Together for Children and Families National Conference on Substance Abuse, Child Welfare and the Courts, Anaheim, CA.

McMann, O. T., Clodfelter, P., Kitchen, A., Simmens, F. (October 2005) *The Missouri Model: Coordinated Services for Families Affected by Substance Abuse*. Substance Exposed Newborns: Weaving Together Effective Policy & Practice US DHHS Conference, Washington, DC.

McMann, O. T., Currier-Ezepchick, J. (2003). The power of parallel process in intervention with families affected by substance abuse. The Source, 12(1) 17-19.

McMann, O. T., Currier-Ezepchick, J., Bouchard, B., Adnopoz, J., Pack, J., & Abruzzino, E. (2003). Development of successful treatment interventions. In National Abandoned Infants Assistance Resource Center (Ed.) AIA best practices: Lessons learned from a decade of service to children and families affected by HIV and substance abuse (25-46). Berkeley, CA: Author.

McMann, O. T., Currier-Ezepchick, J., Bouchard, B., & Bridgeforth, D. (2003). Effective practices in staff development. In National Abandoned Infants Assistance Resource Center (Ed.) AIA best practices: Lessons learned from a decade of service to children and families affected by HIV and substance abuse (57-66). Berkeley, CA: Author.

- McMann, O. T., Currier-Ezepchick, J., (2003, May). The supervisor's role in engagement and retention. 11th Annual National Abandoned Infants Assistance Grantees' Conference, Washington, DC.
- McMann, O. T., Pietrzak, J., Currier-Ezepchick, J. (March 2002) Abandoned Infants Assistance: Investing in and Assisting Vulnerable Children and Families. Children 2002: Making Children a National Priority CWLA National Conference, Washington, DC.
- McMann, O. T., McAdam, W., McMahan, J., (January 2002) Best practices: Innovations in child welfare services, 3rd Annual Juvenile and Family Drug Court Training Conference, Reno, NV.
- McMann, O. T. (June 1999). Supporting families with multiple challenges: Discovering effective strategies. SAMSHA Second National Conference on Women, Los Angeles, CA.
- Summers, J., McMann, O. T., Fuger, K. (1997). Critical thinking: A method to guide staff in serving families with multiple challenges. Topics in Early Childhood Special Education, 17(1), 27-52.

Board Memberships and Related Organizations

- Amethyst Place supported housing program for recovering women and their children
Board Member 2000 - 2010; Board Chair 2001 - 2003, Board Secretary 2004 - 2005
Program Council Member 2010 - present
- Kansas City Metropolitan Task Force on Drug Exposed Infants 1991 - Present
Facilitator 2010 - Present
- Mother and Child Health Coalition of Greater Kansas City Board Member 1998 - 2000
- Renaissance West Women's Place Advisory Board 1991 - 1996
Women in Recovery Advisory Board 1994 - 1996
- University of Kansas School of Social Welfare certified field instructor 1986 - 1988, 2006
- Kansas City Stand for Children Local Committee 1996 - 2000
- Jackson County Family Court Liaison Committee 1995 - 2002
- Missouri Association for Social Welfare - Kansas City Chapter Board 1989 - 1996, Vice Chair 1992

Job Description for Kathryn L. Fuger
University of Missouri-Kansas City (UMKC) Institute for Human Development

Job Title: Principal Co-Director of Evaluation of the TIES Model as a Promising Approach

Job Duties and Responsibilities:

1. Provide oversight for the evaluation of the TIES Model as a Promising Approach.
2. Provide fiscal management for the UMKC subcontract.
3. Coordinate the efforts of all personnel in the UMKC subcontract.
4. Act as liaison to the Kansas Home Visitation Project and its primary evaluators.
5. Serve as lead evaluator of the TIES Program, contributing the lessons learned and participant results as a foundation for the replication of the TIES Model in the Kansas Home Visitation Project.
6. Participate with other key personnel, particularly the Co-Director and the contracted Statistician, in developing and conducting the implementation and effectiveness studies, including the following tasks:
 - Develop and conduct the implementation study.
 - Develop and refine fidelity instruments, protocols, and benchmarks.
 - Report the results of the implementation study.
 - Determine the feasibility and advisability of proceeding to the effectiveness study in Year 4.
 - Develop and conduct the effectiveness study, if applicable, or extend the implementation study, if needed.
 - Report the findings of the effectiveness study, if applicable.
7. Maintain compliance with all requirements of the Institutional Review Boards for research with human subjects.
8. Fulfill other related duties as determined during the development of the project.

Qualifications:

1. Ph.D. in social science or related field.
2. Experience in oversight of evaluation projects.
3. Experience in evaluating complex interventions with families.
4. Extensive knowledge of the TIES Program.
5. Effective oral and written communication skills.
6. Effective teaming skills.

BIOGRAPHICAL SKETCH**June 2011**

NAME**Kathryn L. Fuger****POSITION TITLE****Director of Early Childhood and Youth Programs**

EDUCATION

INSTITUTION	DEGREE	YEAR(s)	FIELD OF STUDY
University of Missouri-Kansas City	Ph.D.	1999	Interdisciplinary – Education and Public Affairs and Administration
University of Missouri-Kansas City	M.A.	1992	Curriculum and Instruction, Emphasis in Early Childhood
Iowa State University	B.S.	1970	Psychology

Professional Experience***Research Associate at University of Missouri-Kansas City Institute for Human Development***

(5/1992-present), serving in these positions:

Director of Early Childhood and Youth Programs (8/2002-present)

Director of Interdisciplinary Training (5/1999-8/2002)

Early Childhood Program Coordinator (11/1993-8/2002)

Selected External Funding***Evaluation (Principal Evaluator)***

Cross-Site Evaluation of Abandoned Infants Assistance (AIA) Programs, grant from U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) Children's Bureau (CB) AIA to University of California-Berkeley National AIA Resource Center (2002-present)

Team for Infants Endangered by Substance abuse (TIES), grant from HHS ACF CB to Children's Mercy Hospitals and Clinics (1995-present)

Kansas City Healthy Start, grant from HHS Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHC) to Mother & Child Health Coalition (2007-present)

StartRight Teen Mentors of Mothers (MOMs), grant from HHS Office of Adolescent Pregnancy Programs (OAPP) to Truman Medical Centers, Inc. (2001-2011)

Thorman Strategies Group, subcontract to evaluate the 40-Hour Initial Pre-Service Training for Entry-Level Child Care Providers developed by the National Association of Child Care Resource and Referral Agencies (2010-2011)

Strengthening Families and Fatherhood: Children of Fathers in the Criminal Justice System Project, grant from HHS Administration on Children, Youth and Families (ACYF) Office of Head Start (OHS) to Missouri Department of Social Services Family Support Division (2004-2008)

Greater Kansas City Early Learning Initiative, grant from HHS CB Early Learning Opportunities Act to Mid-America Regional Council (2006-2007)

Quality Teaching for Quality Outcomes, grant from U.S. Department of Education to Mid-America Regional Council (2003-2006)

Early Learning Evaluation, grant from Ewing Marion Kauffman Foundation to Mid-America Regional Council (2003-2006)

Early Learning Excellence project, grant from HHS CB Early Learning Opportunities Act to Mid-America Regional Council (2004-2005)

Early Learning Center Quality and Child Outcome Evaluation, grant from HHS CB Early Learning Opportunities Act to Mid-America Regional Council (2003)

House Bill 1519 Project, grant from Missouri Department of Social Services (DSS) and Missouri Department of Elementary and Secondary Education (DESE) to University of Missouri Center for Family Policy and Research and University of Missouri-Kansas City Institute for Human Development (2000-2003)

Alternative Dispute Resolution (ADR) Project, grant from Missouri Office of State Courts Administrator (OSCA) and ADR Commission to University of Missouri-Kansas City Institute for Human Development (2003-2005)

Incarcerated Fathers Collaboration Project, grant from HHS Office of Child Support Enforcement (OCSE) to Missouri DSS Division of Child Support Enforcement (DCSE) (2002-2003)

External Program and Child Assessment

Quality Matters-External Assessment, grant from United Way of Greater Kansas City (2009-present)

On-Site Assessment Project, Start Up and Expansion grant from Missouri Department of Social Services to the University of Missouri Center for Family Policy and Research (2008-present)

The Relationship between Missouri Quality Rating System (QRS) Ratings and School Readiness, funding from George K. Baum Family Foundation, The Kansas Health Foundation, The John W. and Effie E. Speas Trust (Bank of America Trust Department), The Francis Family Foundation, and The Hall Family Foundation to Metropolitan Council on Early Learning at Mid-America Regional Council (2008-2009)

Missouri Quality Rating System Program Assessment, numerous local foundations to Metropolitan Council on Early Learning at Mid-America Regional Council and University of Missouri Center for Family Policy and Research (2007-2011)

Tri-County Smart Start Pilot Project, grant from Kansas State Department of Education to Mid-America Regional Council and Kansas Association for Child Care Resource and Referral (2004-2008)

Set for Success Kindergarten Assessment Project, grant from Ewing Marion Kauffman Foundation to University of Missouri-Kansas City Institute for Human Development (2000-2003)

Needs Assessment

Missouri Head Start-State Collaboration Office Needs Assessment in FY 2008 and FY 2010, funding from Missouri Head Start-State Collaboration Office (2008-present)

Consultation and Technical Support

Technical Support and Consultation for Early Childhood Comprehensive System, grant from HHS HRSA MCHB Division of Child, Adolescent and Family Health to Missouri Department of Health and Senior Services Division of Community and Public Health/Special Health Care Needs (2006-present)

Consultation to Early Head Start sites for inclusion of children with disabilities, grant from HHS CB OHS SpecialQuest to University of Missouri-Kansas City Institute for Human Development (2005)

Current Positions:

Member, Missouri State Interagency Coordinating Council for First Steps

Member, Missouri SpecialQuest Leadership Team

Member, Missouri Quality Rating System (QRS) State Committee

Selected Publications & Technical Writing

Technical Writing

Fuger, K. L., Abel, M. B., Stephens, D. J., & Hossain, W. (2011). *Abandoned Infants Assistance Program cross-site evaluation summary: October 1, 2008 – September 30, 2009*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L., & Abel, M. B. (2011). *2011 Missouri Early Childhood Comprehensive System stakeholder team profiles: A work in progress*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Thorman, A., & Fuger, K. L. (2011). *Evaluation of the 40-Hour Initial Pre-Service Training for Entry-Level Child Care Providers developed by the National Association of Child Care Resource and Referral Agencies*. Coconut Grove, FL: Thorman Strategies Group.

Fuger, K. L., Horrell, M. L., & Owsley, Stacey. (2010). *Missouri Head Start-State Collaboration Office Fiscal Year 2010 needs assessment report*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L., & Newkirk, M. K. (2009). *Kansas City Healthy Start evaluation: January 1, 2005 – December 31, 2008*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L., Abel, M. B., & McMann, O. T. et al. (2008). *Final report of the TIES Program evaluation (Team for Infants Endangered by Substance abuse)*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L., Abel, M. B., Duke, D., & Newkirk, M. K. (2008). *Strengthening Families and Fatherhood: Children of Fathers in the Criminal Justice System project "Fathers for Life" – Final evaluation report: July 1, 2005 – June 30, 2008*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L. (2008). *Greater Kansas City Early Learning Initiative: Final evaluation report*. Kansas City, MO: UMKC-IHD.

Fuger, K. L., & Abel, M. B. (2008). *Missouri Early Childhood Comprehensive System final report: Implementation phase, September 1, 2006 – August 31, 2008*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Fuger, K. L., & Hietpas-Wilson, T. (2006). *Quality Teaching for Quality Outcomes: Final evaluation report for Metropolitan Council on Early Learning*. Kansas City, MO: University of Missouri-Kansas City Institute for Human Development.

Publications

- Thornburg, K. R., Mauzy, D., Mayfield, W., Scott, J. S., Sparks, A., Mumford, J., Foulkes, T., & Fuger, K. L. (2010). Data driven decision making in preparation for large-scale QRS implementation. In M. Zaslow, I. Martinez-Beck, K. Tout, & T. Halle (Eds.), *Quality measurement in early childhood settings*. Baltimore, MD: Brookes Publishing Co.
- Fuger, K. L., & Caccamo, J. (2009). Early childhood quality rating system initiative of Greater Kansas City. *Kansas Child*, 22-23.
- LeFebvre, K., Owsley, S., Fuger, K. L., & Morgan, M. (2009). Fathers for Life. *Head Start Bulletin* 80, 63-65.
- Kilbride, H. W., Castor, C. A., & Fuger, K. L. (2006). School-age outcome of children with prenatal cocaine exposure following early case management. *Journal of Developmental & Behavioral Pediatrics* 27(3):181-187.
- Kilbride, H. W., Castor, C. A., & Fuger, K. L. (2003). *Impact of early case management on school-age outcome of children with perinatal cocaine exposure*. Poster session abstract for 2003 Pediatric Academic Societies' Annual Meeting, Seattle, WA. Kansas City, MO: University of Missouri-Kansas City School of Medicine.
- Kilbride, H., Castor, C., Hoffman, E., & Fuger, K. L. (2000). Thirty-six-month outcome of prenatal cocaine exposure for term or near-term infants: Impact of early case management. *Journal of Developmental and Behavioral Pediatrics*, 21(1), 19-26.

Selected Professional Presentations

- Craig, J., Fuger, K. L., & Newkirk, M. K. (2011, May). *Piloting a screening assessment of self-efficacy: Cycle II*. Poster Presentation for Third Healthy Start Interconception Care Learning Collaborative (ICC-LC) Meeting, Washington, DC.
- Fuger, K. L., & Abel, M. B. (2011, April). *AIA cross-site evaluation update: Summary of FY 2009 findings*. Plenary Presentation for 2011 Abandoned Infants Assistance (AIA) Grantees' Meeting, Washington, DC.
- Reich, W., & Fuger, K. L. (2010, June). *AIA cross-site evaluation findings: Impact study of AIA services on family stability*. Plenary Presentation for 2010 AIA/SEN Grantee Conference (Abandoned Infants Assistance and Substance Exposed Newborns Programs), Old Town Alexandria, VA.
- Reich, W., & Fuger, K. L. (2010, February). *Impact study of AIA services on family stability: Web discussion with AIA project directors*. (Web Conference for Abandoned Infants Assistance Project Directors, hosted by University of Missouri-Kansas City Institute for Human Development).
- Fuger, K. L. (2007, April). *Early Childhood Comprehensive System: Missouri's planning process*. Presentation to the Coordinating Board for Early Childhood, Jefferson City, MO.
- Kilbride, H. W., Castor, C. A., & Fuger, K. L. (2003). *Impact of early case management on school-age outcome of children with perinatal cocaine exposure*. Poster session abstract for 2003 Pediatric Academic Societies' Annual Meeting, Seattle, WA. Kansas City, MO: University of Missouri-Kansas City School of Medicine.
- LeFebvre, K., Clements, T., & Fuger, K. L. et al. (2003, November). *Fathers for Life*. Presentation for MO State Legislators and MO Departments of Social Services, Corrections, Workforce Development, and Elementary and Secondary Education, Jefferson City, MO.

Job Description for Ronda Jenson
University of Missouri-Kansas City (UMKC) Institute for Human Development

Job Title: Co-Director of Evaluation of the TIES Model as a Promising Approach

Job Duties and Responsibilities:

1. Fulfill the lead role in the design of the implementation study of the TIES Model as a Promising Approach for the Kansas Home Visitation Project.
 2. Participate with other key personnel, particularly the Principal Co-Director and the contracted Statistician, in conducting the following tasks:
 - Develop and conduct the implementation study.
 - Develop and refine fidelity instruments, protocols, and benchmarks.
 - Report the results of the implementation study.
 - Determine the feasibility and advisability of proceeding to the effectiveness study in Year 4.
 - Develop and conduct the effectiveness study, if applicable, or extend the implementation study, if needed.
 - Report the findings of the effectiveness study, if applicable.
 3. Collaborate with the Kansas Home Visitation Project and its primary evaluators.
 4. Maintain compliance with all requirements of the Institutional Review Boards for research with human subjects.
 5. Fulfill other related duties as determined during the development of the project.
-

Qualifications:

1. Ph.D. in social science or related field.
2. Expertise and experience conducting implementation studies of human service projects.
3. Experience conducting effectiveness studies of human service projects.
4. Effective oral and written communication skills.
5. Effective teaming skills.

BIOGRAPHICAL SKETCH**June 2011**

NAME Ronda Jenson	POSITION TITLE Director of Research
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EDUCATION

INSTITUTION	DEGREE	YEAR(s)	FIELD OF STUDY
University of Kansas	Ph.D.	2004	Special Education, Research
University of Kansas	M.S.	1994	Early Childhood Special Education
University of Kansas	B.M.E.	1990	Music Education

Professional Experience

Research Associate, Director of Research, University of Missouri-Kansas City (UMKC),
Institute for Human Development (2007-present)

Research Associate, Director of Interdisciplinary Training, University of Missouri-Kansas City
(UMKC), Institute for Human Development (2004-2007)

Director, Center for Disability Studies, University of Missouri-Kansas City. (2004-2007)

Director, *Interdisciplinary Leadership in Disability Studies Graduate Certificate* (2005-2007)

Director, *Interdisciplinary Undergraduate Certificate in Disability Studies* (2005-2007)

Selected External Funding***Research and Demonstration Grants***

Co-Principle Investigator, *KC-BANCS: Building Alliances for New Careers in STEM* (2009-
2014). Funded by the National Science Foundation, Research in Disabilities Education.

Co-Principle Investigator, *Safety-First Collaborative* (2006-2009). Funded by the Department of
Justice, Office of Violence Against Women. (\$207,000)

Project Manager and Model Developer, *Missouri Integrated Model Development* (2007-2010).
Funded by the Department of Education, Office of Special Education Programs, State
Personnel Development Grant to Missouri Department of Elementary and Secondary
Education. (\$359,408)

Principle Investigator, *Missouri Integrated Model Implementation Facilitation* (2008-2010).
Funded by the Department of Education, Office of Special Education Programs, State
Personnel Development Grant to Missouri Department of Elementary and Secondary
Education. (\$625,027)

Principle Investigator, *Assessment of Current and Anticipate Needs of Jackson County Residents
with Developmental Disabilities* (2006-2007). Funded by Jackson County Board of Services.
(\$117,841)

Evaluation Contracts

- Evaluator, *Youth LEAD: Leadership, Education, and Advocacy for Youth with Disabilities* (2007-2010). Funded by Administration on Developmental Disabilities to Institute for Human Development, University of Missouri-Kansas City.
- Evaluator, *Missouri State Improvement Grant*, (2006-2008) Missouri Department of Elementary and Secondary Education, Funded by the Department of Education, State Personnel Development Grant to Missouri Department of Elementary and Secondary Education
- Evaluator, *MRDD Systems Transformation Evaluation and Facilitation* (2006-2010), Funded by Centers for Medicare and Medicaid Services to Missouri Department of Mental Health.
- Evaluator, *Kansas Deaf-Blind Project*, Funded by the Department of Education (2006-2009), to Kansas Department of Education.
- Evaluator, *Esperanza Para los Ninos* (2005-2007). Kansas City Health Department, Funded by Substance Abuse and Mental Health Administration Kansas City Health Department

Selected Publications & Technical Writing

Technical Writing

- Jenson, R., Mc-Coy-Harms, S., & Fleming, L. (2009). *Accessibility and responsiveness tool: Improving services for women with disabilities who experience domestic or sexual violence*. Kansas City, MO: UMKC Institute for Human Development, Metropolitan Organization to Counter Sexual Assault, Rose Brooks Domestic Violence Shelter.
- Fleming, L., Mc-Coy-Harms, S., Jenson, R &. (2009). *Safety Planning: Improving services for women with disabilities who experience domestic or sexual violence*. Kansas City, MO: UMKC Institute for Human Development, Metropolitan Organization to Counter Sexual Assault, Rose Brooks Domestic Violence Shelter.
- Jenson, R. (2009). *Measuring outcomes for people with disabilities*. Prepared for United Way of Greater Milwaukee, Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R. (2009). *Missouri Integrated Model: Description of the development phase*. Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R. (2008). *Evaluation of the Missouri systems transformation initiative: Annual report*. Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R. (2008). *Missouri Integrated Model Implementation Blueprint*. Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R., Hope, C., & Fleming, L (2008). *Safety First: Community needs assessment*, Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R. (August 2007). Universal design for college teaching. *Faculty Center for Excellence in Teaching (FaCET) Newsletter*, Kansas City, MO: University of Missouri Kansas City.
- Jenson, R (2007). *Esperanza para los ninos: Final evaluation report*. Kansas City, MO: UMKC Institute for Human Development.
- Jenson, R., Graybill, T., Horn, V., & McCarthy, M. P., Kemp, K., & Saporov, Z. (2007). *Needs assessment: EITAS disability support services of Jackson County*. Kansas City, MO: UMKC Institute for Human Development.
- Graybill, T., Horn, W., & Jenson, R. (2006). *Direct care staff perceptions on abuse and neglect in Missouri Department of Mental Health facilities*. Kansas City, MO: UMKC Institute for Human Development.

Publications

- Heller, T., Schindler, A., Palmer, S., Wehmeyer, M., McVeigh, T., Parent, W., Jenson, R., Abery, B., & Bacon, A (2011). Self-determination issues across the life-span: Issues and gaps. *Exceptionality*, 19(1), 31-45.
- Jenson, R. J. (2004). Discipline preferences and styles among Latino families and the implications for special educators, *Multiple Voices*, 7(2), 60-73.
- Horn, E., Thompson, B., Palmer, S., Jenson, R., & Turbiville, V. (2004). Implementing high quality inclusion in preschool. In Kennedy, C.H. & Horn, E. (Eds.), *Inclusion of students with severe disabilities*. Boston: Allyn & Bacon.

Selected Professional Presentations & Papers Delivered

- Williams, P., Jenson, R., & LePage, J. (2009). Pulling the pieces together: Lessons learned from the development and pilot of the Missouri Integrated Model. Annual OSEP Project Directors Meeting, Washington, DC.
- Jenson, R. (2008). *Missouri Integrated Model: A framework for teaching ALL students*. Association of University Centers on Disabilities. Association of University Centers on Disabilities (AUCD) Annual Meeting. Washington, DC.
- Walker, L., Jenson, R., & Nells, T. (2008). *OurSABE.org: An online self-advocacy community*. Association of University Centers on Disabilities (AUCD) Annual Meeting. Washington, DC.
- Jenson, R. & Fleming, L. (2007). *Collaborating to serve women with disabilities that are victims of violence*. Association of University Centers on Disabilities (AUCD) Annual Meeting. Washington, DC.
- Jenson, R. & Nobles, J. (2007). *Advocating for preschool inclusion: Tool kit for parents*. Family to Family Conference, Independence, MO.
- Dilks, S., Jenson, R., & Chronwall, B. (2006). *Universal design and diversity education: Transforming course design across the curriculum*. Teaching Renewal Conference, Columbia, MO.
- Jenson, R. (2006). *Interdisciplinary leadership in disability studies: Infusing disability studies across professional fields*. Association of University Centers on Disabilities (AUCD) Annual Meeting. Washington, DC.
- Jenson, R. (September, 2004). *Applying Cross-Cultural Competency to Family-Centered Services*. Lunch and Learn Series, University of Connecticut Center for Excellence in Development Disabilities, CT.
- Palmer, S., Horn, E., Thompson, B., Turbiville, V., & Jenson, R. (December 2002). *Supporting Innovation to Spiral Upward from Inclusion to Access the General Curriculum*, DEC, San Diego, CA.
- Horn, E., Thompson, B., Palmer, S., Turbiville, V., & Jenson, R. (April 2002). *Defining Access and Progress in the General Curriculum for Young Children with Disabilities*, CEC, New York, NY.

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME Stephen D. Simon, Ph.D.		POSITION TITLE Research Biostatistician	
eRA COMMONS USER NAME ssimon			
EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)			
INSTITUTION AND LOCATION	DEGREE (if applicable)	YEAR(s)	FIELD OF STUDY
University of Iowa	B.A.	1977	Mathematics
University of Iowa	M.S.	1978	Statistics
University of Iowa	Ph.D.	1982	Statistics

A. Personal Statement

I am a professional statistician with over thirty years of experience in consulting. I have a Ph.D. from the University of Iowa, and was the student leader of the Statistical Consulting Center during my graduate training. As a faculty member, I assisted with the Consulting Center while also teaching applied statistics at Bowling Green State University. At the National Institute for Occupational Safety and Health, I co-authored several award winning papers and also supervised other professional statisticians. At Children's Mercy Hospital, I co-authored another award winning paper and developed a widely-recognized site on statistics, research ethics, and evidence based medicine: www.childrensmc.org/stats. As an independent consultant and a part-time employee of the University of Missouri-Kansas City, I continue to offer statistical guidance to researchers across a broad spectrum of health care research. I continue to offer web-based resources for Statistics at www.pmean.com, and also publish an email newsletter, The Monthly Mean, that has over 200 subscribers. I have a broad background in statistics and have recently co-authored two peer-reviewed publications about Bayesian statistics. I have taken continuing education courses in data mining, microarray data analysis, mixed regression models, model-based clustering, regression splines, survival analysis, and wavelets. In summary, I have a wealth of background and experience with statistical design and data analysis, and can provide outstanding support to this research project.

B. Positions and Honors

Positions

1. June 1979 - August 1981: Research Assistant, Statistical Consulting Center, University of Iowa
2. June - August 1981: Adjunct Instructor, Department of Statistics, University of Iowa
3. September 1981 - May 1987: Assistant Professor, Department of Applied Statistics and Operations Research, Bowling Green State University
4. July 1987 - November 1987: Research Statistician, Division of Biomedical and Behavioral Science, National Institute for Occupational Safety and Health
5. December 1987 - May 1996: Chief, Statistics Activity, Division of Biomedical and Behavioral Science, National Institute for Occupational Safety and Health
6. April 1996 - October 2008: Research Biostatistician, Office of Medical Research, Children's Mercy Hospital, Kansas City, Missouri
7. June 2008 - present: Independent statistical consultant, P.Mean Consulting, Leawood, Kansas
8. February 2009 - present: Part-time Research Faculty, University of Missouri-Kansas City, Kansas City, MO.

Honors

1. Co-inventor on U.S. Patent, A System and Method for Monitoring and Analyzing Data Trends of Interest Within an Organization, under review by the U.S. Patent Office.
2. Co-author of the following award winning research papers:
 - a. Miller et al *Am J Audiology* 2003;24(1):16-18, Editor's Award 2003.
 - b. Moorman et al *Reproductive Toxicology* 1998;12(3):333-46, Alice Hamilton Award 1999 (Biological Sciences Category).
 - c. Schrader et al *Journal of Andrology* 1990;11(1):32-39, Alice Hamilton Award 1991.
 - d. Schrader et al *Reproductive Toxicology* 1988;2:183-190, Alice Hamilton Award 1990.
3. My presentation "Medical Statistics Case Studies on the Web" was voted as the best presentation in the area of Teaching Statistics in the Health Sciences at the Joint Statistical Meetings in Anaheim CA, August 1997.
4. Received Public Health Service Commendation Medal in July 1994 and Public Health Service Achievement Medal in April 1990 for efforts to modernize the computing environment.

C. Selected Peer-Reviewed Publications

1. Horii, K. A., Simon, S.D., Liu, D. Y., Sharma, V. Atopic dermatitis in children in the United States, 1997-2004: visit trends, patient and provider characteristics, and prescribing patterns. *Pediatrics* 2007; 120(3): e527-34.
2. Gaedigk, A., Simon, S.D., Pearce, R. E., Bradford, L. D., Kennedy, M. J., Leeder, J. S. The CYP2D6 activity score: translating genotype information into a qualitative measure of phenotype. *Clin Pharmacol Ther* 2008; 83(2): 234-42.
3. Adjei, A. A., Gaedigk, A., Simon, S. D., Weinshilboum, R. M., Leeder, J. S. Interindividual variability in acetaminophen sulfation by human fetal liver: implications for pharmacogenetic investigations of drug-induced birth defects. *Birth Defects Res A Clin Mol Teratol* 2008; 82(3): 155-65.
4. Sati, L., Ovari, L., Bennett, D., Simon, S. D., Demir, R., Huszar, G. Double probing of human spermatozoa for persistent histones, surplus cytoplasm, apoptosis and DNA fragmentation. *Reprod Biomed Online* 2008; 16(4): 570-9.
5. Gajewski, B. J., Simon, S.D., Carlson, S.E. Predicting accrual in clinical trials with Bayesian posterior predictive distributions. *Stat Med* 2008; 27(13): 2328-40.
6. Gajewski, B. J., Simon, S.D. A One-Hour Introduction to Bayesian Data Analysis for Non-Statisticians. *The American Statistician* 2008; 62(3): 190-194.
7. Jones BL, Abdel-Rahman SM, Simon SD, Kearns GL, Neville KA. Assessment of Histamine Pharmacodynamics by Microvasculature Response of Histamine Using Histamine Iontophoresis Laser Doppler Flowimetry. *J Clin Pharmacol.* 2009;49(5):600-605. [Medline]
8. Midyett LK, Grunt J, Simon SD. Noninvasive radial artery tonometry augmentation index and urinary albumin/creatinine levels in early adolescents with type 1 diabetes mellitus. *J. Pediatr. Endocrinol. Metab.* 2009;22(6):531-537. [Medline]
9. Melissa K Miller, M Denise Dowd, Matthew C Gratton, Jinwen Cai, Stephen D Simon. Pediatric out-of-hospital emergency medical services utilization in Kansas City, Missouri. *Acad Emerg Med.* 2009;16(6):526-531. [Medline]
10. Mercer AM, Teasley SL, Hopkinson J, McPherson DM, Simon SD, Hall RT. Evaluation of a breastfeeding assessment score in a diverse population. *J Hum Lact.* 2010;26(1):42-48.

[71 additional publications between the years of 1985 and 2007 are not listed.]

Principal Investigator/Program Director (Last, First, Middle):

D. Research Support

ACTIVE

NDNQI Services Agreement Work Order No. 3 (Dunton) 02/01/2008 – 12/31/2010

American Nurses Association-Kansas University Medical Center Research Institute

The major goals of this project are to develop a method for unit-based acuity adjustment and to develop a method to calculate hospital level indicators.

H. Curriculum Vitae of Key Personnel

Teri A. Garstka, Ph.D.

1122 West Campus Rd

Lawrence, KS 66045

785-864-3329

garstka@ku.edu

Key Qualifications and Experience

Dr. Garstka has over 14 years of professional research and project management experience in both academic and private government consulting settings. She has conducted basic and applied research and program evaluations in the social sciences and social service systems. She has extensive methodological and statistical data analysis experience and expertise, including working with multiple state and agency-specific Management Information Systems to extract and analyze performance indicators, child welfare outcomes, and other progress benchmarks. Her work has focused on experimental and quasi-experimental designs, multivariate analysis, structural equation modeling, outcome and performance measurement, and qualitative data collection and analysis. Dr. Garstka has a wide range of technical and applied knowledge, including experience conducting large national cross-site process and outcome evaluations related to a variety of evidence-based programs in child welfare, early childhood education programs, substance abuse treatment programs, and court reform.

Education

Ph.D.	Social Psychology (Quantitative Minor)	<i>University of Kansas</i>	1997
M.A.	Social Psychology	<i>University of Kansas</i>	1993
B.A.	Psychology	<i>Purdue University</i>	1991

Employment History

Research Associate

Institute for Educational Research and Public Service

University of Kansas

March 2010 – Present

As Research Associate in the Institute, Dr. Garstka responds to requests for proposals and capability statements to evaluate early childhood initiatives, educational programs, and other community-based programs. Additionally, as required, she provides technical assistance in evaluation for pilot

demonstration programs and special initiatives. Dr. Garstka conducts all aspects of evaluation including developing evaluation frameworks and designing evaluation strategies, collecting data and information to determine intervention effectiveness, analyzing the information collected, drafting final reports and deliverables, and making presentations of evaluation plan and findings to audiences of multiple skill levels.

Dr. Garstka currently devotes her time between two projects:

- **Adolescent and Family Life Care Demonstration Grant.** This five year federal grant was awarded in 2010 to Kansas Children’s Service League and the University of Kansas by the Office of Adolescent Pregnancy Programs (OAPP). This research demonstration grant is focused on evaluating Healthy Families home visiting program, mental health services, and a grandparent education group as a way of improving the ability of parenting teens to make healthy decisions for themselves and their infants. As Principal Investigator, Dr. Garstka leads the research and evaluation component of this grant. This project is using an experimental design to analyze program impact and is using REDCap to develop an integrated project database that incorporates agency-level data and data collected in the field.
- **Project LAUNCH.** This five year federal grant was awarded in 2009 to the state of Kansas by the Substance Abuse and Mental Health Services Administration (SAMHSA). This project fosters the healthy development of all young children birth through age 8 through increased access to services for young children and their families; expanded use of culturally-relevant, evidence-based prevention programs in a range of primary care and early childhood settings; sharing information with families to support healthy child development; and by increasing awareness about child wellness through public education and professional development. As the local evaluator, Dr. Garstka works closely with direct service providers in Finney County, KS to evaluate program outcomes and effectiveness as well as documenting implementation and local system collaboration. This project is developing a community-specific integrated database to capture data across systems, agencies, and services with the end goal of providing data for evaluation analyses and a continuously updated ‘data dashboard’ that tracks system and program level impact.

Senior Research Associate

Evaluation of Children, Youth, and Families Unit

Planning and Learning Technologies, Arlington VA

June 2007 – February 2010

As Senior Research Associate at the for-profit government contracting company located in the Washington DC metro area, Dr. Garstka responded to requests for proposals and capability statements to evaluate child welfare and related programs, and to provide technical assistance in evaluation for pilot demonstration programs and special initiatives. She assumed management of specific tasks and deliverables associated with evaluation projects as well as providing personnel supervision and budget tracking. Dr. Garstka conducted all aspects of evaluation including developing evaluation frameworks and designing evaluation strategies, collecting data and information to determine intervention effectiveness, analyzing the information collected, drafting final reports and deliverables, and making

presentations of evaluation plan and findings to audiences of multiple skill levels. In addition, she assisted in coordinating and tracking personnel, budget, and work plans across projects.

Dr. Garstka divided her time between the following projects:

- **Quality Improvement Center on Privatization of Child Welfare (QIC PCW).** This five year Federal project (DHHS ACF – Children’s Bureau) focused on evaluating the implementation of performance-based contracting (PBC) and quality assurance in child welfare services and its impact on contract performance and on child outcomes of permanency, safety, and well-being. Dr. Garstka led the cross-site process and outcome evaluation project with three states (Florida, Illinois, and Missouri) that have privatized portions of their child welfare service delivery. This included collaborative and coordinated work among multiple agencies to identify data elements for extraction from multiple state and agency-specific Management Information Systems and analysis of performance indicators, CFSR scores, and other progress benchmarks. In addition, Dr. Garstka provided technical assistance to individual sites on their evaluation design and analysis, assisted in developing site-specific performance measures, developed and maintained cross-site qualitative and quantitative databases, analyzed case-level and aggregate outcomes, and synthesized all information and findings to prepare reports. She currently (2011) provides consultation services to the University of Kentucky on this project.
- **Regional Partnership Grants – Support Contract (RPG – SC).** This six year Federal project (DHHS ACF – Children’s Bureau & SAMHSA) focused on providing technical support and assistance to 53 state and regional grantees who received individual *Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse*. These grantees partnered with child welfare, courts, and substance abuse providers to initiate new programs and expand the capacity to serve clients in all systems more effectively. Dr. Garstka acted as program manager and performance management liaison on this project and was responsible for tracking internal project timelines, staffing and budgets, and project coordination and communication. In her role as a performance management liaison, she worked closely with eight individual grantees and the federal project officer to provide technical assistance to coordinate data system reporting requirements, evaluation planning, cost analysis, sustainability, and programmatic resources. Dr. Garstka also served on the data analysis team for this project and was actively involved in the data analysis of over 23 case-level performance indicators and the associated 153 data elements across four domains (child outcomes, adult outcomes, family outcomes, and system outcomes) as well as analyzing clinical measurement instruments. She is currently (2011) continuing this work through consultation services to Planning and Learning Technologies, INC and Children and Family Futures on this project.

Assistant Research Professor/Adjunct Research Professor

Gerontology Center

University of Kansas, Lawrence, KS

May 1999 – Dec 2006

Dr. Garstka served as Project Coordinator for a large multi-year *National Institutes of Health, National Institute on Aging* funded grant on communication and aging. This grant included over 15 separate experimental research studies and included young, middle-aged, and older adult participants. The focus of all research was to understand the role of cognition and communication in perceptions of aging and intergenerational relationships.

- **Project management:** Dr Garstka was responsible for overseeing the day-to-day activities of this multi-study project. In addition to supervising over 30 graduate/undergraduate research assistants, she maintained and tracked budgets and expenses, projected costs and time-to-completion, compiled year-end project progress reports, reviewed and procured research materials and equipment, integrated new technology; managed diverse participant recruitment, ensured IRB compliance, and maintained detailed project logs and records.
- **Research program management:** Dr. Garstka coordinated all aspects of the multi-study research program. These activities included scheduling and supervising the completion of over 15 independent experimental projects, collaborating with PI on study designs and materials, incorporating new software applications and technology (e.g., MediaLab, DirectRT, EPrime), performing extensive data analyses, publishing over 14 peer-reviewed articles and presenting results to national and international research communities.
- **Statistical expertise:** Dr. Garstka's experience and training resulted in demonstrated research and statistical expertise in the following categories: Varied experimental and correlational research designs and methodologies; scale development, construction, and validity/reliability testing; multivariate analysis of variance; linear and non-linear multiple regression; structural equation modeling; multi-level modeling; discourse analysis; expertise in most Windows-based applications and extensive use of statistical software programs (e.g., SPSS, SAS, EQS).
- **Independent Research:** Dr. Garstka also maintained an independent program of research focused on intergenerational relations and age discrimination, publishing her research in referred professional journals.

Research Associate

Ringel Institute of Gerontology

State University of New York, Albany, Albany, NY

July 1997 – May 1999

Dr. Garstka served as Project Coordinator for a large, multi-year *Agency of Healthcare Research and Quality (formerly Agency for Health Care Policy and Research)* funded grant on health education groups for older adult caregivers. She managed project research activities, spearheaded participant recruitment within an HMO, coordinated study groups, assisted Principal Investigator in developing study materials and tracking budget and expenses, supervised graduate students, performed initial data preparation, and assisted HMO personnel in identifying appropriate data fields for healthcare utilization records. She was also involved in several state-funded grants and her activities included data analysis and report preparation. Her work on this project resulted in several publications in referred journals or book chapters.

Graduate Research Assistant

Gerontology Center

University of Kansas, Lawrence KS

August 1991- August 1997

Instructor

Department of Psychology

University of Kansas, Lawrence KS

August 1996- August 1997

Dr. Garstka served as a graduate research assistant on a large, multi-study *National Institutes of Health/National Institute on Aging* funded grant on social cognition, stereotyping, and aging. Her duties included coordinating and conducting multiple experimental research studies, recruiting and maintaining diverse participants, incorporating new technology, software, and methodologies, assisting PI in protocol development, scale construction, data analysis, and publishing results in referred professional journals.

Dr. Garstka also served as an Instructor in the Psychology Department, teaching an upper level class on the Psychology of Aging.

Publications

Professional Peer-Reviewed Journals

Garstka, T.A., Collins-Camargo, C., Hall, J. Neal, M., & Ensign, K. (in press). Implementing Performance Based Contracts and Quality Assurance Systems in Child Welfare Services: Results from a National Cross-Site Evaluation. *Journal of Public Child Welfare*.

Collins-Camargo, C., Hall, J., Flaherty, C., Ensign, K., Garstka, T.A., Yoder, B., & Metz, A. (2007). Knowledge Development and Transfer on Public/Private Partnerships in Child Welfare Service Provision: Using Multi-Site Research to Expand the Evidence Base. *Journal of Professional Development, 10*, 14-31.

Garstka, T.A., Hummert, M.L., & Branscombe, N.R. (2005). Perceiving age discrimination in response to intergenerational inequity. *Journal of Social Issues, 61(2)*, 319-340.

Garstka, T.A., Schmitt, M., Branscombe, N.R., & Hummert, M.L. (2004). How young and older adults differ in their responses to age discrimination. *Psychology and Aging, 19*, 326-335.

Zhang, Y. B., Hummert, M. L., & Garstka, T. A. (2002). Age stereotype traits of Chinese young, middle-aged, and older adults. *Hallym International Journal of Aging, 4*, 119-140.

Hummert, M.L., Garstka, T.A., O'Brien, L., Greenwald, A.W., & Mellot, D. (2002). Using the Implicit Association Test to measure age differences in implicit social perceptions. *Psychology and Aging, 17*, 482-495.

Toseland, R., McCallion, P., Smith, T. Huck, S., Bourgeois, P., & Garstka, T.A. (2001). Health education groups for caregivers in an HMO. *Journal of Clinical Psychology, 57*, 551-570.

- Hummert, M.L., Shaner, J.L., Garstka, T.A., & Henry, C. (1998). Communication with older adults: The role of age stereotypes, context and communicator age. *Human Communication Research, 25*, 124-151.
- Hummert, M.L., Garstka, T.A., & Shaner, J.L. (1997). Stereotyping of older adults: The role of target facial cues and perceiver characteristics. *Psychology and Aging, 12*, 107-114.
- Branscombe, N.R., Owen, S., Garstka, T.A., & Coleman, J. (1996). Judgment consequences of mental simulation: Who might have done otherwise and would it have changed the outcome? *Journal of Applied Social Psychology, 26*, 1042-1067.
- Hummert, M.L., Garstka, T.A., & Shaner, J.L. (1995). Beliefs about language performance: Adults' perceptions about self and elderly targets. *Journal of Language and Social Psychology, 14*, 235-259.
- Hummert, M.L., Garstka, T.A., Shaner, J.L., & Strahm, S. (1995). Judgments about stereotypes of the elderly: Attitudes, age associations, and typicality ratings of young, middle-aged, and elderly adults. *Research on Aging, 17*, 68-189.
- Hummert, M.L., Garstka, T.A., Shaner, J.L., & Strahm, S. (1994). Stereotypes of the elderly held by young, middle-aged, and elderly adults. *Journal of Gerontology: Psychological Sciences, 49*, 240-249.

Invited Book Chapters

- Hummert, M.L., Garstka, T.A., Bonneson, J.L. & Ryan, E.B. (2004). The role of age stereotypes in interpersonal communication. In J.F. Nussbaum and J. Coupland (Eds.), *Handbook of Communication and Aging Research (2nd Ed)* (pp. 91-114). Mahwah: NJ: Erlbaum.
- Garstka, T.A., McCallion, P., & Toseland, R.W. (2001). Using support groups to improve caregiver health. In J. Nussbaum & M.L. Hummert (Eds.) *Aging, Communication and Health: Linking Research and Practice for Successful Aging* (pp. 75-98). Mahwah, NJ: Erlbaum.
- Hummert, M.L., Shaner, J.L., & Garstka, T.A. (1995). Cognitive processes affecting communication with older adults: The case for stereotypes, attitudes and beliefs about communication. In J.F. Nussbaum and J. Coupland (Eds.), *Handbook of Communication and Aging Research* (pp. 105-131). Hillsdale, NJ: Erlbaum

Federal Reports (primary author or contributor)

- Garstka, T.A., Collins-Camargo, C., Hall, J., Neal, M., Ensign, K.E., Yoder, B., & Lee, E. (Sept, 2010). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Final report submitted to Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.
- Center for Children and Family Futures, Planning and Learning Technologies, and Macro International. (Jan 2011). *Regional Partnership Grant Program to Improve Child Safety, Permanency and Family Stability of Children Affected by Methamphetamine and Other Substance Abuse: Second Annual Report to Congress*. Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services. Report to Congress submitted to U.S. House of Representatives Committee on Ways and Means, U.S. Senate Committee on Finance.

Center for Children and Family Futures (April, 2010). *Regional Partnership Grant Program Semi-Annual Data Report: Preliminary Findings and Discussion*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Garstka, T.A., Neal, M., & Ensign, K.E. (March, 2010). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Garstka, T.A., & Ensign, K.E. (Sept, 2009). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Garstka, T.A., & Ensign, K.E. (March, 2009). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Center for Children and Family Futures, Planning and Learning Technologies, and Macro International. (Dec 2008). *Regional Partnership Grant Program to Improve Child Safety, Permanency and Family Stability of Children Affected by Methamphetamine and Other Substance Abuse: First Annual Report to Congress*. Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services. Report to Congress submitted to U.S. House of Representatives Committee on Ways and Means, U.S. Senate Committee on Finance.

Garstka, T.A., & Ensign, K.E. (Sept, 2008). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Garstka, T.A., & Ensign, K.E. (March, 2008). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Garstka, T.A., & Ensign, K.E. (Sept, 2007). *Quality Improvement Center on the Privatization of Child Welfare Services – Cross-Site Evaluation*. Semi-annual report submitted to Children's Bureau, Administration on Children, Youth, and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Computer Skills

Software Applications

Statistical Packages

Programming Packages

Web Applications

- Office suite (Word, Excel, Powerpoint)
- MS Access
- MS Project
- Adobe
- SPSS Base and Advanced Models
- SAS
- EQS – Structural Equation Modeling
- Atlas.ti - Qualitative analysis software
- NVivo – Qualitative analysis software
- MediaLab - Computerized experiment design software
- DirectRT - Response time design software
- EPrime - Computerized experiment design software
- REDCap Survey
- SurveyMonkey
- Go-To-Meeting/Go-To-Webinar

Specialized Statistical Training/Areas of Concentration

- Mixed models for longitudinal data
- Partial Least Squares (PLS) SEM with PLS Graph
- Sequential Analysis of Events
- Methods for Increasing Power and Designing Pre-Post and Multiple Regression Studies
- Determining Sample Size and Power in Study Planning
- Meta-Analysis
- Survival Analysis in Behavioral Research and the Design and Analysis of Longitudinal Studies
- Hierarchical Linear Modeling
- Interactions and Multiple Regression
- Structural Equation Modeling
- Performance Indicators/Measurement
- Cross-Site evaluation design and analysis
- Qualitative Data Extraction and Synthesis

Jared Barton, MSW

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Lawrence, KS 66045

785-864-7440

jaredlee@ku.edu

Key Qualifications and Experience

Jared has five years professional research, service delivery, and data management experience in both academic settings and private-nonprofit organizations. He has extensive experience creating, managing, and linking data in children's mental health, early childhood education, case management information systems, and experimental research projects. Alongside his work with the University of Kansas, he consults with private and non-profit organizations to provide technical assistance on data analysis, program evaluation, and grant contributions.

Education

MSW	Social Work Administration and Advocacy Practice	<i>University of Kansas</i>	2008
BSW	Social Work Generalist Practice	<i>University of Kansas</i>	2007

Employment History

Research Coordinator

Institute for Educational Research and Public Service

University of Kansas, Lawrence, KS

December 2010 – Present

As Research Coordinator in the Institute, Jared handles the daily operations of the evaluation of the Generations Project. He writes protocol for all aspects of an experimental research project. He develops databases and tracking systems to ensure data collection adheres to research and evaluation schedules. He maintains longitudinal study schedules for individual participants, monitors participation and attrition rates, and responds to ongoing needs of the evaluation plan and the requests of the Principal Investigator. Furthermore, he provides technical assistance to community service providers and the Research Assistant conducting field interview work.

Jared currently devotes his time to the following project:

- **Adolescent and Family Life Care Demonstration Grant.** This five year federal grant was awarded in 2010 to Kansas Children's Service League and the University of Kansas by the Office of Adolescent Pregnancy Programs (OAPP). This research demonstration grant is focused on evaluating Healthy Families home visiting program, mental health services, and a grandparent education group as a way of improving the ability of parenting teens to make healthy decisions for themselves and their infants. As research coordinator, Jared Barton develops research

protocols, creates and maintains the REDCap database for the project, works with community agencies to obtain data and recruit participants, and ensures all aspects of the project are completed as designed.

Data Outcomes Specialist

East Central Kansas Economic Opportunity Corporation (ECKAN)

Ottawa, KS

March 2009 – December 2010

As Data Outcomes Specialist for ECKAN, Jared oversaw the evaluation of agency programs across six departments to ensure outcome achievement. He responded to numerous accountability needs of the multi-service, community action agency providing monthly progress reports to ECKAN's Board of Directors on all the departments toward meeting their performance targets and submitting annual and quarterly outcomes data to state and federal officials. While at ECKAN, he conducted a large-scale Community Needs Assessment to all current ECKAN customers and over 6,000 random-sampled community members across nine counties and was charged with analyzing, developing a needs report, and disseminating the results. He also led a strategic-plan committee of five staff members to accomplish an agency goal of unifying intake, data, and reporting procedures across programs. He routinely monitored fidelity as system administrator for a customer database populated with over 7,960 customer households, trained agency staff on agency goals and outcomes, and supervised data entry. Jared continues to serve ECKAN as a consultant functioning in many of these same roles.

Community-Based Case Manager

Parent, Adolescent, and Child Empowerment Services

Wyandotte Center for Community Behavioral Health Care, Kansas City, KS

June 2008 – November 2008

As a case manager, Jared coordinated and implement individualized treatment plans for families with children experiencing serious emotional disturbance (SED). He provided daily community-based psychiatric support and reviewed client eligibility for referral to other mental health services. He collaborated with various community services including schools, foster care contractors, and agencies for developmental disabilities to ensure families were provided the highest quality of care.

Research Assistant

Office of Child Welfare and Children's Mental Health

University of Kansas School of Social Welfare, Lawrence, KS

May 2006 – June 2008

Jared served as a Research Assistant on the Children's Mental Health Research Team. He worked on the Consumer Satisfaction Survey helping to evaluate 27 Kansas Community Mental Health Centers for families receiving services for youth with serious emotional disturbance. He arranged research activities and conducted focus groups with mental health consumers and community stakeholders and supervised

data collection and entry progress at a sub-contracted survey call center. He wrote technical reports for each of the 27 mental health centers and aggregated data for a statewide report. He also responded to manuscript proposals and grant applications. Furthermore, Jared implemented a computer-based survey on mental health stigma with students in a rural Kansas middle school and provided technical assistance to participants and school staff.

Publications and Technical Reports

Barton, J. & Ward, C. (2011). *ECKAN Needs Assessment Update*. Ottawa, KS: East Central Kansas Economic Opportunity Corporation (ECKAN)

Barton, J. & Ward, C. (2010). *ECKAN Community Needs Assessment Report*. Ottawa, KS: East Central Kansas Economic Opportunity Corporation (ECKAN)

O’Brien, M., Byrnes, K., Corrigan, S., Barton, J., & Frehe, V. (2008). *Kansas Consumer Satisfaction Survey Children’s Mental Health: Statewide Report FY2008*. Lawrence, KS: The University of Kansas School of Social Welfare Office of Child Welfare and Children’s Mental Health. Retrieve online at <http://www.socwel.ku.edu/occ/projects/articles/KS%20Consumer%20Sat.%20Round%2011.pdf>

Barton, J. (2007). Affordable housing crisis: The impact of housing cost burdens. *The Community Psychologist, Summer 2007*

Computer Skills

<u>Software Applications</u>	<u>Statistical Packages</u>	<u>Programming Packages</u>	<u>Web Applications</u>
<ul style="list-style-type: none"> • Office suite (Word, Excel, Powerpoint) • MS Access • Adobe 	<ul style="list-style-type: none"> • SPSS Base and Advanced Models 	<ul style="list-style-type: none"> • REDCap Survey 	<ul style="list-style-type: none"> • SurveyMonkey • Go-To-Meeting/Go-To-Webinar • Adobe Dreamweaver • Coffee Shop HTML Editor

Trainings & Recognitions

- June 2010 to October 2010 – Emerging Leaders Academy through the KU Public Management Center.
- January 2010 – Completed Public Issues Facilitation Workshop through Institute for Civic Discourse and Democracy at Kansas State University.
- 2007-2008 Nominee for the Margo Award for Outstanding Performance in Social Work Administration Field Education.
- Spring 2006 through Spring 2007 School of Social Welfare Dean’s Honor Roll.