Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy:

Identifying Program Models to Meet Community Needs

May 2010

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Dear Early Childhood Program Staff:

Enclosed you will find a resource that we hope will be of value for you. It has been developed for the Illinois Department of Human Services, Strong Foundations Project by the Community Systems Development Workgroup (CSDW), the Infant Toddler Committee and the Home Visiting Task Force[1] of the Illinois Early Learning Council, and the Birth to Five Project. The Illinois Early Learning Council (ELC) coordinates existing state programs and services for children from birth to 5 years of age to better meet their early learning needs.

The purpose of this Resource Toolkit is to help you become familiar with research-based home visiting models. It has been designed to help you chose the program model or combination of models that best fit the needs of families in your community.

In this resource you will find materials that will help you:

- Better understand a range of research-based home visiting models
- Assess your current needs and how home visiting best fulfills these needs

We encourage you to explore the additional, larger toolkit developed by the CSDW that supports community partnership-building and -strengthening. This community partnership toolkit contains tools to help you and your partners expand, strengthen, manage, and sustain a network of locally-available resources to more broadly support the early development needs – including the home visiting needs you identify – of young children and families in your community. We hope this toolkit will prove useful for you in creating and sustaining partnerships that empower you in addressing your community's early childhood development and educational needs.

We welcome any feedback that you may have on this resource; please complete the form provided at the end of this Toolkit.

Sincerely,

The Community Systems Development Workgroup of the Illinois Early Learning Council's Infant Toddler Committee and Home Visiting Task Force, and the Birth to Five Project

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Co-Chair Infant Toddler Committee

Denise Simon
Director, Strong Foundations Project, Illinois Department of Human Services

[1] The Home Visiting Task Force is a new committee of the Early Learning Council, whose vision is to move Illinois towards one coordinated high-quality Home Visiting system that reaches all at-risk children under three years of age. The more specific goals of the task force are:

- Expand access to high-quality evidence-based home visitation programs for all at-risk children under three years of age
- Improve the quality of home visitation programs and services in Illinois
- Improve coordination between state and local home visiting programs, as well as between home visiting and all the other services for infants and toddlers
- Serve as an advisory body to the Strong Foundations project

As part of the last goal, the Task Force has been working with the Illinois Department of Human Services, the Illinois Department of Children and Family Services and the Illinois State Board of Education to advise on the implementation of a new project called, "Strong Foundations." This project, supported by a grant from the federal Children's Bureau, is designed to enhance the state's infrastructure for supporting home visiting programs. More specifically, Strong Foundations aims to create an integrated state infrastructure to support three evidence-based models of home visitation in Illinois.

Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy

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Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy

SECTION I

Introduction

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Introduction

How can we ensure that all Illinois children are safe, healthy, eager to learn and ready to succeed by the time they enter school? Moreover, how can we prepare all Illinois children to be resourceful enough to face all the academic and emotional challenges of school and life?

We are fortunate in Illinois to have multiple funding streams supporting home visiting and multiple high quality models being implemented at the local level.

This toolkit will show the similarities and differences among the evidence-based home visiting models available in Illinois, in order to help communities choose the home visiting model or combination of models that best fit their needs. As additional funding becomes available for home visitation services, we hope to improve the way communities think and plan for about home visitation services.

WHY HOME VISITING?

Home visitation is a service delivery strategy that creates supportive environments and relationships for the youngest children by promoting parental competence and successful early childhood development in the family's home.

The results of home visiting are remarkable:

- Children show improved literacy, problem solving, and language skills.
- Families are more likely to have health insurance, to seek well-child care, and to get their children immunized.
- Mothers have fewer pre-term births and their babies are born healthier.
- Cases of child abuse and neglect drop substantially.
- Participation in home visiting is associated with more success in school and college and higher earnings.
- Children will be less likely to drop out of school, become teen parents, or engage in criminal behavior.
- Families rely less on public assistance, have fewer problems with substance abuse, and have less involvement with the criminal justice system.

Home visitation is one general term used to refer to a range of interventions delivered at home. Not only are there a number of program models, but also the same program model can look different in practice to some extent when adapting to specific community needs. This is good for at least two reasons: first, there is no one home visiting model that can fully address the needs of all families and communities, in other words there is no "one size fits all" program or approach; second there are different programs that are eligible for different sources of funding and those differences can be helpful in reducing competition and improving collaboration.

Although evidence-based program models vary, they share some common elements:

- Small caseloads, ensuring home visitors spend adequate time with each family
- Highly-trained staff, ensuring high-quality implementation of the program
- Staff supervision, ensuring staff work with families effectively and participate in professional development in this rapidly changing field

- Cultural competence, ensuring staff are respectful of a family's cultural background and that they tailor their intervention accordingly
- Voluntary participation, ensuring parents are willing and active participants

HOW DOES HOME VISITING FIT IN THE BROAD ILLINOIS EARLY CHILDHOOD SYSTEM?

Communities require a strong continuum of effective programs for children and families in need of support throughout the first years of life.

Illinois is moving toward a coordinated early childhood learning system of programs, policies and services that is responsive to the needs of families, careful in the use of private and public resources, and effective in preparing our youngest children for a successful future. This early childhood learning system will be comprehensive including (a) programs and services such as early childhood education, early intervention and specialized services, social and emotional development, maternal and child health and nutrition, parenting and family support, community services for families with young children such as libraries, parks and communities of faith; and (b) the policies and resources affecting these programs and services, and ultimately families.

In order to achieve this vision at the local level this tool is one in a series intended to help communities move to comprehensive delivery system for young children at the local level.

Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy

SECTION II

Framework for Effective Infant Toddler Programs

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Framework for Effective Infant Toddler Programs

The goal of prevention services for expecting parents, infants, toddlers and their families is to provide early, continuous, intensive, and comprehensive child development and family support services to help families build a strong foundation for learning to prepare children for later school success. Despite some diversity in specific program strategies there are general program principles and guidelines that research has shown to be effective.

Program models implemented through research-based infant toddler programs must be shown to improve outcomes for at-risk infants, toddlers, and their families. The models will address the following principles, parameters and best practices.

A. Program Principles

High quality programs for children birth to three and their families must be:

1) **Focused on prevention and promotion of optimal well-being.** Programs shall support the promotion of early learning and of health and well-being in the child, parents and family in order to prevent, detect and address problems at their earliest stages.

2) **Family-centered.** Staff and families shall work together in relationships based on respect, and the program shall build on family strengths and support parents as the primary nurturers, educators and advocates for their children.

3) **Intensive and comprehensive.** Programs shall offer services of sufficient intensity and comprehensiveness to meet stated goals.

4) **Individualized.** Programs shall be flexible to meet the needs of individual family members and children.

5) **Relationship-based.** Programs shall support and enhance strong, caring relationships which nurture the child, parents, family and care-giving staff, maintaining relationships with caregivers over time and avoiding the trauma of loss experienced with frequent turnover of key people in the children's life.

6) **Culturally responsive.** Programs shall demonstrate an understanding of, respect for, and responsiveness to the home culture and home language of every child.

7) **Community-based.** Programs should be embedded in their communities and contribute to the community-building process.

8) **Voluntary.** Services are offered on a voluntary basis.

9) **Accessible.** Services are provided in a way that overcomes potential barriers to participation, such as lack of English proficiency, lack of transportation, and need for non-traditional service hours.

10) **Well coordinated.** Families who receive multiple services or who participate in multiple programs should experience a "seamless system of services." Service providers should regularly communicate and coordinate their services on behalf of individual families.

B. Parameters

The specific "best practices" for a program will be determined by its goals. Program structure and activities should be linked to expected outcomes through a "logic model" that is developed for each program. The logic model should include long-term expected outcomes, shorter-term measurable indicators of participant outcomes (including a plan for when and how to measure these indicators), and a description of program activities that are expected to lead to these outcomes. The logic model must be regularly reviewed and updated to reflect current program realities and used to continually improve service provision.

The parameters of a program that should be addressed in a logic model include:

- Target population (who will be served by the program)
- Array of services and programs that families will have access to
- Coordination with other services, including outside agencies
- Method and timing of assessment
- How appropriate services will be matched to participant need
- Intensity of services (frequency, duration)
- Staff disciplines, qualifications and training
- Caseloads for staff
- Supervision for staff

C. Best Practices

Despite the great diversity among birth to three programs, there are nine best practices that apply to all of these programs and service systems:

1) **Methods and approaches.** The curriculum or approach chosen must reflect the centrality of adult/child interactions in the development of infants and toddlers and the holistic and dynamic nature of child development. The approach should support and demonstrate respect for families' unique abilities as well as their ethnic, cultural and linguistic diversity. The approach must address all domains of infant and toddler development including physical, social, emotional, and cognitive development.

2) **Periodic assessment.** Because infancy and early childhood are times of such rapid growth and development, assessments (or screenings) must be completed at regular intervals to ensure that children and families are receiving appropriate services.

3) **Inclusion of parents/other family members.** Because infants and toddlers are profoundly influenced by their parents and other family members, no services can be provided to the children in isolation from their families.

4) **Transition planning.** Transitions from hospital to home, from a prevention program into a more intensive intervention program or from a program for birth to three year olds into a program designed for three to five year olds must be carefully planned to ensure continuity of services for the child and family.

5) **Staff knowledgeable about very young children.** Birth to three prevention services must be provided by staff who are knowledgeable about infant and toddler development and who are experienced in working with children this age and their families.

6) **Staff supervision and training.** Staff who work with very young children and their families must be provided adequate supervision and on-going training opportunities in this rapidly developing and changing field.

7) **Multidisciplinary coordination.** For families involved with more than one service provider, services (and assessments) must be provided in a coordinated fashion.

8) **Staff/family ratios.** Staff must have reasonable caseloads or class sizes to devote adequate time to planning and building strong relationships with children and families.

9) **Intensity of services.** Services must be offered on an intensive basis to meet the needs of at-risk families and with increasing or decreasing frequency as appropriate to meet the challenging needs of families.

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Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy

SECTION III

Program Self-Assessment

Community Self-Assessment

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Program Self-Assessment: Assess Your Current Program Components

This assessment will be helpful in communities with existing home visiting programs. It outlines key program components in a format that maps directly to the profiles of research-based program models in Section IV. This self-assessment will help you compare programs with research-based program models and identify potential gaps in the home visiting landscape.

Information that will help you answer the questions in this self-assessment might be found in:

- Your program's mission statement
- Program brochures
- Grant proposals and grant reports
- Other program reports or evaluations

Step 1. Familiarize Yourself with Standards

Become familiar with current characteristics of high-quality programs. See Section II for the *Framework for Effective Infant Toddler Services*, which describes the components of high-quality programs for infants and toddlers.

Step 2. Analyze Your Current Program

If you have existing programs, please continue with **Step 2**. If you do not have existing programs, please go to **Step 3**.

2A. Outline Current Program Components

	Your Current Program
Program Purpose & Description	• What is the purpose (or what are the goals) of your program?
Target Population	• Who is your target population (e.g., teens, immigrants, etc.)?
Key Services	• What are the services that your program provides and how do they provide services?

	Your Current Program
Outreach & Recruitment	• How does your program identify and recruit program participants? • What kind of community outreach do you conduct?
Methods & Approaches	• What are the values or philosophy that your program is based upon?
Intensity of Services	• What is the frequency of contact with program participants? • Does your program provide the same intensity of services to all participants, or does the intensity of service vary with the needs of different participants?
Staff Qualifications & Supervision	• What are the qualifications of your program staff (level of education, years of experience, etc.)? • Who provides supervision to your program staff and how regularly does supervision occur?
Staff Training	• What type and amount of training do your program staff receive? Who provides the training? • Do your program staff have opportunities to obtain additional training? If so, please describe. Who provides this additional training?
Staff Caseload/ Class Size	• What is the caseload or class size, on average, per staff member?

	Your Current Program
Matching Services to Need	• How does your program individualize service provision? • Does your program offer different services to families based on their specific needs?
Coordination of Services	• How does your program coordinate its services with those of other programs or organizations? • How does your program coordinate services for families receiving services from multiple providers?
Parent Involvement	• Does your program involve parents? If so, please describe.
Credentialing or Certification Process	• Is your program affiliated with a national or other model?
Evaluation Requirements	• Does your program conduct a self-evaluation, or is it evaluated by an outside entity? If so, what does this evaluation involve?
Program Costs	• What is the average cost of your program per participant? (Average cost = Your cost to run the program divided by the number of participants)
Supporting Research Citations	• Do you have outcome data supporting the effectiveness of your program?

	Your Current Program
Model-Specific Resources	• Do you use any particular resources or information to help you implement your program?

2B. Outline Program or Logic Model

As you assess your program, think about the *connection* between your program's goals and services: What services do you provide? How do these services help families achieve program goals? Your program should provide services that research has shown to be effective in helping achieve program goals. As part of this process, think about what information you use and what data you collect to determine whether goals are being achieved. This process provides information that can be used to improve the quality of your program. Additional questions to ask yourself include:

- GOALS: What does my program aim to accomplish in working with children and families?
- SERVICES & RESOURCES: What activities does my program undertake and what resources does it use to accomplish its goals?
- MEASUREMENTS & OUTCOMES: Are my program outcomes being measured? How? Is the measurement tool appropriate for what I want to measure? What have the results told me about my program outcomes?

Step 3. Analyze Your Community's Resources and Needs

If you have existing programs, an assessment of your community's resources and needs will help you gain a better understanding of potential unmet needs, current initiatives in the community and where future initiatives should focus.

If you do not have existing programs, begin your program planning with a solid assessment of your community's resources and needs.

Please see the *Community Self-Assessment* in Section III of this Toolkit.

Step 4. Review Key Elements of Research-based Program Models

Review the *Summary & Comparison of Key Components of Program Models* in Section IV. This guide compares the key program elements of Healthy Families, Nurse Family

Partnership, and Parents as Teachers. As you read this guide, ask yourself the following questions:

If you have an existing program …
- Which of these program models is most similar to my current program?
- Which model will best address the needs of my community and the families my program serves?
- What changes would I need to make to my program to implement any of these models?
- What resources would I need to make these changes (including additional funding, program staff, space, etc.)?

If you do not have an existing program …
- Which of these program models best fits the goals of your new program?
- Which model will best address the needs of my community and the families my new program aims to serve?
- In designing my new program, what would I need to incorporate to implement any of these models?
- What resources would I need to implement a new program (including funding, program staff, space, etc.)?

After reading this guide and thinking through these questions, you will have a better sense of which research-based model(s) would best fit your new or existing program.

Step 5. Compare Your Model with Research-based Models

Once you have narrowed down your options, see Section IV and read the detailed *Full Profile* of the model or models that seem the most appropriate for your new or existing program. As you read this additional information, continue to ask yourself the questions from **Step 2** above.

Within each *Full Profile*, see the Model-Specific Resources and the Initial Point of Contact for Program Model Information for additional, in-depth resources on specific program models. The resources listed in these sections will provide further information and guidance on how to implement each program model.

Step 6: Assess Transition Needs and Create a Transition Plan

With an understanding of the community's needs and resources, identify those aspects of your current program that have to change as you adopt the new model or what aspects you will need to incorporate into your new program using the new model:

- Staff Training
- Staffing
- Supervision
- Case load size
- Frequency of home visits/group services
- Curriculum
- Budget

Develop timeline for:

- Hiring any needed new staff and orienting staff to new program model
- Obtaining needed core training for staff on new program model
- Working with participants to inform them of new model and encouraging their continued participation
- Implementing new components of model

Community Self-Assessment: Assess Your Community's Current Early Childhood Needs and Resources[2]

Effective planning begins with a solid assessment of the communities' resources, strengths and needs. This tool is designed to assist you in gaining a better understanding of how young children and their families are faring and where assistance is needed. This tool will assist you in evaluating the success of current initiatives and determining the focus of future strategies to help improve outcomes for young children. This tool was adapted to focus on young children (under age 5) and is customized to Illinois data and demographics.

The community assessment has two sections:

I. **Condition of Young Children:** Indicators and resources aimed at providing an overview of the well-being of children under age 5. See **Data Guide** for assistance with data sources and alternate measures.

A. Demographic, Social, and Environment Indicators
B. Health Indicators
C. Program Indicators: Early childhood programs available in the community and the number of children they serve.
D. Inventory of Local Childhood Resources: Resources available for young children and their families in the community.

NOTES:

- *Use the indictors listed as a guide*. If your locality does not collect some of these data, or does not have it broken down at the community-level, do not be overly concerned. Use alternate measures or add other available data that will help provide a picture of the conditions of young children in the community.
- *Create a more comprehensive inventory* by using the blanks under each category to record specific program names, services, or other activities that are not listed. Identifying key contacts at these organizations or programs can also be helpful.
- *Consider collecting detailed information* about each program in the community.

II. **Condition of Our Community:** A list of statements and questions that can be used to help focus discussions with various community stakeholders, including early childhood service providers and other key stakeholders.

A. Rate these Statements: Statements aimed at guiding assessment of the community's readiness to respond to its early childhood needs.
B. Open-Ended Questions: Questions aimed at guiding the discussion on early childhood needs with community stakeholders.

NOTE:

- *View as an opportunity for engaging constituents* in a meaningful way around early childhood issues.

Listed below are some general suggestions about the community assessment process:

- ***Consider using a team approach*** to the assessment. Since data and other information about local resources will most likely come from a variety of sources, it may be helpful to bring key experts (both within and outside city/county government), data suppliers and other knowledgeable partners together to work on the assessment as a group, rather than requiring one person to track down all the information
- ***High-level leadership*** from a mayor or city/town councilmember can help secure buy-in from the agencies and partners needed to collect data and other important information for the assessment.
- ***Provide opportunities to reflect on the information gathered***. After completing the community assessment, do not just file it away! Instead, set aside time to discuss the results with other

[2] Adapted from the National League of Cities. www.nlc.org/iyef

municipal leaders, staff from key city agencies, and stakeholders. Use these sessions to determine priorities, develop strategies, and build support for taking the next steps to address early childhood needs identified by the assessment.

Part I: Condition of Families with Young Children

For each indicator, program, or resource listed in the tables below, locate community-level data, whether city or county, on children under age 5. Refer to the Data Guide at the end for assistance with data sources and alternate or additional measures. Space is available to include additional indicators, programs, and resources.

Our community is defined as (i.e. County or City): _____

Indicator	Numeric Value	Notes	Data Date
A – Demographic and Social – ***Indicators taken from Census, ACS, IECAM, and Chapin Hall Center for Children see Data Guide Section***			
Number of children under age 5			
Percent of families with children under age 5			
Percent of children under age 5 living in poverty			
Number of households speaking Spanish or other language at home & are linguistically isolated			
Median family income			
Number of children age 5 and under below 185% Federal Poverty Level (FPL)			
Number of children age 5 and under below 200% FPL			
Percent of population 5 years and over that speak a language other than English at home			
Of those that speak a language other than English at home, what percent speak English less than very well			
B – Health – ***Indicators taken from IPLAN, IDPH Health Stats, IL DCFS, CDC, and HRSA see Data Guide Section***			
Percent of infants born with low birth-weight			
Percent of children covered by health insurance 0-5 years old			
Percent of 2 year olds who were immunized			
Percent of mothers who smoke during pregnancy			
Percent of mothers who drink during pregnancy			
Teen birth rate (reported cases per 1,000 children)			

Percent of mothers beginning prenatal in the 1st trimester			
Percent of births by cesarean section			
Infant Mortality Rate			
Percent of children with special healthcare needs (CSHCN) 0-5 years old			
Child abuse and neglect rate for children 0-5 years old (reported cases per 1,000 children)			
Percent of children 6 years old and younger with elevated blood lead levels (based on number of children tested)			
Percent of children 3 years old and younger with elevated blood lead levels (based on number of children tested)			
Number of Medicaid deliveries			
Percent of children with dental exams, caries experience, untreated decay, urgent treatment, sealants			
Breastfeeding initiation rates			
Breastfeeding 6 month duration rates			
Maternal oral health care • Needed to see a dentist for a problem			
• Dental/health care worker spoke about care of gums and teeth			
• Visited dentist or dental clinic			

C – Programs – ***Indicators taken from IECAM – see Data Guide Section***		
	Total Number of Children Served in Your Community	**Notes**
Early Head Start: home-based		
Early Head Start: center-based		
Head Start		
ISBE PreK/Preschool for All		
ISBE 0-3 Programs, home-based*		
ISBE 0-3 Programs, center-based*		
Licensed Child Care Centers		
Licensed-Exempt Child Care Centers		
Licensed Family Child Care Homes		

Healthy Families Initiative (HFI)		
Parents Too Soon (PTS)		
Joint Program (HFI and PTS)		
Early Intervention (EI)		
Part B (Special Education) Caseload – contact your local school district		
Percent of first graders promoted to the next grade – contact your local school district		
*May need to contact programs directly		
D – Inventory of Local Early Childhood Resources – ***Indicate resources available within your community***		
	Available? Y or N	**Notes**
Parent Education/Support		
Family Resource Centers		
Parenting Classes		
Family Literacy Programs		
Early Care and Education		
Child Care Research and Referral (CCR&R)		
Child and Family Connections (CFC)		
Child Health and Safety		
Family Case Management (FCM)		
Food Stamps		
WIC		
Safety Seat Programs		
Smoke Detector Distribution		
Lead Abatement		
FQHCs		
Local Health Department		
Community Health Centers		
Pediatric Practices		
Birthing Hospitals		
Social Services		
Counseling		
Transitional Housing		
Food Pantries		
Neighborhood Resource Centers		
Basic Needs Services		

Faith-Based Services		

Part II: Condition of Your Community

In each section below, consider the early childhood resources and needs of your community. Consider your community's readiness to respond to its unmet needs, as well as how its readiness can be enhanced. We recommend using a team approach to these questions by including key contacts from a variety of partners, as well as high-level leadership. The answers to these questions offer an opportunity to reflect on the condition of your community and to identify next steps.

Part A: Rate These Statements

Use this section to assess your impression of your community's readiness to respond to its early childhood needs.

Statement	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
My community is ready to tackle early childhood issues.					
What is the evidence of this? _____ _____ _____					
There is a general awareness of the importance of successful early childhood in your community.					
How do you know this? _____ _____ _____					
I anticipate sources of resistance to municipal action to promote early childhood success.					
What is the nature of the anticipated resistance? _____ _____ _____					
There is significant need for more quality child care and early education opportunities in my community.					

Part B: Open-Ended Questions

Use these questions to help focus discussions with various community stakeholders, including early childhood service providers and other stakeholders. View these questions as an opportunity for engaging constituents in a meaningful way around early childhood issues.

Questions for All Community Stakeholders

- What types of people/organizations in your community are important to have "at the table" when designing an early childhood agenda? (i.e. who are your key thought leaders?)
- What are some potential barriers to, and opportunities for, reaching out to parents of young children in your community?
- What is the nature of your linkage with the schools?
- What are the biggest unmet needs for young children and families? How do these relate to the data on the condition of young children that is collected in your community?
- Is there an existing coalition or other mechanism that promotes communication and coordination among providers of early care and education, health services, and parent support programs in your community? If so, what is it? How does it work?

Data Guide: Sources and Alternate Measures
(This is not an exhaustive list, but a potential place to start collecting data)

- **Number of children under age 5**

For Illinois (non Chicago) IECAM data (uses 2005 census data estimates):

1) Go to http://iecam.crc.uiuc.edu and click on Search Data.
2) Select the Region/Municipality/County.
3) Under the "Demographics" column, check the box next to "Population."
4) At the bottom of the same column, click the "Submit" button.

For ACS, American Community Survey (2005 – 2007), data (Please note: This is survey, not census data):

1) Go to www.census.gov and click on "American Community Survey."
2) On right side of screen, under "Get Data," click "American FactFinder (AFF)."
3) Select "Data Profiles."
4) Select Geographic Area (state, county, Congressional District, elementary or secondary school district)
5) Select "Demographic" characteristics and search table for data.

Please note: ACS data is survey data, collected between 2005 and 2007. While ACS data is more up-to-date, it is not census data, which is currently available through the 2000 census only.

For Chicago communities: Chapin Hall Center for Children – Early Childhood Programs Supply and Demand

1) Go to http://dcys-ccsd.chapinhall.org/index.html and select Community Area Profiles
2) Select an area and "Child Population & Eligibility"

- **Median family income**

For ACS, American Community Survey (2005 – 2007), data:

2) Go to www.census.gov and click on "American Community Survey."
3) On right side of screen, under "Get Data," click "American FactFinder (AFF)."
4) Select "Data Profiles."
5) Select Geographic Area (state, county, Congressional District, elementary or secondary school district)
6) Select "Economic" characteristics and search table for data.

- **Number of children age 5 and under below 185% Federal Poverty Level (FPL)**
- **Number of children age 5 and under below 200% FPL**

For Illinois (non Chicago) IECAM data (uses 2005 census data estimates):

1) Go to http://iecam.crc.uiuc.edu, and click on Search Data.
2) Select the Region/Municipality/County.
3) Under the "Demographics" Column, check the box next to "185% Federal Poverty Level" and "200% Federal Poverty Level"
4) At the bottom of the same column, click the "Submit" button.

- **Percent of population 5 years and over that speak a language other than English at home**
- **Of those that speak a language other than English at home, what percent speak English less than very well.**

For ACS, American Community Survey (2005 – 2007), data:

7) Go to www.census.gov and click on "American Community Survey."
8) On right side of screen, under "Get Data," click "American FactFinder (AFF)."
9) Select "Data Profiles."
10) Select Geographic Area (state, county, Congressional District, elementary or secondary school district)
11) Select "Social" characteristics and search table for data.

- **Percent of households with children under age 5**

For Census 2000 data:

12) Go to www.census.gov and click on "American Fact Finder."

13) Under the "Data Sets Menu," box choose "Summary File 1."
14) Choose "Quick Tables" from the list on the right-hand side of the page.
15) On the next screen, make sure "List" is indicated for "Choose a Selection Method."
16) Next, choose your state from the "Select a State" drop-down menu. Wait for the page to re-load.
17) Select one or more geographic areas and click "Add." When you have selected all of the areas of interest, click the "next" button at the bottom of the page.
18) On the table, select the "P34: Family Type and Presence of Own Children" category. Click "Go" on the right side of the box. Allow the page to refresh.
19) To capture all families with children under age 6 you must add together the percentages for "Under 6 years only" and "Under 6 & 6-17 years" in the next box.
20) Click on "Show result."

❖ **Percent of children under age 5 living in poverty**

IECAM has numbers of children living in poverty in Illinois, by county/region, while Chapin Hall has number of children under 6 by household income with percentages at or below the federal poverty level.

For IECAM data, which uses 2005 Census data estimates:
1) Go to http://iecam.crc.uiuc.edu, and click on Search Data.
2) Select the Region/Municipality/County.
3) Under the "Demographics" Column, check the box next to "Population."
4) Choose the poverty level you are interested in, and check the box next to it.
5) At the bottom of the same column, click the "Submit" button.
6) The rightmost column contains the number of children at or below that poverty level.

For Chicago communities: Chapin Hall Center for Children – Early Childhood Programs Supply and Demand
3) Go to http://dcys-ccsd.chapinhall.org/index.html and select Community Area Profiles
4) Select an area and "Child Population & Eligibility"

For ACS, American Community Survey (2005 – 2007), data (Percent of children under age 5 in families living in poverty):
21) Go to www.census.gov and click on "American Community Survey."
22) On right side of screen, under "Get Data," click "American FactFinder (AFF)."
23) Select "Data Profiles."
24) Select Geographic Area (state, county, Congressional District, elementary or secondary school district)
25) Select "Economic" characteristics and search table for data.

❖ **Percent of infants born with low-birth weight by county***[Alternate measures: Percentage of women receiving prenatal care in the first trimester; Infant mortality rate (deaths per 1,000 births)]*

The Illinois Department of Public Health has the Illinois Project for Local Assessment Needs website.
For IPLAN data:
1) Go to http://app.idph.state.il.us.
2) Click on IPLAN DATA SYSTEM on the left side of the screen.
3) Click on "County-level report."
4) Select a County or Special Area from the lists.
5) Under "Select Indicator," scroll down to "3.03, Low Birth Weight."
6) Select the year of interest under "Select data years."
7) Choose whether data should include race or ethnicity.
8) Click the "Submit" button.
9) The table will list the percentage of children with low birth weight and very low birth weight, by ethnicity, in the county selected.

Other potential indicators found in IPAN that you may want to include/consider:
- Mothers who smoke or drink during pregnancy
- Prenatal care in the 1st semester
- Teen birth rate
- % births to teens

- Number of Medicaid deliveries

❖ **Child abuse and neglect rate for children under age 5 (reported cases per 1,000 children)**

The Illinois Department of Child and Family Services has data on child abuse and neglect reports, statewide data and some county level data.

Go to http://www.state.il.us/dcfs/index.shtml

❖ **Total number of children enrolled/proposed to be served in:**

IECAM
Early Head Start
Head Start
ISBE Pre-K/Preschool for All (PFA)
ISBE 0 – 3 programs, home-based*
ISBE 0 – 3 programs, center- based*
Licensed Child Care Centers
Licensed-Exempt Child Care Centers
Licensed Family Child Care Homes
Healthy Families Initiative (HFI)
Parents Too Soon (PTS)
Joint Program (HFI and PTS)
Early Intervention (EI)

For Illinois (non Chicago) IECAM data:

1) Go to http://iecam.crc.uiuc.edu, and click on Search Data.
2) Select the Region/Municipality/County.
3) Under the "Early Childhood Service Type", check appropriate box (i.e. Head Start, ISBE PreK/PFA)
4) At the bottom of the same column, click the "Submit" button.

For Chicago communities; Chapin Hall Center for Children- Early childhood program supply and demand can be searched by the following two options:

Community Area Profiles - includes more detailed profiles of the poorest forty-four of Chicago's communities.
Search by Indicators - includes tables of information on all children in Chicago, by community area and maps displaying key trends and indicators affecting childcare demand. Also included is a map of the Community Areas in Chicago.

5) Go to http://dcys-ccsd.chapinhall.org/index.html and select "Search by Indicators" or by "Community Area Profiles"

*ISBE 0 – 3 program data are not available via IECAM. For current data, contact the ISBE Early Childhood Division at (217) 524-4853. You may also need to contact your programs directly for more information.

❖ **Percent of first graders promoted to next grade**
❖ **Part B (Preschool Special Education) caseload**

Source: Contact your local school district.

❖ **Percent of children with special healthcare needs**

For Illinois-level data, go to the Illinois results from the National Survey of Children with Special Healthcare Needs, administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA): http://mchb.hrsa.gov/cshcn05/SD/illinois.htm.

❖ **Percent of children 6 years old and younger with elevated blood lead levels (based on number of children tested)**
❖ **Percent of children 3 years old and younger with elevated blood lead levels (based on number of children tested**

For Illinois' state-level and county-level data, go to the Illinois Department of Public Health Statistics page at: http://www.idph.state.il.us/health/statshome.htm. On this page, go to the "Childhood Lead Poisoning Surveillance Report" section of the page

- **Breastfeeding rates and maternal oral health care**

  For Illinois' state-level data, go to the Illinois Department of Public Health Statistics page at: http://www.idph.state.il.us/health/statshome.htm. On this page, go to the "Illinois Pregnancy Risk Assessment Monitoring System (PRAMS)" section of the page. Breastfeeding data is also grouped by age, race, ethnicity, education, payment for delivery, and marital status.

- **Percent of children with dental exams, caries experience, untreated decay, urgent treatment, sealants**

  For Illinois' data grouped by the following: entire state, urban only, rural only, collar, Chicago, and Cook County, go to the IL Department of Public Health (IDPH), Division of Oral Health: http://www.idph.state.il.us/HealthWellness/oralhlth/home.htm. Data can be found in "Healthy Smile Healthy Growth" assessment document.

Resource Toolkit for Communities Considering and Implementing a Home Visiting Strategy

SECTION IV

Summary & Comparison of Key Elements of Program Models

Full Profiles of Program Models

- Healthy Families
- Nurse Family Partnership
- Parents As Teachers

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Summary & Comparison of Key Components of Program Models

	Healthy Families (HF)	Nurse-Family Partnership (NFP)	Parents As Teachers (PAT)
PROGRAM PURPOSE & DESCRIPTION	Purpose To promote healthy child development and reduce child abuse and neglect among at-risk families. Description Healthy Families (HF) is a voluntary, intensive home visiting program that reduces family isolation, supports parents as children's first teachers and caretakers, and helps parents develop good parenting skills.	Purpose • Improve pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough medical care, improving their diet, and reducing their use of alcohol, cigarettes, and illegal substances • Improve child health & development by helping parents provide responsible and competent care for their children • Improve parental economic self sufficiency by helping parents develop a vision for their own future, plan for future pregnancies, continue their education, and find work Description Nurse Family Partnership is a voluntary program where highly educated nurses visit low-income women in their homes during their first pregnancy and throughout the first 2 years of their child's life to accomplish the above goals. All services are delivered through strength-based and client centered practices.	Purpose To provide the information, support, and encouragement parents need to help their children develop optimally during the crucial early years of life. Description Parents as Teachers (PAT) is a home-based family education and support program for parents with children from the prenatal stage through age 5. Through the program, parents acquire skills that help them make the most of children's crucial early-learning years.
TARGET POPULATION	Families who are at risk of child abuse and neglect. Families are identified during pregnancy or at birth through a structured assessment.	First time low income mothers	All families; PAT is a universal access model. Some PAT programs use funding that requires them to deliver services to a very targeted population. PAT also blends with other early childhood programs that target low literacy parents and/or low-income families. Program intensity is modified based on the needs of the families served.

	Healthy Families (HF)	Nurse-Family Partnership (NFP)	Parents As Teachers (PAT)
KEY SERVICES	• HFI provides voluntary, culturally relevant services to both fathers and mothers. • HFI services include: ○ Teaching and modeling effective parenting skills; ○ Providing social support for new parents to reduce social isolation; ○ Connecting parents to other services in the community; ○ Removing barriers to services such as lack of transportation or child care; ○ Monitoring and promoting children's development; and ○ Supporting parent-child attachment.	Client centered, strength-based, culturally competent services are delivered to the mothers and families using the evidenced based tested NFP Home Visit Guidelines. The Guidelines are structured around the following Home Visit Domains: Personal Health • Health maintenance practices • Nutrition and exercise • Substance use • Mental health functioning Environmental Health • Home • Work, school, and neighborhood Life Course Development • Family planning • Education and livelihood Maternal Role • Mothering role • Physical care • Behavioral & emotional care Family and Friends • Personal network relationships • Assistance with childcare Health and Human Services • Service utilization	<u>Personal Visits</u> • PAT-certified Parent Educators visit families at their homes on a regular basis. Educators work in partnership with parents to share child development and parenting information using a structured, research-based curriculum. Parents observe their child's skills and interact with their children through developmentally appropriate activities. <u>Group Meetings</u> • Group meetings for parents are an opportunity for families to acquire information and gain support from other parents. <u>Developmental Screening</u> • All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year. <u>Connections with Community Resources</u> • PAT programs connect families to needed resources and take an active role in the community. <u>Goal Setting</u> • Parent Educators partner with families to establish and achieve child development and parenting goals.

	Healthy Families (HF)	Nurse-Family Partnership (NFP)	Parents As Teachers (PAT)
METHODS & APPROACHES	• The Healthy Families approach includes the following critical elements: ○ HF services are initiated **prenatally or at birth**; ○ HF uses a **standardized assessment tool** to identify families who are most in need of services; ○ HF services are **voluntary** and HF uses positive, persistent outreach efforts to build trust with families; ○ HF offers services **intensively** (at least once a week); ○ HF services should be **culturally competent**; ○ HF services should **focus on the parent(s)** as well as **supporting parent-child interaction and child development**; ○ At a minimum, **all families should be linked to a medical provider**; and ○ Home visitors should have **limited caseloads** (usually no more than 15 families per visitor).	NFP has Guiding Elements for Service Implementation: Client Elements ○ Voluntary participation ○ First-time mother ○ Low-income ○ Enrolled early in pregnancy (<28 weeks) Intervention Elements ○ One to one visiting with client and NHV ○ Client visited in her home ○ Visits occur during pregnancy and up child's second birthday Qualities of Nurses and Supervisors ○ NHV and supervisors are RN's with BSN training ○ NHV and supervisors complete NFP NSO core education and deliver the intervention with fidelity to the model Application of the Intervention ○ NHV use professional judgment to individualize guidelines to meet client's needs ○ NHV apply theoretical frameworks that underpin the program ○ A full-time NHV carries a caseload of no more than 25 active clients Reflection and Supervision ○ A full-time nursing supervisor supervises no more than eight NHV's ○ Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision. Program Monitoring and Use of Data ○ NHV and Nursing Supervisors collect data and use NFP reports to guide practice, monitor implementation, inform clinical supervision, enhance quality and demonstrate fidelity. Agency Elements ○ NFP implementing agency operated by an organization known for successful provision of prevention services to low-income families ○ NFP implementing agency convenes long-term Community Advisory Board Adequate support and structure shall be in place to support NHV and nursing supervisors to implement the program and assure data is accurately entered into the data base in a timely manner.	• The PAT model is based on the following core values: ○ All parents deserve **support in their parenting role** and participation is voluntary. ○ The **home is the child's first and most important learning environment**. ○ An understanding and appreciation of the **history and traditions of different cultures** is essential in serving families. ○ Design of the program allows for **intensity and duration of services to match family needs**. ○ PAT is committed to promoting the **optimal development and school readiness** of each child. ○ Quality implementation of the PAT program fosters **positive parent-child relationships**, and increases parenting skills. ○ Local programs adapt the PAT model to meet the **unique needs of the community** being served.

	Healthy Families (HF)	Nurse-Family Partnership (NFP)	Parents As Teachers (PAT)
PROGRAM COSTS	<u>Cost per participant</u> • Approximately $3,600 to $4,600 per year (including matching funds from programs) <u>Start-up costs</u> • Approximately 25% of a program's annual budget (about $50,000)	The NFP program costs approximately $4500 per family per year to fund, and can range from $2,914 to $6,463 per family per year. The nurses' salaries are the primary driver that affects variability of costs.	<u>Cost per participant</u> • $3,650 per year (weekly visits to one at-risk family, per year) <u>Start-up costs</u> • $78,002 per program site for one year for a brand new program (includes training and curriculum, program materials, two part-time parent educators, one supervisor, one clerical support staff person, administrative costs, rent and utilities, and quality assurance and evaluation) • $4,470 for an existing early childhood program to adopt the Parents as Teachers model (includes training and program materials) <u>Training costs</u> • $815 per person, including training fee and cost of curriculum

Healthy Families • Full Profile of Program Model

	Healthy Families (HF)
Program Purpose & Description	**Purpose** • To promote healthy child development and reduce child abuse and neglect among at-risk families. **Description** Healthy Families (HF) is a voluntary, intensive home visiting program that reduces family isolation, supports parents as children's first teachers and caretakers, and helps parents develop good parenting skills.
Target Population	• Families who are at risk of child abuse and neglect. Families are identified during pregnancy or at birth through a structured assessment.
Key Services	• HFI provides voluntary, culturally relevant services to both fathers and mothers. • HFI services include: o Teaching and modeling effective parenting skills; o Providing social support for new parents to reduce social isolation; o Connecting parents to other services in the community; o Removing barriers to services such as lack of transportation or child care; o Monitoring and promoting children's development; and o Supporting parent-child attachment.
Outreach & Recruitment	• HF programs typically work with hospitals, clinics and other agencies who serve pregnant women and/or new mothers to provide assessment services. Assessments enable staff to identify family needs and refer them to supportive services such as HF. • HF makes persistent outreach efforts to those families who are hesitant to accept services, but have not clearly indicated an unwillingness to accept services. HF uses these positive, persistent outreach efforts to build trust with families.
Methods & Approaches	• The Healthy Families approach includes the following critical elements: o HF services are initiated **prenatally or at birth**; o HF uses a **standardized assessment** tool to identify families who are most in need of services; o HF services are **voluntary** and HF uses positive, persistent outreach efforts to build trust with families; o HF offers services **intensively** (at least once a week); o HF services should be **culturally competent**; o HF services should **focus on the parent(s)** as well as **supporting parent-child interaction and child development**; o At a minimum, **all families should be linked to a medical provider**; and Home visitors should have **limited caseloads** (usually no more than 15 families per visitor).
Intensity of Services	• HF services are offered during "critical times" (during pregnancy, at birth, and soon after birth). • Services are offered weekly at the outset, with frequency of contact either increasing or decreasing over time based on family circumstances. • Services should be available from birth through 5 years of age, if needed. Artificial or arbitrary time limits on services should be avoided.
Staff Qualifications & Supervision	**Qualifications** • Varied; HF includes both paraprofessional and professional staff. • Service providers should be selected because of their personal characteristics, their willingness to work in or experience working with culturally diverse communities, and their skills to do the job. • Service providers should have a framework, based on education or experience, to handle the variety of experiences they may encounter when working with at-risk families.

	Healthy Families (HF)
Staff Qualifications & Supervision continued	**Supervision** • Appropriately qualified professional staff should provide supervision. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to work with families more effectively; and to express their concerns and frustrations.
Staff Training	• All staff are required to complete the 5-day Healthy Families America Core Training as well as intensive job-specific training. • Assessment workers and home visitors are oriented to the program's goals, services, policies, operating procedures, and philosophy prior to direct work with children and families. • The program provides staff with training on culturally competent practices based on the unique characteristics of the population being served (i.e., age-related factors, language, culture, etc.). • The state system includes a Healthy Families Training Institute that ensures that all staff receive ongoing training specific to each worker's knowledge and skill base.
Staff Caseload/ Class Size	• Home visitors should have limited caseloads so that they can spend adequate time with each family (for most communities, no more than 15 families per visitor).
Matching Services to Need	• See Outreach & Recruitment above. • A service plan specific to each family's needs must be developed. The HF program must work closely with the IDHS' Family Case Management program to develop this plan.
Coordination of Services	• Community participation is required to establish HF programs, with respect to: input into program design, commitment to the operation of the program, and the involvement of health and social service professionals in the community. • Community education programs should be established to inform residents of the nature and extent of child abuse in the community, as well as strategies to reduce and prevent abuse. • The home visitor should work in partnership with the family and other service providers to avoid duplication of home visiting services. • The HF program will collaborate with other home visiting programs, health care providers, and the Family Case Management Program.
Parent Involvement	• Family support workers help foster healthy parent-child interactions by: o Sharing information about child health and development; o Building on the family's natural strengths; o Helping new parents reduce their sense of isolation; and o Linking families to vital community services, including health care providers.
Credentialing or Certification Process	• To become a credentialed Healthy Families America (HFA) program, the following steps must be completed: o Programs complete the **HFA Single Site Application for Affiliation**. Once affiliation is granted, program sites are considered to be provisional. o Within two years of becoming a provisional affiliated site, programs complete the **HFA Credentialing Application**. o Next, programs complete a **Self-Assessment**. o Once the Self-Assessment has been completed and submitted to HFA, a team of at least two external, trained peer reviewers conduct a **site visit**. o The peer review team prepares a **Preliminary Credentialing Report** which is sent first to Prevent Child Abuse America and then to the applicant program. The program has 45 days to respond to the report in writing. o This response is then discussed by the **HFA Advisory Credentialing Panel** and a decision is made. If a site credential is awarded, it lasts for four years.
Evaluation Requirements	• Northern Illinois University, with funding from IDHS, conducted a statewide Healthy Families program outcome evaluation. IDHS-funded Healthy Families programs participated in this study.

	Healthy Families (HF)
Evaluation Requirements continued	• HFI sites located in agencies with access to the IDHS Cornerstone database (e.g., local public health departments) enter participant information into this database. They also submit a narrative quarterly report to IDHS. • HFI sites that do not have access to Cornerstone submit a quarterly report to IDHS with caseload information (number of families served, age, race, and ethnicity) and outcome information (DCFS indicated cases of child abuse and neglect, immunization status, and well-child care).
Program Costs	**Cost per participant** • Approximately $3,600 to $4,600 per year (including matching funds from programs) **Start-up costs** • Approximately 25% of a program's annual budget (about $50,000)

Supporting Research Citations	• Families who did not receive Healthy Families services were reported for abuse or neglect twice as often as families who did receive Healthy Families services. (Daro and Harding, 1999)
	• Parents who participate in Healthy Families show:
	  ○ A significant decrease in their overall potential for maltreatment and parental stress
	  ○ Greater sensitivity to their children's cues
	  ○ Greater comfort in understanding their children's development
	  ○ Less overall distress and rigidity
	  ○ A greater knowledge about alternative forms of discipline (Daro and Harding, 1999)

Model-Specific Resources	• Healthy Families America website: www.healthyfamiliesamerica.org • Healthy Families America Site Development Guide • Healthy Families Critical Elements • Healthy Families Credentialing Standards • Healthy Families Research Folder
Initial Point of Contact for Program Model Information	Mark Valentine Ounce of Prevention Fund 33 West Monroe, Suite 2400 Chicago, IL 60603 312-922-3863 markv@ounceofprevention.org

If you would like a current listing of those Illinois programs that use the Healthy Families Illinois model, with locations and contact information please contact Mark Valentine (markv@ounceofprevention.org).

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Nurse Family Partnership • Full Profile of Program Model

	Nurse Family Partnership
Program Purpose & Description	**Purpose**: • Improve pregnancy outcomes by helping women engage in preventative health practices, including obtaining thorough medical care, improving their diet, and reducing their use of alcohol, cigarettes, and illegal substances • Improve child health & development by helping parents provide responsible and competent care for their children • Improve parental economic self sufficiency by helping parents develop a vision for their own future, plan for future pregnancies, continue their education, and find work **Description:** Nurse Family Partnership is a voluntary program where highly educated nurses visit low-income women in their homes during their first pregnancy and throughout the first 2 years of their child's life to accomplish the above goals. All services are delivered through strength-based and client centered practices.
Target Population	First time low income mothers
Key Services	Client centered, strength-based, culturally competent services are delivered to the mothers and families using the evidenced based tested NFP Home Visit Guidelines. The Guidelines are structured around the following Home Visit Domains: **Personal Health** • Health maintenance practices • Nutrition and exercise • Substance use • Mental health functioning **Environmental Health** • Home • Work, school, and neighborhood **Life Course Development** • Family planning • Education and livelihood **Maternal Role** • Mothering role • Physical care • Behavioral & emotional care **Family and Friends** • Personal network relationships • Assistance with childcare **Health and Human Services** • Service utilization
Outreach & Recruitment Outreach & Recruitment	NFP relies on early enrollment of first-time pregnant, low-income women, no later than the 28th week of gestation realistically by the 25th week. Preferred 16-20 weeks.

	Nurse Family Partnership
Outreach & Recruitment Outreach & Recruitment continued	In order for programs to be successful in recruiting and engaging this population it is critical for Implementing Agencies to establish and sustain referral partnerships with local entities like: • WIC clinics • Family planning / pregnancy testing centers • Obstetricians and Pediatricians serving low-income/ Medicaid clients • Prenatal care providers: clinics, community based organizations, hospitals • Schools/School Health Nurses • Churches • Self-Referrals During the development and initiation phases of an agency start-up NFP provides intense TA to assist sites in identifying key referral partners, designing a plan to engage and sustain referral partnerships, and to assess regularly that these referral partnerships are working. Included in the planning is 1) identifying the number of referrals a partner can realistically make 2) identifying the early referral process to achieve engagement of participants no later than the 28th week of pregnancy 3) a program plan for timely contact and first home visit to a referred participant and 4) regular contact with referral partners to modify the referral plan as needed for ongoing success.
Methods & Approaches	**NFP has Guiding Elements for Service Implementation:** **Client Elements** • Voluntary participation • First-time mother • Low-income • Enrolled early in pregnancy (<28 weeks) **Intervention Elements** • One to one visiting with client and NHV • Client visited in her home • Visits occur during pregnancy and up child's second birthday **Qualities of Nurses and Supervisors** • NHV and supervisors are RN's with BSN training • NHV and supervisors complete NFP NSO core education and deliver the intervention with fidelity to the model **Application of the Intervention** • NHV use professional judgment to individualize guidelines to meet client's needs • NHV apply theoretical frameworks that underpin the program • A full-time NHV carries a caseload of no more than 25 active clients **Reflection and Supervision** • A full-time nursing supervisor supervises no more than eight NHV's • Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision. **Program Monitoring and Use of Data** • NHV and Nursing Supervisors collect data and use NFP reports to guide practice, monitor implementation, inform clinical supervision, enhance quality and demonstrate fidelity.

	Nurse Family Partnership
Methods & Approaches continued	**Agency Elements** • NFP implementing agency operated by an organization known for successful provision of prevention services to low-income families • NFP implementing agency convenes long-term Community Advisory Board • Adequate support and structure shall be in place to support NHV and nursing supervisors to implement the program and assure data is accurately entered into the data base in a timely manner.
Intensity of Services	Services are delivered: • Visits occur during pregnancy and up child's second birthday (Visits are weekly for the first 4-6 weeks upon entering the program; then are biweekly until the birth of the infant; then weekly for 4-6 weeks; then bi-weekly until the child is 21 months; then monthly until the child is two years.
Staff Qualifications & Supervision	**Qualifications** The BSN degree is considered to be the standard educational background for entry into Public Health and provides background for NFP home visiting work. The MSN degree is considered as the preferred standard for the NFP nursing supervisor. It is understood that both education and experience are important. Agencies that may at times find it difficult to fulfill the recommended NFP requirements for hiring and agencies need to consider each individual nurses' qualifications and as needed provide additional professional development to meet the expectations for the roles. Non-BSN nurses should be encouraged and provided support to complete their BSN. **Reflection and Supervision** A full-time nursing supervisor supervises no more than eight NHV's Supervisory activities include 1:1 clinical supervision, case conferences, team meetings and field supervision.
Staff Training	It is the policy of NFP-NSO that all nurses employed to provide NFP services will attend and participate in all core NFP education sessions in a timely manner, as is defined by NFP-NSO policy and the NFP-NSO contract. This is to assure that Nurse Home Visitors and Nursing Supervisors deliver the program with fidelity to the model.
Staff Caseload/ Class Size	**Nurse Home Visitor Caseloads:** • A full-time NHV carries a caseload of no more than 25 active clients
Matching Services to Need	Using the NFP Home Visit Guidelines services are delivered through client centered, strength-based, culturally competent lenses to the mothers and families. NHVs use professional judgment to individualize guidelines to meet client's needs identifying with families their strengths and needs and creating individualized family plans with the family in the lead.
Coordination of Services	An NFP implementing agency is operated by an organization known for successful provision of prevention services to low-income families. The agency builds and maintains community partnerships that provide resources to families. The NFP implementing agency convenes long-term Community Advisory Board that has not only community partners and representatives but includes client representation.
Parent Involvement	**At the Individual Level:** Using the NFP Home Visit Guidelines services are delivered through client centered, strength-based, culturally competent lenses to the mothers and families. NHVs use professional judgment to individualize guidelines to meet client's needs identifying with families their strengths and needs and creating individualized family plans with the family in the lead.

	Nurse Family Partnership
Parent Involvement continued	**At the Community Level:** The NFP implementing agency convenes long-term Community Advisory Board that includes current and past client representation. At the Linkage & Referral Level: The agency builds and maintains community partnerships that provide resources to families.
Credentialing or Certification Process	NFP Model replication has been just in the last five years. NFP currently has staff who are working on the credentialing/accreditation process that NFP expects to implement in 2010.
Program Monitoring and Evaluation	NFP Monitoring and Evaluation includes but is not limited to: 1. Site visits as needed 2. Data Collection that agencies must establish and maintain in accordance with NSO-NFP agreements. RN HV's and Supervisors enter on a weekly, monthly, quarterly basis and this information is used by NFP Nurse Consultants in regular TA to monitor and to assist sites in success in program implementation. 3. See accompanying slide that show the data collection process:
Program Costs	The NFP program costs approximately $4500 per family per year to fund, and can range from $2,914 to $6,463 per family per year. The nurses' salaries are the primary driver that affects variability of costs.
Supporting Research Citations	The program effects that have the strongest evidentiary foundations are those that have been found in at least two of the three trials: • Improved prenatal health • Fewer childhood injuries • Fewer subsequent pregnancies • Increased intervals between births • Increased maternal employment • Improved school readiness **Positive Program Effects Found in First Trial at Child Age 15** Benefits to Mothers • 61% fewer arrests • 72% fewer convictions • 98% fewer days in jail[2] Benefits to Children at Child Age 15 • 48% reduction in child abuse and neglect • 59% reduction in arrests • 90% reduction in adjudications as PINS (person in need of supervision) for incorrigible behavior[3]
Model-Specific Resources	National Service Office-Nurse Family Partnership 1900 Grant St. Ste. 400, Denver Colorado 80203 www.nursefamilypartnership.org
Initial Point of Contact for Program Model Information	Jeanne Marie Anderson, RN PhD Midwest Program Developer Direct: 303-865-8399 Mobile: 217-722-9944 Email: jeanne.anderson@nursefamilypartnership.org

If you would like a current listing of those Illinois programs that use the Nurse Family Partnership model, with locations and contact information please contact Jeanne Marie Anderson, RN PhD (jeanne.anderson@nursefamilypartnership.org).

Parents as Teachers • Full Profile of Program Model

	Parents as Teachers (PAT)
Program Purpose & Description	**Purpose** • To provide the information, support, and encouragement parents need to help their children develop optimally during the crucial early years of life. **Description** • Parents as Teachers (PAT) is a home-based family education and support program for parents with children from the prenatal stage through age 5. Through the program, parents acquire skills that help them make the most of children's crucial early-learning years. The program has four goals: • Increase parent knowledge of early childhood development and improve parenting practices • Provide early detection of developmental delays and health issues • Prevent child abuse and neglect • Increase children's school readiness and school success
Target Population	• All families; PAT is a universal access model. Some PAT programs use funding that requires them to deliver services to a very targeted population. PAT also blends with other early childhood programs that target high needs families. Program intensity is modified based on the needs of the families served.
Key Services	**Personal Visits** • PAT-certified Parent Educators visit families at their homes on a regular basis. During visits, Educators work in partnership with parents to share child development and parenting information using the Born to Learn™ research-based curriculum. Parents observe their child's skills and interact with their children through developmentally appropriate activities. **Group Meetings** • Group meetings provide opportunities for parents to acquire additional information about child development, parenting topics, and positive parent-child interactions while gaining support from other parents. Meetings are held at a variety of times that are convenient for families. **Developmental Screening** • All enrolled children receive developmental, hearing, vision, dental, and health screenings at least once each program year. Screening assists parents in identifying a child's strengths as well as areas of concern. Ongoing monitoring by parents is encouraged. **Connections with Community Resources** • PAT programs connect families to needed resources and take an active role in the community, establishing ongoing relationships with other organizations that serve families. **Goal Setting** • Parent Educators partner with families to establish and achieve child development and parenting goals.
Outreach & Recruitment	• PAT promotes its services in the community, recruits and promptly serves the maximum number of eligible families, and facilitates families' ongoing participation in services. o The support of key community persons is enlisted in recruiting families for the program and in promoting the program in the community.

	Parents as Teachers (PAT)
Outreach & Recruitment continued	○ Informational materials about the program are distributed in visible locations throughout the areas served by the program. These materials include a full description of PAT services. ○ Recruitment strategies and recruitment materials are culturally sensitive. ○ Families indicating a desire to participate are contacted about participation within two weeks. ○ Program staff annually assesses recruitment activities to ensure that efforts are focused on the most effective strategies.
Methods & Approaches	• The PAT model is based on the following core values: ○ All parents deserve support in their parenting role and participation is voluntary. ○ The home is the child's first and most important learning environment and the family is the unit of learning. ○ An understanding and appreciation of the history and traditions of different cultures is essential in serving families. ○ Design of the program allows for intensity and duration of services to match family needs. Quality programs serve families often enough and maintain families in the program for a sufficient amount of time to meet program and family goals. ○ PAT is committed to promoting the optimal development and school readiness of each child through the use of a curriculum based on child development and neuroscience. ○ Quality implementation of the PAT program fosters positive parent-child relationships, helps parents become astute observers of their child, and increases parenting skills, knowledge of child development, and feelings of confidence. ○ Local programs adapt the PAT model to meet the unique needs of the community being served.
Intensity of Services	**Personal Visits** • Ideally, services should be available before birth (prenatal) to age 5. • The number and frequency of home visits depends on family needs as well as program funding. • Home visits should be completed on at least a monthly basis, and weekly or twice a month for families with children who are at risk of school failure. **Group Meetings** • The number and frequency of group meetings depends on the needs and desires of the families being served. Meetings should be offered at least monthly. Group meetings provide opportunities for parents to acquire information about child development, parenting and positive parent-child interaction.

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Staff Qualifications & Supervision	**Qualifications** • Parent Educators should possess the knowledge, skills and sensitivity to respond effectively to families' community, cultural, and language backgrounds. • It is recommended that parent educators have a bachelor's degree in early childhood education or a related field. Those with an associate's degree or less must have several years experience working with young children and their families. **Supervision** • It is recommended that supervisors have a college degree in early childhood education, behavioral or social sciences, or a related field. Individual programs may include additional or alternative education requirements. • Individual programs decide upon the frequency and duration of supervision, utilizing the following guidelines: o Individual or group supervision occurs on a regular basis, at least once a month and includes education, administration and support. o At least annually, a supervisor observes each Parent Educator providing a personal visit and facilitating a group meeting. New parent educators are observed more frequently. o Administration of developmental screening is also observed at least every 3 years. Parent Educators receive at least annual written reviews of their performance and progress toward their professional goals.
Staff Training	• To obtain PAT certification, staff must complete a 5-day training institute on early childhood development, effective home visits, facilitation of parent-child interaction, parent group meetings, community resources, services to high-needs families, and red flags in hearing, vision, and health, as well as program recruitment and organization. Staff must also complete an online Follow-Up day after 3-6 months of program implementation. • All supervisors must complete a 2-day introductory supervision training; a one-day advanced training on reflective supervision is also encouraged. • In order to be re-certified, staff must serve a minimum of 5 families and deliver at least 25 personal visits a year. In addition, staff must also complete annual in-service hours: 20 hours (first year), 15 hours (second year), and 10 hours (third year and beyond).
Staff Caseload/ Class Size	• Program staffing adequately supports the program design and goals.All families must receive a minimum of one visit per month. Parent Educators who serve high-risk families with greater needs and who carry additional program responsibilities serve families more frequently:. o A full-time Parent Educator conducting weekly visits serves 12- 14 families. o A full-time parent educator conducting twice a month visits serves 24-25 families
Matching Services to Need	• Local programs adapt the PAT model to meet the unique needs of the community being served. • Design of the program should allow for variations in program intensity and duration to match family needs. o The program curriculum is individualized to address a child's interest and developmental needs as well as parenting issues.
Coordination of Services	**Connections with Community Resources Program Component** • Parent Educators are knowledgeable about community resources, including informal

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	networks, local customs, and events. • PAT programs connect families to needed resources and take an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families.
Parent Involvement	• Implementation of the PAT model emphasizes the importance of engaging and building relationships with families through parent empowerment, appreciation of diversity, and partnership. • Recognizing that parents are their children's first and most influential teachers, PAT services are aimed at providing the information, support and encouragement that parents need to help their children develop optimally during their early years.
Credentialing or Certification Process	• Parent Educators are certified through the 5-day training institute; certifications must be renewed each year (see Staff Training above). • The PAT National Center offers a site visit and national commendation program based on a self-assessment in all 8 areas of the PAT Standards.
Evaluation Requirements	**Annual Requirements** • The program annually tracks family enrollment, participation, service intensity and attrition. • Staff annually assesses promotion of PAT services, recruitment activities, and engagement and retention methods to ensure that efforts are focused on the most effective strategies. **Recommendations** • The program conducts a structured, comprehensive self-assessment process at least once every three years. Through this process, an external evaluator provides feedback to staff about program strengths and areas for improvement. • The program annually measures outcomes, including: participant satisfaction, parent knowledge and practices, prevention of abuse, identification of delays, and school readiness. • Program evaluation results are used to modify program goals, revise program design, strengthen program operations, and direct strategic planning.
Program Costs	**Cost per participant** • $3,650 per year (weekly visits to one at-risk family, per year) **Start-up costs (estimated)** • $78,002 per program site for one year for a brand new program (includes training and curriculum, program materials, two part-time parent educators, one supervisor, one clerical support staff person, administrative costs, rent and utilities, and quality assurance and evaluation) • $4,470 per program site for existing early childhood programs to adopt the Parents as Teachers model (includes training and program materials) **Training costs** • $815 per person, including training fee and cost of curriculum

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Supporting Research Citations	• Children whose families participated in Parents as Teachers are less likely to receive remedial assistance, less likely to be held back a grade in school and half as likely to have Individualized Education Plans as comparable children whose families did not participate in PAT. (O'Brien, Garnett and Proctor, 2002; Drazen and Haust, 1996) • In families with very low income, those who participated in Parents as Teachers were more likely to read aloud to their child and to tell stories, say nursery rhymes, and sing with their child. (Wagner and Spiker, 2001) • Additional citations available at www.parentsasteachers.org.
Model-Specific Resources	• Websites: www.parentsasteachers.org and http://www.opfibti.org/pat/ • The following materials are all available on the PAT website: o Parents as Teachers Standards and Quality Indicators o Supervisor's Manual and Program Administration Guide o "A Closer Look." Parents as Teachers Standards and Self-Assessment Guide o Parents as Teachers Logic Model o Program Evaluation Handbook - Measuring Program Impact o Outcomes Measurement Tool Kit
Initial Point of Contact for Program Model Information	Clare Eldredge Ounce of Prevention Fund State Leader for PAT in Illinois Phone: 217-522-5510 Email: celdredge@ounceofprevention.org

If you would like a current listing of those Illinois programs that use the Parents as Teachers model, with locations and contact information please contact Maureen Brennan (MBrennan@ounceofprevention.org) or Clare Eldredge (CEldredge@ounceofprevention.org).

FEEDBACK FORM
WAS THIS TOOLKIT USEFUL? HOW CAN WE IMPROVE IT?[3]

Your experiences will help us improve this toolkit.

Agency/Organization Name: _____

Location: _____

Contact Name (optional): _____

1. **How did you receive this toolkit?**

❒ Mailed to your organization
❒ Internet
(which website? _____)
❒ Received hard copy at a training
❒ Received on flash drive at a training
❒Other: _____

2. **Which tool or tools did you use?**

❒ Program Self-Assessment
❒ Community Self-Assessment
❒ Summary/Comparison of Home Visiting Program
❒ Detailed Profiles of Home Visiting Models

3. **How useful was the tool? (Please offer an opinion for each tool you used.)**

Tool	1 - Not Very Useful	2	3 - Useful	4	5 - Very Useful	NOTES

4. **Was the tool easy to understand? (Please offer an opinion for each tool you used.)**

Tool	Yes	No	NOTES

[3] Adapted from "The Partnership Toolkit: Tools for Building and Sustaining Partnerships"

5. **Do you have any suggestions for improving the tools you used? (Please offer an opinion for each tool you used. If you have adapted a tool, please attach it to your completed feedback form.)**

Tool	Suggestions?

6. **Do you have any suggestions for improving the toolkit as a whole?**

_____

_____

_____

_____

7. **Do you have any other comments on the toolkit?**

_____

_____

_____

_____

Thank you for your comments and suggestions. Please send this form to:

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