

REMINDER

DEADLINE FOR SUBMISSION IS

November 6, 2009 at 2 p.m.

REPLIES ARRIVING AFTER THAT DATE AND
TIME WILL NOT BE ACCEPTED

**Palm Beach County
Children's Services Council**

Nurse-Family Partnership Evaluation

**INVITATION TO
NEGOTIATE**

Deadline for Responses: November 6, 2009, 2 p.m.

Children's Services Council of Palm Beach County
2300 High Ridge Road,
Boynton Beach, FL 33426

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Nurse-Family Partnership INVITATION TO NEGOTIATE

PROJECT REQUEST

The Children's Services Council (CSC) of Palm Beach County is seeking an independent evaluator to conduct a comprehensive implementation analysis of the Palm Beach County Nurse-Family Partnership Program (NFP). CSC wishes to contract with the evaluator who can best demonstrate an ability to produce high-quality evaluation products for CSC. Respondents must demonstrate their ability to design and implement an evaluation and to present findings in such a way as to best inform all readers of the evaluation as to the issues regarding implementation among varying populations, the assessment of program implementation fidelity, and an explanation of the issues that contribute to differences in performance between the NFP program as implemented in Palm Beach County and NFP national performance standards.

Funding for this evaluation may be in whole or in part, from the federal government [from the Administration for Children and Families (ACF) through CSC]. Accordingly, the successful vendor will be required to cooperate with any and all requests made from ACF, as well as to provide any reports required by ACF.

1. INTRODUCTION

The Children's Services Council of Palm Beach County (CSC) is an independent government agency authorized by Florida statute in 1986 and created by local ordinance on November 4, 1986. To implement its mandate, the Council is empowered by local referendum to assess an ad valorem tax up to one mill (\$ 1.00 per \$1,000 of non-exempt property valuation).

Mission

The mission of CSC is to enhance the lives of children and to enable them to attain their full potential by providing a unified context within which children's needs can be identified and resolved by all members of the community. In order to achieve its mission, the Council will plan, develop, fund and evaluate programs and promote public policies that benefit Palm Beach County's children and families.

Children's Services Council's funding priorities support the designated sentinel child outcomes:

- Healthy Births
- Fewer children birth through five abused, neglected
- Children ready and eager to learn
- Access to Quality Afterschool Programs

2. ITN PROCESS

2.1 CONTACT PERSON:

Amy Lora
Research & Evaluation Analyst
Children's Services Council
amy.lora@cscpbcc.org (All contact shall be by email only)

2.2 VENDOR DISQUALIFICATION

Vendors are prohibited from contacting CSC personnel or board members regarding this solicitation other than the contact person identified in this document. Any occurrence of a violation may result in the disqualification of the vendor.

Failure to have performed any contractual obligations with CSC in a manner satisfactory to CSC will be a sufficient cause for disqualification. To be disqualified as a vendor under this provision, the vendor must have:

- 1) previously failed to satisfactorily perform in a contract with CSC, been notified by CSC of unsatisfactory performance, and failed to correct the unsatisfactory performance to the satisfaction of CSC; or,
- 2) had a contract terminated by CSC, by any other state agency, or by any Children's Services Council for cause.

2.3 TIMETABLE

October 1, 2009	Display advertisement of ITN appears in Palm Beach Post and posted on CSC website
October 1, 2009- November 6, 2009	ITN packets are available on the CSC website (www.cscpb.org)
October 16, 2009	Final date to submit questions (if any) to CSC contact person
October 23, 2009	Final posting of questions and answers and/or clarification or addenda to ITN (if any) on CSC website (www.cscpb.org)
November 6, 2009	RESPONSE DEADLINE -All ITN responses are due by 2 p.m. at: Children's Services Council 2300 High Ridge Road Boynton Beach, FL 33426 Attention: Reception
November 6, 2009	Proposals are opened publicly at 2:01 p.m. Children's Services Council, 2300 High Ridge Road Conference Room, Boynton Beach, FL 33426
November 9, 2009- November 17, 2009	Evaluation of responses by CSC
November 18, 2009	Notification by email of responses not selected to go on to negotiation phase.
November 18, 2009- December 4, 2009	Negotiation process begins. Selected candidates notified by phone to determine dates for personal interview.
December 10, 2009	Council meeting to award contract to selected vendor; contract award date
January 1, 2010	Contract signed/work begins

2.4 INQUIRIES

All inquiries requesting clarification regarding this ITN must be made in writing and sent by email, to the identified contact person. Vendors should not submit any forms of advertisement during the ITN period. Copies of responses to all inquiries which require clarifications and/or addenda to the ITN will be made available no later than 5 p.m., **October 23, 2009**, on the CSC website.

2.5 ACCEPTANCE OF APPLICATIONS

All Applications must be received by CSC no later than November 6, 2009 at 2:00 p.m. at:

Children's Services Council of Palm Beach County

2300 High Ridge Road

Boynton Beach, FL 33426

Attention: Reception

No changes, modifications or additions to the Applications submitted will be accepted by or binding on CSC after the deadline for submitting applications has passed.

CSC reserves the right to reject any and all applications or to waive minor irregularities when to do so would be in the best interest of CSC. A *minor irregularity* is defined as a variation from the ITN terms and conditions that does not affect the price of the application, or does not give the vendor an advantage or benefit not enjoyed by other prospective vendors, or does not adversely impact the interest of CSC.

APPLICATIONS NOT RECEIVED AT EITHER THE SPECIFIED PLACE OR BY THE SPECIFIED DATE AND TIME OR BOTH WILL BE REJECTED AND RETURNED UNOPENED TO THE VENDOR BY THE CSC.

2.6 PROCEDURE FOR CONDUCTING NEGOTIATIONS

After completion of the scoring process based on the review criteria, CSC will determine whether there are vendors that meet the minimum requirements deemed necessary by CSC for conducting negotiations. Assuming that such minimum requirements have been met, CSC will negotiate with one or more vendors. CSC reserves the right at all times during the negotiation process to negotiate with one or more vendors at the same time, but is under no obligation to do so. A representative of the vendor who is authorized to make decisions must be present in person or by conference call at all scheduled negotiation sessions.

2.7 COMPLIANCE WITH 287.133, FLORIDA STATUTES

Vendor shall submit with its response and execute public entity crime statement required by Section 287.133, Florida Statutes, on the form supplied by the Council (see Attachment).

3. PURPOSE OF THE NFP EVALUATION

The implementation analysis of the Palm Beach County NFP program will provide initial lessons learned from the implementation process. Furthermore, it will guide the implementation in Palm Beach County to obtain the maximum benefits of the program for families as they continue with the program. It is recognized that stringent replication guidelines of evidence-based programs

can lead to challenges and issues at the local level. By looking at causes of differences between implementation in Palm Beach County and the national standards, adjustments can be made in a timely manner and a greater percentage of families in the NFP program in Palm Beach County will be able to achieve the expected outcomes of the program.

3.1 PRINCIPAL RESEARCH QUESTIONS:

- 1) How successful has the CSC provider agency been in targeting intended clients? (What evidence supports this?)
- 2) To what degree has the CSC provider agency achieved fidelity to the NFP model?
- 3) What causes have been identified for differences between local performance levels and national levels?
- 4) To what degree has the Palm Beach County NFP program reached its implementation goals? (What aspects have proven successful and why? What aspects have proven unsuccessful and why?)

3.2 DATA SOURCES

In order to answer these questions, the external evaluator will be provided with:

- 1) Quarterly and yearly NFP reports generated from the national NFP office. The process for compiling these reports begins at the local level, where NFP nurses enter data into the FOCiS database, which is then uploaded to the national NFP office. On a quarterly basis, the national office produces a first-level report to compare local-level data against both NFP statistical averages nationwide as well as national NFP objectives. Once these first-level reports are sent to CSC from the national office, CSC then creates a second-level report highlighting strengths and weaknesses of program implementation.
- 2) A third-level report generated at the end of the year which is a synthesis of trends and connections found in quarterly reports from that year.
- 3) Access to the FOCiS database, Healthy Mothers, Healthy Babies (HMHB) staff, Healthy Beginnings nursing staff, and CSC staff. (The potential for access to clients served will also be examined).

All local level data and reports as well as national level reports will be available to the evaluator. Local and national level reports include data regarding client characteristics (demographic characteristics at intake); client enrollment (referrals by source, client age, and gestational age); implementing agency caseload profiles (number of families and children served and graduated, number of active nurses); client visits (frequency of contacts by phase and content area); and service linkages (referrals to and usage of other services by category and phase).

The external evaluator is expected to deliver:

- 1) An implementation design that will include appropriate research methodology.
- 2) A comprehensive report that will include:
 - a) recommendations for improvement in areas in which local NFP falls short of national NFP averages and objectives as well as identification of areas of strengths.
 - b) an explanation of the issues that contribute to differences in performance between the NFP program as implemented in Palm Beach County and NFP national performance standards.
 - c) because Palm Beach County is large and has a widely diverse population, evaluation will include an explanation of issues regarding service use by varying populations.
 - d) because Palm Beach County's demographic population varies from that of other parts of the country where NFP is implemented, studying the relationship between program context and the level to which the program is implemented for Palm Beach County's varying population will be required.
 - e) a general assessment tracking consistency and fidelity to NFP model in Palm Beach County.
 - f) Lessons learned from current data and expansion from NFP.

3.3 PRODUCT REVIEW

A review process of the product by CSC's evaluation committee will be carried out before the final product is accepted.

3.4 INSTRUCTIONS FOR PREPARING PROPOSALS

All proposals must be typewritten on 8 ½" by 11" paper. All proposals are to be signed by an official/individual who is legally authorized to bind the vendor to the proposed activity. Please submit **1 original and 12 copies** of your proposal in a sealed package. Proposals must be prepared utilizing the format below. The proposal **must** name all persons or entities interested in the proposal as principals. The proposal **must** declare that it is made without collusion with any other person or entity submitting a proposal pursuant to this ITN.

3.5 INCOMPLETE PROPOSALS

Failure to respond to any item, including any requested information, or failure to follow these instructions shall be considered submission of an incomplete proposal and may result in disqualification from further consideration.

3.6 PROPOSAL FORMAT

The typewritten portion of your proposal is to be 1 ½ spaced with font style and size Times New Roman 12 point.

Proposals shall be assembled in the following manner:

- 1) Cover Page
- 2) Proposal Summary - This will summarize in a brief and concise manner the proposed scope of work and the timelines for performance of the work. It will also name all principals and declare that the ITN is made without collusion with any other person or entity submitting a proposal pursuant to this ITN.
- 3) Vendor Qualifications – This section must contain all pertinent data related to the vendor’s organization and experience that would substantiate its qualifications and capabilities to perform the services requested. All information must be provided for the primary as well as for subcontracting (if applicable) vendors. Specifically, respondents should describe their evaluation philosophy/principles and experience in setting up a large-scale evaluation:
 - a) Provide details on the qualifications of the firm or individual, including documentation of experience in research and evaluation projects and particular experience in setting up a large-scale evaluation system.
 - b) Provide details on the qualification of the individual(s) who will supervise the work as a leading evaluator; including the evaluation philosophy/principles and relevant education and experience with similar work. (Please also attach a brief, no more than three-page, vitae of the leading evaluator).
 - c) List no fewer than three former clients (name, address and telephone number) that can serve as a reference on both the development and completion of program evaluation as well as similar work previously performed by the respondent.
 - d) Attach a sample of work completed that involves development, implementation and completion of a similar evaluation project.
- 4) Statement of Work – This section of the response should explain the services provided by the respondent, the methodology used to address the evaluation questions and the items described in the project summary and scope of work. This section shall describe:
 - a) a detailed list of services/tasks to be performed, which will be involved in the NFP evaluation described in the ITN.
 - b) the methodologies to be employed.
 - c) a detailed schedule of activities necessary to fulfill the request of this ITN.
- 5) Availability to Perform the Requested Services – Indicate current and anticipated workload. Explain how, within your company’s current schedule, you will meet the project deadline.

- 6) Budget – Attach a line item budget that delineates all costs, according to the tasks and deliverables.
- 7) Compliance with 287.133, Florida Statutes –A completed and signed compliance with 287.133, Florida Statutes (found on pages 13-15).

3.7 REVIEW AND SELECTION CRITERIA

Vendor selection will be based upon the following criteria:

Vendor’s previous experience and references

1. Vendor Skills
2. Work Sample

Resource Capacity

1. Vendor Qualifications
2. Availability to Perform Requested Services

Proposed Project Budget

Proposed Approach

1. Proposal Summary
2. Statement of Work

3.8 TASKS AND DELIVERABLES

Funding for this project begins on January 1, 2010 and ends September 30, 2010. The final evaluation report for the Nurse-Family Partnership program is expected to include the following tasks and deliverables:

1. February 28, 2010 Research methodology and questions will be submitted to the Children's Services Council’s evaluation committee for review and approval.
2. March 31, 2010 1st Quarter Progress Report.
3. June 30, 2010 2nd Quarter Progress Report.
4. August 15, 2010 Draft of Final Report circulated for review by CSC’s evaluation committee.
5. September 30, 2010 Final Report.

PUBLIC ENTITY CRIMES AFFIDAVIT

SWORN STATEMENT UNDER SECTION 287.133(3) (A), FLORIDA STATUTES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to CHILDREN'S SERVICES COUNCIL OF PALM BEACH COUNTY by _____ (print individual's name and title) for _____ (print name of entity submitting sworn statement) whose business address is _____ and, (if applicable) its Federal Employer Identification Number (FEIN) is _____ (if the entity has no FEIN, include Social Security Number of the individual signing this sworn statement: _____).
2. I understand that a "public entity crime" as defined in Paragraph 287.133 of the Florida Statutes, means a violation of any state or Federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including but not limited to, any bid or contract for goods or services, any lease for real property, or any contract for the construction or repair of a public building or public work, involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.
3. I understand that "convicted" or "conviction" is defined by the Statute to mean a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.
4. I understand that an "affiliate" is defined in Section 287.133(1)(a), Florida Statutes, means:
 - (A) A predecessor or successor of a person convicted of a public entity crime; or
 - (B) An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5. I understand that a "person" as defined in Section 287.133(1)(e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applied to bid on contracts let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.
6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement (indicate by placing a check in front of the statement which applies):

_____ Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members or agents who are active in the management of the entity, nor any affiliate of the entity was charged with and convicted of a public entity crime subsequent to September 1, 1990.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity was charged with and convicted of a public entity crime subsequent to September 1, 1990.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity was charged with and convicted of a public entity crime subsequent to September 1, 1990. However, there was a subsequent proceeding before a Hearing Officer of the State of Florida Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list (attach a copy of final order).

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY, PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, FLORIDA STATUTES, FOR CATEGORY TWO, OF ANY CHANGE AFFECTING THE CORRECTNESS OF THE INFORMATION CONTAINED IN THIS SWORN STATEMENT.

(Signature)

(Date)

STATE OF _____
COUNTY OF _____

PERSONALLY APPEARED BEFORE ME, the undersigned authority, _____, who is personally known to me or who has produced _____ as identification, and who, after first being sworn by me, affixed his/her signature in the space provided above on this _____ day of _____, 2009.

Signature of Notary Public

Name of Notary Public

Title or Rank

Serial Number, if any

(SEAL)
My commission expires:

APPENDIX A: HEALTHY BEGINNINGS BACKGROUND

Healthy Beginnings Program

Through its Healthy Beginnings Program (HB Program), the Children's Services Council of Palm Beach County (CSC) administers a coordinated system of prevention and early intervention services that seek to improve birth outcomes, reduce child abuse and neglect among children birth to five years, and increase the number of children who enter school eager and ready to learn for the families who enter its services. Through coordinated outreach, screening and assessment, and referrals to direct services, the HB Program strives to attain the aforementioned outcomes. An array of direct services is offered within the HB Program. These services – provided by 18 agencies in the community – promote the healthy birth and positive development of infants and young children. These 18 agencies comprise the Healthy Beginnings Program members.

Working as a system, the providers share a common vision, mission, values, and outcomes, and participate in joint planning and quality assurance processes. The HB Program implements six strategies to work toward its system goals. These strategies include: a systems approach; implementation of evidence-based and promising programs; professional development; social marketing; a common client information system; and, data-informed decision-making. Thus, it is the expectation that the HB Program members can rely on a shared infrastructure, including an integrated data system.

The HB Program strives to improve the lives of children and families in Palm Beach County – in particular – through the following sentinel outcomes:

- 1) Increase healthy birth outcomes;
- 2) Reduce the incidence of child abuse and neglect among children ages birth to five years; and,
- 3) Increase the percentage of children entering school eager and ready to learn.

It is anticipated that the HB Program will achieve these outcomes by implementing numerous strategies that will increase accessibility, improve service delivery, and increase accountability. For a detailed, pictorial description of the functions, strategies, and outcomes of the HB system, please see the Healthy Beginnings Program Conceptual Model (Appendix D attached).

The HB Program strives to attain these outcomes through a coordinated set of outreach, entry, and direct services. One of the strategies used to establish a foundation for a comprehensive service delivery model is through the implementation of evidence-based programs (EBPs).

EVIDENCE-BASED PROGRAMS

In 2007, the Children's Services Council of Palm Beach County embarked on a process to evaluate and incorporate an integrated mix of local and evidence-based programs into internal systems. Some of the criteria for Evidence Based Programs include: those which have shown significant and sustained effects; have been successfully replicated; have included quality data collection and procedures.

The HB Program currently implements a variety of EBPs and promising programs, including the Nurse Family Partnership Program. In addition to meeting the Evidence-Based criteria, selected programs also must address one or more of the CSC's sentinel outcomes (previously outlined). NFP was identified as one such program which incorporates several interventions identified as having an impact on the conditions contributing to the CSC's sentinel outcomes. In addition, as the following paragraph illustrates, NFP was selected on its merit of being one of the most well-researched health and human services programs in implementation today.

APPENDIX B: HEALTHY BEGINNINGS PROGRAM THEORY OF CHANGE

Problem Statement

Over the past 15 years, the Children's Services Council (CSC) has transformed its funding from stand-alone programs to systems of care. Much work has been undertaken to describe what a system of care is (Healthy Beginnings ITN, August 2008) and the expectations of a system partner (System Guidelines & Expectations, 2008).

In simple terms, CSC is creating a system of services that operate as a single program focused on healthy births, young children who are free from abuse and neglect, and enter school ready to learn. As a single program, the providers share a common purpose and outcomes, participate in joint planning and quality assurance processes, and are able to rely on a shared infrastructure including an integrated data system.

Background

CSC was established in 1986 with the intent to improve the lives of children and families in Palm Beach County. Traditionally, CSC has funded programs that were responsible for finding families, conducting assessments, delivering the intended program, and achieving individual program goals.

As CSC became more focused in its efforts on early childhood and the sentinel outcomes of healthy births, reduced child abuse and neglect, and school readiness for our young children (Palm Beach County's Pathway to Early Childhood Development, 2007), it became increasingly clear that individual agencies delivering stand-alone programs will not result in sustained outcomes. Rather, it will require a system approach with agencies strategically aligned based on a common purpose, delivering the specific services they are most qualified to deliver, and acting as a single program. Recognizing that our community has limited resources and cannot provide all services universally, CSC's intent is to provide screening more universally and target prevention and early intervention services to a more specific population – those whose risks outweigh their protective factors (CSC Theory of Change, 2008).

The Capacity & Values Analysis (2008) showed that a majority of the 19 CSC-funded agencies serving families with children ages 0-5 provided care coordination or case management services, creating a duplication of services and activities. Some agencies were strategically located geographically to serve specific clients; however, it was indicated that CSC funds multiple providers for a similar service. Few agencies provided direct services. While agencies reported that they would support a collaborative approach to providing services, some agencies felt they could do most services on their own. In many cases, agencies making referral decisions often provided, or claimed to provide, the necessary services. During CY 2008, pregnant women and infants were referred for services based on Alternative Registration Forms (ARFs) and Based on Other Factors (BOOFs) twice as many times as scoring in for services on the appropriate risk screens. Criteria related to referral and entry into the Healthy Beginnings system was unclear and inconsistent.

As early as March, 2007, funded agencies in the Healthy Beginnings division began identifying areas of concern in providing services that attributed to the system redesign of services. Feedback from providers regarding the redesign of the RightTrack cited concerns or issues with, to name a few, the inability to pull or track appropriate data from RightTrack, data not matching services provided, lack of confidentiality of case note documentation, and the intensity of the training for staff (Healthy Beginnings Partnership Meeting, March 2007). The redesign of RightTrack led to the FOCiS system which included an expansion of the functionality of RightTrack. In November, 2007, Healthy Beginnings providers identified recruitment and retention issues of staff within their programs. Areas of concern included: staff turnover due to higher salaries offered by other HB agencies, safety issues for home visiting staff, lack of uniform salaries, obtaining qualified staff and sufficient funding for staff (Healthy Beginnings Partnership Meeting, January 2008).

CSC believes that interconnected services will improve quality and accessibility for families and facilitate families entering, navigating, and exiting services appropriately. The Healthy Beginnings Program (HB Program) is designed to do just that. With the creation of entry agencies, we have separated the screening and assessment process from the actual service delivery, increasing the likelihood that the family's true needs will be identified and responded to rather than influenced by the lens of what service a provider may be able to deliver in-house. Multiple Evidence-Based Programs and locally-designed services will be available to receive referrals from the entry agencies; service providers will no longer need to recruit their own families, improving the provider's ability to work with the target population rather than simply being concerned with achieving capacity. If families experience emerging needs while receiving services, they can be reassessed and receive additional services as appropriate.

Desired Results

The HB Program strives to improve the lives of children and families in Palm Beach County – in particular – by improving the following outcomes:

- 1) Increasing the percentage of healthy birth outcomes;
- 2) Reducing the incidence of child abuse and neglect; and,
- 3) Increasing the percentage of children eager and ready to learn.

It is anticipated that the HB Program will achieve these outcomes by implementing numerous strategies that will increase accessibility, improve service delivery, and increase accountability. For a detailed, pictorial description of how the functions, strategies, and outcomes of the HB Program align, please see the Healthy Beginnings Program Conceptual Model.

Influential Factors

A number of factors exist that can act as potential barriers or supports to the HB Program. Some of the barriers we may face are associated with the competing needs of the families served within the system, as well as external factors associated with the environment in which we reside. Nonetheless, to counter the barriers that may be experienced by the HB Program, a number of supports have been established. Everything from the commitment of staff and system members

to the relationships established with external systems both locally and nationally can be seen as strengths of the HB Program. These supports will help ensure the success of our efforts, despite the barriers that present.

Many of the potential barriers lie outside the scope or control of the HB Program; nevertheless, there are some barriers present within as well. It is imperative to understand any prospective threat to or weakness within the HB Program in order to address it in the best possible way. Some external threats are directly related to the economic environment that currently exists. As resources continue to dwindle, it is necessary to identify other funding opportunities and ensure that those services funded through Healthy Beginnings demonstrate a strong return on investment. Other external barriers exist though. Transportation continues to be a concern for families served by the HB Program, in addition to the competing needs that families have. Although the HB Program cannot be all things to all people, it will be imperative that through our efforts we are able to increase accessibility to services by ensuring system members can explain the services offered so that clients will be willing to consent to services. More importantly, system members will be expected to provide services in a linguistically and culturally sensitive manner to break down any barriers that exist concerning language and culture. As with any new endeavor, individuals and groups must go through a change management process. Communication and buy-in across system members have the potential to be a barrier; however, if addressed early, these can provide a strong sense of support for the HB Program. The same holds true for ensuring that a common client information system is in place to meet the needs of the system.

The current supports within the HB Program are largely associated with established relationships among the HB Program, system members, and external partners. CSC's organizational reputation and stable leadership have helped play a tremendous role in the development of such positive relationships. Healthy Beginnings has worked to establish a rapport with external systems throughout Palm Beach County. These systems work with families in a different capacity that is supportive of the work performed by the HB Program. Other external partnerships that have been developed are with CSC's other funding partners. Our funding partners have been active participants throughout the development phase of the HB Program, providing insight and expertise. We have also developed a relationship with First 5 Santa Clara County who has undergone a similar process. Through discussions with First 5 Santa Clara, lessons learned and suggestions critical for the success of any system have been shared with Healthy Beginnings and CSC. These partnerships, in addition with the relationships created with the system members will be essential in ensuring that the HB Program achieves what it has set out to accomplish.

Strategies and Assumptions

The HB Program seeks to improve the birth, child abuse and neglect, and school readiness outcomes for the families who enter its services. It is through a coordinated set of outreach, entry, and direct services that the HB Program will strive to attain these outcomes. Nevertheless, these components alone are not enough to ensure that families are receiving the high quality services they deserve. Thus, the HB Program is implementing six strategies that establish a foundation for a comprehensive service delivery model. These strategies include:

- **A systems approach**...to build cross-agency relationships, improve service delivery and practice, thus increasing clients' access to culturally-sensitive and developmentally-appropriate services;
- **Implementation of Evidence-Based or promising programs (EBPs)**...to provide families access to services that have proven their ability to attain client-level outcomes;
- **Professional development opportunities**...to provide services staff with the necessary learning opportunities that will help them better engage with families and provide high-quality services;
- **Social marketing**...to create awareness, educate, and create a shift in positive behaviors toward prenatal care, maternal health, postnatal care, and positive child development;
- **A common client information system**...to collect the necessary data for data-informed decision making, and to share information across system members to provide continuity of care for Healthy Beginnings clients; and,
- **Data-informed decision making**...to inform strategic management and planning decisions, based on data collected on services operating within the HB Program, as well as system-level data provided through quarterly reports, performance measures, and evaluations;

It is anticipated that these strategies will work in tandem to support the common vision of healthy babies, raised in a safe, nurturing environment, who arrive at kindergarten ready to learn. These six strategies are further described below, outlining both the strategies the HB Program will take in implementing the strategies, in addition to the related assumptions.

Systems Approach

Systems are not single interventions but a “cluster of change strategies” (Hernandez & Hodges, 2003, p.19). Thus, it is the role of a system to guide organizational changes in policy and practice, as well as the development of services and supports. Although child-specific outcomes are associated with the delivery of specific prevention and early intervention services offered through systems (Hernandez & Hodges, 2003), as improvements in service delivery occur, it is anticipated that, “outcomes for children and families will be superior to those achieved in more traditional service delivery systems” (Vinson, Brannan, Baughman, Wilce, & Gawron, 2001, p.31). More importantly, for systems to truly impact child and family outcomes, they must carefully choose programs that have been proven to achieve outcomes and implement these programs with fidelity (Hernandez & Hodges, 2003).

Much of the research on systems of care (SOC) is based on the original work of Stroul and Friedman (1986). In their work, Stroul and Friedman identified key principles of SOC. Vinson and colleagues (2001) summarized these principles as:

- a) Attention to individual needs/cultural characteristics;
- b) Strengths-based approach;
- c) Involvement of families in child(ren)'s care;
- d) Cross-agency coordination and system management; and,
- e) The use of least restrictive environments.

A number of the five, aforementioned principles are included within the HB Program. One way in which Healthy Beginnings has implemented a systems approach is through regular, bi-weekly system management meetings. Information sharing occurs at multiple levels during these meetings. The system management meetings bring together the system members for the purpose of system development, as well as receiving system and programmatic updates. They also create a forum where the system members review data and discuss system successes and concerns. Therefore, it is through these meetings that a foundation for cross-agency coordination, collaboration, and partnership are formed. An environment in which system members can share ideas, take a strengths-based approach, and problem solve ways to meet their clients' individual needs in a culturally sensitive manner is provided.

Through the system management meetings, system members developed the HB Program vision, mission, and values. Insight provided by a 2007 *System Implementation Issue Brief* (Hodges, Israel, Ferreira, & Mazza, 2007) indicated that one key factor in leveraging system change was values and beliefs. Involvement of system members in the creation of the Healthy Beginnings vision, mission, and values is imperative for three distinct reasons, as outlined by Hodges et al. (2007). The factors that suggest such involvement is necessary include:

- 1) Shared vision, mission, and values are integrated into the tenets of service delivery, resulting in added benefit to children and families;
- 2) Having a common stake in the development of the Healthy Beginnings vision, mission, and values should result in greater accountability and shared responsibility for system functioning; and,
- 3) By creating the vision, mission, and values, system members begin a cultural shift – believing that change is possible – and all necessary components and factions will be in place to move beyond an initial, more fragmented system of services.

It should be noted that through the development of the HB Program vision, mission, and values, system members were able to touch on each of the five, key principles identified by Stroul and Friedman (1986).

Aside from system development and management, another area in which the HB Program takes a systems approach is in its delivery of services. Throughout the system, there are numerous home visiting programs offered. In her 2006 testimony to the Subcommittee on Education Reform Hearing, Dr. Deborah Daro highlighted the many benefits of home visiting programs, in addition to their ability to achieve child outcomes. Home visiting services provide families with the flexibility to receive services in the home, community, or in some cases, at a centralized office; thus, services are provided in such a manner that is not restrictive to families and respects their wishes and values. It is also assumed that such an approach maximizes the families' ability to be involved in their child's care.

The incorporation of these principles is achieved not only through taking a systems approach but through the implementation of the other strategies outlined in this section. Many of the identified strategies address multiple principles. For example, the inclusion of EBPs into the HB Program touches on attention to individual needs/cultural characteristics; taking a strengths-based approach; involving families in their child(ren)'s care; and providing services in the least

restrictive environments. It is anticipated that taking a systems approach will help facilitate the coordination of the other five strategies, as well as move system members toward a level of integration that will benefit the children and families served by the HB Program.

Assumptions:

- System members exhibit a shift in values and beliefs that are consistent with those outlined for the HB Program.
- System management meetings and other venues create opportunities for increased communication and collaboration among system members.
- Services provided are culturally sensitive and offered to families in the most accessible environment/setting possible.

What are the results we expect if we attain a true systems approach?

- Increased accessibility to the correct services for children and families participating in the HB Program.
- Improved service delivery that seeks to reduce the duplication of services offered and provides children and families with engaging, strengths-based services.
- System members work together to review data and experiences that will inform them of the best ways to coordinate services and engage families, thus increasing accountability.

Evidence Based and Promising Programs

(Excerpted from the CSC Publication: *Research Review, Evidence-Based Programs and Practices: What Does It All Mean?*)

Local communities are being asked more than ever to invest in and implement proven programs. “In times of shrinking budgets and increasing federal and state deficits, policymakers and practitioners must make efficient use of prevention resources by opting for programs that have the greatest likelihood of producing positive effects” (Kyler, Bumbarger, and Greenberg, 2005). This means either implementing programs that have already been labeled Evidence-Based (EBPs) through a national process or proving that the programs they are running would be considered Evidence-Based if rated. These communities must prove that their programs work (i.e. that they are effective for the children and families they serve).

In order for Healthy Beginnings to achieve its goals, it is expected that services offered within the HB Program are able to demonstrate – through data – that they are achieving positive results and “doing no harm” to the recipients. In order to be accountable to the children, families and taxpayers of Palm Beach County, the best possible programs and services must be in place. This means that the HB Program will consist of services that are already Evidence-Based, are on a continuum of becoming Evidence-Based, or enable children to enter programs that are Evidence-Based.

Implementing EBPs and promising programs is important to ensure that resources are spent on programs that have a high probability of achieving desired, long-term outcomes and that incorporate principles of effective programming that bring about positive results. Many national organizations and agencies now promote the use of Evidence-Based Programs. The advantage to both funders and providers is that EBPs eliminate the costly and time-consuming efforts of

exploring and experimenting with new methods, strategies and technologies. They provide the best return on investment.

It is a top priority of the HB Program to see that the children and families served by its funded programs achieve the best possible outcomes. Evidence-based and promising programs in social services can vastly reduce hit or miss outcomes and results. Moreover, the implementation of EBPs and promising programs ensures a return on investment, as well as attaining a higher level of accountability.

Through the implementation of EBPs and promising programs, the HB Program is moving towards accountability. Too often programs continue to run without ever showing that what they do works for the children and families they serve. According to researchers, implementing EBPs and promising programs helps ensure that they are based on a proven or tested theory of change. The results or client outcomes are directly related to the services received from the program. Evidence-Based programming also helps ensure that agencies are spending resources on a proven program that works. “Economic analyses of several early childhood interventions demonstrate that effective programs can repay the initial investment with savings to government and benefits to society down the road” (Karoly, Kilburn, and Cannon, 2005).”

The HB Program currently implements a variety of EBPs and promising programs, and it plans to add more. A brief description for each of the eight Evidence-Based or promising programs that are implemented within the HB Program is located below.

- **Centering** – The Centering Pregnancy program provides prenatal care in a group setting, including assessment, education, and support within the group.
- **Healthy Families Florida (HFF)** – HFF is a voluntary home visitation program for pregnant women and mothers of infants. It has been proven to prevent child abuse and neglect and other poor childhood outcomes.
- **Healthy Steps for Young Children (Healthy Steps)** – Healthy Steps is an initiative that focuses on the importance of the first three years of life. Healthy Steps emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age three.
- **Home Instruction for Parents of Preschool Youngsters (HIPPY)** – HIPPY is a home visiting, parent involvement program that helps parents prepare their three, four, and five year old children for success in school and beyond.
- **Nurse-Family Partnership (NFP)** – NFP is a home visiting program for first-time, low-income, at-risk mothers promoting improved maternal, prenatal, and early childhood health.
- **Parent Child Home Program (PCHP)** – The PCHP is a research-based and research-validated emergent literacy and school readiness program. The Program successfully

- **Primary Project** – Primary Project, an Evidence-Based Program developed by the Children’s Institute in Rochester, is a school-based early detection and prevention program designed to prevent school adjustment difficulties and foster children’s social and emotional wellbeing.
- **Triple P** – Triple P is a suite or system of coordinated parenting interventions that “aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills and confidence of parents.”

Assumptions:

- Funded agencies will want to participate in implementing EBPs and promising programs or improve on a continuum of becoming Evidenced-Based.
- Selection criteria at the entry agencies will link families to the most appropriate EBPs.
- Evidence-Based and promising programs will be implemented with fidelity.
- Children and families will reach their full potential if offered the best possible service.
- Evidence-Based Programs provide the best return on investment.

What are the results we expect when EBPs and promising programs are implemented with fidelity?

- Children and families will have a greater likelihood of being born healthy, free of abuse or neglect, entering school eager to learn, and potential for experiencing longer-term outcomes.
- Results will be sustainable over time.

Professional Development for the Healthy Beginnings Program

Professional development encompasses all types of facilitated learning opportunities, ranging from classroom training to reflective supervision in the workplace. It can be intensive and collaborative and ideally incorporates an evaluative stage. There are a variety of approaches to professional development to ensure the transfer of learning to the workplace, including consultation, coaching, communities of practice, lesson study, mentoring, reflective supervision, and technical assistance (National Professional Development Center on Inclusion, 2008).

Professional development for the HB Program is specifically designed to train providers in the most effective strategies for joining with families to provide the best services to assist the children of Palm Beach County in achieving their optimum development. This process of increasing the professional capabilities and competencies of staff is cascaded to families and children in order to reach the goals of the HB Program.

System of Care program management teams are encouraged to utilize the core competencies as a tool in implementing the other key components of the Workforce Development Framework:

- *Interviewing and hiring* staff based on the competencies
- *Performance measurement* of how well staff are demonstrating the competencies in the workplace

- *Workforce planning* by supporting staff to attend training that builds the necessary competencies, and provide reflective supervision to support the transfer of learning

According to data-based industry standards established by the American Society of Training and Development (ASTD, 2008), the highest performing learning organizations link learning with individual and organizational performance by using a core competency matrix. Certification processes help to assure that competencies are being developed and exhibited in the workplace. The ASTD standards also recognize the importance of supervisor support and participation in learning as was stated in the CSC Healthy Beginnings Invitation to Negotiate (ITN): “program staff, to include supervisors, will be expected to participate in an annual certification process to include, but not be limited to: role play testing of skill acquisition, frequent observation and feedback of staff in the field, mentoring, and reflective practice sessions.”

The core competency content of the Healthy Beginnings Professional Development Program teaches and scaffolds knowledge and skills to application in the workplace through case studies, role-plays, reflective practice, reflective supervision, and competency-based program certification grounded in the following research-based, early intervention and prevention approaches and values (CSC Healthy Beginnings ITN):

- Family and child-centered practice
- Cultural and linguistic competency
- Developmental knowledge
- Evidence-Based research
- Recognize/connect families with appropriate and competent service providers
- Quality relationships characterized by trust, support, and growth
- Engagement of children, mothers, fathers, and/or other primary caregivers in positive working relationships.
- Structure, mission and supervisory style support these relationship-building efforts
- Effective leadership involving the implementation and practice of essential functions such as teamwork, planning, reflective supervision, anticipatory guidance, staffing requirements and professional development.

Assumptions:

- Healthy Beginnings management, system members, and CSC staff exhibit a strong interest and commitment to the Healthy Beginnings Professional Development Program.
- Healthy Beginnings management, system members, and CSC staff work together to support the full application of the training to the job.

What are the results we expect when transfer of learning occurs?

- HB services/programs will meet certification criteria when this process is implemented.
- Transfer of learning will result in an increased awareness of the impact of culture on human interactions and communications.
- System members will enhance their delivery of care to families by using relationship-building strategies and communication tools based on the Touchpoints™ Approach
- Providers will have an increased knowledge of early childhood social-emotional wellness, child development, and family relationships.

- Providers will be able to better engage families by focusing on family strengths, having an awareness of barriers, and be able to identify bridges for families.

Social Marketing

Social Marketing uses traditional marketing strategies to promote a voluntary behavior change with the ultimate goal of a social or personal good. According to the Centers for Disease Control's website, one well-known definition of social marketing comes from Alan Andreasen's book, *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment*:

"the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence voluntary behavior of target audiences in order to improve their personal welfare and that of society"

(<http://www.cdc.gov/nccdphp/dnpa/socialmarketing/training/basics/what.htm>).

The CDC stresses that Social Marketing is a:

- Systematic and strategic planning process.
- Social or behavior change strategy.
- Mindset for addressing problems.
- Total package of strategies carefully chosen based on characteristics of the target audience.

And addresses six key factors that differentiate it from other health planning approaches:

1. Audience orientation.
2. Audience segmentation.
3. Influencing behavior.
4. Competition.
5. Exchange.
6. Marketing mix.

While these concepts are partly borrowed from traditional marketing approaches, social marketing considers additional factors that traditional marketing campaigns do not. A clear way to differentiate these factors is by examining the "P's" of traditional and social marketing. These are explained in greater detail by Nedra Weinreich's article, "What is Social Marketing?"

<http://www.social-marketing.com/Whatis.html>

Traditional Marketing considers **four "P's"** in its marketing mix:

1. Product- (for us the HB programs- could also be system outcomes)
2. Price- (for us this is not necessarily the \$, but the total cost to the customer. What do they have to give up to be a part of the system or to change behavior? -Considerations of time/ convenience are weighed versus benefits)
3. Place- is how information about the product reaches the customer (for us via the system and system partners- entry agencies, referral sources, also refers to accessibility).

4. Promotion – often mistaken for Social Marketing as a whole – is the integrated use of advertising, PR, media advocacy that creates/sustains demand for the product. Research crucial to this phase.

Social Marketing adds **4 more “P’s.”**

1. Public - both the internal and external groups involved. Target audiences, secondary audiences (for us taxpayer is an example of secondary, client an example of primary,) policymakers and CSC and funded agency staff all considered here.
2. Partnerships- since our outcomes can be better accomplished with outside help- who must also be considered? (Outside agency partners, synergistic organizations with similar goals DOH/ DCF HB Coalition etc.)
3. Policy-as Social Marketing Seeks to promote change over time, rather than a behavior to complete an individual transaction it also seeks to influence policy change and is often accompanied by media advocacy.
4. Purse Strings- because services we sell do not generate revenue as it is traditionally understood, how will funding be ensured? For HB/CSC communicating the benefits of services graphically over time to the community. See Lisa Williams-Taylor and Shana Cooper article Evidence-Based Programs: A Solid Return on Investment.

The HB Program seeks to change behavior, ensure these behavioral changes succeed within a long-term societal context, cooperate with significant external partners, and must demonstrate results to ensure ongoing and adequate funding streams. These four goals dovetail perfectly with the additional P’s associated with Social Marketing. Moreover, the system seeks a marketing model with proven results in these contexts. Social marketing “is an effective behavior change approach that has been proven effective across a wide range of health promotion,” that has proven particularly effective when aimed at “specific target audiences.”(Evans and McCormack, 2008)

Assumptions:

- The products of the system (programs) will achieve the system outcomes
- Perceived costs (non traditional) of the programs will not prohibit their use by the intended customer.
- The targeted audience will be exposed to and understand program information
- Research targeted to the system demand is accurate
- System partners will support the system based on synergistic outcomes

What are the results we expect if a well-planned, strategic social marketing plan is disseminated?

- Those who receive the messages will have an increased awareness and understanding of Healthy Beginnings.
- Audiences exposed to social marketing will have an increased awareness of prenatal care, maternal health, and positive development of children ages birth to five.
- Social marketing will result in an increase understanding of the importance of early prenatal care, and strategies that can be undertaken to promote maternal health and positive development of children ages birth to five.

- Those exposed to messages will have an increased likelihood of participating in prenatal and early childhood screening.
- Audiences receiving the messages will have an increased likelihood of changing behaviors to promote or participate in activities that lead to improved prenatal care, maternal health, and positive development of children ages birth to five.

Common Client Information System

CSC is committed to investing in services, with the intent that return on investment will be demonstrated by healthy births, young children free from abuse and neglect, and entering school eager and ready to learn. For some families, the amount of support needed to achieve these goals may be minimal, while others may require multiple services delivered over the course of several years. It is incumbent upon the HB Program to ensure resources committed are used efficiently and effectively, from the short-term perspective of the outcome associated with the individual family, as well as relative to the longer-term perspective of what happens within a cohort of children.

In order to uphold its responsibilities, Healthy Beginnings must have data available to strategically focus its resources and services. This requires a common client information system – a virtual framework where information can be used in decision making and strategic planning among its constituent agencies. Multiple data systems would undermine that capability, increasing the complexity and time required to pair data from one agency to another. The HB Program needs to analyze data to understand the impacts of our investments. Are children who participated in the HB Program eager and ready for school, on grade level by 3rd grade, graduating high school, and not parents prior to their 18th birthday? To conduct this level of impact analysis, it is necessary to match individual level data from HB's client information system with other administrative data sets. In order for Healthy Beginnings to ensure that its system is operating at an optimal level, HB staff will need to rely on operational measures that can only come from a common client information system to provide real time performance results.

The ability to share information seamlessly and in real-time will be critical to ensuring sound service delivery decisions, on behalf of the providers and families. By utilizing a common client information system, providers will be able to maintain a continuity of care, allowing the children and families we serve to maximize the benefits they are able to derive from our available mix of services. The primary data system that will serve the HB Program is the Family Outcome and Child Information Systems (FOCiS) database. FOCiS provides a common place where information can be stored on children and families participating in the HB Program. Information that will be stored includes demographic, screening and assessment results, referral, and activities regarding service provision. Referrals between the entry agencies and service provider agencies can occur with minimal administrative and/or clinical redundancies once providers are able to benefit from appropriate levels of information sharing. Furthermore, obtaining a big-picture history of children and families is critical to determining the best course of services to pursue. Obtaining such a history from the family often yields histories with distorted timelines or omitted information. A single data source for the HB Program will help create that macro perspective of care without relying on brief self reports, and permits our system members to

focus on their respective areas of expertise rather than on investigative fact finding. In this way, Healthy Beginnings can work with providers to improve operational performance, and to keep the system functioning and on-course.

Assumptions:

- All HB services will be able to operate within FOCiS
- HB service providers will enter the appropriate codes into FOCiS
- Accurate data is entered into the system
- Sufficient time is allocated for data collection and entry
- Data will be able to be retrieved from FOCiS in a timely and efficient manner

What are the results we expect with a common data system?

- The ability to retrieve data will be beneficial for seeing whether performance measures, programmatic, and system outcomes are being met.
- A common data system provides the ability to monitor the capacity of services offered within the HB Program.
- There will be the ability to track which services children and families received and the overall impact of participation in the HB Program over time.
- A common data system will permit Healthy Beginnings to use data for informed decision making purposes.

Data-Informed Decision Making

In order to help provide the best services to the families in PBC, it is important to understand the effectiveness of the services currently provided and identify ways in which these services can be improved. The utilization of data can be used not only for accountability purposes, but also for continuous improvement. Data can be used to make decisions that impact policies, system design, program infrastructure, and service implementation. Data-informed decision making is a process of collecting and analyzing data to inform policy, services, and decisions in support of outcome achievement (adapted from Cradler, 2008). The HB Program seeks to create and maintain a culture that supports and values the use of data to inform organizational learning and enhance continuous improvement strategies.

Decisions that are based on intuition or instincts are not as easily justified as those that are based on empirical data. Data provides supportive evidence. If data is viewed as valuable and not as a burden or as a third-party requirement, data quality will improve and it will become genuinely useful (Doyle, 2003). There are three key elements that exist in a data-informed decision making culture. These elements include:

- 1) Data collection and analysis that is purposeful and proactive;
- 2) Designated resources and other supports; and,
- 3) Communication strategies about the process of data collection and utilization of findings (MCREL, 2003).

The utilization of data is dependent upon the relevancy of the information gathered. Collecting data in a purposeful and proactive approach enhances the probability that the information will

identify levels of performance and results achieved. Data collection needs to be aligned with the sentinel outcomes the HB Program aims to achieve. It should help inform specific questions that have been identified relating to service provision and management. As referenced in Rand's article (2005), Herman and Gribbons (2001) offer three basic kinds of questions that can be answered with data:

- 1) How are we doing?
- 2) Are we serving the clients well?
- 3) What are our strengths and weaknesses?

Client, program and system data should be aligned to help answer these questions and identify areas which may be improved. The shared common client information system will be enhanced to ensure the collection of various forms of data (e.g. such service dosage) at multiple points in time (historical record) and allow for system members to have access to the information collected to inform decision making at all levels.

The HB Program will have designated resources and other supports that promote a data-informed decision making culture. It is important to have individuals at all levels within the system (e.g. front line program staff, supervisors, system members, etc.) committed to examining the data and sharing findings and offering multiple perspectives. The HB Program will provide the common information data system to assist system members in providing services. System members will have access to real-time data, as well as historical information. The data system will allow system members to access reports and data that they input into the system, in addition to information reported by other system members to be able to provide more comprehensive services to families. Furthermore, system members will have the opportunity to engage in formal evaluation processes.

Communication is another key element in promoting a data-informed decision making culture. Group-based discussions around data are especially effective in helping to guide decisions (Rand 2005). The HB Program has created a formalized mechanism for system members to be able to review and discuss data and identify improvement strategies with other system members. The System Management Meetings will allow for discussions of data and information to be conducted on a regular and timely basis.

Assumptions:

- Data are viewed as valuable and there is motivation to use data to improve services.
- Organizations' culture and leadership encourage data-informed decision making.
- Opportunities to discuss data, implications, and assumptions are provided regularly.
- Individuals have the skills to appropriately use the information.
- Sufficient time is allocated for data analysis and reporting.
- Data measures and collection are consistent.
- Data are aligned with system and services' mission and vision.
- Data are timely, easily accessible, and of high quality and validity. The data reflect what is really happening with the population that is being examined (Marsh, Pane, and Hamilton, 2006).

What are the results we expect if we attain a culture of data-informed decision making?

- Routine review of data
- Better communication around goals, objectives, and/or results
- Better understanding of progress/performance measures
- Decisions made that lead to outcomes/results
- Depersonalization of information so that lessons can be learned and opportunities for growth seized
- Actionable knowledge where data users synthesize the data and apply their judgment to prioritize it and weight the relative merits of possible solutions (Marsh, Pane, and Hamilton, 2006)

Conclusion

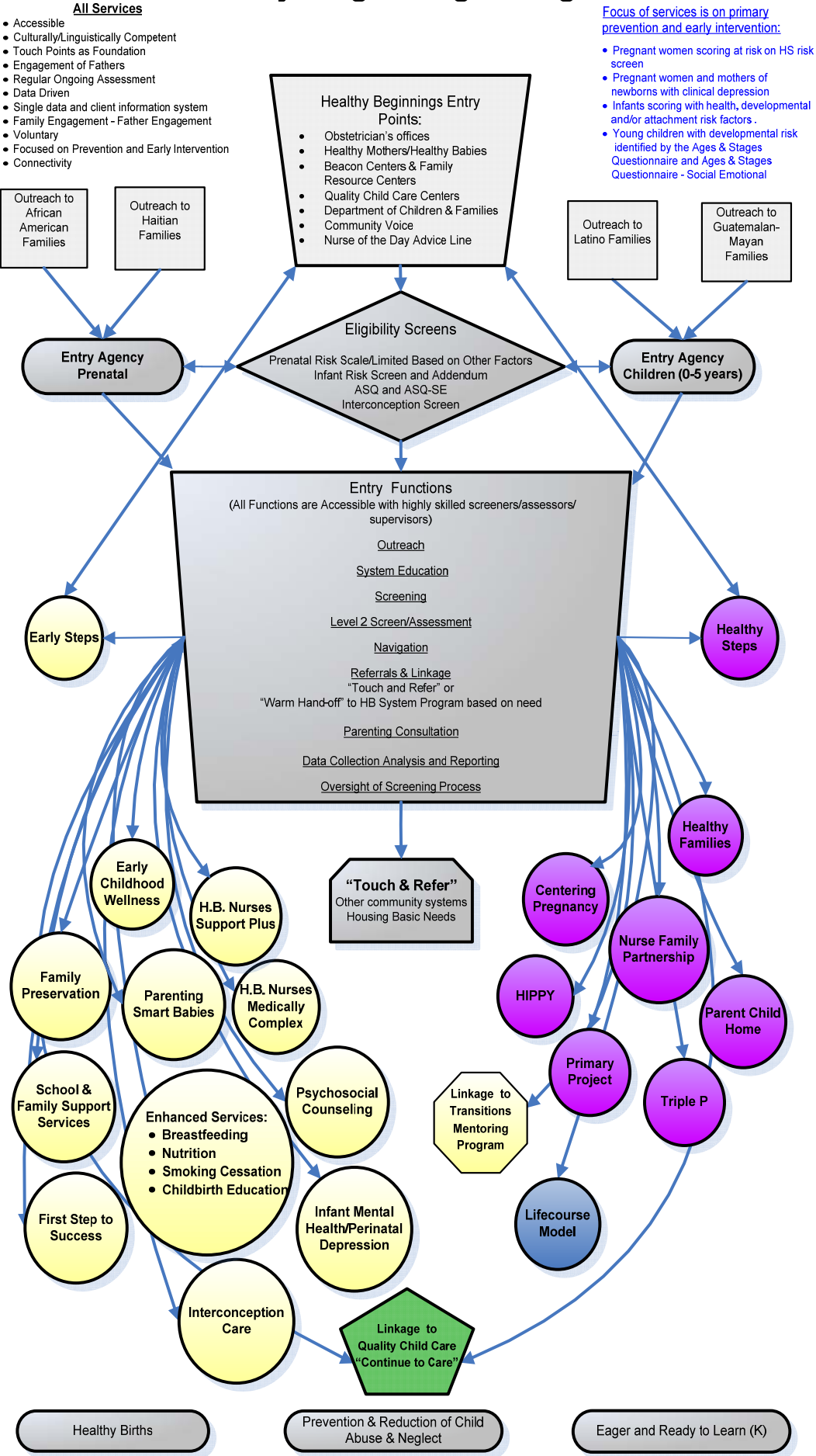
Working in concert, the six strategies listed above will aid the HB Program in achieving the common vision of healthy babies, raised in a safe, nurturing environment, who arrive at kindergarten ready to learn. By taking a systems approach, the HB Program seeks to increase accessibility to services, improve service delivery, and increase accountability. It will also ensure that families are being linked with the appropriate services. However, as a systems approach alone cannot improve all child outcomes, it was decided that EBPs and promising programs would also be implemented. The implementation of such programs helps to ensure that the children and families participating in the HB Program will receive maximum benefit from the services they receive. The staff delivering these programs will be skilled, as they have participated in the Healthy Beginnings Professional Development Program. In accordance with a systems approach, these providers will offer services in a culturally sensitive, strengths-based manner and provide the services in the least restrictive setting. To raise awareness of the HB Program and the services offered within it, a social marketing campaign will be executed. The purpose of the social marketing campaign will not only assist in providing information to families around the HB Program, but it will seek to raise awareness, educate, and change behaviors around issues related to prenatal care, maternal health, and positive development of children ages birth to five.

While it is anticipated that these strategies will be effective in engaging children and families and provide them with the appropriate services, it is necessary to demonstrate that these strategies, in fact, produce results. Having a common client information system where data from across all services can be stored will be essential to demonstrating the effectiveness of the HB Program. FOCiS will be the primary data system that serves this function. The data extracted from FOCiS will be analyzed to determine what level of impact the HB Program has on increasing accessibility to services, improving service delivery, accountability, and of paramount importance, its relation to positive birth and early childhood outcomes. As important as it is to show outcomes, it is just as important to use the data and analyses for continuous improvement purposes. By developing a culture that embraces data-informed decision making, Healthy Beginnings staff and system members will use this information to make educated decisions around the provision of services and gaps within the system to better meet the needs of our clients and the children and families of Palm Beach County.

APPENDIX C: HEALTHY BEGINNINGS CONCEPTUAL MODEL

Draft version as of 08.27.09

Healthy Beginnings Program



APPENDIX D: NURSE-FAMILY PARTNERSHIP PROGRAM

Nurse-Family Partnership Background

In 1977 in Elmira, NY, Dr. David Olds and his colleagues began a research study that delivered nurse-home visitation to a sample of primarily low-income Caucasian, first-time mothers. The findings of the first trial were so strong that Dr. Olds replicated the trial in 1987 with African-American mothers in Memphis, TN. A third trial was conducted in Denver, CO with mostly Hispanic women. All three trials showed impressive outcome improvements for mothers and children. A 15-year follow up of the Elmira sample demonstrated long-term outcomes including dramatic reductions in child abuse and neglect, maternal alcohol and drug use, child and maternal arrests, less smoking, fewer arrests and fewer sexual partners among adolescents.

Description of the NFP Model and Plan

Nurse-Family Partnership (NFP) is an evidence-based community health program which provides first-time, low-income mothers with home visitation services from public health nurses. NFP goals are to improve pregnancy outcomes by helping women engage in good preventive health practices, improve child health and development by helping parents provide responsible and competent care and improve the economic self-sufficiency of the family by helping parents develop a vision for their own future.

Research shows that the impacts of implementing the Nurse-Family Partnership with fidelity include: improved prenatal health; fewer childhood injuries; fewer subsequent pregnancies; increased intervals between births; increased maternal employment and improved school readiness. In addition to these short and long term outcomes among low-income families, numerous independent evaluations on the program's economic outcomes have shown the benefits of investment to outweigh costs by reducing welfare, healthcare and juvenile justice expenditures. The actual dollar amount has been found to range between \$2.88 to \$5.70 for every dollar invested.

Nurse-Family Partnership is a national program currently operating in 28 states and 163 sites. Services start at 12-28 weeks of pregnancy and continue on an intensive schedule of visits until the target child is two years of age.

Program activities occur in 3 home visitation phases, during which registered nurses address a specific set of health and developmental concerns. During the first phase, nurses visit clients weekly for the first month after enrollment and then every other week until the baby is born. Outcomes of concern during this phase include those related to prenatal health. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old.

The NFP Visit Guidelines specify the structure of the home visits, the frequency and timing of the visits and the content to be covered. Adherence to this structure, content and process is essential to achieving fidelity to the model. However, home visitors practice the NFP

intervention by building on existing nursing skills, particularly their knowledge of human growth and development. Based on the NFP Visit Guidelines, home visitors conduct comprehensive, strengths-based client assessments and plan interventions with clients across the six domains of the program model: personal health, environmental health, life course development, maternal role, family and friends, and health and human services.

Fidelity to the NFP model includes the following model elements:

Clients

- Element 1 Client participates voluntarily in the Nurse-Family Partnership program.
- Element 2 Client is a first-time mother.
- Element 3 Client meets low- income criteria at intake.
- Element 4 Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy.

Intervention Context

- Element 5 Client is visited one to one, one Nurse Home Visitor to one first-time mother/family.
- Element 6 Client is visited in her home.
- Element 7 Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current Nurse-Family Partnership Guidelines.

Expectations of the Nurses and Supervisors

- Element 8 Nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing.
- Element 9 Nurse home visitors and nursing supervisors complete core educational sessions required by NFP National Service Office and deliver the intervention with fidelity to the NFP Model.

Application of the Intervention

- Element 10 Nurse home visitors, using professional knowledge, judgment and skill, apply the Nurse-Family Partnership Visit Guidelines individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.

- Element 11 Nurse Home Visitors apply the theoretical framework that underpins the program, emphasizing Self-Efficacy, Human Ecology and Attachment theories, through current clinical methods.
- Element 12 A full time Nurse Home Visitor carries a caseload of no more than 25 active clients.

Reflection and Clinical Supervision

- Element 13 A full-time nursing supervisor provides supervision to no more than eight individual Nurse Home Visitors.
- Element 14 Nursing supervisors provide Nurse Home Visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the Nurse Home Visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision.

Program Monitoring and Use of Data

- Element 15 Nurse Home Visitor and Nursing Supervisors collect data as specified by the NFP National Service Office and use NFP Reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.

Agency

- Element 16 A Nurse-Family Partnership Implementing Agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families.
- Element 17 A Nurse-Family Partnership Implementing Agency convenes a long-term Community Advisory Board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.
- Element 18 Adequate support and structure shall be in place to support Nurse Home Visitors and Nursing Supervisors to implement the program and to assure that data is accurately entered into the data base in a timely manner.

NURSE-FAMILY PARTNERSHIP GOALS AND OUTCOMES

- 1) Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances.

- 2) Improve child health and development by helping parents provide responsible and competent care.
- 3) Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

OVERVIEW OF LOCAL NURSE-FAMILY PARTNERSHIP PROGRAM

In Palm Beach County, Nurse-Family Partnership was introduced in July of 2008 as Florida's first NFP. The program is currently administered by the Palm Beach County Health Department and is staffed with one full time nurse supervisor, six full time nurse home visitors and one data entry clerk. NFP nurses sub-contracted through Palm Beach County Health Department provide home visitation services, developing relationships with the participants to ensure that the clients complete prenatal visits and remain in the program until the child reaches age 2. Currently, the program is serving approximately 150 first-time mothers through a county-wide initiative. It is expected to maintain enrollment capacity of 150 first-time mothers. In the coming months, CSC will be expanding NFP services to include 4 additional nurses (10 total) and 1 nurse supervisor serving 100 more new mothers. Funding for the Palm Beach County NFP program comes from CSC, private foundations and the Department of Health.

Clients enter the NFP program through one of three avenues. The first is through one of the four outreach agencies which then refer potential clients to the HMHB entry agency for initial screening and assessments. Another is by scoring 6 or higher on the prenatal risk screen administered during physician visits. Finally, eligible women in the community are identified through the entry agency (HMHB) directly.

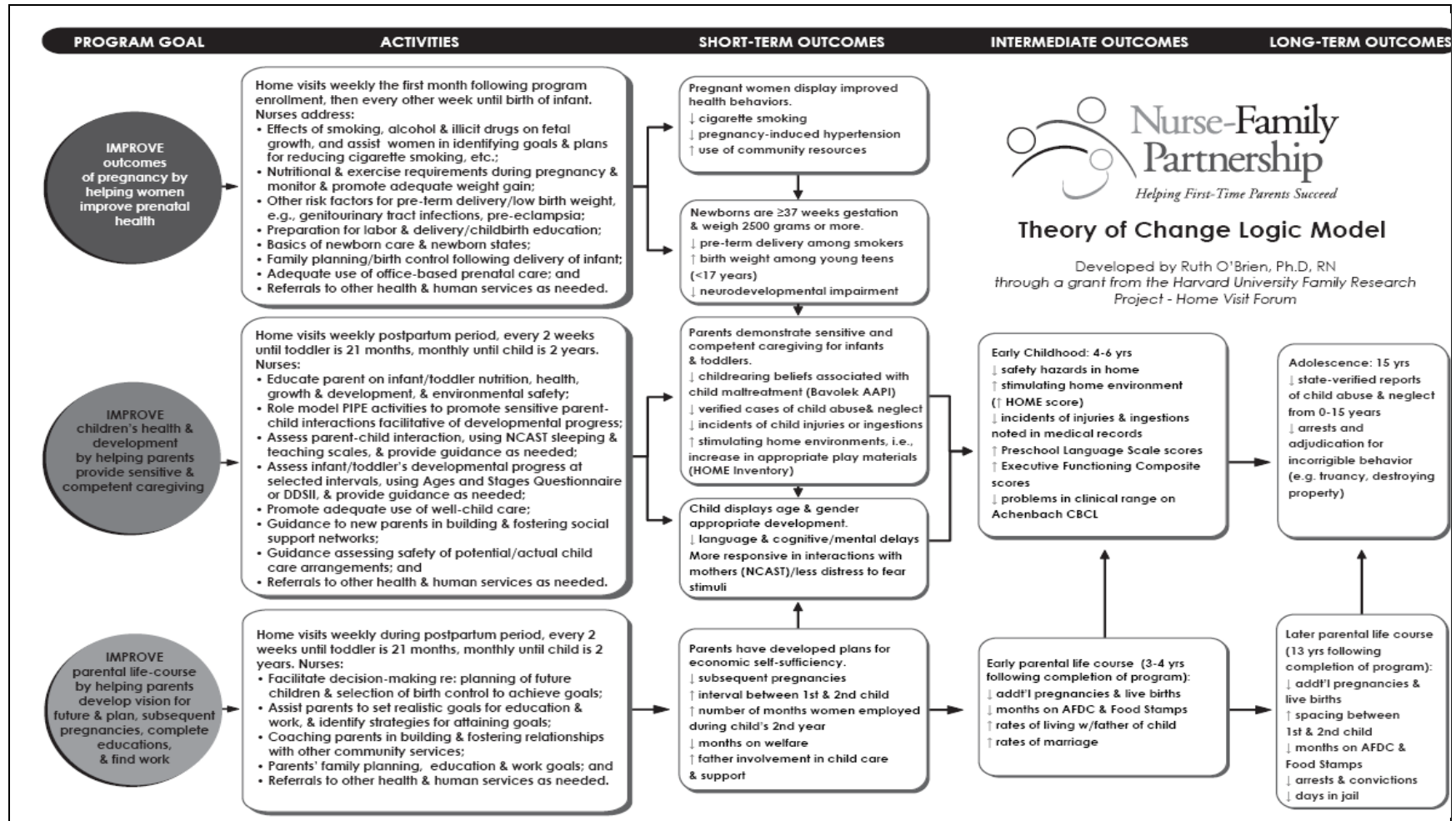
The local NFP Program will receive referrals from the Healthy Beginnings Entry Agency based on criteria match and assessment. Clients are eligible for receiving NFP services if they are first time mothers between 12-28 weeks of pregnancy, are low-income, (e.g. qualifying for Medicaid), and who score 6 or more on the Health Start Prenatal Risk Screen. Teen mothers who do not score 6 or more on the screening but otherwise meet NFP requirements, are still referred to NFP. Unlike other NFP sites, the Palm Beach County program does not rely on HB nurses to conduct outreach activities.

Demographic data is available for all local NFP clients. Additionally, as discussed earlier, reports generated by the CSC and the national NFP office contain a breakdown of specific categories of data regarding client characteristics, enrollment, implementing agency caseload profiles, client visits and service linkages. From these reports, general information regarding clients served is available. A sample of the local NFP client demographic data includes the following:

- 1) The highest percent of clients enrolled in NFP in Palm Beach County are 15-17 years of age. Nationally, the highest percent of clients are 20-24 years of age.
- 2) Approximately 92% of the clients in NFP are unmarried.

- 3) The primary language for 86% of Palm Beach County clients is English. 5% of clients in Palm Beach County claim Spanish as their primary language and 9% of clients claim a primary language other than English or Spanish.
- 4) In Palm Beach County 61% of the clients are Black/African-American (including Haitians), 31.9% of are White Non-Hispanic, and 20% are Hispanic.
- 5) The percent of clients in Palm Beach County that graduated high school is 42.1%. However, Palm Beach County also has a higher percentage of clients still in school.
- 6) Medicaid usage among Palm Beach County clients has averaged at around 84%. 10.2% of Palm Beach County clients had health care coverage other than Medicaid.
- 7) While few Palm Beach clients were found to smoke, they were also more likely to be underweight.

APPENDIX E: NURSE-FAMILY PARTNERSHIP THEORY OF CHANGE LOGIC MODEL



APPENDIX F: NURSE-FAMILY PARTNERSHIP IMPLEMENTATION LOGIC MODEL

Nurse-Family Partnership (NFP) Implementation Logic Model

Developed by Maureen Flory, Ph.D.

ASSUMPTIONS - Implementing Nurse-Family Partnership with fidelity to the model requires implementing agencies, nurse supervisors, and nurse home visitors to make program decisions guided by the theories of self-efficacy, attachment and human ecology. Nursing practice is central to all aspects of the nurse-client relationship.



EXTERNAL FACTORS - The following factors can affect funding, sustainability and the degree to which an agency is able to implement Nurse-Family Partnership with fidelity to model: national, state and local political climates; issues within professional communities of practice; structures of IAs and their systems; physical and cultural environments of individual families.