

## **Implementation and Scale Up of Home Visiting (Part 2)**

**Moderator: Dana Bunker**  
**April 21, 2011**  
**3:00 p.m. ET**

Dana Bunker: Good day, ladies and gentlemen, and welcome to today's webcast entitled, "Implementation and Scale-up of Home Visiting Part II."

Following the presentation, we'll have a short question-and-answer session. You can ask questions at anytime during the presentation – click the Ask a Question button, type in your question in the open area and click Ask Questions to submit. Depending on the time we have at the end, we will try to reply to all questions but we may have to reply via email.

If you should need technical assistance, please type your inquiry into the Tech Support box on the left side of your screen and click the Send button.

It's now my pleasure to turn the webcast over to your speaker, Jackie Counts. Jackie, the floor is yours.

Jackie Counts: Thank you, Dana.

Good afternoon. Welcome to the webinar, "Implementation and Scale-up of Home Visiting Part II: Planning for Quality Implementation of Evidence-Based Programs."

My name is Jackie Counts and I am the HRSA Region VII project officer for Home Visiting and the Early Childhood Comprehensive System.

Together with Charisse Johnson, ACF Child Welfare Program Specialist and ACF Technical Assistance Liaison for Region III, V and IX, we designed this webinar with section 4 of the Supplemental Information Request in mind.

Section 4 requires an implementation plan for a proposed state home visiting plan. Today's webinar will feature two presentation teams to build on the framework presented in part one and it will provide strategies to think about

your implementation plan, engage all levels of the implementation system and plan for sustainability.

The first team will describe the Ohio Department of Mental Health decade-long initiative and that facilitating the uptake and successful implementation of evidence-based interventions throughout Ohio. The presenters will share lessons learned from those research and practice about factors that account for successful implementation and sustainability.

The second team will describe their experience implementing a home visiting evidence-based practice. They will build on the implementation stages described in the webinar on March 24<sup>th</sup> and they will provide specifics in each implementation stage that correspond the requirement to part four of the SIR.

Finally, the presenters will talk about the competencies that your implementation team needs to implement with success. Our presenters today have a wealth of experience. The bios are in order of presentation and are brief today to allow more time for you to hear from them. Their contact information is provided at the end of each presentation if you want to know more.

The first team features Dr. Phyllis Panzano and Patrick Kanary.

Dr. Panzano is an industrial organizational psychologist and visiting professor of the Florida Mental Health Institute in the College of Behavioral and Community Sciences at the University of South Florida.

She is also the president of Decision Support Services, a research and consulting firm in Columbus, Ohio. Dr. Panzano has extensive research and practice experience and is currently involved with pre-implementation research studies on adoption, implementation and sustainability of EBP.

Patrick Kanary is the director of the Center for Innovative Practices at the College of Public Health at Kent State University. Patrick has extensive experience with the identification and dissemination of youth and family focus evidence-based and effective practices within the behavioral health system. He has experience in community-based inter-system policy and program

development and has consulted with all three levels of the implementation system.

The second team features Leanne Barrett, Dana Mullen and Maria Chionchio.

Leanne Barrett is a policy analyst at Rhode Island KIDS COUNT with core responsibility for early learning and early childhood development policies statewide. She is a leader in the early learning field and spearheaded the development of BrightStars, the state's Quality Rating and Improvement System. She also staffs the state's Pre-K Exploration and Design Committees and is currently the project director for the Rhode Island Nurse-Family Partnership Initiative.

Dana Mullen is the assistant administrator of programs at Children's Friend in Providence, Rhode Island. She is responsible for the oversight of multiple child and family services at the agency. Dana serves on various committees and collaborations throughout the state as an advocate for family engagement and timely permanency for children and care.

Maria Chionchio is the director of Health and Nutrition at Children's Friend. She has more than 15 years experience in pediatric and obstetric nursing. Maria was instrumental in the planning and implementation of the first Nurse-Family Partnership program in Rhode Island.

Following the presentation today, there will be a brief question-and-answer period that Dana talked about.

In today's webinar will be archived on the ECCS website under a Home Visiting tab. You will receive an email with the link and the presentation or to the presentation in near future.

Please note that mention of a particular home visiting model during the presentation does not mean a preference or endorsement of that model over the others.

And before we begin, Charisse and I sincerely thank our presenters for their work on this presentation. We would also like to thank Frances Marshman and JM Outer from JSI for hosting the event.

And now, I turn it over to our presenters. Phyllis?

Phyllis Panzano: Thank you, Jackie.

Hi. This is Phyllis Panzano and I'm in our first team from Ohio. And what I'm going to be doing today is join Patrick Kanary to give you both a bird's eye view of what happened in the Ohio Mental Health System in the effort over a decade to facilitate the implementation of evidence-based practices and then Patrick is going to follow up by giving you a ground level nitty-gritty view.

One thing we're stating upfront is that, you know, we all know that sustaining evidence-based practices or really anything in life depends on, you know, what you're doing well in advance to that point of sustainability.

So we're kind of giving you a historical overview of what the Ohio Department of Mental Health has found and what Patrick has found in his real-world practice just to kind of raise, make more salient some of the issues that you really need to be thinking about now and you probably all are.

So my presentation is divided into three parts. I'm gonna to first set the stage very quickly by describing what was going on at ODMH about a decade ago and the formation of Coordinating Centers of Excellence.

And then, even though this is a research project that I'm gonna to be talking about, I don't want to get too researchy. I just want to explain to you sort of what metaphors and models we had in mind as we try to unravel what was happening over time and understand indicators of success and predictors of success and various things that real-world agencies came across in their attempt to implement evidence-based practices.

And then I'm gonna to talk about far more recent findings that point to some factors that seemed to be tied to sustaining practices in real-world settings as long as seven years after an agency started out with the practice.

So in terms of setting the stage, right about 1999, the Ohio Department of Mental Health, the director at that time wanted to come up with a framework so that everybody would be on the same page from case managers and up about what was gonna to be – what it was gonna to take to sort of improve the over-all quality of services in the system. And that was Director Mike Hogan. He's now in New York.

And he identified kind of three big pieces to the puzzle – one was to support the implementation of best practices, promising practices and evidence-based practices – to pay attention to the kind of outcomes that were being achieved in the system and depending on what was seen to sort of – kind of have a constant eye on ways to improve the quality of services. So this was referred to as the quality agenda in Ohio. What I'm going to be focusing on today is the best practice part of that agenda primarily.

So what the department did was the department did a needs assessment kind of statewide and tried to, at the state level, identify some areas of need in the state around services and special populations – so prerequisite for thinking about what practices to facilitate was that idea that there has to be a documented need.

Once that was the case, the department and a whole bunch of stakeholders, you know, said, “What else do we need to consider here?” And they kind of came up with two dimensions that were thought to be very important. One was the evidence-based, how strong was the evidence supporting a particular practice, and the other one was salience.

And what was meant there was, was this practice for a population that the practice was targeted at salient to the community large in Ohio, was it something that politicians and the governors could stand behind?

And the idea with thinking about salience was, you know, as the practices proceeded to be implemented, it was seen as helpful to have political support

to continue those practices, you know, well into the future. So evidence and salience were two very important dimensions considered after needs.

And the Ohio Department of Mental Health identified eight practices focusing on kids populations and adult populations and plotted those on the axis and decided to fund centers to provide education, training and technical assistance to agencies around the state to, you know, autonomously decided that they wanted to pursue one of these practices or at least for entertaining that possibility.

So the CCOEs were developed and they tended to be located in universities or parts of local partnerships. Patrick's center is here at Kent State University. They initially were started out with a CCOE promoting one practice and the CCOE was responsible to provide support, education, training and TA on a statewide basis.

The roles of CCOEs generally speaking were to promote best practices, the practice in particular that they were initially funded to represent. They were to provide training, technical assistance around such things as fidelity monitoring, problem solving, barrier removal, et cetera and really trying to strengthen the systems in the local agencies in terms of their ability to successfully implement. So – and the CCOEs really became sort of a conduit for information sharing at the state level.

At the same time that the CCOEs had been identified and funding was starting to flow from the Ohio Department of Mental Health to the CCOEs so that they could gear up and start focusing, putting together their business model, the Department of Mental Health – let me get it – I might need some assistance here because my slides had some automation. So we may have to pass up on that.

But at the same time, the Ohio Department of Mental Health was asking the question right up front, and this was in real time, “What should we be paying attention to now that will help us understand what we see in the future as the CCOEs go about their enterprise of promoting and facilitating best practice? What should we be looking at?”

So the Ohio Department of Mental Health with support from the MacArthur Foundation funded a study that was called the Innovation Diffusion and Adoption Research Project to in real time, it was a field study, trying to gather information that would help folks understand antecedence to success and implementing and sustaining best practices. So anyway, the train was out of the station and we were quickly gearing up to try and learn from this initiative.

So from the timeline standpoint, this timeline gives you a big picture of kind of how things were happening out in the last decade. The CCOEs received initial funding right about the end of 2000 and we're trying to gear up for that first year. This IDARP study to try and examine what was happening and understand what was happening was funded shortly thereafter. We were gearing up.

And during the course of this IDARP study, we had four sweeps of data gathering where we were talking to experts like you out in the field who were doing real-world stuff about how things were going and trying to understand what's happening.

We studied initially eight sites – 80 sites that entertained adopting one or more evidence-based practices. Fifty of those sites ended up deciding to adopt the practices. And by the end of seven, seven and a half years, of those 50, 42 sites continued to implement those practices.

When we gathered information, we looked – we were looking to the key informants like you and the folks you'd be working with and we primarily use interviews and surveys to gather information that were structured interviews and surveys and we also gathered information from folks at the CCOEs who were working with agencies, and that's how we are putting our puzzle pieces together to try and understand what was going on.

We also had – we had to review the literature and have a variety of frameworks in mind to help us figure out what questions to ask and to guide the research. And I'm going to describe rather than sort of the dry research models to you some big picture messages that were conveyed by the major models that guided us in our thinking in our research study.

And so I'm gonna to talk in terms of metaphors – four different metaphors – the card shark metaphor, the launch metaphor, the Russian doll metaphor and the Dilbert metaphor.

The card shark metaphor model really was geared to trying to understand agency's decisions to either adopt or not to adopt a particular practice that they were considering. And a message in the card shark model is, "The decision to adopt depends on calculated risk. The size of your chip stack does matter." So in other words, we found that agencies really were considering adoption within the context of risk assessment, cost benefits.

And one of the factors that discriminated agencies that decided to go forward from those that did not which would probably come as no surprise to you is how would the resources they had to support implementation, and that was not just monetary resources. It included staff expertise, time and other forms of resources.

I apologize for this, but I had – I don't really know how to animate my slides so parts of my slides are not showing. I'm going to see if I can go back and make that happen just for a minute – hang on. I didn't know how to command the animation. Can I get any suggestions from the technical assistance folks how to do animation or is that...

Dana Bunker: Usually, if you just hit the next button, it should push with that, but that one does not seem to be working.

Phyllis Panzano: Yes. I apologize. And the slides that will be available to you will include some of the detail that you're not seeing.

But what we did find with regard to this first metaphor and there's a paper published to provide more detail is that this risk-based framework did do a pretty good job of explaining implementers or adopters from non-adopters in Ohio.

We also had three metaphors that were – that represented models and frameworks in the literature to explain implementation success, and these



metaphors also guided the kinds of questions we were asking of our informants throughout the project.

The first implementation success metaphor is referred to as the launch metaphor, and what that metaphor suggests is that initial conditions prior to and at takeoff – and we're talking about takeoff of implementation – have important implications for understanding and explaining the implementation success in the short and long term in real-world settings.

A variety of frameworks such as stage-based framework, and Leanne will be talking about those readiness-based frameworks and planning frameworks – all support the idea that what happens now including consensus and buy-in among your stakeholders will be related to the success you see down the road.

The second implementation success metaphor that we – that guided the research is the Russian doll metaphor which suggests that surrounding conditions and circumstances influence implementation success in real-world settings.

There are many, many frameworks out there in the literature that talk about multi-level factors from funding in a system to agency resources to the attitudes of staff that have been found to be linked to implementation success and those are the frameworks who were relying on and coming up with this metaphor to guide our study. So this kind is another kind of way of thinking about the Russian doll metaphor.

And the final implementation success metaphor that affected what we looked at was the Dilbert metaphor, and that metaphor indicates that innovation implementation efforts rise and fall with how soundly the implementation process is managed.

There are many frameworks out there from the non-framework – the National Implementation Research Network framework to Klein and Sorra implementation climate framework that talk about the importance of goal clarity, feedback to implementers, top management support, removal of obstacles and all those types of variables that are tied to good project management, being linked to implementation success.

So those were the metaphors that guided what we paid attention to in the IDARP study. So how did those – how did that information that we were looking at relate to understanding sustainability seven, eight years later? You know, this is the story that we can tell at this point.

The first two boxes here in this model, what have we learned by T3 about five years into the study? Well, as I mentioned, the first thing we learned is that perceived risk of going forward discriminated adopters from non-adopters.

We found out in another mini study that those agencies that had decided to adopt but then later, two, three years later, discontinued where those that turned out not to have adequate resources to continue implementing or agencies that no longer thought that that particular practice was a good fit to their needs.

And we also found that the Dilbert metaphor, the project management climate discriminated how well things were going. The agencies that had stronger climates were doing better.

So that's what we knew going into Time 3, the final stage of the project. So going into Time 3, we're trying to understand – this is not working – we're trying to keep in mind what we had learned from the IDARP study, those three frameworks that I've just discussed, and what was in the literature about sustaining evidence-based practices that might help us better understand what we are going to see for our final round of data gathering.

So we have a variety of frameworks that we looked at including the original IDARP work and we kind of had the metaphor that sort of guided us into the final phase to try and understand sustained use seven and a half years later was what we're calling if the glove still fits, keep wearing it model.

And what that says is that external and internal development influence goodness of fit of evidence-based practices over time. So as environmental factors change and things internal to an agency change, the particular fit of a practice that might have fit very well five years earlier may not fit so well right now.

The framework that guided this research for our glove fit model had a number of elements. We looked at fit from the standpoint of strategic fit, resource fit, operational fit.

We focused on Dilbert factors, project management factors that were going on in an agency such as these listed here whether there was a champion, leadership support, dedicated resources, performance monitoring, et cetera.

And we looked at measures of implementation effectiveness such as the fidelity, commitment of staff and so forth, consistency of delivery. We looked at impact measures, clients' organization and other stakeholders and then we also considered the extent to which both agency informants and CCOE informants were telling us the practice was strongly – still strongly embedded in the agency.

We had a variety of measures that we ask of both CCOE informants and organization informants about those five variable fit through assimilation. We found reasonable agreement with what the CCOE folks were telling us and folks in the agencies with agencies having a slightly more rosy view about how implementation was going, the fit, the climate, fidelity.

We found that those big pieces of the model linked to assimilation sustained use were strongly connected from fit to Dilbert, the implementation climate and our success measures.

We found that fit how well the – what the practice was seen is fitting the organization needs, drove how strong the implementation climate was that managers were – those continued to support the practice and how strongly the practice was still being sustained.

We also found that fidelity was a very important discriminator in determining whether or not the practice was being assimilated.

And finally, the last couple of notes, what about the CCOEs, these technical assistance centers that had been funded and in place? We found that they made a difference. We found that working relationships between adopting

agencies and the CCOEs were very important to understanding whether or not the practice was being sustained. And we also found that that held up over time that prior reports of working relationships with CCOEs explains sustained use three and four and five years later.

So overall, final kind of conclusions here is that our guiding models or metaphors led to insights about the EBP adoption decisions, the de-adoption decision and the implementation success in terms of sustainability.

We found that CCOE and organization points of views generally converge. That fit is an important driver in one which is subject to change, that EBP specific climate for implementation is very important and linked to quality and also sustained use and that the quality of working relationships with CCOEs were particularly important to long-term success at least within the context of this project in the Ohio mental health systems work.

So I'm now going to turn it to Patrick and he is going to be representing the CCOE point of view that will focus on sort of ground level issues related to sustainability.

Patrick Canary: Thanks, Phyllis, and hi, everybody. I'm glad to have the opportunity to share a little bit and quickly about our experience as a CCOE – Center of Excellence.

So you can imagine the only slide I really care about that Phyllis presented was the one that answered the question of, “Do the centers make a difference?” And, of course, I could have told her that without the research that we do.

But it's good to know that the research does support that this notion of having an intermediary function, if you will, and those can come under lots of different shapes and forms, seems to have something to do with the success of not only implementation but perhaps more importantly with sustainability.

So I'm going to just give you a really quick 30,000-foot view of some of the work that we've done. So we were set up to disseminate Multi-Systemic Therapy, MST, to maybe a practice that's familiar to many of you.

But over the years, and we've been in existence now for 10 years, we have expanded our portfolio into a number of other intensive community and home-based services that's kind of our niche here in Ohio, if you will, really focusing on keeping kids and families together and keeping kids in their homes and their communities. So that first slide you'd see there is – it really is now kind of our operational portfolio, if you will, in terms of the services that our center is mostly concerned with.

We kind of grew into our identity and, you know, I don't know that prior to bringing these centers into existence, anybody had a real strong sense. My guess is that 10 years is a long time to be a center nowadays.

As I know, that across the country, folks are looking at continuing to talk about this idea as a way to help implement. I just had a conference with one state this week about the whitepaper they're preparing for their state leadership about the need for a center to focus on particular activities.

So I think about the work that we do as coordinating, navigating, motivating, educating and evaluating. Probably also in there, some people would say that annoying might be a factor kind of nudging people along. That's part of the role of implementation.

But the thing that we are most concerned about is – advance, yes; I'm just going to give it a second to advance. Yes, that's not – that should be on slide three if anybody from the tech group can help me.

One of the challenges in the kids system as you all know out there listeners is the notion that we tend to silo what we do for kids. We silo the funding, we silo the interventions, we silo our systems.

And to some degree, there is a rationale for that, but I think increasingly, we're finding that we probably share some goals and outcomes that heretofore we

really haven't. And so part of our role, I think, is to help kind of de-silo the system and bring into the mix all of the variables that we need to.

So I'm frozen here, folks, so I'm going to proceed but from my control panel, I can no longer advance the slides. So if somebody else can do that.

Female: I have to say it have moved ahead. It's on Demonstrate Program Effectiveness.

Patrick Canary: OK. So thank you. So I'm just going to move ahead. You guys off there in technoland just advance for me.

So one of the things that we want to make sure we do is that we get out in front of people the demonstration numbers that say, "This is why there's the value in it." Having an entity that kind of provides that umbrella and oversight so that that diagram that you see actually should say MST in there more specifically.

Those are our outcomes from our most recent dashboard as we call it. This is the kind of information we push out to our stakeholders, to our funders that are providers push out to their community members as they want to demonstrate the effectiveness of their programs and why people should invest in them. So having that kind of data is really important.

The next slide really looks at the cost benefit analysis. This is not what I would call, you know, a terribly sophisticated chart but it is a way for us to capture kind of making a comparison between business as usual which in our field has largely been treating kids with very difficult issues through residential or other home placement. Clearly, that's an important part of our continuum but I think increasingly, we have the technology and the science to help us do more home-based work.

So we think it's important to try to demonstrate the cost effectiveness as a motivator on why communities might want to kind of build out these particular programs and add it to their continuum. It doesn't replace anything. This is really about what is the right service at the right time for the right kid.

The next slide that talks about fiscal impact is the information we like to push out particularly to our stakeholders to say that, “You know, everybody has limited resources,” and if that’s the case today, are we not be spending our limited dollars on those services that not only have a proven effectiveness clinically but also can – if we figure out the map, can do it also on a fiscal level.

So the kind of the bottom line literally on this slide is the notion of that our typical cost for – of course, of out of home placement for kids – I’m sorry, in home treatment IHBT for kids in Ohio was about \$7,500.

But the implementation reality is – and I think you’ll see this in a much more detail in our friend from Rhode Island is that the reality of doing all this despite our good outcome, despite our financial data quite honestly is that there is a hard reality that we bump into, and that is that it’s an ongoing process. It’s not an event.

So to implement something is really only to begin telling the story. And we agree with our friend at NIRN that it is indeed takes about two to four years to take hold minimum.

And certainly, other experiences would tell us that in some cases, there is good reason for it to take longer. And that we know that the treatment effectiveness is definitely tied to the success and the effectiveness of the implementation at whatever level.

So the next slide which is the one that, you know, kind of shows my, you know, risks ahead, so, you know, what are the challenges if we’re indeed getting all of this good? So the first challenge is really around infrastructure, and so that’s the next slide.

So these are the things I guess I would say that you need to have in place to minimize that risk of reliable partner with you in implementation addressing both the programmatic and the organizational needs, and I know that the Rhode Island folks will talk about this with their implementation project.

The ability to turn around data and get stuff out to people almost immediately, I think, is really important to really have a connection with the developers of the program and have them as part of your partnership.

Some ability to take it to scale so that we're not always talking about a pilot project doing one service in one community and that's some good enough. I think that's what we'll get kind of stuck sometimes in the implementation world is that we don't take it to scale.

And I think it's important for us to obviously understand the local dynamics of the implementation. There is all these dynamics that, you know, take place at the base of the pyramid if you will but if that very top of the pyramid where it actually touches the community, you know, that becomes kind of the real spark.

So the next issue with my picture of the oasis there is the financing. And the reason I used that picture is that, you know, in a world of shrinking resources with a pool during up, you know, we only have a couple of choices. We can either share what's there or we can all make a mad dash to kind of get our – to get out share.

And I think I hope that where we're moving towards is really beginning to look more of the concept of shared out company insured funding because it means shared improvement in our kids and families and then our communities.

Stakeholder engagement is, you know, absolutely critical. Do people that you're working with actually share your vision? Do you say something that they get? And do they say something that you get in terms of why they should support or sustain the program?

And I think that what we're finding at least for the population of kids that we're focusing on is that there are indeed shared inner systems outcome and education, in behavioral health, substance abuse, delinquency, and I think we need to do a better job of framing how good intervention really impacts. I cannot think about Phyllis' model of the Russian dolls.



You know, we've got to influence all those circles and rings, if you will, and our shared stakeholders need to have a shared sense that they're part of that picture. That also, I think, helps encourage people to invest.

The next slide, you know, that I've labeled, shift in emphasis, this is a little bit hard historical journey here kind of the then and now, and I'll just, you know, walk you through real quickly. And when I say then, I mean like perhaps some more than five years ago, so when we were kind of on our first legs of doing this.

I think we felt there was a certain organic approach to this that kind of just if we were out there talking to people that they would kind of get it and see it. And I think what we found was there's always a sense of early adopters but that really to make your message now and it really needs to be strategic.

I think we were a little naïve. I'm not sure that we really surveyed the landscape sufficiently and I think our change in strategy now is to be much more informed and not to think about things in such a global or generic way.

But I really think at the very specific community level that we are working with, what community are we working with, what are their variables, what are their challenges and how do we map those on to what we do know in general are the challenges of implementation and sustainability?

I think we've gone from the ideal to the real and that's a good place to be. It's always good to have your vision but the reality is we're working with folks and their real world tools and that's what's going to make the difference is, how well we can shape what we do and work with those tools effectively.

I think initially, we focused a lot more on this specific intervention, we still do that, but we also try to play it out in terms of how does that impact or roll out in terms of a system. In the past, I think we tended to maybe be a little more of cheerleader than I think we need to be in the world of reality, and I think what we do now is we really highlight the challenges more.

I've had folks say to me when I go out and do presentations on MST, for example, and I'll have people say, "Why are you making this sound so

difficult to do? Aren't you just kind of shooting yourself in the foot?" And my response is, "I think you really need to know how difficult it is to do because I don't want to come back six months or a year or two years from now and have you really struggling with stuff that I know are going to be the struggles."

So I think we really have an obligation to our audience, if you will, to really, you know, get out the stuff that we know is the challenge. So I think we've had an evolution in our strategies. That's our friend, Darwin there in the next slide.

We're more heavily relying on data and getting that information out there. We definitely have the need to do longer term outcomes on the kinds of services that we're doing. Some interventions have more of a history of long-term outcomes, some of the work that we're doing, not as much, so that's a goal for us.

Always engaging the policy and decision-makers more and more, you know, you can't go wrong even if there's tension in the room, even if there is the need to kind of resolve things because that's what you need to do upfront.

And in our work, we're seeing an emerging stronger alliance and behavioral health with both the juvenile justice and the child welfare system. So what we think we've got right and the next slide is we've got the right vehicle, the content, the process, the data, the relevance, the value, the quality and the fidelity. And those are not small things to kind of get right. We don't get them right all the time in always that order, but by and large, that's the platform that we have established.

In the last slide there, the pieces that were really still working on and the scheming that we still need to do is strengthening those critical alliances, really moving beyond collaboration into real genuine partnership to really move the financing system along with us. I think our financing system is so far behind the knowledge we have about implementing services.

Keep on the message regarding cost, keep on the message regarding fundamental transformation that you're not just starting a program that you're

really trying to really shape the health of the community, the health of the family, the health of the system that you're working in.

So we need to align our policy and practices and again, you know, kind of the message we're all getting is this kind of integration with health care and policy. It's all about health. It's all about wellness whether it's under behavioral health or other name.

So that's kind of where we are with our journey. We have a long way to go. We've learned a lot and I know that our colleagues in Rhode Island are going to talk much more specifically about their work. So thanks.

Leanne Barrett: Thank you, Patrick.

This is Leanne Barrett in Rhode Island and we are lucky for doing the small state so we can make the small state way.

We have Maria Chionchio and Dana Mullen and I are all in the same room so we can all contribute to this PowerPoint together. So we will be building on some of the good points that Phyllis and Patrick brought up in their earlier presentation.

So the overview of slide two is – we're having a little delay here, but we're obviously going – slide two – no, okay.

On slide two, I'm getting a little of the background information on how we got involved in evidence-based home visiting in Rhode Island.

In 2008, ACF held a national grant competition called evidence-based home visiting to prevent child maltreatment. The funding was available to support key planning, startup infrastructure development and evaluation activities. But the grant requires states to let those other existing funding teams to support direct services.

The next slide shows our key partners. Rhode Island's evidence-based home visiting project is a partnership from the very beginning. Rhode Island KIDS COUNT where I work is the lead agency and we're acting as a planning

intermediary with three of the key state agencies that are involved – our Department of Health, our Department of Human Services and our Department of Children, Youth and Families which is our child welfare department.

So we partnered with those three state agencies to apply for the application. KIDS COUNT, just a little more background on this is that we are a data organization. We publish an annual fact of over 60 indicators in children's well being for all 39 cities and towns in Rhode Island.

We don't provide direct services to children or families. Instead, we work with policy makers, government agencies and providers to advocate perspective policies and programs to improve child outcomes.

Children's Friend where Maria and Dana work is a direct service agency with a long history of providing services to families and their children in Rhode Island to urban core communities.

They have a particularly strong history of providing home visiting services including home-based Early Head Start and our state existing visiting newborn home visiting program known as First Connections.

Children's Friend is a partner and is the anchor implementing agency for Nurse-Family Partnership in Rhode Island. The Bradley Hasbro Children's Research Center is a brand new university affiliated research center and they already evaluated for the NFP program in Rhode Island.

And I would be remised if I didn't mention the good partnership we have of our Nurse-Family Partnership national office who's provided tons of support to us across all phases of implementation.

The next slide outlines our grant goals. We were working on building up our state's Early Childhood Comprehensive System plan published in 2005. So our first goal was to establish and anchor Nurse-Family Partnership site which is outlined as a priority action strategy in our state early childhood plan to expand the availability of high-quality intensive services for families with multiple risk factors for poor outcomes.

Our anchor site has opened. It opened in July 2010 and served 100 families in four urban communities with blended state funding and it builds on our existing statewide newborn home visiting infrastructure.

The existing newborn home visiting program was the short term program – is a short-term program with one or two state home visits to families with new babies and NFP provide up to 64 home visits to families.

After establishing NFP, our next goal is to expand NFP to serve at least children's 50 families by the end of the grant period and to cover all cities and towns in Rhode Island adding additional implementing agencies as needed.

We are also conducting a rigorous evaluation of the model as implemented in Rhode Island. We are tracking fidelity indicator from child and family outcomes, we see evaluation as a key strategy and support sustainability and growth of effective services overtime.

Finally, we have an intentional plan to build public awareness and support for evidence-based programs in Rhode Island. In fact, on May 4th, we are holding a statewide policy forum evidence-based programs and practices inviting direct service agencies, the government, administrative and legislature.

The next slide outlines the implementation phases that Patrick and Phyllis talked about too. These are from NIRN, the National Implementation Research Network. As part of our EBHV grant, we had the opportunity to work with Melissa Van Dyke from NIRN. I know she presented at the March webinar to this group and she shared a lot of her concept there and we organized the rest of our presentation to follow the four stages of implementation which often stretch out over two to four years, or in our case, much longer than that.

So next slide is the exploration stage. The exploration stage occurs in the monthly reviews leading up to the decision to implement a new program. The goals of this stage are to examine the degree to which the program meets the needs in the settings identified to determine whether adoption and

implementation of the new program and model is desirable and feasible and to create readiness for change.

The next slide describes the exploration phase in Rhode Island. In Rhode Island, the exploration phase for NFP was really over a 10-year process. Interest in the model began in the 1990s during the planning for welfare reforms. Over the years, there have been many, many meetings involving many, many people focused on improving services for our most at-risk families.

During the exploration phase, we begin to identify champions and leaders who can play a role in supporting implementation and to identify systems and planning groups that the program should be connecting with. In our case, we've connected with a variety of groups including successful start in teen parenting programs.

Because NFP has a range of commitments to children and families, we have worked with a variety of these groups including prenatal care and birth outcomes and groups working to prevent and responded child maltreatment from others.

During the exploration phase, we've reviewed data on populations of at-risk children and communities and concentrations of at-risk children and families. I'll show you some of that data on the next few slides.

We also looked at the existing set of services available to families in Rhode Island and models that we're working in other states. We also established a relationship with the NFP National Service Office during the exploration phase.

They have to understand the amount of requirement, cost and financing options using other states. They can also help you identify agencies that are likely good candidates to becoming a strong NFP implementing agency.

The key activity that brought the exploration phase to close was the effort to write and submit our state applications for the EBHV funding. In the

application process, we had outlined a financing plan, identify a service area and implementing agency and submit letters of support from key partners.

This is all ran in 2008, but actually, we had a (fastest) run with this in 2007 when Rhode Island applied for a smaller ACF competition focused on nurse home visiting.

Unfortunately, we didn't receive the grants in 2007, but just a process to put a good, strong application together helps secure volumes from the key partners in these.

The next slide was an example of some of the least effective we did. In Rhode Island, data on children at risk are updated annually. For every city and town published in Rhode Island KIDS COUNT fact book including data on children and poverty, women with delayed prenatal care, preterm birth and low birth weight infant, birth to teens, child maltreatment, et cetera.

But as the research indicates, there hasn't been any one single risk factor that would support outcomes, rather, it is the presence of multiple overlapping risk factors in families and children across are most worried.

We work to understand the numbers of young children in each city with multiple risk factors by examining the newborn risk screening data collected by the Rhode Island Department of Health.

The Department of Health conducts a chart review of all Rhode Island newborns to identify risk, supportability of outcomes including inadequate prenatal care, establish developments of condition, low Apgar scores, low maternal education, young maternal age, et cetera.

These are put into a database and we can run reports. And as you can see in this table, the middle column showed that 86 percent of all babies born in the state in this year had at least one risk factor for poor development through outcome.

We sought to narrow this tool down to identify those babies who were at highest risk because of the presence of multiple risk factors. We chose three

socioeconomic indicators that can be identified prenatally and then are linked to poor outcomes, their mother's age, education and marital status at the birth of the baby.

Studies have shown that babies born to single mothers who were under age 20 without a high school diploma are more likely to grow up in poverty than children without any of these risks. And these babies experience all the negative outcomes associated with poverty.

Maternally, it also seems to be especially important for child maltreatment. We've been very impressed by the research in Illinois that showed that more than 60 percent of the children in three foster care had mothers who first gave birth as teenagers and 75 percent had mothers who first gave birth before age 22.

So just to walk you through the table, the cities listed on the left-hand side of the table are the core cities in Rhode Island or the six cities with the highest level of child poverty. The remainder of the state includes the data from the remaining 33 communities that have lower levels of child poverty.

So just looking at the bottom line on this chart, you can see that within the state of Rhode Island, we had about 12,000 babies born in 2007 that means we have about 12,000 babies born per year and 10,372 had at least one risk factor which is 86 percent of the population, following 648 had the three risk factors I identified earlier.

This is only five percent of the population in a much more municipal numbers. And as you can see, most of those babies who live in the poor cities of the state with a very strong concentration in Providence, our largest city.

The next slide talks about how we're reviewing options for programs to meet the needs of high risk families. In 2005, Rhode Island KIDS COUNT conducted a statewide inventory of parenting and family support programs and we outlined the continuum of support are based by the intensity of family needs and risk.



This issue-based recognizes that all families need and benefit from support visits protect some families and we believe it is a relatively small number, probably less than 10 percent, really benefit from the availability of intensive comprehensive long-term parenting support. We concluded that there were not enough high risk – high quality intensive programs meeting the needs of families with multiple risk factors.

We've recommended in this issue-based that the state considering testing in a program like NFP and also expand access to Early Head Start. These recommendations were also included in priority actions strategies, in this case, Successful Start Planning which was released in 2005.

OK. My next slide is the last slide with data on it. It shows again how we went deeper into the data as we look at specifically implementing NFP and it's identifying the potential eligible population.

We had the health department mandated for us on the number of births paid for by Medicaid which would indicate the mom with low income and that were first-time births and we did it by city and town instead of by county or by region.

We had the – the data also runs by maternal age since we knew there was a strong connection between maternal age and mix of child maltreatment and our key target outcome for the EBHV funding is reducing child maltreatment.

So the data is organized by regions of the states, uses for other kinds of systems projects including First Connections and our child welfare programs and the state has helped us in planning for NFP and clearly shows that the place to start NFP was in the core urban regions.

So now, Dana will talk a little bit more about how Children's Friend handled the exploration phase.

Dana Mullen: Hello. I'm Dana Mullen, assistant administrator at Children's Friend, the implementing agency for the Nurse-Family Partnership.

Our mission at Children's Friend is to promote the well-being and healthy development of Rhode Island's vulnerable children by providing flexible, effective and culturally relevant services that support and strengthens families and communities. That being said, the Nurse-Family Partnership fit in nicely with our agency's directors and programs that serve pregnant mothers and their families.

Children's Friend began as Early Head Start program in 1999, early intervention in 2000 and became Rhode Island's First Connections contractor in 2007 providing nursing and social work home visits to newborns, infants and parents with specific risk factors to core developmental outcome.

For years, Children's Friend has several programs that served pregnant mothers and their children. However, none of these programs have a nurse home visiting program that is up the duration of the Nurse-Family Partnerships and that is evidence-based.

In 2007, Children's Friend hired a new executive director. Shortly after that, the request for proposal came out for the Nurse-Family Partnership program. Our agency's management team and the executive leadership team met and agreed this program fit in nicely with the agency's mission.

Children's Friend's staff met with other agencies in Rhode Island to determine which agency will take the lead and which agencies would support the implementation agency. Because the grants support a system building an infrastructure and made sense, the KIDS COUNT to become the grantee and Children's Friend to become the implementing agency.

And now, I'm going to turn it over to Leanne who will talk in greater detail about Rhode Island's exploration.

Leanne Barrett: OK. So in the final stages of exploration, we were completing our ACF application and we work intensively with the NFP National Service Office to better understand the model.

Our grant planning team included state agencies, private funders and other few stakeholders. We were able to secure a letter of support from the NFP office for the Rhode Island application which was very helpful.

A key activity during the phase again was to clarify the start-up operating process and the model in Rhode Island. NFP has a big budget but it needs to be customized for your state including developing any specific staffing plan and plugging in, you know, adequate Rhode Island allies and benefits to attract and retain nurses and we work hard to develop an initial financing model and secured funding commitments from partners.

Our financing model is illustrated on the next slide, and on this slide, you'll see the cost per child per year for NFP in Rhode Island is \$6,500. This is for a core program including four full-time nurse home visitors and a full-time nurse supervisor.

We also have enhanced the basic NFP staffing plan by building into our model funding for a dedicated interpreter and a part-time consulting social worker.

The financing model on this slide shows that funding sources in green circles and the intermediary organizations in blue diamonds. The solid lines and arrows reflects the relationships and funding mechanisms that are in place now for the model, and the dotted line from Medicaid funding is still in the planning phase.

We have worked to understand the outcomes that funders are speaking to achieve by investing funds in NFP, so we can make sure if we track these outcomes in our evaluations.

For example, the health department is investing WIC outreach money in NFP and it's particularly interested in improved children's health, nutrition and development, support for breastfeeding and improved prenatal health and birth outcomes.

The Department of Human Services TANF office is investing TANF funds in NFP and its facility is interested in improved maternal education and

economic self sufficiency, reduced frequency of repeat birth for teens and increased birth intervals.

The Department of Children, Youth and Families is investing in child maltreatment preventions funds in NFP and is particularly interested in reduced child maltreatment and reduced out-of-home placement while the Medicare office is particularly interested in improved health outcomes for both mothers and children and cost savings associated with reduced use of NICU and emergency room visits.

So it took a lot of time developing the financing model and the next phase, installation is actually more work to get there mechanisms in place for the funding.

So slide 14 shows the NIRN overview of the installation which the goal of installation is to work to make structural and instrumental changes necessary to initiate services.

And next slide talks about Rhode Island's activities during the stage. We were very focused on the work to establish financing mechanisms including contacting and billing. We are actually still working on that after startup with a blended funding model, the work involved in setting up these systems is significant.

We also had to pay attention to the associate of reporting and accountability requirements associated with each of these funding streams. We established a formal advisory committee structure for NFP during the installation phase which works to connect the programs in successful startup phase Early Childhood Comprehensive System planning effort.

Children's Friend work closely with the NFP National Service Office during this phase to complete the implementation plan and how it would be approved at NFP. They have to do an informal approval at each implementing agency. And Dana and Maria will talk about those activities now.

Dana Mullen: The Nurse-Family Partnership application was a lengthy process taking over a year to complete. It involves working with multiple public and private agencies to gather relevant data.

The application must establish the community needs for the Nurse-Family Partnership program. In Rhode Island, as Leanne mentioned, we recorded a number of babies born in the proposed communities and data around those births, how many were considered high risk birth.

We also reported child protective services investigations and data indicating that the zero to three population in Rhode Island comprised almost 1/3 of the Department of Children, Youth and Families case loads.

The application requires the agency to report us on all other comparable programs in the community. In Rhode Island's case, there was no nurse home visiting program of this duration.

We will also ask to demonstrate our agencies' commitment and alignment of Nurse-Family Partnership with our mission. Children's Friend had over 175 years of providing services to high risk, low-income children and families. Children's Friend had a proven history of nursing services, home visiting, working with pregnant mothers and reaching children in their earliest years.

Our agency also had experience in implementing other evidence-based programs such as Early Head Start with fidelity. The application also requires agencies to report on its ability to use data to monitor program performance and quality and the application required us to report on how we would recruit nurses and how we would retain nurses. The agency must demonstrate its ability and commitment to provide ongoing reflected supervision to nurse home visitors.

We were asked to establish a recruitment plan for enrolment into the program and to describe existing community linkages that would help to ensure sufficient referrals.

The component that took the longest for us to secure was the financing piece. The National Service Office required us to have signed letters of agreement

describing a three-year financing plans and how the program would be sustained locally before we could submit our application.

All of this would require, as I've said, in advance in order to establish Children's Friend as an appropriate Nurse-Family Partnership implementing agency. I'm now going to turn it over to Maria Chionchio who will further talk about Rhode Island installation and implementation.

Maria Chionchio: Hi. I'm Maria Chionchio, I'm a registered nurse overseeing the Nurse-Family Partnership here in Rhode Island.

And on slide 17, you will see some of what we needed to do to have this program up and running. Dana talked to you about the process of completing the application.

And upon receipt of our acceptance letter which was in February of 2010, the NFP National Service Office provided us ongoing support via telephone and email almost daily as we needed it.

We were immediately notified by our state nurse consultant who is very much active with us today – daily and together, we spoke about the information and material we would need to implement NFP.

We at that time developed a timeline to guide us in this process so that we would stay within the timeframes and really get this program up and running. Within days of all of this happening with the acceptance letter being notified by our state nurse consultant, we received implementation orientation packet which was mailed to our agency.

In this, was all of the important information that we needed including the information from the space we needed for staff, jobs, sample job description, interview questions, how do we establish a network of referral sources that refer low income first time mom, how do we inform the community, how do we work with the media.

The Nurse-Family Partnership office has been supported towards 100 percent of the way. They provided us with the visit to visit guidelines and all the

materials to help the nurse supervisor and then the nurse home visitors implement this program with fidelity to the model element.

We have gone through a data collection change. Originally, when we began this program, it was called CIS. We are now calling the data collection efforts to outcomes. They have supplied us with the data collection manuals, with the introduction in the process of gathering and recording the clinical and program indicated data that we need to do daily.

Also available is the ETO User Manual which provides information on assessing, entering data and generating report. During this initial implementation stage, we had a great advantage.

We were able to visit an existing site in New Jersey which was extremely helpful. I went along with the supervisor and two of the nurses to actually see the program up and running in New Jersey which helped us immensely.

When we went on to higher the entire team, we began the NFP education series and that will be on slide 18. You will see the difference between the trainings that is offered and which needs to be completed by all of the nurses before this program is actually up and running and we are seeing clients.

So we started with unit one which was a distance cost designed to equip the newly hired nurses and the supervisor with the foundational knowledge of NFP and the home visiting intervention.

And this we did here in Rhode Island, on unit two was a face-to-face weeklong education series designed to build on the foundation of unit one and to prepare new home visiting to implement the program with fidelity to the NFP model.

This – the entire team including the interpreter went to Colorado for one week. And along with all of the trainings that was happening for unit two, we were able to network with other existing program that were already running the NFP which is very helpful to us.

Unit three was a distance course that provided the nurse home visitors with a chance to deepen your understanding of the NFP model specifically in regards to infant temperament, motivational interviewee and model fidelity.

The supervisor and myself as the administrator went back to Colorado for an additional distance education and also had the lessons on how to orient the supervisors to the new NFP role and responsibility.

Unit three, the supervisors also receive instruction assessing the quality of the nursing practice and implementation.

Unit four was a face-to-face education session for the supervisors only focusing on promoting supervisory skills around teambuilding, jobs, stress and burnout. And it also builds our reflective supervision which we offer weekly to all of our nurses in which we also have the ability to have our licensed clinical social workers who meets with our team on a weekly basis and more as needed if that's the case for them.

The national office has been an incredible support through us and they are still a support to us on a daily basis. They have come for a visit, they will come again next May to see where we are going and we have daily supports with them so we are very grateful for their support.

Thank you.

Leanne Barrett: Okay, back to me again. In slide 19, the two key challenges highlighted around the installation phase are things that Maria brought up. Any new program requires startup resources and we were very fortunate to have dedicated funding from ACF to support the planning and the startup activities including the intensive training that was required to occur before our clients could be enrolled because there aren't a lot of financing and billing system to support an agency startups before they serve clients.

The other key challenge is associated with the fact the new program brings changes to an agency and to the community. Whenever possible, it helps to anticipate these changes and work to keep people informed and part of the ongoing planning process.



Slide 20 is where we are now – initial implementation. As the new program starts out, the old financial implementation stage are to survive the awkwardness of startup, learn from mistakes, continue efforts, keep key people informed and supportive and to meet those expectations that services and initial outcomes.

In Rhode Island, I mentioned we are right in the middle of the initial implementation. Now, the NFP program began enrolling clients in July 2010 immediately after the nurses returned from unit two training in Denver.

NFP provides intensive consultation to new sites to ensure sites start out with strong practices and learn as they move along.

We worked hard – Children’s Friend worked very hard to classify referral systems and mechanisms for NFP. They built very strong relationships from referral agencies that are continually strengthened and solidified.

We worked to launch an official NFP implementation team in August 2010 based on the NIRN recommendations, and I’ll get into those in the next couple of slides.

We held a high profile launch event with U.S. Senator Jack Reed who is a key champion from the NFP program in Rhode Island. This event generated some the initial media coverage of the program and featured stories of clients who are benefiting from the program.

We are continuing to work on media planning as we’ve had a reporter interested in following a nurse on home visits and that’s just something to anticipate during the early start of this that you’re probably going to have the people who want to write articles about it.

Another key activity during this phase has been coordinating services with other systems and programs such as First Connections. I mentioned short-term home visiting programs. We wanted to avoid dislocation of services and to improve the effectiveness at NFP by having it declare to a family what the primary program that they’re enrolled in is.

We worked out systems so that NFP clients would not also get a First Connections home visit. We clarified that NFP would be considered an alternate program to the state's youth success program for pregnant and parenting teens who are receiving cash assistance. So clients would not have to participate in two similar programs.

Children's Friend has also worked closely with the NFP to plan enrolment cycles over the past nine months so that clients are phased out. The initial pattern of client enrollment is a key factor for long-term success within NFP as a mark to make sure that you have clients at different stages and you don't have all the babies being born at once.

Nurses need to be able to manage all their clients, recognizing that family needs intensify right after the birth of the baby. And finally, we continue to work on financing and sustainability. We still have financing mechanisms that are in the discussion and development base.

Slide 22 is the background from NIRN. NIRN recommendations to establish implementation teams to strengthen a program rollout. This slide shows that strong implementation is often guided by a team of individuals that are submitted to ensuring the program as a success and will take action to address challenges and make system improvement.

Leaving responsibility for implementation in the hands of a direct service agency by themselves is often not successful.

Slide 23 talks about implementation teams and there are relatively small individuals who are charged to describing the over-all implementation of the program. In addition to our presenters from the implementing agency, a high functioning team includes key representatives from critical systems such as key community referral and service linkage programs, funders and other relevant systems that work with the same client.

The teams can provide a focus and accountable structure to increase the likelihood of success.

Core competency is core implementation teams from NIRN and we work very hard at NIRN as we design our implementation teams to think carefully about the membership of who to include and we now only needed to know – at least – some representatives to know the innovation and implementation very well.

In our state, we didn't have an NFP yet so we really needed to include representatives from NFP nationals who have been actively involved. They know the NFP model the best and they know implementation struggles and success is very well as well.

We've had numbers who know about improvement titles, continued quality improvement and how to identify and make changes to improve implementation over time. And importantly, they know that we are capable of making changes within the land systems in Rhode Island at multiple levels to create hospital cultures, policies and funding streams.

The Rhode Island implementation is on slide 25. We've included representatives from the key state agency funders help the DHHS and the DCYF, representative from other relevant state systems including home visiting and community health centers.

As I mentioned, we have the active enrollment of the NFP national office with our program developer and our nurse consultant. We have high-level managers at Children's Friend at the table among the Rhode Island KIDS COUNT and our evaluator.

The key component that NIRN talked about a lot that I totally agree with is that for the successful implementation, you need multiple leaders. You can't just have one leader. And you need to have a very strong agency who understands the value of evidence-based programs and is capable and interested in working with a model purveyor which takes a certain kind of skill and you need people who represents various systems that have the ability to intervene with their systems to make implementation easier.

Slide 26 talks about our goals. So our implementation team, our first goal is to ensure that NFP is strong. We have implemented the fidelity and it's

effective in improving outcomes for vulnerable children and the NFP is sustainable in Rhode Island.

Our second goal was to assess and facilitate NFP's fit with other families and children services in Rhode Island.

Our third is to assist with connecting analogy with families to appropriate services. We think that it's critical as we are always going to have families referred to the program who are not eligible.

For NFP, they could be families that are having a second child or women who are identified to late in pregnancy, passed the 28 weeks of gestation and they really can't get in to NFP where you're going to get those families referred to you. And we work to keep track of these referrals and advocate to ensure that there are a variety of options for families, especially those with high levels of risk factors.

We've also had periods during this initial year when the NFP program cannot accept eligible families because of the enrollment guidelines from NFP national that are designed to space out clients.

Our final goal is to assess the demand for and the availability of services for families. We know that by the end of the initial years of operation, the NFP program will be full to capacity.

We will then need to look at management of referrals and enrollment, linkages to other programs and to consider NFP expansion.

Key topics we discussed at our regular meetings include, are we reaching the most vulnerable families, is the model being implemented with fidelity. Our goal is to improve fidelity overtime.

Of course, we always talk about financing and sustainability issues. We discussed coordination of NFP with other services and systems and we discussed successes and challenges.

For example, at a recent meeting, Children's Friend shared challenges that some clients were having access and contraception at hospital discharge and/or at the six-weeks post-partum visit.

Because we have the right people at the table, we are able to follow up to address this challenge by having the health department intervenes with community health centers and other providers. This kind of system intervention helps not only the clients and NFP but other families as well.

One of the key benefits of the implementation team is that systems level problems can be openly discussed and improvements can be made. Oftentimes, implementing agencies and staffs on the front line are well aware of the system problem but they feel powerless to fix it.

They can try to help one family at a time but they often don't have the right connections or authority to address systemic issues.

Slide 27 is goal implementation. This again is from NIRN, the final slide that outlines goals for full implementation where you continue to work on improving your frontline practice, you build agency wide support, you strengthen your frameworks and linkages and infrastructure and data systems.

In the full implementation, the program components are integrated and fully functioning. Program staffs are fully competent and with skill that implementing the program model with a variety of clients and situations.

Often, there have been changes in policy at the agency system and state levels and ideally, the program is ready to be evaluated for expected outcomes.

To note that we are still working towards full implementation as the model rolls out in Rhode Island. It takes two and half years for your first client to complete NFP. So NFP considers a three-year timeline for new agencies to become fully skilled and experienced at implementing all the components of the model.

And our last slide, slide 28, again, it gives our contact information. We'd be happy to answer questions about our experiences in Rhode Island now or you

can connect with any of us at any time. We'd be happy to talk with you.  
Thank you.

Charisse Johnson: Hello. This is Charisse Johnson. We would like to thank our presenters for such a wonderful presentation, and we hope that you found this information both informative and useful as you continue with developing your state plan.

This is the Q&A portion of the webinar. We have several questions. And the first question is, to Rhode Island, how many families or children are being served by the Rhode Island Nurse-Family Partnership program?

Maria Chionchio: Hi. This Maria. I can answer that for you.

At this place right now, we have 69 clients being served. We will be servicing 100 clients and our timeframe for that is June 1st. So we will be serving 100 as of June 1. Right now, we have 69.

Charisse Johnson: Yes, thank you.

The second question is directed to Patrick. Patrick, will you talk a bit more about moving beyond collaboration?

Patrick Kanary: Sure, sure. You know, that's probably the word that we've used the most in our field over the last oh probably decade, and I think what it conveys to me is, you know, collaboration is a willingness to kind of come together to, you know, share thoughts, even maybe come to some shared agreements about the kinds of things that need to be done.

I think that's different than going to the next level which is more of a partnership which I think is expressed more about a shared risk and benefit with implementation as opposed to you're the implementer and yes, I'll be happy to help you out, I'll be happy to support you the best I can, give you the data that you need, give you – that to me is really good collaboration and we need that. I'm not saying we don't need that.

But I think from an implementation point of view, what we are finding is that implementation really requires a strong partnership and commitment to the intervention that is being implemented.

So it could be a funding partnership and probably should given the situation that most states are in now and a partnership that actually agrees on what it is that we're going to kind of measure and use as outcomes.

So I think it kind of pushes beyond kind of coming together in a collegial way and taking it to the next level.

Charisse Johnson: Thank you, Patrick.

Our third question, and it's for any presenter, the caller would like for you to talk more about the intermediary agency and their role in implementation process or the implementation system.

Patrick Kanary: This is Patrick. I'll take that just real quick, because I think that in implementation world, the notion of an intermediary organization is actually I don't know if I would say it's common but it's not rare. So that what you've got is on one end of the continuum, you've got the intervention, so let's just use, you know, MST as an example here.

On the other end of the continuum, you have the provider who is going to be responsible for the actual implementation of that program. The role that we play in Ohio is that we provide all of the technical assistance, the training, the coaching and the support to the provider to see that that program gets implemented effectively.

We also can be used as a way to help join stakeholders together in the provider's community just as I was saying about the notion of partnership. So we play a role not only in the actual intervention of the service but also in the setting the tone and the environment for actually having a successful implementation. And Phyllis has a comment.

Phyllis Panzano: Yes. And I would add to that that in the Ohio experience, in most cases, the intermediary organization was not the developer of the practice. It was an

organization that had expertise, was in good communication with the developer and expanded the developer's capacity to assist folks with scaling up whether it'd be at the state level or community level.

We did have a couple of instances where the – in Ohio where the intermediary organization was also the developer of the practice. And one thing we've picked up more from qualitative information than anything else was that agencies often responded very differently to that sort of a situation in that they potentially felt that the intermediary of innovation, you know, was really selling the practice based on an interest – you know, a direct interest on the developer end. So that is something to think about.

And one other thing that I will say in Ohio is I think it became evident by Patrick's description of what the Center of Innovative Practices is up to. Initially, in 2000 when the CCOEs were funded, it was to represent one practice statewide.

And a couple of the CCOEs continued to do that but folks like, you know, Patrick's group, a group at Case Western University has expanded well beyond representing one practice. And so we see differences throughout the state of Ohio in that aspect of the intermediary organization also.

Charisse Johnson: Thank you, Phyllis that was great feedback and Patrick as well.

The final question is directed to Rhode Island in regards to talking a bit more about your implementation team and any lessons learned as you develop this strong team to support your work in Rhode Island.

Leanne Barrett: Well, we have a group of individuals working on behalf of NFP for and towards implementation over the exploration phase and the installation phase. We didn't know we officially launched implementation team until after services started.

So I think I would do it now than start it earlier and officially name it, give it a clear charge and direction from the beginning. You can always add people. People can, you know, they'll come out and go off and as the case maybe but



it's helpful, I think, to have it relatively small. We have usually 10 people approximately at the meeting.

During the early implementation, we had monthly meetings but we are now having meetings every other month. Our agenda is often, you know, sort of follow what I – you know, we talk about enrollment, we talk about – we've recently started doing a case review which is very helpful actually in highlighting system challenges.

We talk about the financing and we already talk about the evaluation and site meeting as well because we have a whole amount of complicated evaluation system going on related to the EBHV grant that has to be coordinated with the regular rollout of NFP as well.

Charisse Johnson: That concludes our Q&A session. We appreciate all the questions that were submitted. And at this time, Jackie Counts will close out this webinar.

Jackie Counts: Thank you, Charisse. And thank you very much to all the presenters today. We have had a wealth of information and experience about implementing evidence-based practices.

I know it's a lot to absorb so I encourage you if you have questions to use these resources and experiences and the presenters have all graciously agreed to answer your questions in the future.

So with that, I conclude and say thank you very much to everyone. Good day.

Operator: This concludes today's conference. You may now disconnect.

END