Appendix A

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

September 20, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Re: Letter of Concurrence

Dear Ms. Yowell:

This letter serves as concurrence with the Kansas Home Visiting State Needs Assessment submitted to your agency in response to the requirements of the "ACA Maternal and Infant, and Early Childhood Home Visiting Program."

As the director of the State Maternal and Child Health Title V agency, I can assure you of our support for meeting the needs of high risk communities in Kansas that have been identified through this process.

Sincerely,

Roderick L. Bremby
Secretary
Kansas Department of Health and Environment

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1367
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Kansas state department of Education

Special Education Services

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September 20, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Re: Letter of concurrence

Dear Ms. Yowell:

Please accept this letter as support for the Kansas Home Visiting State Needs Assessment identifying gaps in services and our most at-risk communities that should be prioritized for home visiting services in response to the requirements of the "ACA Maternal and Infant, and Early Childhood Home Visiting Program."

As the state education agency in Kansas, we are able to continue our support in a number of ways through the expertise of our staff in Parents as Teachers services delivery. Our agency supports a coordinated Home Visiting system designed to meet the needs of high risk communities in Kansas that have been identified through this process.

Sincerely,

Diane M. DeBacker

Diane M. DeBacker, Ed.D.
Commissioner of Education

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Mark Parkinson, Governor
Don Jordan, Secretary

www.srs.ks.gov

September 20, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Re: Letter of Concurrence

Dear Ms. Yowell:

This letter serves as concurrence with the Kansas Home Visiting State Needs Assessment submitted to your agency in response to the requirements of the "ACA Maternal and Infant, and Early Childhood Home Visiting Program."

As the Single State Agency for Substance Abuse Services and for the Head Start State Collaboration office, I can assure you of our support for meeting the needs of high risk communities in Kansas that have been identified through this process.

Sincerely,

Don Jordan
Secretary

OFFICE OF THE SECRETARY
Docking State Office Building, 915 SW Harrison, Street, 6th Floor, Topeka, Kansas 66612-1570
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KANSAS
Children's Cabinet and Trust Fund

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September 20, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Re: Letter of Concurrence

Dear Ms. Yowell:

This letter serves as concurrence with the Kansas Home Visiting State Needs Assessment submitted to your agency in response to the requirements of the "ACA Maternal and Infant, and Early Childhood Home Visiting Program."

As the director of the Kansas Title II Child Abuse Prevention and Treatment Act (CAPTA), I can assure you of our support for meeting the needs of high risk communities in Kansas that have been identified through this process.

Sincerely,

James Redmon, MSW, MPH
Executive Director

JIM REDMON, EXECUTIVE DIRECTOR
Landon State Office Building, 900 SW Jackson St., Rm 152, Topeka, KS 66612-1221
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Home Visitation Service Availability for Women with Substance Use Dis

Appendix B

Purpose: To assess state capacity for providing home visiting services to high risk pregnant women with substance use disorders

*Note: Target communities have not been selected yet by KDHE, we will follow up on specific questions identified with an * once those communities have been identified.*

Assessment and Referral Coordination with existing Home Visiting Programs

1. Could you talk about the general process of a client accessing recovery services? What are the typical entry points for clients coming into care?
2. What are the standardized assessment tools used by RADAC to identify those needing treatment?
3. What is the average wait time between referral and assessment through RADAC? How does this vary by community?*
4. Do you have data on the number of referrals **to** RADAC assessment **from** existing HV programs within state/community?
5. Do you have data on the number of referrals **from** RADAC services **to** existing HV programs within state/community?
6. Do RADAC staff utilize other input (e.g. from HV staff) to identify the most appropriate level of recovery services for a given client?
7. Can you describe the collaboration between RADAC, community recovery service providers and HV staff? At what levels?
8. Do recovery service providers share information about client progress with home visitation staff who is working with that client? What are the barriers to sharing this information?

Recovery Service Capacity & Accessibility

9. How many total slots are there available within the target communities? *
10. In general, are available recovery services in communities matched with forecasts of treatment need in those communities?
11. How does treatment need in the target communities compare with utilization of AAPS funded slots?*
12. What is the average wait time between assessment and entry into recovery services?
13. What are the identified priority populations for recovery services? How many slots are set aside for priority populations?
14. Are there any programs addressing specific target populations (e.g. gender specific, cultural populations, substance specific)?
15. How many state-funded recovery service providers have child-care resources available for clients?

Gaps and Barriers to Accessing Services

16. In your opinion, what are the perceived gaps in available resources for people in need of recovery services across the state? Within the identified communities?*
17. In your opinion, what are the biggest barriers or challenges a client in home visiting services might face to accessing recovery services?
18. Specific to the home visiting model, how might the state and local community providers work together to coordinate services?

Home Visitation Service Availability for High Risk Pregnant Women with Substance Use Disorders- Community Level | 2010

Availability/Accessibility of Services

- Could you provide an overview of the services that your organization provides?
- What is the continuum of recovery services available in this community (e.g., outpatient, intensive outpatient, residential, wraparound)?
    - What services are available to pregnant women and women with young children?
- What types of supports are available to facilitate participation in recovery services (e.g. multiple locations, transportation, child care, etc.)?
- What barriers to accessing recovery services do you see in your community? How do providers address the barriers?

Treatment capacity

- Are there enough slots available within the community to meet the need? Are there enough slots to serve pregnant women and women with young children?
- What is the average length of time between referral to assessment? Assessment to treatment?
- Are there waiting lists for recovery services in the community? What is the average wait time for an open slot?
    - How does this differ for pregnant women and women with young children?
- How does the program balance serving priority populations with limited slots available?
- What is the average length of treatment in your community?
    - Does treatment length vary based on primary problem at admission?
- How does the community address the substance use disorder needs of diverse populations?
- What is the capacity to expand services if there were an increase in referrals?
    - What are the challenges to expansion (e.g. staff, funding, etc.)?

Assessment and Referral Coordination with existing HV programs

- Do you specifically coordinate services with home visitation programs? What does the coordination among the programs look like?
    - Do you track the number of referrals from HV programs within the community?
- In your community, do staff typically utilize input from community partners to help create and coordinate a treatment plan for a given client?
- If Home Visitation Services were available for current clients being served in your program, would you make the appropriate referrals and sign the necessary releases? If not, why not?
- What are the reasons that you would refer to home visiting? When would you refrain from referring?
- Describe your primary community partners that you use to support families who have identified needs.
- Do you do any specific community outreach (to HV programs or other partners) to help identify SA and know how to make referrals?

- How might home visiting programs in your community build capacity to serve multi-risk families in which SA is an issue?

General

- What would you need in your community in order to provide all services and resources needed for pregnant women and families with young children with multiple risk factors such as substance use, domestic violence, etc?

Home Visitation Service Availability for High Risk Pregnant Women with History of Domestic Violence Victimization- Community Level | 2010

Purpose: To assess capacity for providing home visiting services to high risk pregnant women and women with young children who have a history of domestic violence victimization

Availability/Accessibility of Services

- Can you give us a background about the services your organization provides and the populations served?
- What is the continuum of services available in this community for pregnant women and mothers with young children (e.g., outreach, shelter-based, etc.)?
- Could you discuss the process by which you identify pregnant women and mothers with young children in need of services? How do you go about engaging them in services?
    - Do you use standardized assessment tools to identify those needing services? If so, what assessment tools?
- What types of supports are available to facilitate participation in your services? (e.g. public transportation, child care, etc.)
- What other barriers to service access do you see in your community? How do you address the barriers?

Service capacity

- What is the capacity of your program?
    - Is shelter available for women and their children?
    - Are there frequently waiting lists for your services?
    - If services (shelter, groups, etc.) are at capacity, are other arrangements made?
    - What is the capacity to expand services if there were an increase in referrals?
- What is the average length of time between referral to assessment? Assessment to shelter or other service provision?
- What is the average length of stay in shelter? Other services? What is stay length based on?
- How do you address the needs of diverse populations?

Assessment and Referral Coordination with existing HV programs

- Do you specifically coordinate services with home visitation programs? What does the coordination among the programs look like?
    - Do you refer to HV services for pregnant women and women with young children who are receiving services? For pregnant women and women with young children who are in shelter?
    - If so, which HV programs do you most frequently refer to?
- Is there collaboration between DV staff and HV staff? At what levels?

- What are the reasons that you would refer to home visiting? When would you refrain from referring?
- Describe your primary community partners that you use to support families who have identified needs.
- Do you frequently receive referrals from HV programs?
    - Do you do any specific community outreach (to HV programs or other partners) to help identify DV and know how to make referrals?
- How might home visiting programs in your community build capacity to serve multi-risk families in which DV is being perpetrated?
- What should HV staff know about the dynamics of DV as it relates to home visits? Safety issues?
- What barriers exist for home visiting programs to serve families where DV is being perpetrated?

General

- What would you need in your community in order to provide all services and resources needed for pregnant women and families with young children with multiple risk factors such as substance use, domestic violence, etc?

Home Visitation Service Availability for High Risk Pregnant Women - Community Level Health Department | 2010

Purpose: To assess capacity for providing home visiting services to high risk pregnant women and women with young children

Availability/Accessibility of Services

- Can you give us a background about the services your agency provides and the populations served?
- Of all pregnant women receiving services in your agency, what percentage would you estimate as having multiple risk factors (e.g., substance use, DV, etc)?
    - Who serves the majority of high risk women in your community?
- What is the continuum of services available in this community for pregnant women and mothers with young children who have multiple risk factors?
- What are the most common needs of pregnant women and mothers with young children who come into contact with your agency?
    - Which services are hardest to obtain for pregnant women and mothers with young children?

- Do you use standardized assessment tools to identify the needs of high risk women/families? If so, what assessment tools?
    - Do you use a standardized developmental screening/assessment tool for children who come in for services?
        - If so, what is it?
        - How is it used to provide services if indicated?
    - In your community, are other health care service providers using any developmental screening tools for children? If so, do most providers refer to services based on results?
- What types of supports are available to facilitate participation in your services? (e.g. public transportation, child care, etc.)
- What other barriers to service access do you see in your community? How do you address the barriers?

Assessment and Referral Coordination with HV programs/Service Capacity

- How do you coordinate services for pregnant women or mothers with young children within your own agency?
- Do you specifically coordinate services with home visitation programs? What does the coordination among the programs look like?

  - Do you refer to HV services that are not affiliated with the HD for pregnant women and women with young children?
  - If so, which HV programs do you most frequently refer to? Why?
  - About how many women do you refer to all HV programs in a given month?
- Is there collaboration between HD staff and HV staff? At what levels?
- What are the reasons that you would refer to home visiting within your agency and outside of your agency? When would you refrain from referring?
- How might home visiting programs in your community build capacity to serve multi-risk families?
- What challenges exist for home visiting programs to serve high risk pregnant women and women with children?
- How do you address the needs of diverse populations?

General

- What would your community need to improve birth outcomes and reduce childhood exposure to risk factors such as substance use, domestic violence, etc?

Home Visitation Service Availability for High Risk Pregnant Women - Community Level SRS | 2010

Purpose: To assess local capacity for providing home visiting services to high risk pregnant women and women with young children

Availability/Accessibility of Services

- Tell me a little bit about the role that SRS Child and Family Services plays in your community.
- Are referrals handled differently based on presenting risk factors (i.e. substance use, maltreatment/physical abuse, neglect, etc)?
    - For example, could you explain the process that would be followed if a substance-using pregnant women was referred?
        - How is Family Preservation's new service for Pregnant Women Using Substances being used in your community? What is working well? What are the challenges?
    - Could you explain the process that would be followed if a family with young children (b-5) was referred due to substance use in the home?
- Can you describe when you would open a child protection case, refer to family preservation, or refer to outside services?
    - If the case is unsubstantiated, are those families referred to any services? If so, how is need assessed to determine what services are needed?
    - For families with a need for substance use disorder treatment, are those services readily available in your community?
- What are the challenges of meeting the needs for child welfare services in your community?
    - How does this impact your "ideal" service-delivery model?
- What is the child welfare response in your community if a child is born substance exposed?
    - How does the community structure (i.e. DA, courts, etc) influence the process for substance exposed newborns?
    - Is there an established process for identifying substance exposed newborns at birth?
- Has the change in the Child Protection Reporting Center impacted community-level relations/referrals/communication?

Assessment and Referral Coordination with HV programs/Service Capacity

- How do you coordinate services for pregnant women or mothers with young children within your own agency and contractors?

- Do you specifically coordinate services with home visitation programs? What does the coordination among the programs look like?
    - Is HV ever a court-ordered service for high risk families?
    - Do you refer to HV services for pregnant women and women with young children?
    - If so, which HV programs do you most frequently refer to? Why?
    - About how many women do you refer to all HV programs in a given month?
- Is there collaboration between SRS staff/contractors and HV staff? At what levels?
- What are the reasons that you would refer to home visiting programs? When would you refrain from referring?
- How might home visiting programs in your community build capacity to serve multi-risk families?
- What challenges exist for home visiting programs to serve high risk pregnant women and women with children?
- How do you address the needs of diverse populations?

General

- What would your community need to improve birth outcomes and reduce childhood exposure to risk factors such as substance use, domestic violence, etc?

Home Visiting Capacity Assessment – Community Partner Focus Groups 2010

Service Provision:

- What home visitation services are available in your community?
- Does the community have a common vision for early childhood HV services?
- Are there enough slots to serve the families who need services?
- How are waiting lists handled?
- What are the characteristics of families that participate in services? Of families that aren't participating?
    - Who isn't receiving services that need them?
- What are the program barriers to serving families that aren't currently participating?
    - What methods work to engage reluctant families to services?
- If families left the program/did not complete services, why?
- What are the reasons given for not participating in services?
    - What are the real and perceived risks for families to participate in home visitation services?
- How do you engage with fathers and extended family members?
- How is outreach to pregnant teens occurring in the community?
    - What adaptations to HV services have had to be made to engage this population well?
    - What hasn't worked?
- How is outreach to non-English speaking/culturally diverse populations occurring in the community?
    - What adaptations to HV services have been made to engage this population well?
    - What hasn't worked?

Coordination of Services:

- What other community collaborations (i.e. with other early childhood programs, family support services, etc) are already in existence? Are they aware of HV services?
- How does the community work together to meet professional development needs of home visiting staff?
- How do things work now with regard to referrals and information releases between agencies?
    - How would you like it to work?
- How do you track referrals and drop-out rates?
- What happens when a need is identified but there are not services available in the community to meet the need (i.e. mental health services, substance use disorder services, etc)?
- What has already been done at the community level to address the identified challenges?
    - What might work to address them?

Implementation & Fidelity

- How do we know that HV services are working?
    - What does success look like?
- What are the strengths and weakness of home visitation services available in the community?
- Is professional development linked to fidelity monitoring?
- What is the fidelity and implementation process at the community level?
- How does this translate into hiring, training, and safety assessment skills?

- What workers are doing the visits particularly well and what are they doing?
- What is the capacity for local programs to evaluate impact?

Substance Use Disorder Specific Questions

- How do you engage a SA client effectively?
- What is the local policy for child removal as a function of substance abuse?
    - Does this impact HV working with clients who are in recovery services?
    - Does this impact willingness of families to receive HV services if they may be involved in substance use?
- How are the referrals to recovery services happening?
    - Who is doing the screening/assessment?
    - What is the hand off process from HV to recovery services?

General

- What would you need in your community in order to provide all services and resources needed for pregnant women using substances and other high risk families?

Family Focus Group Questions

- If enrolled in services, what were the difficulties you faced in getting services?
  - How did you manage to fit them into your schedule?
- If you are not enrolled in services, why did you choose not to?
  - What was the journey to get or not get services?
  - What would have changed your mind?
- What was your understanding of HV services prior to receiving them?
  - How do you feel about them after?
  - Did the services you received meet your expectations?
- How did you learn about HV services?
- What did you most appreciate about what a HV worker did and what did you least appreciate about what a HV worker did?
- What would make it easier to invite someone (like a home visitor) into your home?
- How did HV assist you in receiving other community services?
  - What worked and what didn't?
  - Did you receive any follow-up calls if you were referred to other services?
  - Are there services within HV that you wished you had received but didn't?
- Who do you get parenting information from?
- What special things did HV staff do to involve the entire family (fathers, extended family members)?
  - Is there anything HV staff could have done to involve the entire family but didn't?
- What would the ideal HV program look like?
  - How long should it be?
  - How often?
- What you do need that you are not currently getting ?