ATTACHMENT A

2018 GRANT SUMMARY PAGE

MENTAL HEALTH, CHEMICAL DEPENDENCY, AND THERAPEUTIC COURTS RFP
KITSAP COUNTY HUMAN SERVICES DEPARTMENT

Organization name: Kitsap Public Health District

Proposal Title: Improving the Health and Resiliency of High-Risk Mothers and their Children"

Please Check One ☐ **New Grant Proposal** **x Continuation Grant Proposal**

Please check which area of the Continuum this addresses:

x **Prevention, Early Intervention and Training**	☐ **Medical and Sub-Acute Detoxification**
☐ **Crisis Intervention**	☐ **Acute Inpatient Care**
☐ **Outpatient treatment**	☐ **Recovery Support Services**

Proposal Summary:
KPHD is requesting a grant of $124,762 to continue its *Improving the Health and Resiliency of High-Risk Mothers and their Children* project. This project ensures low-income, first time mothers in Kitsap County are linked to and provided promising practice and evidence-based nurse home visitation and wrap-around services to improve the health and well-being of new families. The program has two areas of focus: 1) providing evidence based Nurse Family Partnership (NFP) services to at least 12 low-income, high-risk first-time mothers and their babies *at any given time*, and 2) bilingual outreach and linkage through our community health outreach worker to engage new clients (especially immigrant, English as second-language mothers), create new referring partners, and strengthen existing referring systems. The project deepens ties within our two home visitation programs (NFP and Maternity Support Services - MSS), as well as strengthens relationships between our programs and a broad range of external partners who serve women and children. This continuation proposal adds to the original proposal the tracking and monitoring of the NFP Community Advisory Board (CAB), an important sustainability and quality improvement tool for the *Improving Health* program.

Requested Funds Amount: $124,762.00
Matching/In-kind Funds Amount: $128,385.22
Street Address: 345 6th Street, Suite 300
City: Bremerton State: WA Zip: 98337
Primary Contact: Katie Eilers Phone: 360-728-2224
E-Mail: katie.eilers@kitsappublichealth.org
Non-Profit Status: 501C3 of the Internal Revenue Code? ☐ Yes x No
Federal Tax ID Number: 42-1689063

Signature	Title	Date
	Administrator	1/28/17

KITSAP PUBLIC
HEALTH DISTRICT

345 6th Street, Suite 300
Bremerton, WA 98337
360-728-2235

2017 KITSAP PUBLIC HEALTH BOARD OFFICERS

Chair: Commissioner Ed Wolfe
Vice Chair: Mayor Patty Lent

2017 KITSAP PUBLIC HEALTH BOARD COMMITTEE ASSIGNMENTS

Finance & Operations	Mayor Becky Erickson Commissioner Charlotte Garrido Mayor Patty Lent
Policy	Mayor Becky Erickson Commissioner Rob Gelder Mayor Rob Putaansuu
Personnel	Councilperson Sarah Blossom Mayor Patty Lent Commissioner Ed Wolfe

KITSAP PUBLIC
HEALTH DISTRICT

345 6th Street, Suite 300
Bremerton, WA 98337
360-728-2235

Councilperson Sarah Blossom
City of Bainbridge Island
280 Madison Avenue North
Bainbridge Island, WA 98110
Work: (206) 715-3204 FAX: (206) 780-8600
e-mail: sblossom@bainbridgewa.gov
Board Membership: 1/1/2012
City Staff: Amber Richards 206-842-2545
Staff email: arichards@bainbridgewa.gov

Mayor Becky Erickson
City of Poulsbo
200 NE Moe Street, Poulsbo, WA 98370
Work: 779-3901 FAX: 697-3666
e-mail: berickson@cityofpoulsbo.com
Board Membership: 1/1/2010
Staff: Kati Diehl 394-9711
Staff email: kdiehl@cityofpoulsbo.com

Commissioner Charlotte Garrido
Commissioners' Office, MS-4
Kitsap Administration Building
614 Division, Port Orchard, WA 98366
Work: 337-7080 FAX: 337-4632
e-mail: cgarrido@co.kitsap.wa.us
Board Membership: 1/1/2009
Staff: Alex Jarrett 337-7097
Email: ajarrett@co.kitsap.wa.us
Staff: Deanna Erstad 337-4426
Staff email: derstad@co.kitsap.wa.us

Commissioner Robert Gelder
Commissioners' Office, MS-4
Kitsap County Courthouse
614 Division, Port Orchard, WA 98366
Work: 337-7146 FAX: 337-4632
e-mail: rgelder@co.kitsap.wa.us
Board Membership: 4/1/2011
Staff: Alex Jarrett 337-7097
Email: ajarrett@co.kitsap.wa.us
Staff: Deanna Erstad 337-4426
Staff email: derstad@co.kitsap.wa.us

Mayor Patty Lent (Vice Chair)
City of Bremerton
Norm Dicks Government Center
345 6th Street, Suite 600
Bremerton, WA 98337-1866
City Hall: 473-5266 FAX: 473-5883
e-mail: mayor@ci.bremerton.wa.us
Board Membership: 1/1/2010
Staff: Elaine Valencia 473-5266
Staff email: Elaine.Valencia@ci.bremerton.wa.us

Mayor Rob Putaansuu
City of Port Orchard
216 Prospect, Port Orchard, WA 98366
Work: (360) 876-4407 FAX: 895-9029
e-mail: rputaansuu@cityofportorchard.us
Board Membership: 1/1/2016
Staff: Jenine Floyd 360-876-7024
Staff e-mail: jfloyd@cityofportorchard.us

Commissioner Edward Wolfe (Chair)
Commissioners' Office, MS-4
Kitsap County Courthouse
614 Division, Port Orchard, WA 98366
Work: 337-4414 FAX: 337-4632
e-mail: ewolfe@co.kitsap.wa.us
Board Membership: 1/1/2015
Staff: Deanna Erstad 337-4426
Staff email: derstad@co.kitsap.wa.us

Gretchen Dunmire, back up for Deanna
Commissioners Front Desk Assistant
(360) 337-7080
Staff email: gdunmire@co.kitsap.wa.us

ATTACHMENT C

2018 NARRATIVE TEMPLATE FOR CONTINUATION GRANT PROPOSALS

MENTAL HEALTH, CHEMICAL DEPENDENCY, AND THERAPEUTIC COURTS RFP
KITSAP COUNTY HUMAN SERVICES DEPARTMENT

1. One Page Summary of your Current Project

The "Improving Health and Resiliency of High-Risk Mothers and Their Children" (hereafter referred to as "*Improving Health* program") ensures that low-income, first time mothers in Kitsap County are provided promising practice and evidence-based practice nurse home visitation services. The Improving Health program also facilitates wrap around services to improve the health and well-being of new families in the near and long term.

The program has two areas of focus:
1) providing evidence-based Nurse Family Partnership (NFP) services to at least 12 low-income, high-risk first-time mothers and their babies (note that because of client graduations during the grant period, the actual number of clients served is greater than 12), and 2) strengthening bilingual outreach and linkage through our community health outreach worker (CHW) to engage new clients (especially immigrant, English as second-language mothers), create new referring partners, and strengthen existing referring systems.

The project deepens ties within our two home visitation programs (NFP and Maternity Support Services - MSS), as well as between our programs and a broad range of external partners who serve women and children. This continuation proposal adds to the original proposal the tracking and monitoring of the NFP Community Advisory Board (CAB), an important sustainability and quality improvement tool for the *Improving Health* program. This continuation proposal also includes an outcome measure related to an increase in the number of referring agencies to our services.

The *Improving Health* program is central to Kitsap Public Health District's (KPHD) strategic commitment to "promote healthy child development and health equity by ensuring all children have healthy starts" as it not only expands our ability to provide NFP to families in the County, but also supports the addition of a CHW to our parent/ child health team, which has bolstered other perinatal and infant support services, including MSS. While the goals for our NFP and MSS programs are many, the primary focus of these interventions is to:

- Ensure women begin prenatal care early
- Provide women with specialty mental health support through our Behavioral Health Counselor during the perinatal period and refer them to long-term mental health counseling as needed. Depressive disorders are common

during pregnancy and the first 3 months post-partum (11% of women experience minor depressive disorder, 3-5% experience major depressive disorder), and support of parents is considered a key modifiable factor to mitigate the potential negative impact of maternal depression on children.
- Provide women with encouragement and support to discontinue substance use during pregnancy and early parenting and refer them to chemical dependency recovery services as needed.
- Ensure babies are born on time at healthy weights and that women have adequate spacing between pregnancies
- Strengthen maternal self-efficacy skills in caretaking, parenting, and self-care through client-initiated goal setting
- Ensure mothers and babies/toddlers are connected to a medical home and are fully and timely immunized

The *Improving Health* program comprises a foundational component of Kitsap County's Continuum of Care pyramid as a behavioral health prevention and early intervention program.

2. Accomplishments to Date

A. Progress to Date

Our progress to date can be expressed both quantitatively and qualitatively. The table below outlines our SMART goals with accompanying measures, as well as additional outcome measures of our program that are not captured in our quarterly reporting. This is followed by qualitative progress on the project. *Please note that we had a significant public health nurse staff reduction due to attrition in April of 2017, which has affected our cumulative progress against a few benchmarks.*

It is important to remember the context for these interventions and achievements. Pregnancy and early childhood offer an un-matched opportunity for prevention efforts, and are particularly important for low-income women and immigrant women, as significant disparities exist along socioeconomic lines. Some helpful statistics to keep in mind for Kitsap County include:

- 35% of women on Medicaid (up to 185% of the federal poverty level) do not start prenatal care during the first trimester; this increases to 47% among women born in Spanish-speaking countries (compared to 20% of higher income women who do not initiate early prenatal care)
- 7.1% of low-income women had low-birth weight babies (compared to 5.4% among higher income women)
- 1 in 3 civilian babies are born into poverty
- 25% of low-income women smoke (compared to 6% of higher income women)
- Adverse Childhood Experiences (ACEs) are quite pervasive among low-income women in our programs, especially when compared to the general Kitsap County population. The mean ACEs score for NFP clients was 4.6

and was 3.0 for MSS ($p=0.0012$). Nearly two-thirds (72%) of the NFP clients had 3 or more ACEs, and 48% in the MSS program had 3 or more ACEs ($p<0.0001$). In the general population of Kitsap County prevalence of having 3 or more ACEs is much lower at only 28% of adults.

- Mental health concerns are the most commonly identified "problem" among our NFP and MSS clients.

SMART Objective	Progress to Date
Funded case load of 12 mothers (pregnant or with infant(s)) will be maintained through December 31, 2017.	21 mothers to date served by this funding (6 graduated, 3 discontinued service due to moving out of the area)
Enrollment of clients referred to MSS will increase from 22% to 30% by December 31, 2017.	Reported in barriers section below
Increase the number of nursing and Behavioral Health Specialist visits to MSS and NFP clients by 10% by December 31, 2017.	This is a complete measure and will be reported at end of program
By 12/31/17 CHW conducts outreach/case mgmt to >=400 (includes outreach to providers)	Almost 200 outreach/case management contacts; additional information reported in barriers section below
95-100% of NFP clients with an identified mental health problem will show improvement in knowledge, behavior, or status at discharge as measured by the Omaha System	100% (Note that "discharge refers to graduation of a client. If a client does not graduate but is lost to follow up for a variety of reasons, we do not report this data because the intervention has not had sufficient time to influence KBS measures meaningfully)
95-100% of NFP clients with an identified substance use problem will show improvement in knowledge, behavior, or status as measured by the Omaha System Problem Rating Scale at discharge from services	100%
80% or more of NFP clients with a parenting/caretaking problem will show improvement in knowledge, behavior, or status as measured by the Omaha System Problem	100%

Our bilingual CHW has proven to be a critical link for our Latina immigrant women in need of perinatal support. At the time of proposal, she has conducted direct outreach and linkage for almost 200 individuals, and has been particularly instrumental in

engaging MSS immigrant clients in our "Grupos de Mamas" Spanish-language group. This group meets monthly, and provides culturally tailored support, using a linguistically adapted curriculum that focuses on child development, parenting, and self-care in a group setting. As a Latina and parent herself, our CHW builds trust quickly and easily with marginalized pregnant women and parents in the community. This has been especially important related to mental health issues among our clients born in Spanish-language countries, as there is considerable stigma around perinatal depression and seeking behavioral health supports in these cultures. Our CHW has routinely connected Latina clients with our own Behavioral Health Specialist, Kitsap Mental Health Services, and Peninsula Community Health Services for mental health resources and clinical management if needed. This short client note highlights the type of support our CHW provides:

> *A client from Mexico struggled with depression during her pregnancy. Her partner did not understand her emotions and was not open to pharmaceutical or counseling treatment. Among Latinos, it is a common to disregard depression and mood disorders as just bad moods. Her PHN and BHS recognized that client needed more attention in this aspect. My role as CHW involved providing her with important information about mental health from her BHS and PHN in her language. With encouragement, the client had the courage to see a primary care provider at the local community clinic and disclose her symptoms. I was there to support her in addition to the provider and certified translator. She was prescribed medication and referred to counseling sessions. After several months, the client reached out and reported that she was feeling better and her husband was supportive of her treatment and counseling after observing the positive changes in his wife.*

B. Barriers to Implementation

We faced a significant unexpected reduction in nurse home visiting staff during this program period that impacted some of our achievements towards our SMART objectives. In April of 2017, three of our home visiting nurses transitioned to new positions within the agency, leaving a gap in nurse FTE within both our MSS and our NFP programs. Despite this reduction in service, we had no disruption in our NFP service and we were still able to maintain a service uptake level of 24% in our MSS program (58 of 239 referrals enrolled in our services). Prior to this reduction in staff, in 3rd quarter we had seen an increase in enrollment rate to 30% (our goal).

Over the past year, we have recognized that the clients served by our CHW require a higher level of engagement and linkage referral services than anticipated. We had originally projected that she would be able to conduct outreach and case management services to at least 400 women, but because she is working most frequently with immigrant clients and clients faced with language barriers when they interface with behavioral care, primary care, and health care systems, she has engaged more deeply with clients. We expect her outreach numbers may be closer to 325 than 400 by the end of the program year.

C. Outreach

Our outreach plan for 2018 is focused on 3 main areas: 1) strengthen systematic referral to our perinatal programs, including NFP, and continue targeted outreach to potential referring partners who already serve low-income mothers; 2) strategically outreach to community partners and groups who specialize in helping immigrant families to promote our programs to this underserved population, 3) provide leadership to the NFP CAB in order to strengthen referral networks and sustainability opportunities for NFP.

Specific outreach strategies include:

- Encourage the Olympic Community of Health that they promote NFP and other supportive perinatal programs through their provider networks. This provides a different level approach to provider outreach than previously employed.
- Collaborate with the NFP Community Advisory Board (CAB) to host a celebration event. A broad range of people and organizations would be invited to expand exposure to our program and thereby referrals to our program.
- Develop an outreach plan and timeline for CAB members to present an overview of the NFP program to community agencies and health care providers.
- Build on existing relationships with the criminal justice system and jails to streamline referrals to our programs; address policy issues related to providing home visiting services in the jail setting for pregnant women.
- Co-facilitate monthly "Grupos de Mamas" (perinatal support group for Guatemalan immigrant women) to create a direct link to women in community and spread awareness about program availability via word of mouth.
- Expand outreach to birthing centers and local doulas, family planning clinics, Harrison Family Residency program, and Planned Parenthood to reach potential clients.
- Direct outreach to potential clients who receive other KPHD services.
- Expanded Expand outreach efforts to alternative schools, with the goal of exploring the possibility of whether they might give high school credit to clients who graduate from NFP or participating in other perinatal support programs
- Conduct outreach to churches and other faith centers regarding perinatal support programs.

All of KPHD's Parent-Child Health programs have strict eligibility requirements regarding income, trimester of pregnancy, and other risk factors. Outreach efforts are focused on partners who serve low-income, pregnant teens and women – the target population of our program.

D. Integration & Collective Impact

This program fundamentally aims to ensure that all low-income pregnant and parenting women in Kitsap County receive some level of perinatal and early childhood service, with a particular focus on reaching first time, high risk moms who would benefit from

NFP and connecting immigrant, non-English speakers to supportive programs. The work of our CHW has focused heavily on strengthening relationships with physical and behavioral health care providers, educators, government and social service providers, criminal justice, and other agencies who serve pregnant women and young children to streamline warm hand-offs to service. These agencies share common goals with KPHDs maternal and child health programs - they want to ensure children have a healthy start in life. As we have pursued funding through the Medicaid waiver (discussed more thoroughly in the Sustainability section) for NFP, much of our conversation has been with partners from Early Head Start, Head Start, and Parents as Teachers to focus on how we can create a highly-coordinated continuum of prenatal, infant, and young child programming that ensures a healthy start in life for all Kitsap residents. We will continue to work towards this integrated and collective goal in the next year.

The NFP CAB is a collaboration of community partners who seek to ensure the NFP program's success and growth in Jefferson, Clallam, and Kitsap Counties. The CAB has shared objectives and measures across the programs it supports because of fidelity to the NFP model. The CAB's mission is to successfully support the NFP program through providing leadership, community involvement, engagement and maximizing funding. Its vision is that all families in the region will have access to services of a strong, widely supported, and well-funded NFP program. Progress towards collective impact is seen in creating the structure needed to move the CAB forward, including expansion of membership, development of by-laws, and filling of executive positions.

E. Key Accomplishments

NFP requires an intensive investment of monies, staffing expertise, and time, but these investments pale in comparison to the long-term impact the program has on the well-being of families. Recent published results of a 21-year randomized, controlled trial of the program in Tennessee found that the intervention reduces preventable causes of death among children and all causes of death among mothers. Mothers in the trial who did not receive nurse-home visits were nearly 3 times likely to die from all causes of death and 8 times more likely to die from external causes (including unintentional injuries, suicide, drug overdose, and homicide) than nurse-visited mothers. Other research on the program has indicated the following at a national level:

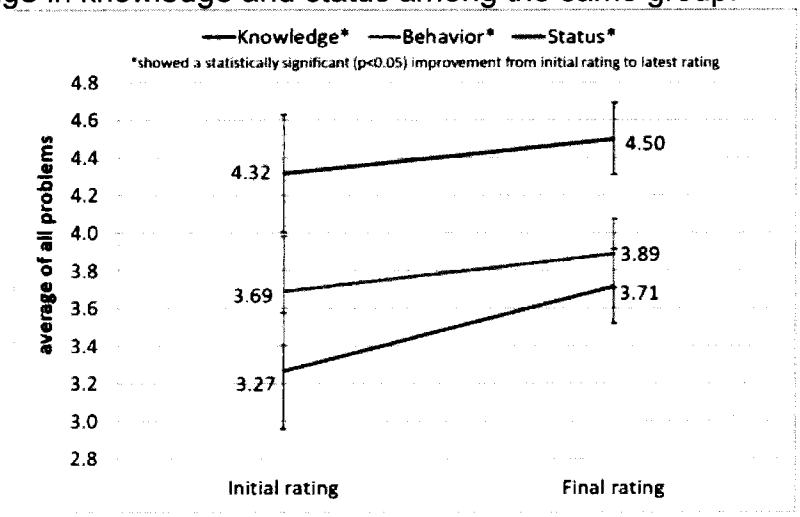
- By 2031, NFP will have prevented 36,000 intimate partner violence incidents and 90,000 violent youth crimes. Intimate partner violence is one of 10 adverse childhood experiences (ACEs). ACEs are connected to increased risk over time to mental illness, substance abuse and chronic disease.
- By 2031, NFP will have prevented 500 infant deaths in the US and 42,000 incidents of child maltreatment. Child maltreatment (child abuse, child neglect, child sexual abuse) comprises 5 of 10 adverse childhood experiences.
- Every dollar spent on NFP can yield $4.40 in return savings to the health care system, criminal justice system, and social welfare systems
- NFP is linked to a 67% reduction in behavioral and emotional problems of children at age 6 and a 67% reduction in 12-year old children's use of cigarettes, alcohol, or

marijuana. This prevention outcome is directly in line with the Kitsap County Board of Commissioners goal to "*reduce the incidence of chemical dependency and/or mental health disorders in youth*"

- A California study in 2010 founds that families who participated in NFP demonstrated a 38.2% reduction in recidivism for mothers and a 15.7% reduction for children. Children not enrolled in NFP, compared to those who are, were more than twice as likely to be convicted of a crime by the time they were 19 years old. This prevention outcome supports the Kitsap County Board of Commissioners goal to "*reduce the number of chemically dependent and mentally ill youth and adults from initial or further criminal justice system involvement*"

While at a local level, we are unable to conduct randomized, controlled research to identify the long-term impacts of NFP on our community, we know that with high fidelity to the NFP model, the families we serve will experience similar positive short and long-term outcomes. Our permissions by the NFP National Service Office to operate an NFP program are dependent on high fidelity to the model elements, and we have been able to operate our NFP program fully because we adhere strictly to the model.

KPHD conducts statistical analyses on impact of the NFP program over time. Our data reveal that as long as we maintain high fidelity to the NFP model, clients will have statistically significant changes in knowledge, behavior and status (KBS) around their key "problems". The most common problem areas for clients include low income, mental health issues, caretaking/parenting deficits, and lack of healthcare supervision. We also identify pregnancy as a "problem" because our intervention centers on improving health and well-being during this critical time in a future child's life. The table below shows statistically significant changes in KBS for the top 5 problems among clients who graduated from our NFP program in 2015 and 2016 (note that this includes data for all of our NFP clients and not solely the clients supported by this funding). Although substance use is not in the top 5 problems, we also see a statistically significant change in knowledge and status among the same group.



NFP is designed to build client self-efficacy over time to empower mothers to identify and reach wellness goals for themselves and their young children. This process can

sometimes best be highlighted in a client case review, such as this one which follows the journey of an NFP client funded by this grant:

"Rebecca" was a 19 years old and 21 weeks gestation when she was enrolled in the NFP. She was attending an alternative high school and living with her parents, siblings and father of the baby (FOB) in a cluttered and small home. Rebecca shared with her PHN that she did not complete high school because of a 9-month hospitalization for substance use treatment and inpatient psychiatric therapy after multiple suicide attempts. During her pregnancy, she was not receiving behavioral health counseling or medication. After several discussions, the client agreed to begin meeting with the KPHD Behavior Health Specialist (BHS). Following a complicated pregnancy and delivery at 39 weeks, the client moved in with the FOB and baby into a travel trailer. During this stable housing period, the client exclusively breastfed and attended all orthopedic and well-child check-ups for her baby. Rebecca appeared bonded with her newborn and continued her BHS visits.

After a couple months of living in the trailer Rebecca, the FOB and newborn moved in with a friend whose home was very cluttered and dirty. In this environment, the client's mental health worsened and she began self-harming behavior. She discontinued breastfeeding her infant. The PHN referred her to a mental health professional who prescribed mood stabilizing medication and began monthly appointments with Rebecca. The PHN used motivational interviewing to help the client identify her desires for herself and for her son. During this time, the client disclosed that she had an ACEs score of 5 and did not want her son to experience the same childhood she experienced.

With support of her home visitor, Rebecca discontinued the relationship with the FOB, moved into an apartment with her infant, and is now receiving Food Stamps, TANF, WIC and Medicaid. She continues her psychiatric medication and meets with her mental health counselor monthly. Her son is meeting his growth and developmental milestones and Rebecca is an attentive mother, often reading to her son and playing with him. Rebeca has recently decided to enroll in a technical school and will be starting classes this fall. She is surrounding herself with supportive people and taking appropriate steps to improve her situation. According to the NFP model, she now is visited by her PHN every other week.

In relation to our expanded community outreach efforts conducted by our CHW, we have several new referring partners, including Salmonberry Birth Center, the Kitsap County Jail, Harrison Health Partners, Planned Parenthood, and Kitsap Community Resources.

3. Budget Narrative

A. Expenditures

At the time of this submission, we have approximately 20% of the fund balance and 33% of the grant year remaining, indicating we have been billing the grant down more quickly than planned. To date, only the travel time for the CHW was charged to this grant but moving forward, home visitor travel will be billed to the grant. We anticipate fully billing this grant out in a timely manner, with invoices estimated to be $6,100 a month through the end of the grant period.

B. Funding Request

We request funds in the amount of $124,762 for a 12-month continuation grant of the *Improving Health* program. This represents a slight annual cost-reduction from our previous budget request because we have solidified funding for 0.25 FTE of our CHW from other sources. There is no other notable difference in our funding request from the previous to current budget. In addition to continuing to reach program outcomes identified in our existing project plan, the most significant additional milestones relate to our CAB, on which the Director of Community Health, Parent-Child Health Supervisor, and CHW serve. Our revised evaluation plan includes outcome measures associated with this work.

C. Funding Modifications

Other than the reduction in CHW salary by 0.25 FTE because of matching funds, there are no changes to the proposed budget resulting in modifications to project activities.

4. Sustainability

A. Leveraged Funds

Along with other NFP program leads, KPHD worked diligently to advocate for NFP to be a covered program under the Health Care Authority's (HCA) Medicaid Waiver Toolkit, which ultimately was included as a fundable program. These represent Affordable Care Act Medicaid funds granted to Washington State. KPHD collaborated with Peninsula Community Health services and two partners in Jefferson and Clallam County to submit a regional NFP and Parents as Teachers expansion proposal. Unfortunately, according to the Olympic Community of Health, it is unlikely this proposal will be funded because of the incentive payment structure the HCA has established for maternal and child health outcomes (essentially, although NFP is an allowable program under the Waiver, the incentive payments are structured to focus almost entirely on short-term outcomes rather than long-term outcomes). We have submitted an alternate recommendation to the OCH that they consider funding our CHW position in the future to support systems-level improvement in linking health care providers with community-based maternity support services like MSS and NFP.

We have been working successfully with the Health Care Authority MSS program to cover a portion of salary costs of our CHW. Moving forward, we will be able to bill MSS for 0.25 FTE of our CHWs salary for her work on the *Improving Health* program.

We are currently working with the Washington State Department of Health (DoH) to explore the possibility of contributing to NFP PHN staffing costs through the Maternal and Child Health Block Grant (MCHBG). These funds are federal monies passed on to the Washington State DoH. Initial conversations look promising for some level of funding to be available in 2019 to support the NFP program.

Finally, we leveraged Healthy Start Kitsap funds towards projected training costs in 2018. Healthy Start Kitsap is a small fund of the Kitsap Community Foundation, and provides a local giving opportunity for donations in support of NFP. As we expand our CAB outreach for NFP, we will highlight Healthy Start Kitsap fund as a location where contributions can be made to support the NFP program. As of now, the balance of the Healthy Start Kitsap funds are being held to support NFP training costs and NFP client scholarship costs.

KPHD receives one other dedicated grant from the Home Visiting Services Account administered by the Department of Early Learning to support its NFP programs. Beyond that funding, KPHD uses local public health dollars to support the NFP program. We exhaust all other funding sources prior to tapping into this limited public health funding and the 1/10th of 1% funding.

B. Sustainability Plan

We anticipate that NFP will always require some level of grant funding, but our goal is increase the amount of dedicated funding to the program through the Home Visiting Services Account (HVSA). To this end, we work with the NFP National Service Office to advocate for federal and state expansion of the HVSA.

We are also working on a funding and sustainability plan with our NFP CAB. Other communities have been able to conduct outreach and promotion through their CABs and secured funding for local and foundation donors. Part of the CAB's workplan in 2018 is to host a regional celebration of the impact of NFP on our families, and to use this event as an opportunity to solicit donations and other types of advocacy and recruitment support for NFP.

As mentioned above, we are advocating for our state Maternal and Child Health Block Grant (MCHBG) grant to cover a portion of our NFP costs. The MCHBG has historically had strong bi-partisan support year after year, making it a good option for sustainable funding for a portion of our program.

For our CHW work, which we believe is critically important to the sustainability of our programs, we will continue to purse MSS funding and Medicaid Waiver funding.

EVALUATION WORKSHEET

INSTRUCTIONS:

Evaluation is the collection of information about a program in a systematic and defined manner to demonstrate success, identify areas for improvement and lessons learned. Every program has at least one end goal and might have several – one or more activities are required to make progress toward meeting the goal. Progress is measured with one or more objectives that might cover an output (number of something) or outcome (change over time) due to the program. The type of outcome (column D) and expected timeframe for change (column E) should be defined. Objectives must follow the "SMART" guideline: specific, measurable, attainable, realistic, and time-bound (column C). Each objective should include an expected target result and completion date ("time-bound" part of column C).

New and continuing grant proposals must fill out the Evaluation Worksheet.

DEFINITIONS:

Goal:	A broad statement or a desired, longer-term, outcome of a program. A program can have one or multiple goals. Each goal has a one or more related specific objectives that, if met, will collectively achieve the stated goal.
Activity:	Actions taken or work performed to produce specific outputs and outcomes.
Objective:	A statement of a desired program result that meets the criteria of being SMART (specific, measurable, achievable, realistic, and time-bound).
Output:	Results of program activities; the direct products or deliverables of program activities; such as number of: sessions completed, people served, materials distributed.
Outcome:	Effect of a program (change) - can be in: participant satisfaction; knowledge, attitude, skill; practice or behavior; overall problem; or a measure of return-on-investment or cost-benefit. Identify any measures that are "fidelity" measures for an evidence based practice.
Timeline:	Is the outcome expected to measure short-term, medium-term or a longer-term change? When will measurement begin? How often will measurement be done (frequency: quarterly, semi-annual, annual, other)?
Baseline:	The status of services or outcome-related measures before an intervention against which progress can be assessed or comparisons made. Should include data and time frame.
Source:	How and from where will data be collected?

EVALUATION WORKSHEET

PROJECT NAME: Improving the Health and Resiliency of High-Risk Mothers and Their Children

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE Data and time	G. SOURCE
Prevent mental illness, behavioral problems, and future addiction in young children by intervening with families who either have, or are at risk for substance abuse and/or mental health problems.	Provide continuing NFP home visits to at least 12 low-income, first-time mothers and infants (at any given time – total served will be greater) who were originally funded for services by Healthy Start Kitsap	Funded case load of at least 12 mothers and infants will be maintained through December 31, 2018.	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☒Medium ☐Long Start date: 1/1/18 Frequency: ☒Quarterly ☐Semi-annual ☐Annual ☐ Other:____	12 as of 7/1/17	Nightingale Notes Electronic Health Record (NN) and NFP Efforts to Outcomes (ETO) database
	Provide bilingual CHW targeted outreach and case management to maintain goal enrollment rate of high risk low-income pregnant women into MSS and NFP	Expand referral base to KPHD home visiting and wrap-around services by at least 5 new agencies/organizations, at least one of which specializes in service to immigrant women, by December 31, 2018	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☒Medium ☐Long Start date: January 1, 2018 Frequency: ☐Quarterly ☐Semi-annual ☒Annual ☐ Other:____	8 as of 7/1/17	CHW Outreach log, NN client records of referrals
		Maintain an average enrollment rate of 27% for MSS or NFP services over the course of the program year (January – December 2018)	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☐Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☒Medium ☐Long Start date: 1/1/18 Frequency: ☐Quarterly ☐Semi-annual ☒Annual ☐ Other:____	Average of 27% for July 1, 2017- June 30, 2018	NN Electronic Health Record

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE Data and time	G. SOURCE
Prevent mental illness, behavioral problems, and future addiction in young children by intervening with families who either have, or are at risk for substance abuse and/or mental health problems. (Continued)		By December 31, 2018 CHW conducts outreach and case management to at least 200	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☒Medium ☐Long Start date: 1/1/18 Frequency: ☒Quarterly ☐Semi-annual ☒Annual ☐ Other:____	0 as of 1/1/18	NN Electronic Health Record
	Provide ACEs screening and education to NFP clients who voluntarily accept screening Offer referral to MSS Behavioral Health Specialist to all NFP clients with ACE score of ≥ 3 Screen all NFP clients for anxiety and depression and refer those showing risk factors Provide all NFP clients education on perinatal mood disorders and when to seek help	90-100% of NFP clients with an identified mental health problem will show improvement in knowledge, behavior, or status as measured by the Omaha System Problem Rating Scale at graduation from services	☐Output ☐Outcome: Participant satisfaction ☒Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem (status) ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☐Medium ☒Long Start date: 1/1/18 Frequency: ☐Quarterly ☐Semi-annual ☒Annual ☐ Other:____	2016-2017 100%	NN Electronic Health Record
	Screen all NFP clients for substance use and refer those screening positive for appropriate diagnostic and treatment services	90-100% of NFP clients with an identified substance use problem will show improvement in knowledge, behavior, or status as measured by the Omaha System Problem Rating Scale at graduation from services	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem (status) ☐Return-on-investment or cost-benefit	☐Short ☐Medium ☒Long	2016-2017 100%	NN Electronic Health Record

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE Data and time	G. SOURCE
Prevent mental illness, behavioral problems, and future addiction in young children by intervening with families who either have, or are at risk for substance abuse and/or mental health problems. (Continued)	Provide all NFP clients education on the harmful effects of substance use during pregnancy		If applicable: ☐Fidelity measure	Start date: 1/1/18 Frequency: ☐Quarterly ☐Semi-annual ☒Annual ☐ Other:____		
	Provide all NFP clients with education on parenting, child growth and development, and parental emotional well-being and stress management Link NFP clients to community resources	90-100% or more of NFP clients with an parenting/caretaking problem will show improvement in knowledge, behavior, or status as measured by the Omaha System Problem Rating Scale at graduation from services	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☒Outcome: Practice or behavior ☒Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☐Medium ☒Long Start date: 1/1/18 Frequency: ☒Quarterly ☐Semi-annual ☐Annual ☐ Other:____	2016-2017 100%	NN Electronic Health Record
NFP PHNs and CHW maintain high fidelity to the NFP evidence-based model	PHNs meet 18 model fidelity elements according to NFP requirements such that KPHD maintains its permissions to operate an NFP program	By December 31, 2018, KPHD will maintain required high fidelity to the NFP model, as required by the National Service Office.	☐Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☒Fidelity measure	☐Short ☒Medium ☐Long	2016-2017 100%	Nightingale Notes Electronic Health Record (NN) and NFP Efforts to Outcomes (ETO) database

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE Data and time	G. SOURCE
NFP CAB strengthens collective impact of NFP through its mission	NFP CAB members develop and implement outreach plan	By December 31, 2018, NFP CAB completes at least 5 outreach activities on its outreach plan (outreach includes educational presentations, advocacy efforts to increase funding, and promotional events)	☒Output ☐Outcome: Participant satisfaction ☐Outcome: Knowledge, attitude, skill ☐Outcome: Practice or behavior ☐Outcome: Impact on overall problem ☐Return-on-investment or cost-benefit If applicable: ☐Fidelity measure	☐Short ☒Medium ☐Long Start date: 1/1/18 Frequency: ☐Quarterly ☐Semi-annual ☒Annual ☐ Other:____	0 as of 7/1/17	NFP CAB Outreach Plan and Meeting Minutes