Summary of Universal Home Visiting Programs

Program name:
Welcome Home Baby

Specific geographic locations served (e.g. county, zip code, state):
Kent County, Michigan

Target population (all births, all first time births, teen parents, etc.):
Kent County residents who are one or more of the following: first-time parent, parent age 25 or younger, parent giving birth in the United States for the first time.

Provider characteristics (e.g. educational requirements/skills of all team members):
Home Visitors are registered nurses with expertise in maternal-child health, Hospital Liaisons are social workers, Intake staff are Bachelor's-level prepared, and Management positions are Master's-level.

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
WHB Hospital Liaisons screen the EMR at local hospitals and visit eligible families in postpartum rooms during their hospital stay.

Number of service contacts and nature of each contact (home visit, telephone, etc.):
Hospital contact: offer services, gain consent, complete brief interview.
Scheduling phone contact: establish home visit appointment date and time.
One home visit: comprehensive assessment, education, breastfeeding support, provision of resources and community referrals.
Follow-up phone contact: check on family transition, ensure family connected to referrals, offer additional resource information, collect data points.

Assessment tools used (standardized instruments, informal interview, etc.):
Welcome Home Baby developed its own intake and assessment forms that are utilized for every client. Edinburgh Postnatal Depression Screening is used along with WHB assessment.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
Assessment includes mother and baby physical health, infant feeding and nutrition including breastfeeding assistance, environmental assessment including safe sleep, psychosocial risk screening including Edinburgh Postnatal Depression Screening. Connection to medical home, support system, and basic needs are also addressed.

Is assessment process used to triage participants to subsequent level of service?
Yes ☒
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
Families are offered a menu of services based on their eligibility and local programs' current capacity. With parent consent, families are referred to any number of services including home visiting (these include Healthy Families America, Early Head Start, Federal Healthy Start, Parents as Teachers, the Maternal Infant Health Program, as well as several other programs providing home visiting services in our community). Welcome Home Baby also refers directly to programs that provide phone support, playgroups, and developmental monitoring. Additionally, Welcome Home Baby provides resource information and contacts for a number of other needs including lactation support, childcare, basic needs, environmental concerns, domestic violence, and counseling.

Are you currently evaluating your efforts?
Yes ☒
No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:

The initial evaluation goals included: 1) WHB serves as a gateway for families to early childhood services, 2) Participant families take their newborn to an initial medical home visit within five days of life, 3) Participant families have a low incidence of emergency department use and hospital re-admittance, 4) Participant family needs are identified and referred to appropriate community services as agreed upon by families, and 5) WHB increases referrals into the early childhood services system. The Year One (2010-2011) Evaluation was conducted utilizing both quantitative data as well as qualitative information from hospital and referral partners, clients, and staff.

The WHB 2012 Dashboard measured acceptance rates (72% acceptance at hospitals, 79% home visit completion rate), newborn ED visits within 30 days of life (5% parent self-report for 10 months of data), exclusive breastfeeding at 30 days of life (40% parent self-report for 10 months of data), and parent acceptance of MIHP referrals (93% continuous, 64% new referrals).

WHB is exploring the possibility of combining its future evaluation with several local home visiting programs to further evaluate the gateway function and long-term impacts of WHB.

Current funding level and source:
Current budget: approximately $700,000
Funders:
Douglas & Maria DeVos Foundation
Heart of West Michigan United Way
Helen DeVos Children's Hospital (in-kind)
Kent County Health Department (Medicaid Outreach)
March of Dimes- Michigan Chapter
Mike & Sue Jandernoa
W.K. Kellogg Foundation

Potential for ongoing funding:
WHB is continuing to work on diversifying its funding. Ongoing philanthropic funding is available, but WHB is pursuing possibilities for earned income as well.

Key partners:
Metro Health Hospital
Saint Mary's Healthcare
Spectrum Health
Helen DeVos Children's Hospital
Arbor Circle
Believe 2 Become
Catholic Charities West Michigan
Cherry Street Health Services
Family Futures
Head Start for Kent County
Inter-Tribal Council of MI – Kent County
Kent County Health Department
Kent Intermediate School District
MOMs Bloom
Spectrum Health MOMS

Your name and contact information:
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616-818-8341
cpavlak@firststepskent.org
First Steps 118 Commerce Ave. SW Grand Rapids, MI 49503

Summary of Universal Home Visiting Programs

Program name:
Iowa Virtual Home Visitor System

Specific geographic locations served (e.g. county, zip code, state):
Intent is for this to be a statewide program but it could be expanded beyond Iowa if there is interest

Target population (all births, all first time births, teen parents, etc.):
All parents with children 0 to kindergarten entry

Provider characteristics (e.g. educational requirements/skills of all team members):
The virtual home visitor system is being designed, implemented and maintained by Iowa State University with sub-contracts with Texas A&M and Illinois State University

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
Ideally, there will be multiple points where a parent could become familiar with the virtual home visitor system. The intent is to engage parents prior to the birth of their child but they can become involved at any point. The virtual home visitor system will be linked to the Coordinated Intake and Referral system in Iowa that exists to provide information and referral to family support programming and Early Intervention Services (Part C.)

Number of service contacts and nature of each contact (home visit, telephone, etc.):
The system will have a variety of different levels of services. All parents may access the system and screen their child using the ASQ. Parents then will have the option of sharing the results of the ASQ with their health care provider, grandparents and child care provider. They will also have the opportunity to complete additional family assessments that will gauge family functioning and other aspects of healthy families. Families that choose to use the system at this level will receive lesson plans and activities that they can implement at home based on their assessment portfolio results. They will also have the option to access Iowa experts with their specific questions. They will also have access to podcasts, moderated chats and other methods to build skills and informal networks of support. Families, based on risk characteristic, may be referred to "real" home visiting programs at any time. All communication/contact is online in the virtual home visitor system.

Assessment tools used (standardized instruments, informal interview, etc.):
At this point in time, only the ASQ 3rd edition, and ASQ-SE have been identified but others assessment and screening tools will be used. The coordinated intake system utilizes a standard intake form to gather information including the ASQ to refer parents to appropriate services.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
We have discussed all of the above, including resources, parental relationships, family functioning, coping skills, caregiver depression, etc.

Is assessment process used to triage participants to subsequent level of service?
Yes ☐x
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
Enrollment in group-based parent education programs, intensive home visitation, referrals to other community-based resources.

Are you currently evaluating your efforts?
Yes ☐x

No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:
ISU is charged with developing an evaluation of the effectiveness of the virtual home visitor system. The evaluation has not yet been designed.

Current funding level and source:
$1 mil. Per year - MIECHV

Potential for ongoing funding:
Sponsors/advertisers/private pay fees

Key partners:
IDEA Part C – Early ACCESS, Iowa State University, Texas A&M, Illinois State University, parents

Your name and contact information:
Janet Horras, Home Visitation Director
Iowa Department of Public Health
321 E. 12th Street
Des Moines, IA. 50319
Janet.horras@idph.iowa.gov

Summary of Universal Home Visiting Programs

Program name:
Durham Connects/Northeast Connects

Specific geographic locations served (e.g. county, zip code, state):
Durham County, NC and now Beaufort, Bertie, Chowan and Hyde Counties, NC

Target population (all births, all first time births, teen parents, etc.):
All births.

Provider characteristics (e.g. educational requirements/skills of all team members):
RN, preferably BSN with public health and/or maternal child health and home visiting experience.

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
Scheduled in hospital directly after birth. Promoted by OBs and Peds with option to sign up online.

Number of service contacts and nature of each contact (home visit, telephone, etc.):
3-5 (hospital, 1-3 home visits/phone follow ups, 1 final phone follow up.

Assessment tools used (standardized instruments, informal interview, etc.):
Family risk screening assessment tool (proprietary), CAGE-aid, Edinburg, Conflict-tactic scale

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
Maternal/infant health assessment, social support, material supports, healthcare plans, child care plans, mother mental health, family relationships, parenting skills/support.

Is assessment process used to triage participants to subsequent level of service?
Yes ☒
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):

Teaching in home when able to resolve. If screened for higher risk, referral and connection to other service provider. Often other intensive home visiting services for high risk families. Connections to primary health providers in every case.

Are you currently evaluating your efforts?
Yes ☒
No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:

RCT is completed, however we are evaluation on-going implementation effectiveness (participation rates, referral outcomes, customer satisfaction)

Current funding level and source:
Approx. 1.2M. The Duke Endowment, Durham County, NC Early Learning Challenge Grant, other small grants and private donations.

Potential for ongoing funding:
Philanthropy, corporate funding, government funding and grants.

Key partners:
Health Dept. University, Hospital system, non-profits, State Division of Public Health.

Your name and contact information:
Jeannine Sato, Program Director, j.sato@duke.edu, 919-357-0324, www.durhamconnects.org.

Summary of Universal Home Visiting Programs

Program name:
Healthy Start Home Visitors

Specific geographic locations served (e.g. county, zip code, state):
98 counties in Kansas

Target population (all births, all first time births, teen parents, etc.):
Prenatal and postnatal women and their infants

Provider characteristics (e.g. educational requirements/skills of all team members):
None required - Paraprofessionals

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
County health department

Number of service contacts and nature of each contact (home visit, telephone, etc.):
One - three home visits on average; Provide health and safety information and community referrals as needed.

Assessment tools used (standardized instruments, informal interview, etc.):
None. Converse with mother to determine needs.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
Health needs and needs for referrals.

Is assessment process used to triage participants to subsequent level of service?
Yes ☐
No X☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
Click here to enter text.

Are you currently evaluating your efforts?
Yes ☐
No X☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:
Click here to enter text.

Current funding level and source:
State tobacco settlement funds dollars granted by the state children's cabinet - $237,914; and Title V MCH Block Grant funds (dollar amount unavailable).

Potential for ongoing funding:
Depends on the above

Key partners:
County health departments; state children's cabinet; local community resources/programs

Your name and contact information:

Debbie Richardson, Kansas Dept. of Health and Environment, 785-296-1311 drichardson@kdheks.gov

Summary of Universal Home Visiting Programs

Program name:
Hampton Healthy Families Partnership

Specific geographic locations served (e.g. county, zip code, state):
Hampton, Virginia 23669

Target population (all births, all first time births, teen parents, etc.):
All births, residents of the City of Hampton

Provider characteristics (e.g. educational requirements/skills of all team members):
Family Resource Specialist: Degree in Social Work, Human Services, or related field preferred. Skills: ability to communicate effectively verbally and in writing, ability to quickly form trusting relationships, computer skills to include use of Microsoft WORD, excellent time management skills, ability to exercise good judgment while working independently, experience in home visitation preferred.
Family Support Worker: Education or experience in child care, child health, child development preferred. Skills: Ability to establish long term, trusting relationships, ability to maintain professional boundaries, ability to communicate effectively both verbally and in writing, demonstrate non-judgmental approach, practice positive time management skills, ability to adapt to ever changing work environment, skilled in team work and collaboration, ability to exercise good judgment skills and keep supervisor fully informed of issues within assigned caseload, must be able to compile and submit reports. Knowledge of community resources.
Program Managers/Supervisors: Degree in Nursing, Social Work, Human Services or related field required. Experience in case management and child development, home visiting preferred. Must have the ability to exercise sound professional judgment with independent thinking skills. Must communicate effectively and professionally both verbally and in writing. Experience in Microsoft Word, Excel. Ability to function as an effective team member. Positive customer service skills. Ability to utilize Reflective Supervision skills. Experience in professional documentation, compiling and submitting reports in a timely manner. Facilitate team meetings and provide training, coaching, compile performance appraisals, participate in hiring process.

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
Multiple points to include hospitals, physician offices, WIC, Department of Human Services, Schools, Health Department, self-referral

Number of service contacts and nature of each contact (home visit, telephone, etc.):
Service contacts are dependent on the leveling system through Healthy Families America. Families enter services on Level 1, which is weekly home visits. Telephone calls, emails, text messages, and collateral contacts are ongoing and occur frequently in between home visits.

Assessment tools used (standardized instruments, informal interview, etc.):
Kempe Family Stress Checklist is used as the standardized assessment for entry into home visitation services and it is delivered via informal interview.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
Childhood history, mental health issues, substance abuse issues, issues with violence or anger management, basic care such as housing, food, clothing, employment, existence of a support system, expectations regarding the pregnancy or the new baby, plans for discipline, perception of the infant, and other resources that may be in place

Is assessment process used to triage participants to subsequent level of service?

Yes ☒
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
All of the above

Are you currently evaluating your efforts?
Yes ☒
No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:
Intensive evaluation in place since the beginning of the program in 1992. Evaluation design and ongoing structure per Dr. Joe Gallano and Dr. Lee Huntington. Program participates in Benchmark studies.

Current funding level and source:
Level is uncertain at this time. Source: City of Hampton, State funds, Promoting Safe and Stable Families

Potential for ongoing funding:
Current climate is uncertain. Potential for ongoing funding is good; amount of funding is the challenge with each fiscal year.

Key partners:
City of Hampton, Department of Human Services, Health Department, Riverside Hospital, Mary Immaculate Hospital, Smart Beginnings, Healthy Families Virginia

Your name and contact information:
Angie Russ, RN
Program Manager
Hampton Healthy Families Partnership, aruss@hampton.gov, 757-727-2611

Evaluators: Joe Galano and Lee Huntington

Summary of Universal Home Visiting Programs

Program name:
First Connections
Specific geographic locations served (e.g. county, zip code, state):
Statewide
Target population (all births, all first time births, teen parents, etc.):
See attached
Provider characteristics (e.g. educational requirements/skills of all team members):
Nurses, social workers and community health workers (MCH team)
Initial point of engagement (prenatal clinic, hospital, service center, etc.):
Birthing Hospitals: Newborn Developmental Risk Assessment
Number of service contacts and nature of each contact (home visit, telephone, etc.):
Home Visit: Up to three home visits.
Assessment tools used (standardized instruments, informal interview, etc.):
See attached
Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):

Is assessment process used to triage participants to subsequent level of service?
Yes, however no standard assessment used at the time to move from low intensity resource and referral program to long term evidence based program. Based on families identified needs.
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
Click here to enter text.

Are you currently evaluating your efforts?
Yes ☐
No x

If yes, briefly describe your evaluation design and any key outcomes you have identified:
Click here to enter text.

Current funding level and source:
Medicaid, Early Intervention Part C, Immunization, Legislative Grant

Potential for ongoing funding:
Ongoing funding
Key partners:
Early Intervention, Department for Children Youth and Families, Office of Medicaid, Birthing Hospitals, Community Based Agencies such as housing, community action programs, Primary Care Providers/Pediatricians

Your name and contact information:
Kristine Campagna
RI Department of HEALTH
401-222-5927
Kristine.campagna@healath.ri.gov

Summary of Universal Home Visiting Programs
Massachusetts Department of Public Health (MDPH)

Program name:
Welcome Family Massachusetts (WFM)

Specific geographic locations served (e.g. county, zip code, state):
Initial WFM services will provided in 17 MIECHV communities across the Commonwealth including Boston, Brockton, Chelsea, Everett, Fall River, Fitchburg, Holyoke, Lawrence, Lowell, Lynn, New Bedford, North Adams, Pittsfield, Revere, Southbridge, Springfield and Worcester.

The program will be piloted in two of the 17 communities in the spring of 2013. The pilot communities are Boston and Fall River.

Target population (all births, all first time births, teen parents, etc.):
WFM will provide a universal one time home visit to all new mothers residing in one of the 17 MIECHV communities following birth.

Provider characteristics (e.g. educational requirements/skills of all team members):
WFM services will be provided by a public health nurse with a current registered nurse(RN) license issued by the Massachusetts Board of Registration, Division of Professional Licensure, with either:

a) a bachelor's degree in nursing from an accredited program, with at least 3 years clinical experience in prenatal, newborn, infancy or maternal services; or
b) a Master of Science degree in Nursing in Maternal and Child Health, Family Health or Community Health, or related specialty, and two (2) years clinical experience in prenatal, newborn, infancy or maternal services.

Additional qualifications include:

1. All Nurses are skilled in childbirth education including, but not limited to:
   - Anatomy and physiology of pregnancy, birth and postpartum period;
   - Pain Management following birth;
   - Physical and emotional changes related to postpartum period; and
   - Preparation for postpartum changes.

2. All Nurses are skilled in women's health issues including the ability to counsel and assess for issues such as:
   - Healthy weight and physical activity;
   - Sexual activity following birth;
   - Breast health and breast and cervical cancer; and
   - Reproductive health and family planning.

3. All Nurses are skilled to:
   - Recognize the spectrum of postpartum mood disorder symptoms through questions and observation of the mother, infant, and family; and
   - Assess parent-infant attachment and parenting skills.

4. All Nurses are skilled to:
   - Understand the dynamics of domestic violence, the safety and autonomy of abused women, and elements of culturally competent care;
   - Know how to ask about whether someone has experienced violence and/or other types of abuse and respond with appropriate information, including initial safety planning, and referrals to local community resources as appropriate;
   - Identify signs of and risk factors for child abuse and neglect; and
   - Understand mandatory reporting laws for children, elders and those with disabilities and methods that can be employed to more safely report when necessary.

5. All Nurses are skilled in infant behavior assessment and teaching points with parents around infant development and behavior.

6. All Nurses have advanced skills in breastfeeding support. Advanced skills are defined by regular attendance at professional development workshops or courses specifically targeting the development of breastfeeding counseling skills. Training resulting in a breastfeeding specialist credential (such as CLC) is preferred. Certification as an International Board Certified Lactation Consultant (IBCLC) is optimal.

7. All Nurses are skilled in motivational interviewing, brief intervention techniques, and understanding stages of change.

8. All Nurses are skilled in screening, brief intervention and referrals related to Alcohol, Tobacco and Other Drugs (ATOD).

9. All Nurses know the range of services available through local programs and service providers as well as through hospital- or community health center- based prevention programs to ensure all families identified with a need are connected to community based resources as appropriate.

10. All Nurses provide culturally competent service provision to a diverse population.

11. All Nurses have experience with providing home visiting services.

12. All Nurses are supported in accessing on-going professional development opportunities and trainings.

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
WFM will be marketed to new families in multiple locations within each community including prenatal care services, community health centers, WIC, birth hospitals, and other community based agencies. Referrals into WFM will be accepted from any agency or new family residing in one of the 17 MIECHV communities.

Number of service contacts and nature of each contact (home visit, telephone, etc.):
The WFM public health nurse will provide one 90 minute home visit to each family. A follow up phone call will be conducted a few weeks later to determine the outcomes of any referrals made during the home visits and to provide any additional referrals.

Assessment tools used (standardized instruments, informal interview, etc.):
The WFM public health nurse will bring a new parent bag, provide a brief screen, answer questions, provide linkages for families, and triage to appropriate services. The assessment tool remains in development but will include validated screening tools whenever possible.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
The brief screen conducted during the WFM home visit will focus on the following maternal child health and development topic areas: 1) unmet health needs, 2) maternal and infant nutrition, 3) breastfeeding, 4) emotional health (including maternal depression), 5) substance use, and 6) interpersonal violence.

Is assessment process used to triage participants to subsequent level of service?
Yes **X**
No ☐
If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
WFM is designed to be an information and referral programs for all new families residing in one of the 17 MIECHV communities. Participants in WFM will be connected to a range of community resources (including other intensive home visiting programs) based on the assessment and identified needs.

Are you currently evaluating your efforts?
Yes **X**
No ☐
If yes, briefly describe your evaluation design and any key outcomes you have identified:
The Evaluation Plan is currently being completed by Harvard Catalyst, and will include an assessment in the following key areas:

1. Universality

2. Program Operations (ie where it succeeds/fails)
3. Identification of Need
4. Referrals
5. Satisfaction, Capacity and Competency
6. Childhood and Family Outcomes
7. Program Outcomes

Current funding level and source:

$970,000= program support
$180,000 = materials development, storage, and distribution (new parent bags)
Source= MIECHV funds/ Affordable Care Act

Potential for on-going funding:
WFM will be exploring the opportunity of third-party reimbursement.

Key partners:
Boston Public Health Commission, Catholic Charities, Charlton Memorial Hospital, Crittenton Women's Union, Harvard Catalyst, Massachusetts Children's Trust Fund, Massachusetts Department of Children and Families, & People Incorporated.

Your name and contact information:
Beth Buxton: Beth.Buxton@state.ma.us
Claudia Catalano : Claudia.Catalano@state.ma.us
Karin Downs : Karin.Downs@state.ma.us
Larisa Mendez-Penate : Larisa.Mendez-Penate@state.ma.us

Summary of Universal Home Visiting Programs

Program name:
Iowa Virtual Home Visitor System

Specific geographic locations served (e.g. county, zip code, state):
Intent is for this to be a statewide program but it could be expanded beyond Iowa if there is interest

Target population (all births, all first time births, teen parents, etc.):
All parents with children 0 to kindergarten entry

Provider characteristics (e.g. educational requirements/skills of all team members):
The virtual home visitor system is being designed, implemented and maintained by Iowa State University with sub-contracts with Texas A&M and Illinois State University

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
Ideally, there will be multiple points where a parent could become familiar with the virtual home visitor system. The intent is to engage parents prior to the birth of their child but they can become involved at any point. The virtual home visitor system will be linked to the Coordinated Intake and Referral system in Iowa that exists to provide information and referral to family support programming and Early Intervention Services (Part C.)

Number of service contacts and nature of each contact (home visit, telephone, etc.):
The system will have a variety of different levels of services. All parents may access the system and screen their child using the ASQ. Parents then will have the option of sharing the results of the ASQ with their health care provider, grandparents and child care provider. They will also have the opportunity to complete additional family assessments that will gauge family functioning and other aspects of healthy families. Families that choose to use the system at this level will receive lesson plans and activities that they can implement at home based on their assessment portfolio results. They will also have the option to access Iowa experts with their specific questions. They will also have access to podcasts, moderated chats and other methods to build skills and informal networks of support. Families, based on risk characteristic, may be referred to "real" home visiting programs at any time. All communication/contact is online in the virtual home visitor system.

Assessment tools used (standardized instruments, informal interview, etc.):
At this point in time, only the ASQ 3rd edition, and ASQ-SE have been identified but others assessment and screening tools will be used. The coordinated intake system utilizes a standard intake form to gather information including the ASQ to refer parents to appropriate services.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):
We have discussed all of the above, including resources, parental relationships, family functioning, coping skills, caregiver depression, etc.

Is assessment process used to triage participants to subsequent level of service?
Yes ☐x
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):
Enrollment in group-based parent education programs, intensive home visitation, referrals to other community-based resources.

Are you currently evaluating your efforts?
Yes ☐x

No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:
ISU is charged with developing an evaluation of the effectiveness of the virtual home visitor system. The evaluation has not yet been designed.

Current funding level and source:
$1 mil. Per year - MIECHV

Potential for ongoing funding:
Sponsors/advertisers/private pay fees

Key partners:
IDEA Part C – Early ACCESS, Iowa State University, Texas A&M, Illinois State University, parents

Your name and contact information:
Janet Horras, Home Visitation Director
Iowa Department of Public Health
321 E. 12th Street
Des Moines, IA. 50319
Janet.horras@idph.iowa.gov

Summary of Universal Home Visiting Programs

Program name:
Welcome Baby

Specific geographic locations served (e.g. county, zip code, state):
14 Best Start Communities within Los Angeles County (consisting of census block groups)

- Central Long Beach
- Compton/East Compton
- East Los Angeles
- South El Monte/El Monte
- Lancaster
- Metro Los Angeles (Koreatown, Pico Union, South LA, south downtown)
- Pacoima
- Palmdale
- Panorama City
- South Los Angeles/Broadway-Manchester
- South Los Angeles/West Athens
- Southeast LA
- Watts/Willowbrook
- Wilmington

Target population (all births, all first time births, teen parents, etc.):
All births at participating hospitals, currently limited to 25 of 60 LA County birthing hospitals delivering the most Best Start community births, with an at least 8% market share of births in at least one Best Start community. All births will be served whether family lives in our outside Best Start communities, but level of service differs between these two categories.

Provider characteristics (e.g. educational requirements/skills of all team members):
There are three types of providers in the Welcome Baby model:
A Parent Coach who conducts five home visits and two phone calls: Bachelor's degree in child development, social work, psychology, human development or related field, Child Development Associate (CDA) and experience in providing home visitation services, or community health worker/promotora
A Hospital Liaison, who conducts the hospital visit: Bachelor's degree in child development, social work, psychology human development or related field, or Medical Assistant certification and previous work experience in maternal and newborn health services preferred
A Nurse who conducts the first post-partum visit within a week of discharge: Registered Nurse

Initial point of engagement (prenatal clinic, hospital, service center, etc.):
For Best Start families: Prenatal clinic
For Non-Best Start families: Birthing hospital

Number of service contacts and nature of each contact (home visit, telephone, etc.):
Best Start Families (9 points of contact)

- One hospital visit, two phone calls, 6 home visits

Non-Best Start Famiies (Up to 4 points of contact)

- One hospital visit
- Two home visits & one phone call, as needed

Assessment tools used (standardized instruments, informal interview, etc.):

- Patient Health Questionnaire 9 (PHQ-9)
- Bridges for Newborns Risk Screening
- Home Observation for the Measurement of the Environment (HOME)
- Ages and Stages Questionnaire (ASQ)
- Life Skills Progression (selected sections being considered)

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):

- Family risk factors in the areas of basic needs, health, mental health, social support and child welfare
- Maternal depression
- Developmental milestones
- Parenting practices
- Home Environment

Is assessment process used to triage participants to subsequent level of service?

Yes ☒

No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):

Continuation of program or enrollment in intensive evidence-based home visitation programs, as well as referrals to existing community resources

Are you currently evaluating your efforts?

Yes ☒

No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:

The evaluation design is under development, but will focus on progress towards program objectives, outcomes and measures, as well as program quality and standardization. In addition, the evaluation plan will be supported by a program data system that will allow for comprehensive documentation of program level characteristics, direct service staff characteristics, participant level variables and participant experience. Staff time studies will also be supported by the data system to contribute to analysis of program efficiency and cost-efficiency.

Current funding level and source:
2012-2013 Projected Expenditures for Pilot and six new sites beginning February 1st: $4,513,778;
Commission funds on a zero-based annual programmatic budgeting process.

Potential for ongoing funding:
Commission committed through 2015, with expected continued commitment of undetermined length/scope.

Key partners:
Oversight Entity
Department of Public Health's Home Visitation Consortium
Other county departments
Best Start Community partnerships

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Summary of Universal Home Visiting Programs

Program name:

First Steps Georgia

Specific geographic locations served (e.g. county, zip code, state):

We currently have 19 active sites in Georgia based in the following communities: Savannah, Brunswick, Dalton, Conyers, Stockbridge, Covington, Rome, Clarkston, Cordele, Columbus, Decatur, Cartersville, Athens, Warner Robins, Statesboro, Fort Benning, Thomson, Griffin and LaGrange. Most communities serve a number of counties depending on community partners and funding.

Target population (all births, all first time births, teen parents, etc.):

Expectant parents, children 0-5 and their families within the geographic boundary established by the community. This is often all births at a local hospital.

Provider characteristics (e.g. educational requirements/skills of all team members):

At minimum, an associate's degree is required. See attached First Steps Coordinator job description which offers more detail.

Initial point of engagement (prenatal clinic, hospital, service center, etc.):

Varies depending on community. Traditionally, families are seen in a hospital or clinic setting.

Number of service contacts and nature of each contact (home visit, telephone, etc.):

The initial contact is most often done in person and follow up, if offered, is done by phone, email or regular mail. The initial contact includes an information interview (see next category) and a discussion of the needs of the family. A parent packet is provided to the family and materials from that packet are also discussed during the initial visit including the localized resource directory. First Steps will also provide linkages to other resources using the directory and materials. Follow up contacts vary depending on the site and the preferences of the family, but always include an opportunity for families to ask questions.

Assessment tools used (standardized instruments, informal interview, etc.):

First Steps is part of Great Start Georgia. FSG staff members use the Central Intake Entry Screen as a tool for the initial interview. Staff is trained to interview families using an informal, conversational style.

Core areas addressed during the assessment (parental capacity/skills, levels of support, basic care needs, etc):

Insurance for mom and child; primary care provider for mom and child, basic baby care needs, postpartum depression/baby blues, crying, home and community health and safety topics, safe sleep, shaken baby syndrome. Materials provided to families in each of the following categories: Maternal Health, Newborn/Child Health, Home and Child Safety, Community and Family Safety, School Readiness, Family Economics/Self-sufficiency

Is assessment process used to triage participants to subsequent level of service?

Yes Z
No ☐

If yes, what service options are offered to families (enrollment in intensive HV services, referral to other community resources, general information, etc.):

Family needs are assessed and as available and appropriate, families are referred to intensive home visiting services, public health services, mental health services, school and job training programs, substance abuse services, etc.

Are you currently evaluating your efforts?
Yes Z
No ☐

If yes, briefly describe your evaluation design and any key outcomes you have identified:

We are in the 4th year of a 5 year study being conducted by Johns Hopkins. Many of our sites have also chosen to participate in the Period of Purple Crying evaluation. Seven of our sites are associated with the Georgia MIECHV project which is being evaluated. In addition, every site offers families the opportunity to provide feedback on their experiences with the program through a short survey that is provided at the time of service, mailed, emailed or taken by telephone.

Current funding level and source:
Site funding was made available through a grant from the Georgia Governor's Office for Children and Families (GOCF) last year and 9 of our sites received that funding. Some sites receive partial funding from GOCF as a part of the MIECHV project or System of Care grant. Technical Assistance and Training services and data collection costs are also covered by funding through GOCF. Individual sites also receive funding from local partners and through fundraisers.

Potential for ongoing funding:

We continue to explore funding opportunities both at the state and local

levels. Key partners:

Governor's Office for Children and Families, Center for Family Research at the University of Georgia and site local partners.

Your name and contact information:

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