National Health Policy Forum

Promoting Evidence-Based Interventions:
Maternal, Infant & Early Childhood Home Visiting (MIECHV)

A State Perspective on Home Visiting
New Jersey Home Visiting Initiative

Contact Information:
Sunday Gustin, RN, MPH
Administrator, Early Childhood Services
NJ Department of Children & Families
sunday.gustin@DCF.state.nj.us

Dr. Lakota Kruse, MD, MPH
Medical Director, Family Health Services
NJ Department of Health
lakota.kruse@doh.state.nj.us
# Growth of Home Visiting in New Jersey

## Evidence-Based Home Visiting (HV)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>HFA model in 19 cities</td>
<td>1500 families Birth to Age 5 Title IVB/TANF</td>
</tr>
<tr>
<td>2000</td>
<td>Child Welfare Reform</td>
<td>HFA statewide expansion 1800 families–Birth to Age 5 TANF Funds – 2004-05 1st NFP site JJDP-2002 HV Workgroup</td>
</tr>
<tr>
<td>2005</td>
<td>↑ capacity / multiple models</td>
<td>Pregnancy to Age 3 HF, NFP, PAT (2006-07) State $$ NFP &amp; PAT (2008-09) ACF grant 2,400 families</td>
</tr>
<tr>
<td>2010</td>
<td>↑ HV availability</td>
<td>3 models in all 21 counties HF, NFP, PAT 5,000+ families 2011/2012 MIECHV Funds</td>
</tr>
<tr>
<td>2015</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>

CI to link HV within the MCH System in 2 cities

HRSA Healthy Start 2002

Central Intake (CI) Expansion

First NFP site JJDP-2002 HV Workgroup

Essentials for Scaling Up - Collaboration

Building Relationships and a Shared Vision

**NJ Statewide HV Workgroup** (early planning 2002-2006)

- Children & Families – CAN Prevention / Early Childhood
- Human Services – TANF, Medicaid, Child Care
- Health – Maternal & Child Health / Title V
- Education – Early Head Start/Head Start, Preschool
- Implementing HV Sites – HF, NFP, PAT, and HIPPY
- National Model Developers – HF, NFP and PAT
- Other Child and Family Advocates
Essentials for Scaling Up - Shared Vision

Build State & Local infrastructure to improve perinatal/early child coordination

- Link pregnant women, parents and families earlier to Home Visiting and/or other appropriate services.

Increase availability, capacity & positive impacts of HV services for at-risk families

- Focus on maternal (prenatal) and child health, child development, family functioning, self sustainability, child safety, and early learning.
Essentials for Scaling Up - Funding

Interdepartmental Partnerships - Braided Funds

• DCF – Federal ACF Title IVB (1994) - $2 million
• DHS – TANF (1995 and increase in 2005) - $5 million
• DCF – State Funds - $4 million
• DOH – HRSA Maternal, Infant & Early Childhood Home Visiting Formula Grant - $2 million // Competitive Grant - $9 million

Acknowledging Partner Strengths/Clarify Roles

• DOH Administrative Role for MIECHV funding (Title V)
• DCF Co-Lead Implementing Agency (co-funder for MOE)
• DHS (co-funder and coordination with TANF)
• DOE (coordination with existing Early Head Start sites)
Common Model Elements:
• Research-driven models
• Strengths-based / family-centered approach
• Relationship-based / Multi-Dimensional
• Visits begin early – prenatal/birth
• Voluntary participation of families
• Frequent, long-term home visits

Core design includes a focus on:
• Prenatal & parent health
• Infant and child health & development
• Parent-child interaction / infant mental health
• Parent Education / Family Social Support
• Early Literacy / School Readiness
• Path to Parent/Family Self-Sufficiency
## Multiple EBHV Models to Reach At-Risk Families

<table>
<thead>
<tr>
<th>Target Population</th>
<th>NFP</th>
<th>HF</th>
<th>PAT</th>
<th>EHS-HBO</th>
<th>HIPPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income, 1st time mother-to-be</td>
<td>Any at-risk pregnant woman/mother/family</td>
<td>Any at-risk pregnant woman/mother/family</td>
<td>Low income, pregnant woman/mother/family</td>
<td>Any family with a pre-school child</td>
<td></td>
</tr>
<tr>
<td>Pregnancy; no later than 28 weeks of gestation</td>
<td>During pregnancy or at birth; TANF families may enroll in infancy</td>
<td>Pregnancy, at birth, or anytime to age 3</td>
<td>Pregnancy, at birth, or anytime to age 3</td>
<td>Families with a child age 3 or 4 years old</td>
<td></td>
</tr>
<tr>
<td>Pregnancy up to age 2</td>
<td>Pregnancy and birth to age 3</td>
<td>Enrollment to ages 3 (to 5)</td>
<td>Enrollment to age 3</td>
<td>To age 5 or Kindergarten</td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>Family Support Workers</td>
<td>Parent Educators</td>
<td>Home Visitors</td>
<td>HIPPY Grads (part-time)</td>
<td></td>
</tr>
<tr>
<td>25 families (maximum)</td>
<td>15 to 25 families (maximum)</td>
<td>25 families (maximum)</td>
<td>12 families (maximum)</td>
<td>10 to 12 families</td>
<td></td>
</tr>
</tbody>
</table>
State Infrastructure for Multiple Models

Planning and Implementation (across models)
- Clarifying Roles: state oversight, national model developer (NFP), intermediary (HF/PAT), and implementing agencies
- Training: core and supplemental trainings
- Technical Assistance: fidelity, standards, outcomes, CQI

Data Collection & Tracking Systems (across models)
- State and Federal Benchmarks
- Reporting and Performance Tracking

Evaluation & Quality Improvement (across models)
- Collaborative approach with state/local/national HV partners
- Implementation & CQI focus (Johns Hopkins University)
Common Objectives Across HV Models
State and Federal Benchmarks

NJ State Process and Outcome Measures (2008)
- Level of Service (LOS) - enrollment / capacity
- Retention – are families staying connected? How long?
- Dosage – completed vs. expected home visits

MIECHV Six Target Areas – 36 Measures (2011)
1. Improving Maternal and Newborn Health
2. Reducing Child Injuries, Child Abuse & Neglect, Emergency Visits
3. Improving School Readiness & Achievement
4. Reducing Domestic Violence
5. Strengthening Family Economic Self-Sufficiency
6. Improving Coordination & Referral Linkages for Community Resources
Local HV Sites in New Jersey - 2014

NJHV capacity of 5,000 families
3 models serving all 21 counties

- 23 HFA - 2,100 families
- 21 NFP - 1,600 families
- 21 PAT - 1,200 families

Other EBHV Sites

- 1 HIPPY - 100 families
- 14 EHS Home-Based - 500 families
# HV Demographics (FY-2014)

<table>
<thead>
<tr>
<th>HV Participants</th>
<th>HF</th>
<th>NFP</th>
<th>PAT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families Served</td>
<td>3208</td>
<td>1625</td>
<td>1656</td>
<td>6489</td>
</tr>
<tr>
<td>• Pregnant at Intake</td>
<td>45%</td>
<td>100%</td>
<td>49%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Race &amp; Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hispanic</td>
<td>45%</td>
<td>45%</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>• Black Non-Hispanic</td>
<td>32%</td>
<td>34%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>• White Non-Hispanic</td>
<td>17%</td>
<td>15%</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>• Multiracial/Other</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Age: Teens (≤ age 19)</strong></td>
<td>35%</td>
<td>39%</td>
<td>26%</td>
<td>33%</td>
</tr>
</tbody>
</table>
# HV Impact & Outcome Measures* (FY-2014)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WOMEN - PREGNANCY:</strong></td>
<td>On-schedule Prenatal Care Visits</td>
<td>74%</td>
</tr>
<tr>
<td><strong>WOMEN - POSTPARTUM:</strong></td>
<td>Kept Postpartum Medical Visit</td>
<td>80%</td>
</tr>
<tr>
<td><strong>LOW BIRTH WEIGHT</strong></td>
<td>(2010 NJ rate 8.2% for all --13.3% for Black women)</td>
<td>11.3%</td>
</tr>
<tr>
<td><strong>MOTHERS:</strong></td>
<td>Initiated Breastfeeding (still breastfeeding at 4 weeks = 64%)</td>
<td>80%</td>
</tr>
<tr>
<td><strong>WOMEN:</strong></td>
<td>Subsequent Pregnancy (&gt;18 months birth to conception)</td>
<td>83%</td>
</tr>
<tr>
<td><strong>INFANTS/CHILDREN:</strong></td>
<td>Health Insurance / Medical Home</td>
<td>96%</td>
</tr>
<tr>
<td><strong>INFANTS/CHILDREN:</strong></td>
<td>Up-to-date for Developmental Screening</td>
<td>93%</td>
</tr>
<tr>
<td><strong>INFANTS/CHILDREN:</strong></td>
<td>Up-to-date for Immunizations</td>
<td>80%</td>
</tr>
<tr>
<td><strong>WOMEN:</strong></td>
<td>Mother Working or in School by the time child is age 2</td>
<td>60%</td>
</tr>
</tbody>
</table>

*NJHV preliminary data - CQI tracks many other performance indicators.
How do NJ families get linked to HV services?

**Systems-Building in NJ – Central Intake Features**

**Single Point of Entry** (toll-free number) - *easy access* for
- Information, eligibility, assessment & referral to family support services

**Reach Families Earlier** – beginning in pregnancy *(voluntary)*
- Universal Perinatal Risk Assessment (PRA) – 4 P’s Plus

**Effective Use of Limited Resources**
- HV programs stay focused on service delivery--not outreach
- Central Intake helps local HV programs reach capacity
- Reduces duplication of services / Identifies gaps in services

**Locally Driven** – Each county has a local lead coordinating agency
- Designated Central Intake Coordinator (1 FTE)
- Partnering with local outreach / Community Health Workers
Central Intake Features - continued

Feedback Loop - for incoming & outgoing referrals

Local Partnerships/Community Advisory Board – cross-sector input
  • Providers--prenatal, behavioral health, child health, HV, early intervention, social services, family support, early childhood, etc.
  • Parents and families

Referral and Data Tracking to local services
  • **SPECT** – Single Point of Entry Client Tracking System
  • Interagency agreements

Expanding Partnerships:
  • Child Care / Child Care and Development Fund (CCDF)
  • Child Welfare / Child Protective Services
NJ’s Early Childhood System of Care

Prenatal Care Providers

Primary Care Providers

Community-Based Agencies

Consumers and Families

Community Health Workers (CHW)
- Community Outreach
- Early identification of women & families needing services
- Refers to Central Intake (CI) via SPECT
- Followed for short term case management

Central Intake (CI)
CI staff reviews, refers & links parent/family to an appropriate partner agency for voluntary follow-up for an initial assessment, prevention education, and/or other needed services. Children are linked to a medical home and developmental.

Prenatal & Early Childhood Community-Based Services
- Home Visiting – HF, NFP, PAT, HIPPY
- Early Head Start / Head Start Programs
- Pregnant/Parenting Teen Services
- CCR&R - Infant & Child Care Providers
- State-Funded Preschool - Family Outreach
- Early Intervention - Part C - Birth to Age 3
- Special Education - Part B - Age 3 and up
- Special Child Health Services – Birth to 21
- Other Local Programs (vary by county): e.g. High-Risk Infants, Family Success Centers, Public Health Nurses, Centering Pregnancy

Community-Based Health, Family Support & Social Services
- Medical Home/Primary Care
- Mental Health & Addiction
- Child Behavioral Health
- Developmental Disabilities
- Domestic Violence Services
- WIC Program
- Food Assistance / SNAP
- Infant & EC Mental Health
- Family Success Centers
- Fatherhood Support
- School-Based Services
- Parent Education & Support
- Child Lead Poisoning
- Local Health Departments
- CHIP/Health Insurance
- Public Assistance
- Housing / Transportation
- Immigration Services
- Child Protective Services
- And more...

Agenda for Local Collaboration
- Develop interagency agreements for referral and data sharing
- Establish a referral flow chart with community partners
- Provide cross-training & shared inservice
- Use data system for tracking & analysis
- Identify gaps in referral resources
- Consumer Community Advisory Board
Aligning Early Childhood Initiatives

Continue to Strengthen Collaboration across sectors HV, Health, EHS/HS, Child Care, Preschool, Education, Early Intervention, Special Child Health, Child Welfare, Family Support, etc.

Systems Integration
- Early Childhood Comprehensive Systems (ECCS)
- Help Me Grow (to age 5)
- Project LAUNCH (to age 8)
- Race To the Top—Early Learning Challenge (RTT)
- Healthy Start