

# Strategies for Building a Statewide System of Home Visiting in West Virginia

Findings from  
Key Informant Interviews  
and Other Sources

Report prepared for  
Partners in Community Outreach  
By Julie Pratt

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# Strategies for Building a Statewide System of Home Visiting in West Virginia

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### **Project Advisors**

Michele Baranaskas, Partners in Community Outreach  
Stephanie Barnett, Northern Panhandle Head Start/Early Head Start – MIHOW Program  
Angie Davis, Tucker County Family Resource Center – Parents As Teachers  
Jennifer Freeman, Mountain State Healthy Families  
Laurie McKeown, TEAM for West Virginia Children  
Mindy Nicholson, Brooke-Hancock Family Resource Network – Parents As Teachers  
Jennifer Parsons, Upper Kanawha Valley Starting Points – Parents As Teachers  
Nonie Roberts, Vanderbilt University School of Nursing MIHOW Program

## Introduction

Home visiting programs have been operating in West Virginia for more than 30 years, starting with Maternal Infant Health Outreach Workers (MIHOW), launched in 1984 by the New River Health Association, in collaboration with Vanderbilt University. Over the years, other programs started that employ home visitors to provide services to pregnant women and new parents in their homes, including Early Head Start, Healthy Families America, Healthy Start/Helping Appalachian Parents and Infants (HAPI), Parents As Teachers and Right from the Start.

Despite mounting evidence of their effectiveness, home visiting programs have lacked steady and sufficient funding, resulting in limited access to services in many communities. That is beginning to change with the implementation of the federal Maternal Infant Early Childhood Home Visitation (MIECHV) program, which provides millions of dollars to West Virginia each year to build a statewide system of evidence-based home visiting programs.

Partners in Community Outreach sponsored this project to examine strategies for building a statewide system of home visiting that promotes quality services and positive outcomes for young children and their families. Partners in Community Outreach is a coalition of West Virginia's evidence-based In-Home Family Education (home visiting) programs.

Part 1 of the report examines what is being done in our state and nation to advance home visiting practice with families where domestic violence, mental health and/or substance abuse issues are present. Part 2 explores issues related to the development of state home visiting systems, and Part 3 offers key questions to consider as we move forward as a state. The Project Advisors (listed on previous page) will discuss the report findings and next steps in June.

The report focuses primarily on the opportunities provided for West Virginia's home visiting programs that are recognized under MIECHV as evidence-based (Early Head Start, Healthy Families America and Parents As Teachers) or promising practices (MIHOW). It also includes helpful "lessons learned" from other programs and states.

Sources of information for this report included consultation from Barbara Gebhard, ZERO TO THREE; a forum with 20 Partners in Community Outreach members in December 2014; and 12 key informant interviews conducted in April and May 2015 with people from home visiting programs in West Virginia; state home visiting administrators in Montana, Oklahoma, Washington and West Virginia; and other partnering organizations (see Appendix A).

### **For more information about Home Visiting:**

West Virginia Home Visitation Program  
Office of Maternal, Child and Family Health  
<https://www.wvdhhr.org/wvhomevisitation/>

Partners in Community Outreach  
<http://www.wvpartners.org>

Maternal Infant Early Childhood Home Visiting  
(MIECHV) Program  
<http://mchb.hrsa.gov/programs/homevisiting/index.html>

# Part 1: Critical Issues in Home Visiting Practice

## *The Challenges of Domestic Violence, Mental Health and Substance Abuse Issues*

Home visitors frequently work with families for whom domestic violence, mental health and/or substance abuse issues (DV/MH/SA) are a serious concern, where it is common for multiple issues to be present. While home visiting alone is insufficient to address these problems, home visitors play an important role in the overall community response, which also involves health and mental health providers, child welfare agencies, law enforcement, the courts and others.

During the forum and interviews, home visitors identified strengths and challenges in working with families affected by DV/MH/SA, which are summarized in the table below. At the center of “what works” in home visiting is a trusting relationship between the home visitor and family, which enables families to feel safe in discussing and working on problems. Among the top challenges are situations that threaten the safety of home visitors and family members, which many home visitors feel are increasing due the rise in illegal drug use.

<b>Working with families with domestic violence, mental health and substance abuse issues</b>	
<b>What works?</b>	<b>What are the challenges?</b>
<ul style="list-style-type: none"> <li>• Rapport and trust between family and home visitor that builds over time</li> <li>• Longevity and experience of home visitor</li> <li>• Specialized training and consultation for home visitors regarding DV/MH/SA</li> <li>• Services and resources that are available and accessible in the community to help families address these issues</li> <li>• Collaboration among home visitors and other community programs</li> <li>• Public policies and funding that effectively address DV/MH/SA</li> </ul>	<ul style="list-style-type: none"> <li>• Situations that threaten the safety of home visitors and family members and sometimes preclude meeting in homes; in some cases, lack of home visitor awareness of risks.</li> <li>• Maintaining a program culture of positivity and providing sufficient training and support for home visitors</li> <li>• High expectations and low wages of home visitors, which contribute to high turnover</li> <li>• Social stigma and other consequences for families of disclosing some issues; families leaving programs after home visitors ask questions about DV/MH/SA</li> <li>• Cultural norms that encourage or condone substance abuse</li> <li>• Lack of high quality and timely services to help families address DV/MH/SA in some parts of the state, coupled with financial and transportation barriers</li> </ul>

## *Current and Potential Efforts to Address DV/MH/SA in West Virginia*

Interviewees and forum participants identified numerous initiatives focused on supporting home visitors in their work with families where DV/MH/SA issues are present. In addition to the model-specific training, guidance and support provided by each home visiting program, the following resources pertain to home visiting in general:

- Assessment and identification of DV/MH/SA
- Early Childhood Mental Health Consultation
- Early Childhood Partnerships at University of Pittsburgh
- Healthy Moms, Happy Babies: A Train the Trainers Curriculum
- Incarcerated parents initiatives
- Michigan Association for Infant Mental Health
- Moving Beyond Depression (In-Home Cognitive Behavioral Therapy)
- Substance abuse prevention coalitions
- West Virginia Perinatal Partnership: Drug-free Moms and Babies
- West Virginia Home Visiting Conference

Each of these initiatives is described below. While these efforts are having positive effects in West Virginia, some are yet to be implemented throughout the state and embedded as ongoing practices.

**Assessment and identification of DV/MH/SA** are part of staff training and development for each home visiting model operating in West Virginia. Questions about substance use are included in the initial family assessment conducted by each program, and the Healthy Start/HAPI program uses SBIRT (Screening, Brief Intervention and Referral to Treatment). Home visiting programs that receive MIECHV funding through the West Virginia Home Visitation Program (WVHVP) are required to use the HITS screening tool for domestic violence and the Edinburgh screen for maternal depression.

Interviewees and forum participants reported that DV/MH/SA concerns are often not reported by parents during the initial assessment/screening due to fear of losing their children or other trouble if they disclose. Only after parents have developed trust with their home visitors are they likely to disclose such problems. There was broad consensus that home visitors need to approach these subjects with respect and sensitivity in order to maintain their relationships with the parents and empower them to make healthy choices for themselves and their families. Home visitors also need to be knowledgeable and prepared to involve child protective services when such action is required.

Many interviewees and forum participants noted that they were pleased with the training available in West Virginia on maternal depression, but felt they needed more training and support for other serious mental health issues they encountered with families, such as bipolar disorder, PTSD and schizophrenia, as well as psychotropic medications and their use.

**Early Childhood Mental Health Consultation** involves a partnership between an early childhood mental health professional and home visiting programs, staff, and families. This integrated model promotes parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the mental health needs of children and families. Equally important, the consultant provides mental health support for the home visitors. A helpful article on the subject is “Enhancing Home Visiting With Mental Health Consultation” by Barbara Goodson and others, published in 2013 in *Pediatrics*. See article at: [http://pediatrics.aappublications.org/content/132/Supplement\\_2/S180.full.pdf](http://pediatrics.aappublications.org/content/132/Supplement_2/S180.full.pdf).

The WVHVP and Partners in Community Outreach are working with First Choice Health Systems to develop a pilot project in Early Childhood Mental Health Consultation in West Virginia, which would offer three levels of consultation from a mental health expert via a toll-free number, tele-health or Skype, in-person group consultation regarding families, and individual therapy sessions for home visitors.

Northern Panhandle Head Start/Early Head Start has had a similar type of relationship with **Early Childhood Partnerships (ECP) at University of Pittsburgh** for the past 12 years. ECP is a community-based consultation, mentoring, direct service, and applied research collaborative among the University of Pittsburgh Schools of Education (Psychology-in-Education – Applied Developmental Psychology program; the Office of Child Development), and Pediatrics (affiliated with Children's Hospital of Pittsburgh of UPMC) and with regional, state, national, and international partners. ECP consults with Northern Panhandle Early Head Start home visitors on a range of developmental and behavioral health issues, including home visits with families.

**Healthy Moms, Happy Babies: A Train the Trainers Curriculum** was created by Futures Without Violence to support state agencies and home visitation programs in developing a core competency strategy and to ensure that all home visitors have training and resources to help women and children living in homes with domestic violence. The WVHVP is working with the West Virginia Coalition Against Domestic Violence (WVCADV) to bring that training to the state.

This initiative expands on the “Domestic Violence 101” training workshops that WVCADV has been providing home visitors for several years. Laurie Thompsen of WVCADV and others attended a national Train the Trainers workshop and have begun training home visitors here using a three-phase approach:

- One-day intensive training workshops in May conducted at five different locations
- A series of webinars after the initial training
- Local in-person follow-up meetings for further consultation and learning

Texas offers an example of efforts to institutionalize policy and practice regarding domestic violence and home visiting. **Project Connect |Texas** worked with Futures Without Violence and the Texas Healthy Start Alliance to develop the *Domestic Violence Protocol for Home Visiting*

*Programs and Home Visitation Guidelines on Screening, Assessment and Response to Domestic Violence.* These tools offer guidance to home visiting programs on developing a locally informed domestic violence protocol and an outline for building collaborative partnerships with local domestic violence programs. They also seek to build the capacity of home visiting programs to support clients experiencing violence and offer guidance to home visitors on how to safely and sensitively assess for and respond to domestic violence.

**Incarcerated parents** often have DV/MH/SA issues, and some home visiting programs in the state are working with parents in the corrections system. One nationally recognized program is the Keeping Infant Development Successful (KIDS) program, a collaboration between Early Head Start and the Lakin Correctional Center for women in Mason County, where new mothers live with their babies and receive parenting education and support for up to 18 months. An article about the program was published by the American Correctional Association and is available at: [http://www.aca.org/ACA\\_PROD\\_IMIS/Docs/Corrections%20Today/2014%20Articles/Nohe.pdf](http://www.aca.org/ACA_PROD_IMIS/Docs/Corrections%20Today/2014%20Articles/Nohe.pdf).

Another example is the New River Health Association MIHOW program, which is collaborating with the Fayette County Day Report Center to facilitate a weekly parent mutual self-help group called Circle of Parents. Mercer County Starting Points is in the process of launching a Circle of Parents group with their local Day Report Center. Circle of Parents has also been offered in the past by the Pocahontas Family Education and Outreach Center to inmates at Greenbrier Birthing Center, which is operated by the Federal Bureau of Corrections.

**Michigan Association for Infant Mental Health (MI-AIMH)** is an organization devoted to strengthening relationships between infants, parents and other caregivers (<http://www.mi-aimh.org>). The goal of “infant mental health” is to assure nurturing relationships for all infants and toddlers to provide the essential formative context in which every infant and toddler acquires the basic emotional, cognitive, and social capacities and attitudes that influence later development.

TEAM for WV Children has entered into a licensing agreement with MI-AIMH to use the MI-AIMH Competency Guidelines and the MI-AIMH Endorsement® to develop and recognize competency-focused, relationship-based practice promoting infant mental health. In conjunction with this, the West Virginia Infant/Toddler Mental Health Association was recently established and is developing a website at <http://www.nurturingwvbabies.com>.

**Moving Beyond Depression** is a program of In-Home Cognitive Behavioral Therapy (IH-CBT) developed by researchers at Every Child Succeeds and Cincinnati Children’s Hospital Medical Center. The program involves three phases instituted over two years: (1) on-site training of home visitors in identification of maternal depression and their role in the program, (2) training of therapists in Cincinnati in IH-CBT treatment, (3) ongoing training and support of therapists, Team Leaders, and program leadership in implementation of the program. For more information, see <http://www.movingbeyonddepression.org>.

The WVHVP is working with the Pretera Center on plans to bring the Moving Beyond Depression program to West Virginia, starting in southern part of the state. Therapists would bill Medicaid for the sessions, and WVHVP would cover travel costs for the home visits.

**Substance abuse prevention coalitions** are active in most counties, and Northern Panhandle Head Start contracts with the Ohio County Substance Abuse Prevention Coalition to provide training to home visitors. The DHHR Bureau for Behavioral Health and Health Facilities provides \$1.8 million in funding for prevention services. For a state directory of substance abuse services (prevention, early intervention, treatment and recovery) see:

<http://www.dhhr.wv.gov/bhhf/Sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Documents/WV%20Substance%20Abuse%20Services%20Directory%201.13.15.pdf>.

Another example of substance abuse training tailored to home visitors is a day-long training event called *Substance Abuse During Pregnancy and Beyond - A Conference focusing on Home Visiting*, sponsored by the **New Hampshire Children's Trust**. The program featured nine presentations from health, mental health, social service and law enforcement professionals. The program and presenters are posted at <http://www.nhchildrenstrust.org/event/substance-abuse-during-pregnancy-and-beyond-a-conference-focusing-on-home-visiting>.

**West Virginia Perinatal Partnership: Drug-free Moms and Babies** is a comprehensive and integrated medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services. The four pilot sites are Shenandoah Valley Medical Systems (Eastern Panhandle), Thomas Memorial Hospital (South Charleston), Greenbrier Valley Medical Center (Ronceverte), and West Virginia University Ob-Gyn Department (Morgantown). See Appendix B for a description of the program and the issues involved in working with women using substances during pregnancy, as well as appropriate care for their newborns.

Another collaboration that addresses perinatal substance use is the parenting group conducted by the New River Health Association MIHOW program at the Turning Pointe facility in Beckley, which provides residential treatment and support services for pregnant and postpartum women. In Ohio County, the Wheeling Hospital Center for Pediatrics is creating a social work position dedicated to helping pregnant and postpartum women get addictions treatment and services.

**West Virginia Home Visitation Conference** is held annually by the WVHVP for home visitors, supervisors and administrators. The conference includes numerous workshops related to working with families where DV/MH/SA issues are present. See 2015 conference program at [https://www.wvdhhr.org/wvhomevisitation/files/WVHC\\_Conference\\_Materials\\_2015.pdf](https://www.wvdhhr.org/wvhomevisitation/files/WVHC_Conference_Materials_2015.pdf).



## Part 2:

# Key Issues in Developing a Statewide System

Home visiting involves multiple models with separate sets of credentialing requirements and funding from multiple sources, each with their own rules and expectations. To get the most from our available resources, West Virginia needs a statewide home visiting *system* that makes sense to parents, communities and providers and that achieves the best possible outcomes for children and families.

Efforts to create such a system are already underway. Based on comments from interviewees and forum participants, the following emerged as key issues to address as we move forward:

1. What unifies home visiting programs as a system?
2. Who will be served by a statewide system?
3. What home visiting models will be used, and how?
4. What infrastructure is needed for home visiting?

Each question is addressed below with comments made by home visitors and supervisors; state home visiting administrators in West Virginia, Montana, Oklahoma and Washington; and partners in allied organizations. The intent is to offer insights, versus definitive answers, in order to help frame the issues for further discussion by home visiting stakeholders.

### 1. What unifies home visiting programs as a system?

Marlene Midget, Executive Director of Northern Panhandle Head Start and Early Head Start, has seen a lot of changes during her nearly three decades in Head Start. During her interview, she observed that the most successful changes are usually ones where **all stakeholders are at the table** and actively involved in planning the change and how it will be implemented. Conversely, the lack of involvement of all parties often results in problems that are difficult, if not impossible to resolve.

The Governor's Early Childhood Planning Task Force reached similar conclusions in its Zero-to-Four Early Learning Expansion Study in 2014. The study examined ways to increase high-quality early learning opportunities for children under four years old in group settings, including lessons learned from the development of four-year-old Pre-K in West Virginia. The final report emphasized the importance **collaborative relationships** among all stakeholders:

“Relationships are the lynchpin for creating an effective and responsive system. These include the relationships program providers have with the children and families they serve, with other programs in their community, and with the state and federal agencies that fund their efforts. The relationships take time, transparency and trust to build and maintain. Support for meaningful parent involvement, strong local collaboration and

effective communication among partners at all levels is essential.” (Page 10 in *Relationships, Resources and Results: Highlights of Key Informant Interviews*, available at <http://www.wvecptf.org/docs/Relationships%20Resources%20Report%20FINAL.pdf>)

Sue Julian was a co-founder of the West Virginia Coalition Against Domestic Violence in 1984 and one of its first staff members. During her interview, she reflected on the early work of forming the Coalition and the importance of the members agreeing on how they would work together to build a statewide system. Their first collective project was the development of **“Principles of Unity.”** (See Appendix C.) These have served as the philosophical underpinning of the Coalition’s work and relationships as it has evolved over the years. In addition, the Coalition agreed on a **method of decision-making** to use in all aspects of its work, as well as a commitment to fairness across programs and transparency.

In the absence of a formalized lead state agency for home visiting prior to 2010, Partners in Community Outreach members created a voluntary “system” of sorts, collaborating across models on issues related to funding, best practices and staff development. With the creation of MIECHV, many requirements for home visiting are spelled out by the federal government, with limited state and local discretion. The lead state agency has established a **Home Visitation Stakeholders Team**, which meets several times a year and includes representatives from each MIECHV-approved program model in the state and other partnering organizations.

## 2. Who will be served by a statewide system?

There was broad agreement among the interviewees and forum participants that an effective statewide home visiting system would assure the provision of home visiting to **all families who want it**. While program models vary in their eligibility criteria related to income and age limits, the idea is that – collectively – the programs would be able to serve all families who are expecting or have young children.

Estimating the number of **families who would actually participate** in home visiting if it was well-advertised and widely available is challenging. At the request of the Early Childhood Planning Task Force in 2013, Partners in Community Outreach developed an estimate of *likely* participation rates if evidence-based home visiting programs were fully implemented statewide over the next ten years. The group contracted with Steve Heasley, who estimated that about 9,000 families and 12,000 children would be served annually, based on the factors described in the table below. These numbers should be considered the *minimum* likely participation rates and could increase, depending on how well the programs are promoted. (For more detail on these cost estimates, see the full report *Statewide Access to In-Home Families Education Services: Estimating Costs of Universal Access for West Virginia Families at* <http://www.wvpartners.org/documents/2013UniversalAccessReport.pdf>.)

## Estimate of Likely Participation Rate in Statewide System of Evidence-Based Home Visiting

Line		#	Source
1	# pregnant women (3+ mos) & children <5	113,085	US Census ACS, 3-yr estimates, 2009-11
2	# prenatal to 5 population with risk factor	74,636	NCCP, WV estimate of 66%
3	# families represented in above number	57,412	PCO estimate of 1.3 children <5 per family
4	# families likely to participate	20,094	OMCFH estimate of 35% based on RFTS rates
5	Average # years of participation	2.5	OMCFH estimate based on current families
6	Total years of participation	50,236	Line 4 multiplied by Line 5
7	Range of years of participation	5.5	three months pregnant to child'd 5th birthday
8	<b>Average # families served annually</b>	<b>9,134</b>	Line 6 divided by Line 7
9	<b>Average # children served annually</b>	<b>11,874</b>	Line 8 multiplied by 1.3

### 3. What home visiting models will be used, and how?

For many years, home visiting programs in most states existed on a small scale and scattered basis, piecing together various funding sources to stay afloat. The federal funding stream provided by the MIECHV Program offers the opportunity to create a quilt from these local efforts and enlarge it over time to cover the entire state.

Questions that most states are grappling with include (1) the models of home visiting in which to invest public funding and (2) how the different program models fit together in a statewide system. The experiences of three other states (Montana, Oklahoma and Washington) are summarized in Appendix E. Like West Virginia, all three states support multiple evidence-based models. Overall, the approaches fall into four following categories:

- Geographic designation of programs
- Age-based designation of programs
- Service integration
- Model integration

#### *Geographic designation of programs*

This approach allocates public funding to particular programs to serve particular areas. This has been the primary strategy for allocating MIECHV funds in West Virginia. Early on, there was a community planning process that included communities choosing the MIECHV-approved model they wanted to implement (Healthy Families America, MIHOW or Parents As Teachers). More recently, expansion of services has occurred by the WVHVP contracting with established home visiting to expand into adjoining counties. Communities are still engaged in the planning for home visiting, but do not choose the model or provider, since the WVHVP views the models as having comparable goals.

Montana supported three home visiting models prior to MIECHV – Parents As Teachers, Nurse-Family Partnership and a small public health-based home visiting program. As the state developed its plan for MIECHV, the decision was made to continue to support more than one evidence-based model because of the strong identities of local communities and the desire to respond to local needs and preferences.

Based on Montana’s experience to date, state administrator Dianna Frisk continues to support providing multiple evidence-based models and allowing local coalitions to choose what’s most appropriate for them. She has also learned how much time and effort it takes to build that local capacity and the need to structure subcontracts with specific expectations and timelines.

In Washington, former state administrator Kelli Bohanon said the state uses a portfolio approach to invest in a range of models and programs that will meet the needs of diverse populations. The portfolio attempts to balance grant distributions statewide and distribute funds to achieve geographic and racial/ethnic diversity. The portfolio also reflects an investment in making allocations to organizations with a range of capacities. Typically, they invest in organizations with high capacity, moderate capacity, and low capacity at equal rates per model.

#### *Age-based designation of programs*

This approach allocates public funding to particular programs to serve families at different stages of pregnancy and early childhood. In some cases, this happens by default. In West Virginia, for example, Right from the Start starts prenatally and ends no later than the child’s first birthday. If families want to continue home visiting services beyond that time, they must enroll in one of the MIECHV-funded programs, which serve families until their children are at least three years old. (The exception is the counties where HAPI collaborates with RFTS to serve families until the child’s second birthday, as described in the next approach.)

Oklahoma recently formalized this age-based approach for home visiting programs that receive public funding. The change was prompted by problems with providers competing with each other for certain families, according to state administrator Annette Jacobi. The new approach works as follows:

- Nurse-Family Partnership serves first-time mothers up to 29 weeks of pregnancy, and is provided only by county health departments.
- Healthy Families America serves first-time mothers who seek home visiting between the 29<sup>th</sup> week of pregnancy and the child’s third month, and can be sponsored by county health departments or nonprofit agencies.
- Parents As Teachers serves families who don’t meet either of the above criteria, and can be sponsored by county health departments or nonprofit agencies.
- SafeCare serves families that need more intensive services than the other three programs provide, and is available only in metropolitan areas where they can recruit qualified therapists.

Annette said that the new system isn't perfect, nor is it popular with some providers. But it does make home visiting services easier for families to navigate. She cautioned that you can't compare the outcomes of NFP, HFA and PAT under this system because NFP starts serving families earlier, resulting in better outcomes.

### *Service integration*

Under this approach, two or more programs formally pool their financial and human resources to serve families. An example of this approach in West Virginia is the collaboration between Right from the Start and the Healthy Start/HAPI program in eight counties in the northern part of the state. Right from the Start is the state's Medicaid perinatal case management home visitation program. HAPI is a federally-funded Healthy Start project, administered and implemented by West Virginia University, to improve maternal well-being during pregnancy, postpartum and the interconceptional period.

By creatively "braiding" their funding, the two programs accomplish more than they would if working separately, according to HAPI Director Penny Womeldorff. Families are able to receive a wider range of services over a longer period of time, up to the child's second birthday. The programs provide families a seamless experience by working through the same local care coordinators. For a more detailed description of this approach, see Appendix D.

### *Model integration*

This approach combines different models and resources under one agency. Oklahoma is in the process of implementing two experiments with model integration, which are being evaluated by a university researcher:

1. In three rural counties with MIECHV funding, local health departments, using NFP, HFA and PAT resources, will hire a team of the following positions:
  - 2 nurses
  - 2 parent educators
  - 1 community connector (to develop and support referral network)
2. In four counties with state funding only, the county health department is ending its NFP model and adding a nurse to its PAT program.

Oklahoma state administrator Annette Jacobi emphasized how important it's been to be clear about what they hope to accomplish, including the number and needs of families to be served, along with the type and intensity of home visiting needed to achieve the desired outcomes. It's especially important for policymakers to have realistic expectations of the likely returns on investment. For example, the most dramatic outcomes are typically found with programs that target high-need families and provide high-intensity services, at a correspondingly higher cost. Less intensive services may be more appropriate for lower-risk families, at a lower cost.

In West Virginia, state administrator Jackie Newson wants to support stronger teamwork among home visiting programs, the medical case management provided by Right from the Start and the early intervention services offered by Birth to Three. Her vision is for families to have a seamless experience when receiving more than one of these services. This could be accomplished through interagency “teams” of staff across programs working from a shared plan and reinforcing each other’s work. Agencies that provide two or three of the programs could do the same thing under a single agency umbrella.

#### 4. What infrastructure is needed for home visiting?

Home visiting programs cannot succeed in a vacuum. They depend on local collaboration with other early childhood, health, mental health and social service programs, and on public agencies to provide support, leadership and resources. The infrastructure issues that emerged most often during the interviews included governance, funding and community capacity building.

##### *Governance*

There are several features of other state early childhood governance structures that are worth noting. One of those features in a number of states is the adoption of a **comprehensive plan for early childhood**, which includes home visiting as a core component. In West Virginia, the Early Childhood Planning Task Force collaborated with the Early Childhood Advisory Council to create a Development Plan for Early Childhood, which ranked home visiting second out of nine recommendations that require additional funding. The plan was submitted to Governor Tomblin in late 2014, and no official action has been taken to date. (See plan at [http://www.wvecptf.org/docs/WVECPTF%20Development%20Plan\\_single%20page.pdf](http://www.wvecptf.org/docs/WVECPTF%20Development%20Plan_single%20page.pdf).)

In Montana, the state home visiting program has focused considerable effort on **building local capacity and leadership**, not only for home visiting, but for the local early childhood system upon which home visiting relies. Montana has 23 Best Beginnings local coalitions, serving 17 of the state’s 56 counties and six of its seven reservations. The local coalitions work to increase coordination across child and family systems at the grass roots level. They conduct community needs assessments; develop plans and priorities for the early childhood system; provide professional development; build capacity, infrastructure, and communication; focus on sustainability; and support the implementation and integration of home visiting programs within the early childhood system.

Montana’s MIECHV Development Grant helped to strengthen the state-level Best Beginnings Advisory Council and to expand the number of local coalitions. When the grant funding ended, the state continued to support the local coalitions with money from the Children’s Trust Fund and Project LAUNCH.

Washington is well-known for its **strong public-private partnership**. Former state administrator Kelli Bohanon said the partnership with the private sector was key in positioning the state to respond to federal opportunities like MIECHV, Project Launch, and Race to the Top Early Learning Challenge. The key entities of the partnership include the following:

- Department of Early Learning (DEL), the nation’s first cabinet-level department for early childhood, was formed by Governor Christine Gregoire in 2006. Early learning programs and provider professional development opportunities, which had been under several different state agencies, were unified in DEL. DEL also provides information and tools for parents.
- Thrive Washington represents the private arm of the public-private partnership. In January 2014, Thrive by Five Washington and the Foundation for Early Learning, two of the state’s key early learning organizations, merged to form Thrive Washington, with an annual budget of more than \$16 million. Thrive partners with DEL on ongoing development of the EC system, including supporting Regional Early Learning Coalitions, administering certain grant programs (including home visiting), and advancing parent engagement and racial equity.
- There are 10 Regional Early Learning Coalitions, which serve areas closely aligned with the state’s Educational Service District boundaries. The Coalitions include service providers in the region but do not provide direct services (similar to WV’s FRNs). They assist in implementing the State Early Learning Plan and aligning regional efforts to statewide priorities. Kim said their #1 charge is representing the unique needs of their regions. She said that the “latest coolest thing” is the involvement of the Coalitions in public policy advocacy, supported by training from Thrive using private dollars.

In West Virginia, the evolution of the statewide system of domestic violence programs offers potential insights for home visiting. The Coalition Against Domestic Violence developed the original plan for 14 service regions that would cover all counties as funding became available. The plan included expansion of the 12 existing programs and addition of two new programs. When the lead state agency decided that a set of standards were needed for DV programs, it asked the Coalition to develop them. The Coalition has also worked with the state to establish funding formulas for how the different funding streams are allocated across member programs.

### *Funding*

The state home visiting administrators talked about the **importance of developing multiple funding streams** for home visiting. One reason is that most public funding is quite prescriptive about how the funds can be used and for whom, so creating a universal system of home visiting required blending and braiding available funds. The second reason is to promote sustainability by not relying too heavily on any one source. Third, the state administrators appreciated having private sector dollars in the mix, not only for the financial benefit, but also to develop business champions and advocates for home visiting.

The State of Washington has been particularly successful in attracting private funds. In 2010, the state legislature created the **Home Visiting Services Account (HVSA)** to blend federal, state, and private dollars to efficiently and effectively serve families across the state and to provide technical assistance to programs. An estimated \$15 million will be invested in home visiting in FY 2014-15, including 71 percent federal funding, 11 percent state funding and 18 percent private funding. The Department of Early Learning oversees the HVSA, and Thrive Washington administers it. Thrive also raises private funds to match public support. (E.g. Bill Gates' father made an \$8 million donation to the HVSA.)

In West Virginia, Partners in Community Outreach contracted with Steve Heasley to research financing options for supporting In-Home Family Education programs in the state, including direct and indirect state and federal appropriations; flexibility within categorical funding streams; Medicaid options; and private and market-based financing strategies. The full report is available at <http://www.wvpartners.org/documents/HomeVisitingFinancingReport12-31-2013.pdf>. The report concluded that:

“Increasing the resources available for local programs is a matter of deciding on one or more financing strategies that appear to be most viable and working with others to pursue that strategy. Careful consideration should be given to how particular financing strategies may or may not require changes in the way services are delivered and/or impose additional administrative costs on already underfunded programs. Clearly, the goal is to achieve a net gain in program capacity and delivery of high quality services to families. Any increased level of financing achieved by tapping additional funding streams should be weighed against any additional costs associated with reporting, billing, and record keeping to assure there would be a sufficient net gain in program capacity at the service delivery level.”

Jackie Newson, West Virginia's state administrator for home visiting, is pursuing strategies to diversify funding for home visiting programs, with particular focus on three areas:

- a. **Support from businesses** that see the value of home visiting in helping parents engage and succeed in the workforce. While the amount of funding may be modest, it could help pay for various improvements that existing budgets can't address. In addition, a stronger relationship with local businesses could also help develop more private sector "champions" for sufficient public funding for home visiting programs.
- b. **Support for home visiting from other DHHR programs** around shared goals, with funding from those programs to support outreach and education by home visitors on those issues. Examples include immunizations, safe homes and smoking cessation.
- c. **Title I funding** to support the "school readiness" benefits of home visiting, especially but not limited to PAT and Early Head Start-Home-Based Option, which serve children over three years old.

Jackie is committed to collecting and using credible data to evaluate programs, improve quality, track outcomes and be accountable to funders. She is pleased with the evolution of the state's



home visiting data system as required by MIECHV. She would like to see all home visiting programs collect and report their data in a timely fashion to assure quality and sustain funding. While the state agency is charged with creating and implementing the home visiting data system, its success hinges on program participation, and the program partners are often the best source of ideas for each other on how to establish timely data reporting by home visitors.

### *Community capacity-building*

Montana received fewer proposals than expected when it released its first RFP under MIECHV because many communities felt they didn't have the capacity and infrastructure needed. That led to the decision to use a substantial amount of the first grant for developing local coalitions to serve as planning and coordinating bodies for early childhood, including home visiting. Dianna Frick believes that the approach of "growing from where you are" applies not only to the families served by home visiting, but to home visiting organizations and communities as well. State agencies need to be prepared to start at as basic a level as needed.

Dianna referenced the following as a valuable resource in their system development work: "Active Implementation Frameworks for Program Success: How to Use Implementation Science to Improve Outcomes for Children," by Alison Metz, available online at: <http://www.iod.unh.edu/APEX%20Trainings/Tier%20%20Manual/Additional%20Reading/4.%20Implementation%20article%20Metz.pdf>.

In West Virginia, the WVHVP supports a community planning process in areas where home visiting programs are being introduced. Nationally, ZERO TO THREE has developed a Home Visiting Community Planning Tool (<http://www.zerotothree.org/public-policy/state-community-policy/home-visiting-community-planning-tool-fillable-pdf.pdf>) to help communities:

- Identify community needs and strengths based on data,
- Explore current home visiting assets and service gaps,
- Choose an evidence-based program model, and
- Analyze components of both program-level and system-level implementation that are critical to the replication of high-quality home visiting programs.

## Next Steps

As Partners in Community Outreach continues to work with the WVHVP and other partners on the issues described in this report, the following are key questions to consider:

### Assuring quality in home visiting

- As home visiting continues to expand in West Virginia, how will we assure that new and existing programs have the guidance and support they need to provide high quality, family-centered services?
- How will we preserve home visiting's primary focus on relationship-building and teaching through conversation, given the substantial and time-consuming federal requirements for assessments and data reporting?

### Working with families where DV/MH/SA are present

- What can we do to further embed best practices throughout the home visiting system and among allied organizations serving families with DV/MH/SA issues?
- What local, state and federal policies changes are needed to better support families who are dealing with these issues?

### Building a unified system

- What are the roles of the various players – parents, home visiting providers, other prenatal and early childhood programs, state agencies and funders?
- Who is involved in making decisions, and how?
- How can we take full advantage of the experience and wisdom that the stakeholders have to offer?

### Priorities regarding families to be served

- Since it takes both money and time to establish or expand programs into unserved areas, how should we focus our efforts?
- While funders and credentialing agencies have their own particular priorities about families to be served, what are our priorities for the system overall, and how can we blend and braid funding to reach all families?

### Home visiting models to be used

- How can we assure that all families, regardless of where they live and what model is used, receive type and intensity of home visiting services they need and want?
- What programs are best suited to meet those needs in cost-effective ways?
- When multiple programs are available in a community, how will it be determined who serves which families?

- How can West Virginia’s home visiting services be organized and delivered to provide the maximum benefit to families, as well as support for home visitors and programs?

#### Infrastructure needed for home visiting

- What can state and local agencies do to strengthen community capacity to support home visiting?
- What is the true cost of providing quality home visiting services at the level of intensity needed, by a qualified workforce that receives competitive wages and benefits? (For additional information on compensation, see *West Virginia In-Home Family Education Compensation Study*, conducted by Angie Whitley for Partners in Community Outreach, <http://www.wvpartners.org/documents/12-31-12In-HomeFamilyEducationCompensationStudy.pdf>.)
- How can we incentivize (or at least not penalize) programs that go the extra mile to reach hard-to-serve families?
- How can additional funding sources be developed and maximized? (For additional information, see *Statewide Access to In-Home Families Education Services: Estimating Costs of Universal Access for West Virginia Families*, by Steve Heasley at <http://www.wvpartners.org/documents/2013UniversalAccessReport.pdf>.)
- How can state-level planning and governance be strengthened to better support home visiting and related early childhood programs? (For additional information, see *Building a System for Early Success: A Development Plan for West Virginia’s Early Childhood System* at [http://www.wvecptf.org/docs/WVECPTF%20Development%20Plan\\_single%20page.pdf](http://www.wvecptf.org/docs/WVECPTF%20Development%20Plan_single%20page.pdf).)
- What other aspects of infrastructure need to be further developed to assure the best possible outcomes for the families served by home visiting?

APPENDIX A  
Key Informant Interviewees

1. Kelli Bohanon, former administrator in the Washington Department of Early Learning and current Assistant Director of MIECHV TA Coordinating Center, April 23, 2015.
2. Janine Breyel, Project Manager, Substance Use During Pregnancy, West Virginia Perinatal Partnership, May 12, 2015.
3. Dianna Frick, Maternal and Early Childhood Home Visiting Section Supervisor, Montana Department of Public Health and Human Services, April 22, 2015.
4. Sherry Friederick, Supervisor, Mountain State Healthy Families, TEAM for West Virginia Children, May 11, 2015.
5. Diane Hughes, Programs Manager, Upper Kanawha Valley Starting Points (UKVSP/PAT) and West Side Project Launch PAT, May 13, 2015.
6. Annette Jacobi, Director of Family Support and Prevention Service, Oklahoma Department of Public Health, May 4, 2015.
7. Sue Julian, former Team Coordinator for West Virginia Coalition Against Domestic Violence, April 28, 2015.
8. Marlene Midget, Executive Director, Northern Panhandle Head Start, May 18, 2015.
9. Jackie Newson, Director, WV Home Visitation Program, April 9, 2015.
10. Laurie Thompsen, Health and Behavioral Health Coordinator, West Virginia Coalition Against Domestic Violence, May 11, 2015.
11. Debbie Withrow, MIHOW Director, New River Health Association, May 11, 2015.
12. Penny Womeldorff, Project Director, Healthy Start/Helping Appalachian Parents & Infants (HAPI) Project, working in partnership with Right From the Start, May 18, 2015.

## APPENDIX B

# Substance Use During Pregnancy: WV Perinatal Partnership

Summary of Interview with Janine Breyel  
Project Manager, Substance Use During Pregnancy  
May 12, 2015

Janine Breyel directs the Drug Free Moms and Babies Project, a comprehensive and integrated medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services. This project is supported through funding from DHHR's Division of Behavioral Health and Health Facilities and the Office of Maternal, Child and Family Health, along with a grant from the Benedum Foundation.

In 2012, the Perinatal Partnership awarded funding to four pilot project sites:

- Shenandoah Valley Medical Systems, Inc. – A federally qualified community health center that serves the Eastern Panhandle and surrounding counties.
- Thomas Memorial Hospital – A private, non-profit community hospital located in South Charleston that serves a twelve county area in the southwestern part of the state.
- Greenbrier Valley Medical Center – A small, rural hospital located in Ronceverte that serves six West Virginia counties and one county in Virginia.
- West Virginia University Ob-Gyn Department – A large, tertiary center located in Morgantown that serves women from West Virginia and surrounding states.

Key aspects of the Drug Free Moms and Babies Project include:

- Screening, Brief Intervention, Referral and Treatment (SBIRT) services integrated in maternity care clinics
- Collaboration with community partners for the provision of comprehensive medical, behavioral health, and social services. Janine is currently making plans to convene **local/regional resource meetings** to bring together various providers on a regular basis for training and networking, and these would be good opportunities for home visitors to connect with health providers in their area.
- Long term follow up for two years after the birth of the baby provided by a **recovery coach**. In addition, **home visits** and other services to help women maintain sobriety and access needed resources are provided. Janine said that two of the four pilot sites are backing away from home visits due to **safety concerns** and meeting with mothers in other community locations instead.

- Program evaluation of effective strategies for identifying women in need, preventing addiction and abuse, treating women with substance abuse problems, and delivering recovery coaching services.
- Provider outreach education to other maternity care clinics in West Virginia to facilitate the duplication of successful model programs.

Janine identified the other critical issues for providers who serve women using substances during pregnancy, including:

- Providing services in ways that **keep pregnant women and new moms coming back**, even if they are using substances, so the child continues to benefit from the care.
- **Educating health and human service providers** on how to handle and care for drug exposed babies. In cases of Neonatal Abstinence Syndrome (NAS), the initial withdrawal is usually handled in the hospital, but it may take 6 months to a year for a baby to fully recover. Continuity of appropriate care in the community is key, and home visitors can play a valuable role. The WV Perinatal Partnership is developing a **fact sheet for parents and home visitors**, which will be available this summer.
- **Confidentiality and trust between families and providers** are critical and complicated when working with women using substances during pregnancy. More clarity of policies and education of providers are needed.
- Policies and practices need to be informed by our emerging understanding of the **impact of trauma and the co-occurrence of mental health, domestic violence and substance abuse**.

### Resources

WV Perinatal Partnership. The “Substance Use During Pregnancy” web page includes resources and policy recommendations. <http://www.wvperinatal.org/initiatives/substance-use-during-pregnancy/>

WV Perinatal Partnership. *Drug Free Moms and Babies* presentation by Janine Breyel, 2014. [http://www.wvhicollaborative.wv.gov/betterhealth/Documents/Better%20Health%20Presentation\\_Drug%20Free%20Moms%20and%20Babies.pdf](http://www.wvhicollaborative.wv.gov/betterhealth/Documents/Better%20Health%20Presentation_Drug%20Free%20Moms%20and%20Babies.pdf)

## APPENDIX C

# Building a Statewide Coalition: WV Coalition Against Domestic Violence

Summary of Interview with Sue Julian  
Former Team Coordinator for WV Coalition Against Domestic Violence  
April 28, 2015

Thirty years ago, the state's domestic violence programs were at a similar stage of development as In-Home Family Education (home visiting) programs are today. There were 12 programs around the state providing services, but not in all counties. In 1984, those programs came together to work together on funding, public policies, best practices, service expansion and public awareness – much like Partners in Community Outreach has been doing with home visiting since 1999.

Today the WV Coalition Against Domestic Violence has **14 member programs that cover all counties in the state**, with paid staff who provide training and technical assistance, promote public awareness and work on a variety of public policy issues. The Coalition provides no direct services, nor does it administer any of the funding that goes to member programs. (A Coalition brochure is available at <http://www.wvcadv.org/WVCADV%20Brochure%2012.13.10.pdf>.)

Sue Julian previously co-directed a domestic violence program, was a founding member of the Coalition and was hired as WVCADV Co-coordinator along with Diane Reese in 1988. During this interview, Sue reflected on the Coalition's early efforts in the 1980s to build a statewide system, which may help inform current efforts to create a statewide system for home visiting. Key lessons learned included the following:

1. The first collective project undertaken by the Coalition (pre-staff) was the development of the its **"Principles of Unity."** These have served as the philosophical underpinning of the Coalition's work and relationships as it has evolved over the years:
  - *We believe* that violence is a societal configuration and not an individual psychological dysfunction.
  - *We concur* that oppressions such as racism, sexism, heterosexism, and classism contribute to the perpetuation of violence.
  - *We commit* ourselves to the work of building a non-profit coalition among domestic violence service providers by promoting communication, support, and networking that will ensure the availability of comprehensive quality services.
  - *We advocate* for social change at all levels.
  - *We encourage* the development of model programs within the member programs.
  - *We support* implementation of projects with regional focus.

- *We agree* that a priority of resources shall be to ensure that victims of domestic violence, both within and without shelters, shall have access to adequate direct and preventive services.
  - *We recommend* that abusive partners be referred to adequate and appropriate programs.
  - *We recognize* the autonomy of local programs.
  - *We agree* that WVCADV and its member programs shall not discriminate against any person on the basis of race, color, gender, religion, sexual identity, national origin, handicap, age, marital status, or any other basis prohibited by law.
  - *We agree* that WVCADV will participate in national and regional organizations committed to the prevention of violence against women.
2. The Coalition played a key role in the development of **infrastructure** for the DV system during the early years:
- At the same time the Coalition developed its Principles of Unity, it developed a plan for **14 service regions** that would cover all counties as funding became available. The plan included expansion of the 12 existing programs and addition of two new programs.
  - When the lead state agency decided that a set of **standards** were needed for DV programs, it asked the Coalition to develop them.
  - The Coalition has worked with the state to establish **funding formulas** for how funds are allocated across member programs, which are specific to each funding stream.
  - The Coalition agreed on a method of **decision-making** to use in all aspects of its work, as well as a commitment to **fairness** across programs and **transparency**.
3. Sue believes that the Coalition plays a vital role in the public-private partnership to address domestic violence in West Virginia, including:
- Building **relationships and trust** among Coalition members and with other allied organizations, public and private.
  - Staying abreast of **emerging issues** in the field, in the state and in local communities.
  - **Thinking outside the box**, always looking beyond what we're currently doing, connecting with people in other state and national organizations and bringing people to present in West Virginia.
4. Sue believes the transformative work that home visitors and domestic violence advocates do involves **helping individuals and families** and **working for social change**. She said, "Partners in Community Outreach has among its members the resources and tools to provide leadership in the state, to explore cutting edge issues, and to link in meaningful ways with others working for justice, safety, and wellness for all."



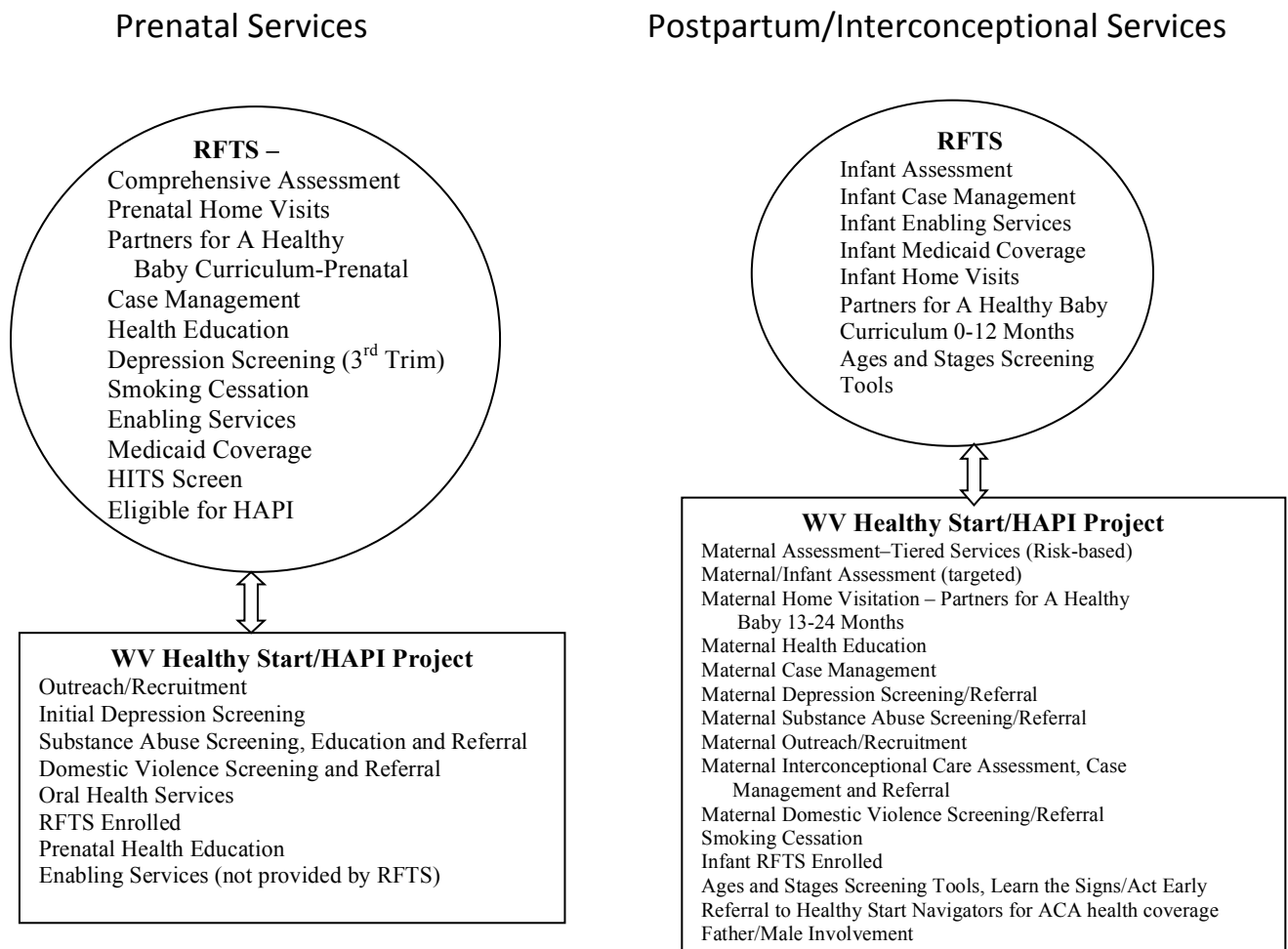
5. In her own practice, Sue has identified the following shifts in her work and relationships:
- *People versus Enemies*: Perception of 'others' as people with a different understanding of issues; respect.
  - *Collaboration versus collusion*: Being clear about principles; lift up transparency – avoid secretive deals or horizontal competitiveness.
  - *Process versus goal*: How we arrive at the goal is much more important than actually arriving there.
  - *From SIMPLICITY to COMPLEXITY*: Sound bites and jargon are shallow; grapple with challenges in their fullness.
  - *From JUDGMENT to UNDERSTANDING*: Blaming creates barriers; understanding builds bridges.
  - *From SEPARATION to CONNECTION*: Silo thinking invites isolation; connecting creates solidarity and stronger alliances.
  - *From BURNOUT to BALANCE*: Take time for vacation; there is much more to life than work; nurture yourself and relationships.

APPENDIX D

## Service Integration: Right from the Start and Healthy Start/Helping Appalachian Parents and Infants (HAPI)

Right from the Start and Healthy Start/HAPI collaborate to serve pregnant and postpartum women and their babies in eight counties in the northern part of the state. Right from the Start is the state’s Medicaid perinatal case management home visitation program. HAPI is a federally-funded Healthy Start project, administered and implemented through West Virginia University, to improve maternal well-being during pregnancy, postpartum and interconceptional period.

By creatively “braiding” their funding, the two programs accomplish more than they would if working separately, according to HAPI Director Penny Womeldorff. Families are able to receive a wider range of services over a longer period of time, up to the child’s second birthday. (See graphic below.) The programs provide families a seamless experience by working through the same local care coordinators.



## APPENDIX E

# State Home Visiting Administrator Interviews: Montana, Oklahoma, Washington and West Virginia

## Montana

Summary of Interview with Dianna Frick  
Maternal and Early Childhood Home Visiting Section Supervisor,  
Montana Department of Public Health and Human Services  
April 22, 2015

### Overview of Montana's EC System

Montana is even more rural than West Virginia, with 46 of its 56 counties designated as "frontier" counties, where the average population is fewer than six people per square mile. Like many other states, Montana has strengthened its state-level early childhood council in recent years. In addition, the state used early MIECHV funding to expand local early childhood coalitions, recognizing them as a valuable resource for the development and expansion of home visiting.

- At the state level, the **Best Beginnings Advisory Council** was established in 2011 to ensure Montana has a comprehensive, coordinated, early childhood system, with a governance structure and strong collaboration to best meet the needs of Montana's youngest citizens (<http://dphhs.mt.gov/hcsd/ChildCare/BestBeginningsAdvisoryCouncil.aspx>). The Council was formed as an enhancement to the Montana Early Childhood Advisory Council (MECAC), expanding the scope from primarily early childhood education to a broader focus on systems impacting children and families. The Council is located in the Department of Public Health and Human Services - Early Childhood Services Bureau, which administers the state's child care program.
- There are 23 **Best Beginnings local coalitions**, serving 17 of the state's 56 counties and six of its seven reservations. The local coalitions work to increase coordination across child and family systems at the grass roots level. The local coalitions conduct community needs assessments; develop plans and priorities for the early childhood system; provide professional development; build capacity, infrastructure, and communication; focus on sustainability; and support the implementation and integration of home visiting programs within the early childhood system. The federal MIECHV Development Grant funding helped to strengthen the state Best Beginnings Advisory Council and to expand the number of local coalitions. When the grant funding ended, the state continued to support the local coalitions with money from Children's Trust Fund and Project LAUNCH.
- The Best Beginnings Advisory Council **Needs Assessment and Strategic Plan** (posted at <http://dphhs.mt.gov/hcsd/ChildCare/BestBeginningsAdvisoryCouncil.aspx>) were developed in 2012-2013, with substantial involvement of the local coalitions. (See needs assessment

methodology on pages 15-16; home visiting is referenced on pages 30-32 of the needs assessment and page 13 of the strategic plan.)

- Dianna feels that the diligence with which Montana approached with the **planning process and governance decisions** was essential in building relationships and the capacity to work together and make tough decisions.

### HV System Development

The Montana Maternal and Early Childhood Home Visiting is located in the Public Health and Safety Division of DPHHS. Prior to the federal MIECHV funding, Montana had a small public health-based home visiting program, which was not evidence-based, along with **Parents As Teachers** and **Nurse-Family Partnership**. As the state developed its plan for MIECHV, the decision was made to continue to support more than one evidence-based model because of the strong identities of local communities and the desire to respond to local needs and preferences. **SafeCare-Augmented** was added as a voluntary home visiting program for families under the federal MIECHV grant and non-voluntary for families referred through Child Protective Services. Home visiting programs currently serve 19 counties.

The state received fewer proposals than expected when it released an RFP under the first MIECHV grant because many communities felt they didn't have the **capacity and infrastructure** needed. That led to the decision to use a substantial amount of the first grant for developing local coalitions to serve as planning and coordinating bodies for early childhood, including home visiting.

Based on Montana's experience to date, Dianna continues to support **providing multiple evidence-based models** and **allowing local coalitions to choose** what's most appropriate for them. She has also learned how much time and effort it takes to build that local capacity and the need to structure subcontracts with specific expectations and timelines.

Dianna believes that the approach of **"growing from where you are"** applies not only to the families served by home visiting, but to partnering organizations and communities as well. State agencies need to be prepared to start at as basic a level as needed.

Dianna referenced the following as a valuable resource in their system development work: "Active Implementation Frameworks for Program Success: How to Use Implementation Science to Improve Outcomes for Children," by Alison Metz.

<http://www.iod.unh.edu/APEX%20Trainings/Tier%202%20Manual/Additional%20Reading/4.%20Implementation%20article%20Metz.pdf>

## Oklahoma

Summary of Interview with Annette Jacobi  
Director of Family Support and Prevention Service  
Oklahoma Department of Public Health  
May 4, 2015

I first met Annette last year by phone during a conference call related to estimating home visiting participation rates for the WV Early Childhood Planning Task Force. I thought she had some valuable insights about HV model selection and collaboration, and she graciously agreed to a follow-up call.

Oklahoma has **four home visiting programs**: Healthy Families America, Parents As Teachers, Nurse-Family Partnership and SafeCare. As they are implemented in Oklahoma, NFP and SafeCare are the most prescriptive and intensive, with SafeCare being a 6-month highly intensive service. HFA and PAT have a more flexible structure and moderate intensity. (Annette mentioned that their PAT is more intensive than most other states.)

To address the problem of some HV providers competing with each other for certain families, even though there were more than enough families in need of services, Oklahoma implemented **a system for designating which models serve which families**:

- **NFP** serves first-time mothers up to 29 weeks of pregnancy, and is provided only by county health departments.
- **HFA** serves first-time mothers who seek home visiting between the 29<sup>th</sup> week of pregnancy and the child's third month, and can be sponsored by county health departments or nonprofit agencies.
- **PAT** serves families that don't meet either of the above criteria, and can be sponsored by county health departments or nonprofit agencies.
- **SafeCare** serves families that need more intensive services than the other three provide, and is available only in metropolitan areas where they can recruit qualified therapists.

Annette said that the new system isn't perfect, nor is it popular with some providers. But it does make home visiting services easier for families to navigate. One caution, she added, is that you can't compare the outcomes of NFP, HFA and PAT under this system because NFP starts serving pregnant women earlier, resulting in stronger outcomes.

Oklahoma is also implementing two experiments with **model integration**, which are being evaluated by a university researcher:

1. In 3 rural counties with MIECHV funding, local health departments, using NFP, HFA and PAT resources, will hire a team of the following positions:
  - 2 nurses
  - 2 parent educators
  - 1 community connector (to develop and support referral network)

2. In 4 counties with state funding only, the county health department is ending its NFP model and adding a nurse to its PAT program.

Annette emphasized how important it's been for them to be clear about what they hope to accomplish, including the number and needs of families to be served, along with the type and intensity of home visiting needed to achieve desired outcomes. It's especially important for policymakers to have **realistic expectations of the likely returns on investment**. For example, the most dramatic outcomes are typically found with programs that target high-need families and provide high-intensity services, at a correspondingly higher cost. Less intensive services may be more appropriate for lower-risk families, at a lower cost.

Oklahoma promotes home visiting in general through its parentPRO initiative marketing campaign, which connects parents with a home visiting programs. Through television, radio and print, parentPRO attempts to normalize the idea of families seeking support AND if appropriate, connecting families to the "best-fitting" home visiting program if available in their area. In addition the marketing campaign, a parentPRO website has been launched and a toll-free phone number has been established. The website ([www.parentPRO.org](http://www.parentPRO.org)) and phone line allow parents to learn about services and enroll in home visiting.

## Washington

Summary of Interview with Kelli Bohanon

Former administrator in the Washington Dept. of Early Learning and

Current Assistant Director of MIECHV TA Coordinating Center

April 23, 2015

### Overview of Washington's EC System

Washington has had an exceptionally strong public-private partnership for the past decade or more. Kelli said the partnership with the private sector was key in positioning the state to respond to federal opportunities like MIECHV, Project Launch, Race to the Top Early Learning Challenge, etc. Key aspects of the partnership include:

- **Department of Early Learning (DEL)**, the nation's first cabinet-level department for early childhood, was formed by Governor Christine Gregoire in 2006. Early learning programs and provider professional development opportunities, which had been under several different state agencies, were unified in DEL. DEL also provides information and tools for parents. <http://www.del.wa.gov>
- **Thrive Washington** represents the private arm of the public-private partnership. In January 2014, Thrive by Five Washington and the Foundation for Early Learning, two of the state's key early learning organizations, merged to form Thrive Washington, with an annual budget of more than \$16 million. Thrive partners with DEL on ongoing development of the EC system, including supporting Regional Early Learning Coalitions,

administering certain grant programs (including home visiting), and advancing parent engagement and racial equity. <https://thrivewa.org>

- There are 10 **Regional Early Learning Coalitions**, which serve areas closely aligned with the state’s Educational Service District boundaries. The Coalitions include service providers in the region but do not provide direct services (similar to WV’s FRNs). They assist in implementing of the State Early Learning Plan and aligning regional efforts to statewide priorities. Kim said their #1 charge is representing the unique needs of their regions. She said that the “latest coolest thing” is the involvement of the Coalitions in public policy advocacy, supported by training from Thrive using private dollars. <http://thrivewa.org/partnerships-mobilization/early-learning-coalitions/>
- **State Early Learning Plan:** In 2007 the State Legislature charged DEL and its Early Learning Advisory Council (ELAC) with developing a statewide early learning plan that ensures school readiness for all children. In 2009 the DEL, the Office of Superintendent of Public Instruction (OSPI) and Thrive by Five Washington signed the Early Learning Partnership Joint Resolution, formalizing a relationship among significant cross-sector partners. As the result of a broad-based planning effort, the State Early Learning Plan was released in September 2010 to create a comprehensive system of care, education, supports and services for children prenatal through third grade. Home Visiting is Strategy #5 on page 84 of the Plan. <http://www.del.wa.gov/publications/elac-gris/docs/ELP.pdf>
- **State Birth to Three Plan:** In 2010, the State Legislature passed HB 2867, which required the Department of Early Learning (DEL) to “develop a comprehensive birth-to-three plan to provide education and support through a continuum of options, including, but not limited to, services such as: Home visiting; quality incentives for infant and toddler child care subsidies; quality improvements for family home and center-based child care programs serving infants and toddlers; professional development; early literacy programs; and informal supports for family, friend, and neighbor caregivers.”

DEL contracted with Thrive to facilitate and write the plan. A collaborative group of key stakeholders helped develop the plan, which consists of actionable policy recommendations in seven high-level focus areas and specific “next steps” that build on existing efforts to improve services and achieve measurable outcomes. Home Visiting is addressed on pages 14-17 of the plan. <http://www.del.wa.gov/publications/research/docs/Birthto3Plan.pdf>

### HV System Development and Funding

In 2010, the state legislature created the **Home Visiting Services Account (HVSA)** to blend federal, state, and private dollars to efficiently and effectively serve families across the state and to provide technical assistance to programs. The most frequently funded models are Parents As Teachers and Nurse-Family Partnership, along with four others that include Early Head Start – Home-Based Option. An estimated \$15 million will be invested in home visiting in FY 2014-15, including 71 percent federal funding, 11 percent state funding and 18 percent private funding.

DEL oversees the HVSA, and Thrive administers it. Thrive also raises private funds to match public support. (e.g. Bill Gates' father made an \$8 million donation to the HVSA.) Over the past five years, the HVSA has expanded from four grantees serving about 120 children, to **30+ grantees** with the capacity to serve more than **2,000 children** statewide, while decreasing the cost per child through economies of scale. (See grantee list and roll-out of funding at [http://thrivewa.org/wp-content/uploads/cohort\\_chart.pdf](http://thrivewa.org/wp-content/uploads/cohort_chart.pdf).)

The HVSA invests in a **portfolio approach** to fund a range of models and programs that will meet the needs of diverse populations. The portfolio attempts to balance grant distributions statewide and distribute funds to achieve geographic and racial/ethnic diversity. Because of its multiple funding streams, grants are not limited to the priority areas of MIECHV.

The HVSA Portfolio also reflects an investment in making allocations to organizations with a **range of capacities**. Typically, HVSA invests in high capacity, moderate capacity, and low capacity at equal rates per model/program.

Thrive WA is leading a collaborative effort with DEL to support **rural communities** to prepare for, implement, and sustain evidence-based home visiting programs. Communities will identify the “match” of their needs and preparedness with requirements of evidence-based home visiting programs. Participants receive intensive planning support, capacity-building and resources to strengthen their local efforts.

## West Virginia

Summary of Interview with Jackie Newson  
Director, WV Home Visitation Program  
April 9, 2015

### Creating a statewide system of home visiting: Some key issues

#### **1. Funding**

Jackie's strategy has been to diversify funding for home visiting programs as much as possible so they are less vulnerable to funding fluctuations. Three areas she would like to see further developed are:

- a. **Support from businesses** that see the value of home visiting in helping parents engage and succeed in the workforce. While the amount of funding may be modest, it could help pay for various improvements that existing budgets can't address. In addition, a stronger relationship with local businesses could also help develop more private sector “champions” for sufficient public funding for home visiting programs.
- b. **Support for HV from other DHHR programs** around shared goals, with funding from those programs to support outreach and education by home visitors on those issues. Examples include immunizations, safe homes and smoking cessation.



- c. **Title I funding** to support the “school readiness” benefits of home visiting, especially but not limited to PAT and Early Head Start-Home-Based Option, which serve children over three years old.

## **2. Data**

Jackie is highly committed to collecting and using credible data to evaluate programs, improve quality, track outcomes and be accountable to funders. She is pleased with the evolution of the state’s home visiting data system as required by MIECHV. She would like to see all home visiting programs collect and report their data in a timely fashion in order to assure quality and sustain funding.

While the state agency is charged with creating and implementing the home visiting data system, its success hinges on program participation, and the program partners are often the best source of ideas for each other on how to establish timely data reporting by home visitors.

## **3. Program collaboration and integration**

Jackie is very interested in supporting stronger teamwork among home visiting programs, the medical case management provided by Right from the Start and the early intervention services offered by Birth to Three. Her vision is for families to have a seamless experience when receiving more than one of these services. This could be accomplished through interagency “teams” of staff across programs working from a shared plan and reinforcing each other’s work. Agencies that provide two or three of the programs could do the same thing with an intra-agency team approach.

## **4. Community Partners**

Jackie sees the development of a statewide system of home visiting as the shared responsibility of state agencies and local partners, and Partners in Community Outreach as a major player in this effort.

On a regional level, several nonprofit agencies have emerged as providers of home visiting in a multi-county area, such as Burlington in the Eastern Panhandle, Children’s Home Society in central WV and TEAM in southwestern WV. Jackie envisions home visiting continuing to expand in this organic kind of way as agencies have the administrative capacity to work in additional counties and communities. While she sees community engagement essential in planning for new home visiting programs, the state office will choose the model and the provider.

Jackie feels that expansion should progress as agencies are able to do so without shortchanging quality and putting families and programs at risk. While there are still guidelines about focusing on high-need areas, she feels that case could be made for parts of all counties and it isn’t a limiting factor in terms of planning.

Addressing domestic violence, mental health and substance abuse

## 1. Domestic violence

Futures Without Violence has created **Healthy Moms, Happy Babies: A Train the Trainers Curriculum** to support state agencies and home visitation programs in developing a core competency strategy and to ensure that all home visitors have training and resources to help women and children living in homes with domestic violence. The WVHVP is working with the Coalition Against Domestic Violence to bring that training to WV. Laurie Thompsen and others attended a national Train the Trainers workshop and are about to start training home visitors here using a three-phase approach:

- 5 one-day intensive training workshops in May conducted at different locations
- A series of webinars after the initial training
- Local in-person follow-up meetings for further consultation and learning

## 2. Mental health

- Moving Beyond Depression** is a program of In-Home Cognitive Behavioral Therapy (IH-CBT) developed by researchers at Every Child Succeeds and Cincinnati Children's Hospital Medical Center. The program involves three phases instituted over two years: (1) on-site training of home visitors in identification of maternal depression and role in the program, (2) training of therapists in Cincinnati in IH-CBT treatment, (3) ongoing training and support of therapists, Team Leaders, and program leadership in implementation of the program. The WVHVP is working with Pretera to bring the program to WV, and Pretera may be sending therapists to the next training in July. Therapists would bill Medicaid for the sessions, and WVHVP would cover travel-related costs.
- Michigan Association for Infant Mental Health (MI-AIMH)** is an organization devoted to strengthening relationships between infants, parents and other caregivers. TEAM for WV Children has entered into a licensing agreement with MI-AIMH to use the MI-AIMH Competency Guidelines and the MI-AIMH Endorsement<sup>®</sup> to develop and recognize competency-focused, relationship based practice promoting infant mental health. Jackie sees this as an important workforce development tools that encourages and recognizes staff for increasing their knowledge and skills.
- Early childhood mental health consultation** involves a partnership between a professional consultant with early childhood mental health expertise and home visiting or family support programs, staff, and families. This integrated model promotes parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the unmet mental health needs of children and families. Jackie would like to try a pilot project with 3-4 sites in WV that would offer three levels of consultation from a mental health expert – a toll-free number, telehealth/Skype, and quarterly in-person meetings. She's working with Michele Baranaskas on potential funding through Benedum to support the phone line and telehealth components, with WVHVP paying for the quarterly meetings.

### **3. Substance abuse**

Jackie views substance abuse as perhaps the toughest issue for home visitors to address due to the reluctance of parents to acknowledge illegal drug activity or anything else that might trigger a CPS referral. She is exploring the potential use of SBIRT (Screening, Brief Intervention and Referral to Treatment) by home visiting programs, as well as possible collaborations with the court system. We talked about Jessica Zukowski's highly successful Circle of Parents group at the Fayette County Day Report Center.