Universal Home Visiting

Best Beginnings Committee Meeting
November 15, 2018

PUBLIC HEALTH DIVISION
Maternal and Child Health Section

Universal Home Visiting: Why?

- Birth of a child is a big change for **any** family.
- Most families report they welcome support as they move through the transition.
- Safe and healthy environments during early childhood forms the foundation for lifelong physical and mental well-being.
- It is important to meet families where they are.
- Providing services to all families is the route to community-level change and population impact.

Home Visiting in Oregon: Strengths

- Current evidence-based home visiting (HFO, EHS, NFP)
- Effective collaboration and partnerships
- Home visiting governance structure – Home Visiting Steering Committee
- Workforce diversity
- Tracking Home visiting Effectiveness in Oregon (THEO) data system

Home Visiting in Oregon: Gaps

- Current screening efforts do not reach all Oregon families.
- Only about 20% of families eligible for current programs are being served collectively by the home visiting system.
- Investments are not uniform across the state creating capacity differentials from community to community.
- A universal human touch point is missing that can connect families with matched local community services and resources based on individually identified needs and family wishes.

Proposal for Oregon

- Implement Universal Home Visiting (Family Connects model) through Local Public Health Authorities
  - Nurse Home Visitor Workforce
  - Targeted Case Management (TCM) State Plan Amendment (SPA)
  - Mandate to coordinate prevention and health promotion programs and services
- Phased-in approach – Phase I – 1st Biennium
  - Community Alignment
  - Medicaid population
  - Start with communities of readiness

Goals of Universal Home Visiting

- Offer support to all new parents in Oregon (regardless of risk and insurance status)
- Increase access to community services and supports
- Promote collaboration and coordination across Oregon's early childhood and home visiting systems
- Improve health outcomes for families across the life-course

Key Points

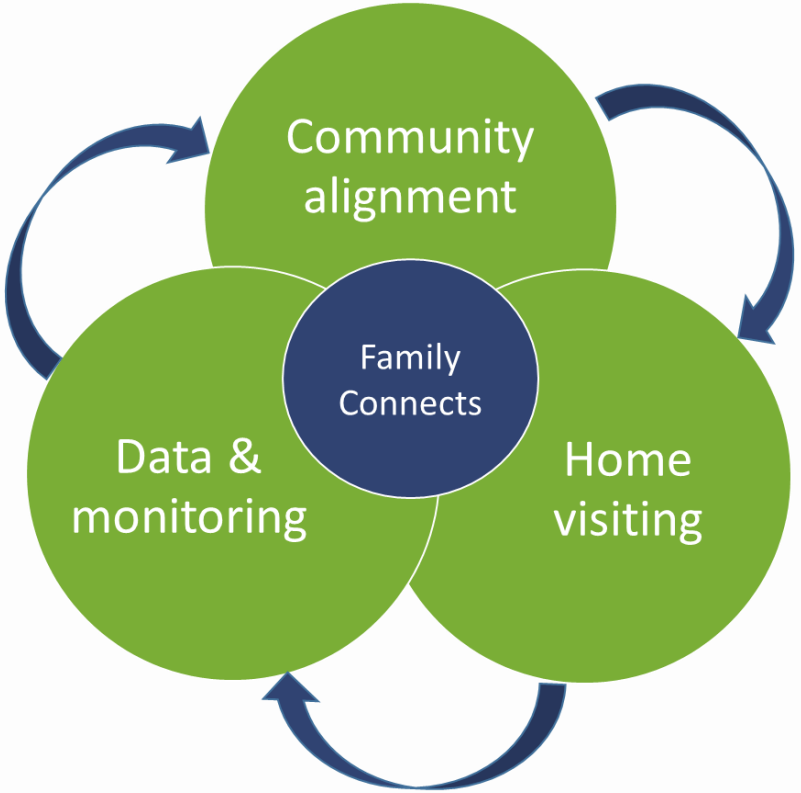
- Universal Home Visiting
  - Begins with community alignment
  - Does not replace intensive home visiting programs
  - Supports prenatal outreach efforts
- Gradual ramping up over 3 biennia
- Commercial Health Plans will be engaged to cover the non-Medicaid families
- Other funding opportunities will continue to be explored

Current Status

- Forming a Planning Workgroup
- Senator Steiner Hayward
  - Engaging commercial plans
- Preschool Development Grant Birth to Five Grant (PDG B-5)
  - Inclusion of Universal Home Visiting as a strategy
- Revising Targeted Case Management (TCM) State Plan Amendment (SPA)
  - leverage state investments to draw down federal Medicaid match for the 50% of all Oregon births covered by Medicaid.
- Ongoing Meetings/Calls with Family Connects International

Family Connects

- Program Components
  - Community Alignment
  - Home Visiting
  - Data and Monitoring
- Evaluation Highlights
- Coordination with other home visiting programs
- Prenatal pilot



Community Alignment Domains

- Recruitment & Visit Scheduling done in Hospital typically within 24 hrs. of birth
- Comprehensive In-Home Visit (~2 hours) Newborn & mother health assessments, education about newborn care (e.g., breastfeeding). Assessment of family strengths & needs (Risk Assessment) -12 factors empirically linked to child maltreatment risk
- Referrals to matched community agencies for identified risk. 2nd or 3rd visits made as needed to conduct additional assessment and assure community connections
- Follow-up phone call 4 wks. after case closure to ensure connections are made

Family Support Matrix Domains

Support for Health Care

1. Maternal Health
2. Infant Health
3. Health Care Plans

Support for a Safe Home

7. Household Safety/Material
8. Family and Community Safety
9. History with Parenting

Support for Infant Care

4. Child Care Plans
5. Parent-Child Relationship
6. Management of Infant Crying

Support for Parent(s)

10. Parent Well Being
11. Substance Abuse in
12. Parent Emotional Support

Each factor is rated as:
1 = No family needs
2 = Needs addressed during visit
3 = Community resources needed
4 = Emergency intervention needed

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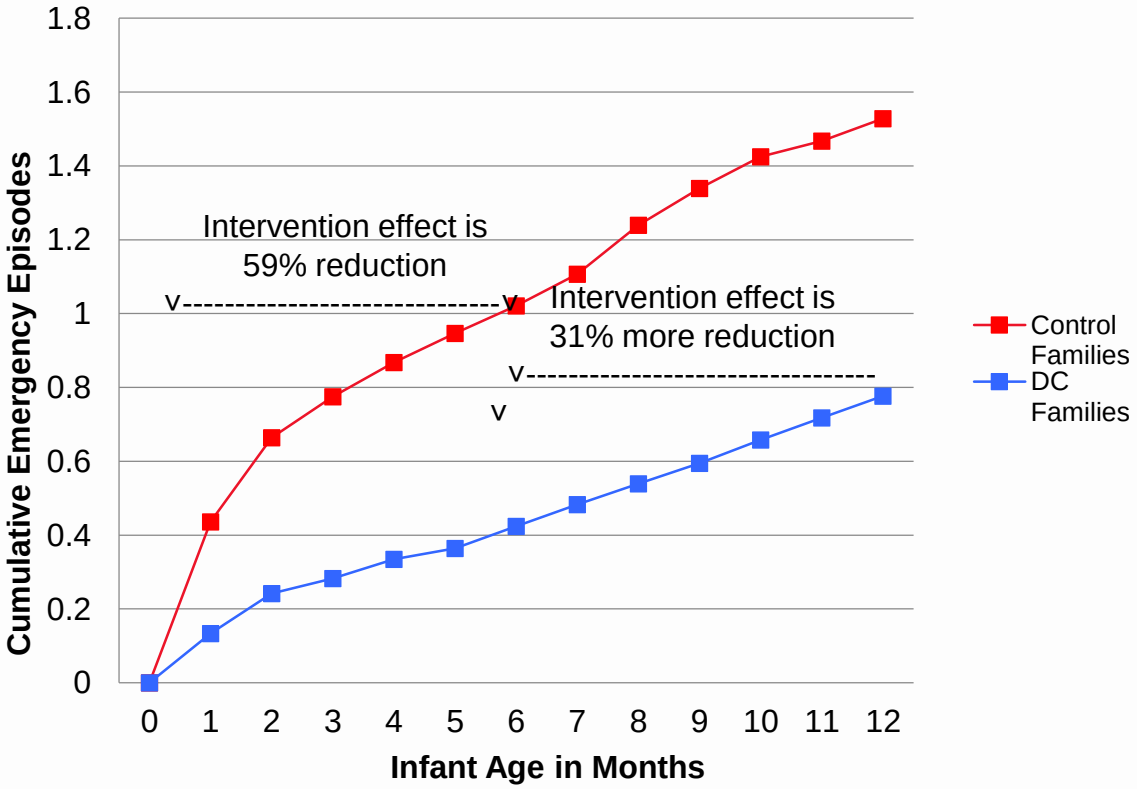
RCT Evaluation Results:
Child Hospital Administration Records

Results at infant age 12 months from aggregate hospital records

- *50% less total infant emergency medical care (ER visits + overnights in hospital)*

Results at infant age 24 months from aggregate hospital records

- *37% less total infant emergency medical care (ER visits + overnights in hospital)*



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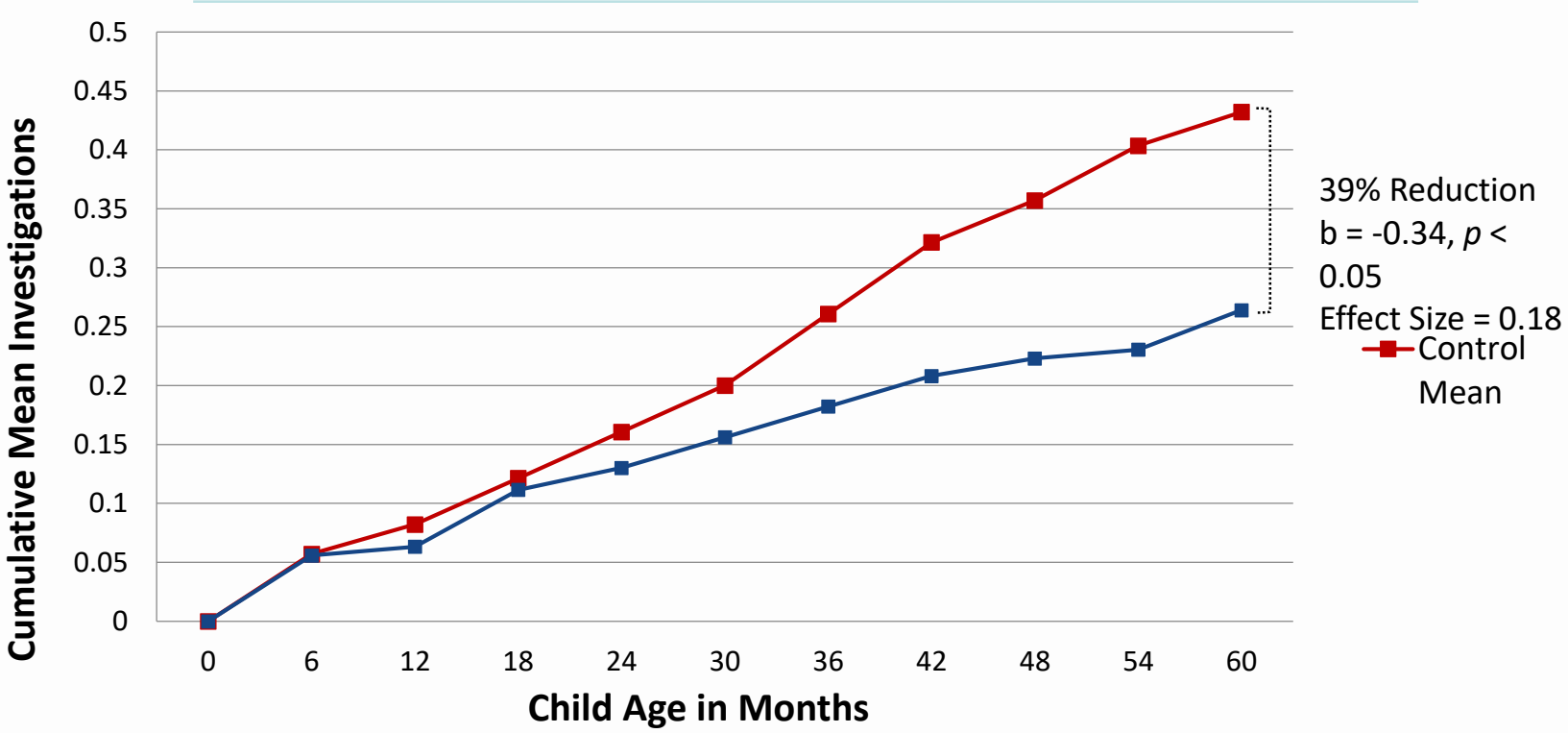
RCT Evaluation Results: Age 60-month CPS Investigations



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RCT Evaluation Results: Age 6-Month in-Home Interviews

Compared to control families, Durham Connects-eligible families had:

- More connections to community services / resources
- More mother-reported positive parenting behaviors
- Higher quality (blinded observer-rated) mother parenting behavior
- Higher quality and safer (blinded observer-rated) home environments
- Higher quality child care for those that chose out of home care
- Less maternal reported anxiety

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Model Innovations

- Early literacy assessment and connection (Tulsa, OK)
- Universal prenatal connection (Guilford County, NC)
- Universal lactation support (pre-home visits) (Santa Barbara, CA)
- Connection to Healthy Steps (pediatric specialists) (Guilford and Durham Counties, NC)

Questions?