VOICES FOR OHIO'S CHILDREN

HOME VISITING MATTERS

AN OHIO PRIMER

safe | healthy | educated | connected | employable

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CONTENTS

ABOUT
VOICES FOR OHIO'S CHILDREN

Voices for Ohio's Children is a nonprofit, nonpartisan advocacy organization dedicated to keeping Ohio children safe and healthy; educated in quality programs from preschool through high school; connected to their families, friends, and communities; and employable by ensuring their access to afterschool programming and work opportunities.

Voices does exactly what it sounds like—we give Ohio kids a voice in the public policy process. We do this by providing proactive leadership on our policy priorities—which are based on need, trends, and community feedback—and by partnering with national and state advocates, service providers, and government offices. Voices is also an experienced convener and facilitator of diverse stakeholder groups.

Voices offers regular public education opportunities on a variety of children's issues. Join our Policy Team each month for our Public Policy Partner webinar series. You can also get involved in Voices' work by becoming a Public Policy Partner. Visit our website at RaiseYourVoiceForKids.org to learn more and to sign up for our weekly e-newsletter and upcoming events.

OUR MISSION

Voices for Ohio's Children advocates for public policy that improves the well-being of Ohio's children and their families.

THE CONTRIBUTORS

Dana Dunlap • *Policy Director*
Dana manages the policy team and consultants with the goal to achieve positive policy changes for Ohio's children and the systems that serve them. Previously, she has served the offices of former State Senator Shannon Jones, Governor John Kasich, and Secretary of State Jon Husted, working on pressing issues like infant mortality.

Dana Schmersal • *Communications Director*
Dana manages all Voices' signature events, coordinates organizational communications, and leads Voices' juvenile justice advocacy. She has previously served with the Ohio Chapter of the National Association of Social workers where she managed professional development programming, provided legislative advocacy support, and ran the Social Work Advocacy Group.

Brandi Slaughter • *CEO*
Brandi manages the overall operations of Voices and leads the organization's federal advocacy efforts. She has been instrumental in developing and implementing policy that impacts children and families at both the state and federal levels. Her policy expertise includes juvenile justice, child welfare, afterschool/out-of-school time and youth development.

Lynanne Wolf • *Policy Associate*
Lynanne provides leadership in policy areas including child welfare, early care and education, child mental health and oral health. She joined Voices after being in private practice as a child and family law attorney for the past five years. Lynanne also served as a Senior Legislative Aide in the Ohio General Assembly.

JP Design • *(Jennifer Peters)*
Jennifer brings design implementation to briefs and marketing materials for Voices. With a diverse background of marketing and design experience, she utilizes inherent passion and energy combined with industry expertise to produce a wide variety of communication projects.

HOME VISITING IS A POWERFUL TOOL FOR FAMILIES.

RESEARCH SHOWS THAT HOME VISITS BY A NURSE, SOCIAL WORKER, EARLY CHILDHOOD EDUCATOR OR OTHER TRAINED PROFESSIONAL DURING PREGNANCY AND IN THE FIRST YEARS OF LIFE IMPROVE MATERNAL AND CHILD HEALTH, PREVENT CHILD ABUSE AND NEGLECT, INCREASE POSITIVE PARENTING AND ENHANCE CHILD DEVELOPMENT AND SCHOOL READINESS. [1]

INTRODUCTION

Long-term developmental well-being, safety and early school success of children are important public policy and social objectives. These goals are not achieved through a single effort, but through many small, consistent efforts that improve a parent's ability to care for a child and themselves. According to the PEW Charitable Trusts, "Home visiting is proved to be an excellent spark for initiating such change and for placing young families on the right track." [2]

Home visiting delivers early education and support to families on their terms and in their own homes, which eliminates environmental constraints such as transportation and structured hours of operation. [3] This allows home visitors to observe family processes in their natural environments.[4] Through stand-alone programs, or in partnership with center-based services, voluntary home visiting educates families, provides resources for health, child development and school readiness.[5] Families who participated in home visiting services were half as likely to be involved with Child Protective Services.[6] Home visiting bridges community resources for participating families in order to build a better future for themselves.

Home visiting is a tool for reducing Ohio's abysmal infant mortality rate. Ohio's 2015 infant mortality rate was 7.2 infant deaths per 1,000 live births, a rate 21percent higher than the most recently reported national rate. The white infant mortality rate was 5.5 and the black infant mortality rate was 15.1, with black babies dying at nearly three times the rate as white babies.[7] Studies have found that high-quality home visiting programs yielded better birth outcomes. Children whose parents participated in home visiting programs are born with fewer instances of low birthweight and are more likely to be breastfed.[8] An Ohio study found infants whose families did not receive home visiting were 2.5 times more likely to die in infancy compared to those infants whose families received home visiting services.[9]

This home visiting primer will focus only on Ohio's state and federally funded home visiting programs.

STUDIES HAVE FOUND THAT HIGH-QUALITY HOME VISITING PROGRAMS YIELDED BETTER BIRTH OUTCOMES.

WHAT IS HOME VISITING?

Home Visiting IS AN IN-PERSON, EVIDENCE-BASED SERVICE THAT PROVIDES PREGNANT WOMEN AND FAMILIES—PARTICULARLY THOSE CONSIDERED AT-RISK—THE NECESSARY RESOURCES AND SKILLS TO RAISE CHILDREN WHO ARE PHYSICALLY, SOCIALLY AND EMOTIONALLY HEALTHY AND READY TO LEARN.

One home visitor is assigned per family and becomes the family's primary point of contact. Visits take place within everyday environments and must be voluntary, confidential, culturally sensitive and respectful of the family.

Home visits include health and wellness screenings, research-informed parenting education and curriculum, referral and linkage to needed medical and social supports and transition by age three into child development programs in the community, such as Early Head Start, Head Start, and child care.

Ohio's state and federally funded home visiting services are primarily provided through three home visiting programs: Help Me Grow (HMG), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and the Ohio Infant Mortality Reduction Initiative (OIMRI).

In State Fiscal Year 2016 (SFY16) Ohio's Help Me Grow and MIECHV programs served 10,586 families[10] through 114,617 home visits.

Evidence-based

IN ORDER TO RECEIVE STATE FUNDS THROUGH HELP ME GROW OR FEDERAL FUNDS THROUGH MIECHV, THE HOME VISITING MODEL MUST BE DESIGNATED AS EVIDENCE-BASED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS).

The Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) review to conduct a thorough and transparent review of the home visiting research literature. HomVEE provides an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth through age five.

Evidence-based

TO MEET DHHS' CRITERIA FOR AN "EVIDENCE-BASED EARLY CHILDHOOD HOME VISITING SERVICE DELIVERY MODEL," PROGRAM MODELS MUST MEET AT LEAST ONE OF THE FOLLOWING CRITERIA:

1. At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains;
2. At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain.[11]

According to the PEW Charitable Trusts, "Decades of research show that these family support programs are effective and ultimately save money for taxpayers. When quality programs, carried out in local communities, are properly implemented, they lead to increased family self-sufficiency, lower health care costs, and reduced need for remedial education." [12]

HOME VISITING PROGRAMS MUST BE SHOWN TO BE EFFECTIVE AND CONSISTENTLY IMPROVE MEASURABLE OUTCOMES FOR OHIO'S CHILDREN AND FAMILIES. SUCCESS IS MEASURED BY DEMONSTRATING IMPROVEMENT IN SIX BENCHMARKS:

1. Improvement in maternal and newborn health;
2. Reduction in child injuries, abuse, and neglect;
3. Improved school readiness and achievement;
4. Reduction in crime or domestic violence;
5. Improved family economic self-sufficiency; and
6. Improved coordination and referral for other community resources and supports.[13]

HELP ME GROW

Help Me Grow (HMG) Home Visiting is Ohio's evidence-based, voluntary family support program for pregnant women or new parents. The program is administered by the Ohio Department of Health and includes two components: home visiting services and central coordination. Home visiting services are part of the HMG program, and are delivered through providers in local communities. Communities are given the flexibility to determine which federally recognized evidence-based home visiting model best fits their local needs.

Help Me Grow services are delivered in all 88 counties through home visiting contractors. These contractors meet appropriate requirements as defined in the Ohio Administrative Code to provide services directly to qualifying individuals. In SFY16 Help Me Grow served 8,719 families[14] through 94,762 home visits.

The goals of Help Me Grow Home Visiting are:

1. Improve maternal and child health;
2. Prevent child abuse and neglect;
3. Encourage positive parenting; and
4. Promote child development and school readiness.[15]

Help Me Grow program eligibility rules require at least 85 percent of the contractor's capacity be used to serve families that meet all three of the following criteria: 1) first-time mothers; 2) with a child prenatal to six months old; 3) with a household at or below 200 percent Federal Poverty Level (FPL). The additional 15 percent of capacity may be used to serve expectant first-time mothers (no income requirement), first-time mothers or fathers with an infant or toddler under age three (no income requirement), infant under 6 months (no income or caregiver requirements) or expectant mothers or a birth biological or adoptive parent who is in the military.[16]

IN SFY16:
HELP ME GROW SERVED
8,719 FAMILIES[14]
THROUGH
94,762 HOME VISITS.

State Funding

OHIO'S HELP ME GROW PROGRAM RECEIVES FUNDING FROM STATE GENERAL REVENUE FUNDS (GRF). THE GOVERNOR'S SFY18-19 PROPOSED BIENNIAL BUDGET SHOWS SFY16 SPENDING OF GENERAL REVENUE FUNDS OF $29,132,068 FOR HELP ME GROW. [17]

The proposed budget estimates state funding for SFY17 of $20,958,971 and proposes continued state funding for SFY18 and SFY19 also at $20,958,971. Although budget documents do not identify state funding levels specific to each of the components of HMG, the actual and projected enrollments of families in HMG home visiting suggest that state funding for home visiting is projected to be maintained at current levels.

It is important to note in House Bill 483 of the 131st General Assembly the responsibility of implementing the state's Part C Early Intervention Services Program, through which eligible infants and toddlers receive Early Intervention services in accordance to federal law, was transferred from the Ohio Department of Health's Help Me Grow program to the Ohio Department of Developmental Disabilities (ODODD). This legislation, which became effective October 12, 2016, also designated ODODD as the "lead agency" responsible for the administration of funds provided for the program. With that said, House Bill 483 required a $25.1 million transfer of funds in FY17 from the Ohio Department of Health's Help Me Grow (440459) line item to ODODD through the Federal Public Health Programs (440618) line item in the state's budget.[18] This transfer addresses the reduction in state funding for the Help Me Grow line item from SFY16 to SFY17.

In some communities Help Me Grow home visiting services are further supplemented with local funding from tax levies or private foundations. This supplemental support allows some communities to provide additional services, a more in-depth evaluation of programs or extend eligibility beyond the target population.

While there are several federally recognized evidence-based home visiting models, currently two models are implemented in Ohio through Help Me Grow funds: Parents as Teachers® (PAT) and Healthy Families America® (HFA).

SEE TABLE A FOR MODEL DESCRIPTIONS.
(NEXT PAGE) >>>

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TABLE A: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HOME VISITING EVIDENCE OF EFFECTIVENESS DESCRIPTIONS OF SELECT MODELS

MODEL	Theoretical Model	Program Components	Target Population	Targeted Outcomes
Parents as Teachers®	Affecting parenting knowledge, attitudes, behaviors and family well-being impacts the child's developmental trajectory. Grounded in Urie Bronfenbrenner's Human Ecology Theory and Family Systems Theory. The three areas of emphasis within the approach—parent-child interaction, development-centered parenting and family well-being—are informed by additional theories including the developmental parenting approach, attribution theory, and self-efficacy theory.	1. One-on-one personal (or home) visits; 2. Group connections (or meetings); 3. Health and developmental screenings for children; and 4. Linkages and connections for families to needed resources.	Affiliates select the specific characteristics and eligibility criteria of the target population they plan to serve. Such eligibility criteria might include children with special needs, families at risk for child abuse, income-based criteria, teen parents, first-time parents, immigrant families, low literate families, or parents with mental health or substance abuse issues. Model designed to serve families pregnancy through kindergarten entry and enrollment may happen at any time during this timeframe. Resources available through kindergarten if chosen.	1. Increase parent knowledge of early childhood development and improve parenting practices; 2. Provide early detection of developmental delays and health issues; 3. Prevent child abuse and neglect; and 4. Increase children's school readiness and school success.
Healthy Families America®	Theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment and bio-ecological systems theories and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; strengths-based; family-centered; culturally sensitive; and reflective.	1. Screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; 2. Home visiting services; and 3. Routine screening for child development and maternal depression. In addition, many HFA sites offer services such as parent support groups and father involvement programs. HFA encourages local sites to implement enhancement services such as these that further address the specific needs of their communities and target populations.	Designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence. Family completion of a comprehensive assessment to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences is required. Requires families be enrolled prenatally or within three months of birth. Services offered until the children's third birthday and preferably to the child's fifth birthday.	1. Reduce child maltreatment; 2. Improve parent-child interactions and children's social-emotional well-being; 3. Increase school readiness; 4. Promote child physical health and development; 5. Promote positive parenting; 6. Promote family self-sufficiency; 7. Increase access to primary care medical services and community services; and 8. Decrease child injuries and emergency department use.
Nurse Family Partnership®	Shaped by human attachment, human ecology, and self-efficacy theories. NFP nurse home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. Nurse home visitors build on parents' own interests to attain the model's goals.	One-on-one home visits between a registered nurse educated in the NFP model and the client.	Designed for first-time, low-income mothers and their children. Requires a client to be enrolled and receive her first home visit no later than the end of the woman's 28th week of pregnancy. Services are available until the child is 2 years old.	1. Improve prenatal health and outcomes; 2. Improve child health and development; and 3. Improve families' economic self-sufficiency and/or maternal life course development.

CENTRAL COORDINATION

CENTRAL COORDINATION WAS DEVELOPED TO PROVIDE A SINGLE ENTRY POINT FOR FAMILIES WHERE SCREENING COULD BE USED TO SYSTEMATICALLY IDENTIFY FAMILY NEEDS AND REFER EACH FAMILY TO THE PROGRAM THAT BEST FITS THEIR NEEDS.

Each county must have a centralized system where all home visiting and Early Intervention referrals are initiated. This is known as the Centralized Intake and Referral System, and is operated through contracts by the Ohio Department of Health. These Central Coordination contractors are required to coordinate public awareness activities inclusive of both Help Me Grow and MIECHV home visiting and Early Intervention services as well as implement Child Find which seeks to identify children and families who meet qualifying eligibility criteria for services.

Staff help families determine whether their child is eligible for home visiting or Early Intervention services. For the families referred to a home visiting program, a home visitor must be assigned in a timeframe that enables all initial program requirements to be met within the first 45 days following referral.

In SFY16, 42,322 families were referred to early childhood programs through central coordination. Of those referrals, 8,701 were for home visiting programs and 24,402 were for Early Intervention services. The Ohio Department of Health is seeking to improve the efficiency and effectiveness of Centralized Intake as well as incorporate referrals to OIMRI in SFY17.[19]

IN SFY16, **42,322 FAMILIES** WERE REFERRED TO EARLY CHILDHOOD PROGRAMS THROUGH CENTRAL COORDINATION. OF THOSE REFERRALS, **8,701 WERE FOR HOME VISITING PROGRAMS** AND **24,402 WERE FOR EARLY INTERVENTION SERVICES.**

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV)

THE **MIECHV** PROGRAM IS A FEDERAL/STATE PARTNERSHIP ACTIVE IN ALL 50 STATES THAT FUNDS HOME VISITING MODELS FOR STATES, TERRITORIES AND TRIBAL ENTITIES.

Similar to Ohio's Help Me Grow program, MIECHV is not a home visiting model or direct service provider, but a name given to the federal program that funds federally recognized evidence-based home visiting services across the nation.

Jointly administered by the U.S. Department of Health and Human Services' Health Resource Administration and the Administration for Children and Families, the Affordable Care Act appropriated five years of funding for the program in 2010 and the funding was extended to March 2017 by the passage of the Medicare Access and CHIP Reauthorization Act of 2015. In Federal Fiscal Year 2016 (FFY16), Ohio received $5,819,100 MIECHV funding—resulting in a total program capacity to serve 1,687 families.[20] The number of home visits provided will be determined at the end of the FFY closing September 30, 2017.

The U.S. Department of Health and Human Services requires 75 percent of granted MIECHV funds be used to implement approved evidence-based home visiting models and up to 25 percent may be used on promising approaches rather than approved models. Ohio's MIECHV funds support expanded access to home visiting by broadening the eligibility base to encompass additional families who previously could not participate in HMG home visiting services funded by the state, as well as systems-building initiatives, quality improvement processes, partnership development, targeted outreach and public education.[21]

The Ohio Department of Health is the MIECHV lead agency and is charged with the execution of the statutory purposes of the program which include: strengthen and improve the programs and activities carried out under Title V of the Social Security Act; improve coordination of services for at-risk communities; and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.[22]

The MIECHV program targets pregnant women under age 21 and families who are: low income; live in at-risk communities, have a history of child abuse; potential substance abuse; smokers in the home; children demonstrating low achievement; children who have developmental delays; and mothers who have served or serve in the armed forces.

Priority for MIECHV funding is given to families living in at-risk communities as identified by a statewide needs assessment.[23] Thirty one counties were identified by the Ohio Department of Health as being at-risk for poor birth or family developmental outcomes in a 2010 needs

PRIORITY FOR MIECHV FUNDING IS GIVEN TO FAMILIES LIVING IN AT-RISK COMMUNITIES AS IDENTIFIED BY A STATEWIDE NEEDS ASSESSMENT. [23]

assessment. Within these counties there are communities, neighborhoods, and/or census tracts with individual and clustered risk indicators that rate even higher than the county or state averages identified as the most at-risk communities to be served with the MIECHV program.[24]

In FFY16 there were 27 unique Local Implementing Communities receiving MIECHV funding to provide services in Ohio. MIECHV was expanded to Cuyahoga County on October 1, 2016. Counties served include Adams, Allen, Ashtabula, Clark, Clinton, Columbiana, Coshocton, Crawford, Fayette, Franklin, Gallia, Hamilton, Harrison, Jefferson, Lucas, Mahoning, Marion, Meigs, Montgomery, Pike, Ross, Scioto, Stark, Summit, Trumbull and Vinton.

Similar to Help Me Grow, the program gives states flexibility to identify the issues most pressing to their communities and select their programs which are locally implemented where the participating families live.[25] Currently Ohio's MIECHV funds support implementation of the Nurse Family Partnership® (Cuyahoga, Franklin and Montgomery) and Healthy Families America® models.

(See Table A, page 9 for model descriptions.)

THE GOALS OF MIECHV ARE:

- IMPROVE MATERNAL AND CHILD HEALTH;
- PREVENTION OF CHILD INJURIES, CHILD ABUSE, NEGLECT OR MALTREATMENT AND REDUCTION OF EMERGENCY DEPARTMENT VISITS;
- IMPROVEMENT OF SCHOOL READINESS AND ACHIEVEMENT;
- REDUCTION IN CRIME OR DOMESTIC VIOLENCE;
- IMPROVEMENTS IN FAMILY ECONOMIC SELF-SUFFICIENCY; AND
- IMPROVEMENTS IN THE COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS.[26]

OHIO INFANT MORTALITY REDUCTION INITIATIVE (OIMRI)

OIMRI WAS ESTABLISHED IN 1994 TO RESPOND TO A SIGNIFICANT DISPARITY IN POOR PRENATAL AND BIRTH OUTCOMES FOR AFRICAN AMERICAN WOMEN AND INFANTS. THE INFANT MORTALITY RATE FOR AFRICAN AMERICAN BABIES IS NEARLY THREE TIMES THE RATE FOR WHITE BABIES.

This program is funded to provide community-based outreach and care coordination services in targeted communities with high-risk, low-income, African-American, pregnant women and families. When a disparate health condition affects the general population, it affects low-income and people of color at a higher rate and more severely.[27]

Unlike Help Me Grow and MIECHV, OIMRI is a home visiting model and is based on community care coordination. This model addresses barriers African American women and children experience such as financial, geographical and cultural challenges. The goal of OIMRI is to reduce infant mortality by improving maternal health, birth outcomes and infant and child health.

This model empowers communities to eliminate disparities by employing Community Health Workers (CHWs). Community Health Workers are trained advocates employed to empower pregnant women to access resources. These community-based workers provide a cultural link to community resources through family-centered services that focus on achieving success in health, education and self-sufficiency. Community Health Workers are vital to the success of this model; their role includes conducting case findings, making home visits regularly, identifying and reinforcing risk reduction behaviors, providing appropriate education, incorporating life-changing behaviors and collaborating with other agencies in making referrals to assure positive outcomes.[28] The Ohio Infant Mortality Reduction Initiative is not a federally recognized model.

The Ohio Department of Health outlines the OIMRI home visiting model's five core components:

1. Planning: use data to target neighborhoods and identify needs;
2. Training: on-going training of CHWs;
3. Supervision: nursing and/or physician consultation;
4. Standardized care processes: delineates expected outcomes based on needs; and
5. Data collection and evaluation: measure program outcomes.

These components are achieved through: active community-based recruitment of at-risk African American pregnant women; prenatal and postpartum home visits until the child reaches 2 years of age; comprehensive assessment and screening; identification and referral coordination of necessary community-based resources and research-informed prenatal and parenting education.[29]

Currently OIMRI operates in 14 counties with high infant mortality rates: Allen, Butler, Clark, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Richland, Stark, Summit and Trumbull. In SFY16 OIMRI had $2,644,000 in total funding and a total capacity of 1,322 families.[30] Currently OIMRI has a different program name in each of the communities it serves, has no primary performance measurement plan and no statewide data capacity.

Beginning SFY17 OIMRI will receive a statewide name and become a standalone, competitive solicitation. A statewide performance plan is being created and OIMRI communities will be expected to be at 85 percent capacity of families served and will only serve children to age one.[31]

SFY16 OUTCOMES FOR HOME VISITING

DATA ON HMG HOME VISITING AND MIECHV HOME VISITING PROGRAMS ARE COLLECTED BY THE OHIO DEPARTMENT OF HEALTH. IN SFY16, HIGHLIGHTS OF THE OUTCOMES ACHIEVED BY OHIO'S HMG AND MIECHV PROGRAMS WERE AS FOLLOWS:

The average length of stay for a child in a home visiting program was 414 days. Forty-two percent of families were enrolled in home visiting prenatally and 38.6 percent of those mothers started receiving services in her first trimester. Nearly all (99.45 percent) of the mothers who received services in their first trimester had one or more pregnancy risks. Seventy one percent of mothers enrolled prenatally reported accessing prenatal care.

Of the moms who enrolled in home visiting in their first trimester and reported smoking, 50 percent of those moms quit smoking. The statewide average of pregnant women who quit smoking was only 17.76 percent.

Mothers in home visiting programs determined by screening to be at high risk for maternal depression was 22.3 percent and 47.2 percent of those moms received a community referral for treatment.

Child developmental screenings of children in home visiting programs resulted in 13.92 percent identified as having a potential developmental delay, 5.09 percent identified as at-risk for social emotional delays and 9.32 percent needed connected to Early Intervention services.

THE NUMBER OF REFERRALS MADE TO HOME VISITING PARTICIPANTS FOR COMMUNITY-BASED SUPPORTS WAS 15,316.

Social:	2,335
Child Care:	922
Electric:	212
Financial:	2,873
Health:	1,351
Gas:	115
WIC:	657
Mental Health:	1,280
EHS	99
Dental:	157
Department of Job and Family Services:	730
Housing:	1,131
Suspected Child Abuse/Neglect:	140
Food:	674
Job Training:	336
School:	881
Medical:	1,423

Of the families served 27.7 percent of them included a teenager as the primary caregiver at childbirth. Thirty percent of adult program participants had less than a high school education.

Program participants identified as 50.24 percent racial/ethnic minority. 8.08 percent of participants identified as being Hispanic, Mexican, Puerto Rican, Latino or Cuban. Of the remaining 91.93 percent of participants who reported being Non-Hispanic, 57.8 percent reported being White, 31.38 percent reported being Black or African American, 6.86 percent reported being White/Black or African American and 1.88 percent reported being Asian.

Over half of participating families (58.10 percent) had household incomes at or below 50 percent Federal Poverty Level (FPL) and 96.90 percent had household incomes at or below 200 percent FPL.

CONCLUSION

Parenting IS DIFFICULT FOR EVERYONE, BUT IT CAN BE PARTICULARLY CHALLENGING FOR LOW-INCOME FAMILIES.

In 2014, there were 136,570 babies born in Ohio. of these, 51.7% were born to low-income families.[32] Home visiting programs offer education and resources to at-risk families who often lack key parenting support and resources.

Research shows home visiting programs work. A number of studies find evidence of effectiveness across a spectrum of home visiting models in improved health outcomes for families and children and reduced need for remedial education.

HOME VISITING PROGRAMS OFFER EDUCATION AND RESOURCES TO AT-RISK FAMILIES WHO OFTEN LACK KEY PARENTING SUPPORT AND RESOURCES.

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HOME VISITING

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CONTACT US:

toll-free: 877.881.7860
info@raiseyourvoiceforkids.org

5246 Broadway Ave., #200
Cleveland, OH 44127

33 N. Third St., Suite 420
Columbus, OH 43215

VISIT:
www.RaiseYourVoiceForKids.org